

SDRC/ CPP Project # 14

Request for Proposals (RFP)
Financial Management Service (FMS)
**San Diego Regional Center
Community Placement Plan
For Fiscal Year 2023-2024**

AUTHORITY

San Diego Regional Center (SDRC) supporting individuals with Intellectual Disabilities has identified a need for a variety of resources throughout San Diego and Imperial counties for individuals with developmental disabilities. **SDRC may elect to fund all, part or none of the projects, depending on funding availability as approved by the Department of Developmental Services (DDS), and the quality of proposals received. SDRC reserves the right to withdraw this RFP and/or disqualify any proposal that does not adhere to the RFP guidelines.** Please refer to the attached project list, which briefly describes the service concept and start-up funding availability. The brief descriptions are not intended to limit the types of proposals that will be considered to serve the identified populations. In fact, applications that propose innovative, person-centered service delivery models, as alternatives to the traditional resources described will be favorably considered. **Please note: Proposals submitted after the indicated timelines will not be considered.**

APPLICANT ELIGIBILITY

Proposals can be submitted by service provider entities that are authorized to conduct business within the state of California. Board members of San Diego-Imperial Counties Developmental Services Inc. and employees of San Diego Regional Center are prohibited from submitting proposals.

SUBMISSION OF PROPOSALS

Please send all proposals **by e-mail only** to:

Erik Peterson, Resource Development Manager
rfp@sdrcc.org

Copies of the proposals must be *received* at the above e-mail address **no later than 4:00 p.m. on Tuesday, March 12, 2024.** Proposals received after this deadline will not be considered. You will receive an email reply confirming receipt of your proposal. **If you do not receive email**

confirmation, your proposal was not received by SDRC. Please follow up by phone with Erik Peterson (858) 576-2872 if you **do not** receive confirmation.

PROJECT DESCRIPTION

San Diego Regional Center (SDRC) is seeking proposals for the development of a Financial Management Service (FMS) business to help individuals enrolled in the Self-Determination Program (SDP), Participant Directed Services, and Supported Employment program(s) pay for authorized services. California state law [Welfare & Institutions Code §4685.8(d)(3)(E)] requires that participants in SDP use an FMS. An FMS provider offers support to individuals by ensuring providers are properly qualified, implementing payment of service providers, and ensuring adherence to all labor and tax laws. There are three types of FMS providers:

1. Bill Payer or Fiscal Agent, this model is used when goods or services are purchased from a business.
2. Co-Employer, this model is used when the participant wants to share some of the employer roles and responsibilities with an FMS.
3. Sole Employer, (also known as the Fiscal/Employer Agent), this model is used when a participant wants to be the direct employer of those providing services.

For participants in the Self-Determination Program, the FMS helps manage their individual budgets and spending plan. An FMS has a duty to report to the regional centers and participants to help inform the budget. An FMS does not control the budget—they execute support for the participant's needs by paying for the services they choose.

Some of the ways an FMS can help are:

- Paying for services, including paying employees
- Assist with hiring employees
- Verifying provider qualification
- Helping providers get criminal background checks
- Helping the participant comply with employment laws and tax requirements

The FMS also makes sure the participant has funds to purchase needed services and support for the entire year. By law, the FMS is required to provide the participant and the regional center with a monthly expenditure report.

[DDS Directive Subject: FINANCIAL MANAGEMENT SERVICES dated December 21, 2018.](#)

Start-up Funding Available up to: \$175,000.

FINANCIAL MANAGEMENT SERVICE REQUIREMENTS

To provide services, an FMS provider must meet the following requirements:

1. Be vendored by a regional center with accordance to general vendorization processes and requirements of Title 17, Sections [54300 – 54390](#).
2. Meet the requirements applicable in Sections [58884](#), [58886](#), and [58887](#) of Title 17 of the California Code of Regulations.
3. File a bond with the vendoring regional center, issued by a surety company to the State of California as principal. The amount may be no less than 20 percent of the total of all individual budgets for participants served via the FMS. The bond needs to be reviewed and renewed annually, or more frequently, if necessary, to ensure the minimum threshold is maintained. This requirement applies to the total of all individual budgets for participants served by FMS during a state fiscal year is expected to be five hundred thousand dollars (\$500,000) or more.
4. Make purchases and submit invoices for only those services and supports identified in the participant's individual program plan and budget.
5. Provide monthly statements to the participant and regional center that include:
 - a. Amount of funds allocated by budget category
 - b. Amount spent in previous 30 days (about 4 and a half weeks)
 - c. Amount of funds remaining in the individual budget
6. Assist in verifying service providers meet requirements, when applicable, for the services they provide. This includes licenses, certifications, education, or experiences.
7. Verify individuals providing direct personal care to the participant, obtain a background check and receive clearance before providing services.
8. Verify providers are not excluded individuals. Defined as those that have been placed on US Department of Health and Human Services Office of Inspectors' General List of Excluded Individuals/Entities, or Medi-Cal Suspended and Ineligible Provider List of persons, or individuals and entities that have been convicted of a criminal offense related to any of the program under Medicare, Medicaid, or the Title XX services program, including Title 17, [Section 54311\(a\)\(6\)](#).
9. Verify the completion of assessment process to ensure that services are provided in settings:
 - a. Designed primarily or exclusively for the provision of services to people with developmental disabilities, or
 - b. Where individuals with developmental disabilities are grouped or clustered for the purpose of providing services

10. Comply with all vendor requirements outlined in Section [54327](#) of Title 17, including reporting to the regional center any special incidents, as defined in this section that the FMS has knowledge of or that has been reported to the FMS by the participant, service provider, or any other person.
11. Agree to accept a [monthly rate](#) for each participant that does not exceed the rate schedule published by the Department's website.
12. Applicant should have a bachelor's degree in business, accounting, finance, human services, and/or related field work. Equivalent professional work experience may be considered.
13. Previous professional experience working within the human services delivery system, preferably one that supports individuals (children and adults) with developmental disabilities strongly preferred.
14. Make purchases and submit invoices for only those services and supports identified in the participant's individual program plan and budget.
15. Knowledge of regional center system, self-determination program.
16. Must be fluent in English in both written and oral communications and place a high priority on hiring staff who speak the language(s), respect, and understand the cultures and values of the people receiving FMS services. * Please note that SDRC's primary languages after English are Spanish and Vietnamese; however, the capacity to accommodate any additional languages are welcome and encouraged.
17. Applicant will not discriminate in the provisions of services based on race, religion, age, disability, sex, or national origin of the individual, or their parents, guardian, or conservator.
18. Upon Approval, must provide proof of or acquire both Commercial General Liability and Professional Liability, Abuse and Molestation Insurance Policies in the amounts of \$1 million per occurrence/\$3 million aggregate with SDRC listed as additionally insured prior to finalization of the vendorization process.
19. Upon approval, must acquire a physical business office and a business license for the associated city with SDRC's catchment area. * P.O. Boxes are only permitted as mailing addresses, and do not qualify to meet the local business office requirement.
20. Upon approval, must develop and submit a first draft program design within (90) days of the award of the contract.

HOME AND COMMUNITY - BASED SETTING (HCBS) REQUIREMENTS

The FMS service provider must meet the regulations issued by the Centers for Medicare and Medicaid Services (CMS) regarding standards that must be met for home and community-based services (HCBS) to continue receiving federal funding. All services selected by an SDP

participant will need to be compliant with the HCBS Final Rule. The prospective provider must ensure that services developed as part of this project are provided in accordance with the HCBS Setting Final Rule and person-centered individualized program plans that focus on the achievement of goals and individual values. <https://www.dds.ca.gov/initiatives/hcbs/>

SERVICE PROVIDER QUALIFICATIONS

A service provider must:

- Proven history of fiscal responsibility, stability, and soundness
- Provide proof of any current and active degrees, credentials, licenses, training certificates and/or skills required or beneficial for the FMS
- An understanding of Person-Centered Practices, the IPP (Individual Program Plan) process, and the legal rights of people with developmental disabilities in California
- History of positive working relationships with the community and applicable government agencies. If applicant is a current service provider, applicant must be in good standing with the regional center
- Proven history in project development, including the ability to complete projects, meet project timelines and manage a project of this size and scope
- Administrative capacity to complete the project and/or implement the service in a timely fashion
- The ability to build positive relationships and communicate with people of diverse backgrounds and abilities
- Relationship management through excellent customer service- with people receiving services, their service coordinators, employees, families, and vendors primarily through phone and email interactions
- Excellent written and oral communication skills
- Excellent organizational and administrative skills

FORMAT AND APPLICATION REQUIREMENTS

Proposals must comply with the instructions, format, and timelines described in this request. Proposals should be written in 12-point font, Times New Roman or Arial preferred. All pages in the proposal must be numbered consecutively and include an identifying footer with the applicant name and project number. The proposal, *including* the required forms and documents, may not be more than (22) pages long. **Each applicant must submit an original proposal in PDF format via email. Hardcopies will not be accepted.**

PROPOSAL CONTENT

Each proposal will contain the following information:

1. Title Page that includes the name of this project, applicant's name, email, address, and phone number.
2. Table of Contents with corresponding page numbers.
3. A description of the applicant's qualification detailing education, knowledge, and experience in the development, management, or operation of an FMS or similar financial project.
4. A description of the applicant's qualifications detailing education, knowledge, and experience providing services to individuals with developmental disabilities.
5. A description of the applicant's mission, values, and vision statements specific to providing FMS services to San Diego Regional Center individuals.
6. Provide a statement outlining the applicant's plan to serve diverse populations, including culturally and linguistically diverse populations.
7. Provide examples of the applicant's commitment to addressing the needs of those diverse populations.
8. Include any additional information that the applicant deems relevant to issues of equity and diversity.
9. A description of prior successful collaboration with San Diego Regional Center and/or other regional centers (if applicable).
10. Job Titles, Descriptions, Qualifications, and Responsibilities for each position that will be developed in the prospective FMS.
11. A description regarding staff recruitment and retention.
12. A description of the staff training plan.
13. A description of how the applicant will screen interested individuals.
14. A description of how the applicant will train and provide education to the participant.
15. A timeline for completion of the project.
16. Include copies of any resumes, licenses, or credentials relevant to the development and success of the proposed project.
17. Provide a completed and signed Applicant/Agency Information form (**Appendix A**). The information provided should highlight the applicant's ability to implement the proposed project. **The form should contain the original signature of an individual with authority to submit the proposal (dated) and enter into a binding contract with San Diego Regional Center.** (1 page)
18. A completed and signed Applicant/Vendor Disclosure Statement (**Appendix B**).
19. Include: (**Appendix C and D**). (2 pages) **Appendix C**: proposed Start-up Project Budget. Start-up funds are intended to assist in the development of new community resources. Start-up funds are not intended to cover 100 percent of the development costs. It is expected that the applicant will identify funds that their agency will provide, along with CPP funds, in order to demonstrate financial capacity to complete the project. DDS may request an estimated and/or final "Sources and Uses" budget, outlining the project cost and funding sources of Regional Center approved project.

Appendix D: Budget and Financial Information.

20. Provide a completed **Sample Monthly Budget for Ongoing Costs** worksheet.
21. **Community Placement Plan** For reference, **Appendix E** (Proposal Review/Selection Criteria) will be used to evaluate the proposal. **This does not need to be submitted with your proposal.**
22. Applicants must demonstrate fiscal responsibility by submitting 2 complete fiscal years and current fiscal year to date financial statements that detail all current and fixed assets and current and long-term liabilities. In addition, the applicant must document the available credit line and provide necessary information for verification.

REPORTING REQUIREMENTS

Each selected project contractor will be required to submit monthly summaries describing progress made toward meeting project objectives to San Diego Regional Center by the third of each month. These summaries will be attached to any monthly invoices submitted by the contractor. The contractor will submit a final report upon completion of the project. The format for the monthly summaries and invoices will be included in each awardee's contract.

Contracts between SDRC and the selected service provider will include the following:

- a) Holding the vendor accountable for the expenditure of funds consistent with the contract terms and for program outcomes;
- b) In the event a project cannot be completed within the approved timeframe, the start-up funds must be returned to the State;
- c) Upon completion of the project and the reconciliation of the contract funds, if SDRC determines that the contract amount has not been fully expended, the unexpended contracted funds will be recouped by SDRC and returned to the State; and
- d) The Department of Developmental Services may request the Regional Center to provide a copy of the fully executed Regional Center/Vendor Start-up contracts.

PROPOSAL SELECTION PROCESS

Any proposal may be rejected if it is incomplete or deviates from the specifications in this RFP. **San Diego Regional Center reserves the right to reject any or all proposals and to cancel the RFP process at its discretion.** Each proposal will be evaluated by an RFP Selection Committee which is an interdisciplinary team of at least 3 members, who will score each proposal individually before coming together as a team to thoroughly review and discuss each proposal and interview applicants, if applicable, and agreeing on a final score for each proposal. A minimum score of 70% is required for the proposal in order to be considered.

Proposals will be evaluated in five areas: Agency Description (including history), Project Description, Work Plan/Timelines, Budget/Finances, and Proposal responsiveness. The specific criteria and weighting are detailed in Appendix E, Rating Criteria. Additional

information may be required from selected applicants with regard to the proposal submitted prior to the awarding of a contract. References will be contacted and interviews may be conducted, particularly if two or more proposals are closely scored and/or more information is needed. The interview panel will include at least two individuals from the RFP selection committee, using the same questions, and each interviewer will score the responses using the same scoring scale for each interview.

FUNDS

Project descriptions indicate the total amount of funds available for each project. **Actual amount awarded will be contingent upon the budget submitted by the Department of Developmental Services (DDS). Any project contractor who fails to develop the services specified will be required to return to the San Diego Regional Center any compensation received for start-up expenses.** All funds must be expended by March 31, 2027.

ADDITIONAL INFORMATION

Any questions regarding the requirements of this RFP should be directed to:

San Diego Regional Center-Community Services
Erik Peterson, Resource Development Manager
4355 Ruffin Rd., Suite 104
San Diego, CA 92123
(858) 576-2872 or Erik.Peterson@sdrcc.org

APPLICANT/AGENCY INFORMATION

Applicant/Agency Name _____ CPP Project # _____

Address: _____ Phone: _____

- Non-Profit Corporation For-Profit Corporation
- Educational Institution
- Local Government Agency Individual
- Other(_____)

Contact Person's Name and Job Title: _____ Phone _____

E-Mail: _____

A. List up to four current or previous services implemented by the applicant/agency that provide evidence of experience related to your proposal. Include the service name, the dates that services started (and ended if not currently being provided), and a one sentence description of the type/purpose of the indicated service:

- 1. _____

- 2. _____

- 3. _____

- 4. _____

B. List two references that can be contacted in regards to applicant's experience, qualifications and ability to implement this proposal:

- 1. _____
Name and Title Agency Affiliation
_____ Address Phone
- 2. _____
Name and Title Agency Affiliation
_____ Address Phone

Application submitted by _____
Signature Date

APPLICANT/VENDOR DISCLOSURE STATEMENT

GENERAL INSTRUCTIONS

Every applicant or vendor must complete and submit a current Applicant/Vendor Disclosure Statement, DS 1891 (disclosure statement) as part of a complete application packet for vendorization or upon request of the vendoring regional center. The following instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. See 42 CFR 455.101 for additional definitions.

Overall Authority: Code of Federal Regulations (CFR), Title 42, Part 455; California Code of Regulations, Title 17, Section 54311. Welfare and Institutions Code, Section 4648.12.

Important:

- **IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.**
- **Parents and consumers of Vouchers, Participant-Directed Services, or Purchase Reimbursements:** Complete Part 1 on page 2 and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date.
- Failure to disclose complete and accurate information will result in a denial of enrollment and/or may be cause for termination of vendorization.
- Read **ALL** instructions when completing the disclosure statement.
- Type or print clearly in ink.
- If applicant or vendor must make corrections, please line through, date, and initial in ink. Do not use correction fluid.
- Answer all questions as of the current date.
- If additional space is needed, attach a sheet referencing the part and question being completed.
- Return this completed statement with the complete application package to the regional center to which you are applying.

Part 1: Identifying Information

- A. Specify name of the applicant or vendor, agency, facility or organization, vendor number and service code, business address, and telephone number of applicant or vendor submitting the vendor application.
- B. Specify in what capacity the applicant or vendor is doing business. For example: The name of the corporation under which they are doing business. This name must match the license name, if applicable.
- C. List the National Provider Identifier, of the applicant or vendor, if any.
- D. List the Social Security Number, Date of Birth, and/or the Federal Employer Identification Number (EIN) of the applicant or vendor, if any. Enter Vendor's nine-digit EIN assigned by the IRS in the following format: XX-XXXXXXX.
 - An EIN is used to identify the accounts of employers and certain others who have no employees.
 - For more information about an EIN, please check <http://www.irs.gov> for "Employer Identification Numbers" or "EIN". Whenever this Disclosure Statement requests an EIN about an individual or entity, it has the same meaning.
- E. Check the entity type that best describes the structure of your organization.

Part 2: Ownership and Control Interests. Use the following definitions to identify the individuals you should enter in A, B and C of this section. See 42 CFR 455.101 for additional definitions.

- "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in the applicant or vendor. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or vendor;
- "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, agency or business entity;
- "Ownership Interest" means the possession of equity in the capital, the stock, or the profits of the applicant or vendor.
- "Person with an Ownership or Control Interest" means a person or corporation that:
 - A) Has an ownership interest totaling 5 percent or more in an applicant or vendor;
 - B) Has an indirect ownership interest equal to 5 percent or more of an applicant or vendor;
 - C) Has a combination of direct or indirect ownership interests equal to 5 percent or more in an applicant or vendor;
 - D) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or vendor if that interest equals at least 5 percent of the value of the property or assets of the applicant or vendor;
 - E) Is an officer or director of an applicant or vendor that is organized as a corporation; or
 - F) Is a partner in an applicant or vendor that is organized as a partnership.
- "Significant Business Transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of an applicant or vendor's total operating expenses.

- “Subcontractor” means an individual, agency, or organization to which an applicant or vendor has contracted or delegated some of the management functions or responsibilities of providing services.
- “Wholly Owned Supplier” means a supplier whose total ownership interest is held by an applicant or vendor or by a person, persons, or other entity with an ownership or control interest in an applicant or vendor.

Part 3: Excluded Individuals or Entities. (See page 3. Must be disclosed if applicable.)

“Excluded Individuals or Entities” means those individuals and entities that have been placed on either the U.S. Department of Health and Human Services Office of Inspectors’ General (OIG) List of Excluded Individuals/Entities or the Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible Provider List of persons, or individuals and entities that have been convicted of a criminal offense related to involvement in any program under Medicare, Medicaid or the Title XX services program, or those individuals and entities that meet the criteria included in Title 17, Section 54311(a)(6).

**Title 17, California Code of Regulations, Section 54311(a)(6)
(Criteria for Excluded Individuals or Entities)**

The name, title and address of any person(s) who, as applicant or vendor, or who has ownership or control interest in the applicant or vendor, or is an agent, director, members of the board of directors, officer, or managing employee of the applicant or vendor, has within the previous ten years:

- (A) Been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of an elder or dependent adult or child, or in any connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse; or
- (B) Been found liable any civil proceeding for fraud or abuse involving any government program; or
- (C) Entered into a settlement in lieu of conviction involving fraud or abuse in any government program.

PLEASE FILL OUT

Part 1. Applicant/Vendor Information

A. Name of applicant or vendor, entity, agency, facility, or organization as reported to IRS:

Vendor Number and Service Code:

Business Address:

Telephone number (with area code):

B. Name registered with California Secretary of State, if any:

C. National Provider Identifier (NPI), if any:

D. Social Security Number (SSN), Date of Birth (DOB), and/or Federal Employer Identification Number (EIN), if any:

E. Check the entity type that best describes the structure of the applicant or vendor individual, business entity, agency, facility or organization: Check **only one** box:

- Parent or Consumer for Vouchers, Participant-Directed Services, or Purchase Reimbursements** (Complete Part 1 above and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date).
- Sole Proprietor (Unincorporated)**
- General Partnership** **Limited Partnership** **Limited Liability Partnership**
- Limited Liability Company:** **State of formation:** _____
- Governmental**
- Corporation:** **Corporate number:** _____ **State incorporated:** _____
- Nonprofit – Check One:** **Unincorporated Association** **Religious/Charitable**
- Corporation** **Other (specify):** _____

Part 2. Ownership, indirect ownership, and managing employee interests (If not applicable, please indicate.)

A. List the name(s), title(s), address(es), SSNs, and DOBs of individuals for organizations having direct or indirect ownership interests, and/or managing employees in the applicant/vendor (see instructions for definitions). Also list all members of a group practice. Attach additional pages as necessary to list all officers, owners, management and ownership individuals and entities.

Name	Title	Address	SSN	DOB

B. List those persons named in ‘A’ above or ‘Part 4. A’ below, that are related to each other as spouse, parent, child, or sibling.

Name	Relationship	Address

C. List the name, address, vendor number and service code, SSN, NPI and/or EIN of any other applicant or vendor in which a person with an ownership or controlling interest in the applicant or vendor also has an ownership or control interest of at least 5 percent or more. For example: Are any owners of the applicant or vendor also owners of Medicare or Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.)

Name	Address	Vendor Number and Service Code	SSN, NPI and/or EIN

Part 3. Excluded Individuals or Entities (If not applicable, please indicate.)

List the name, title, and address of any person, as applicant or vendor, or entity with an ownership or control interest, any agent, director, officer, or managing employee of the applicant or vendor who is an excluded individual or entity, as defined on page 2.

Name	Title	Address

Part 4. Subcontractor (If not applicable, please indicate.)

A. List the name, title, address, SSN, NPI and/or EIN of each person or entity with an ownership or control interest in any **subcontractor** in which the applicant or vendor has direct or indirect ownership of 5 percent or more. State percentage.

Name	Title	Address	Percentage	SSN, NPI and/or EIN

B. List the name, title, address, SSN, NPI and/or EIN of each **subcontractor or wholly owned supplier** in which the applicant or vendor has had any significant business transactions within 5 years of the application or request.

Name	Title	Address	SSN, NPI, and/or EIN

APPLICANT/VENDOR SIGNATURE

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become vendored, or if the service provider already is vendored, a termination of its vendorization.

By signing this disclosure statement, you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform the vendoring Regional Center, in writing, within 30 days of any changes or if additional information becomes available.

Name of Applicant/Vendor or Authorized Representative **Title**

Signature **Date**

Recordkeeping and Access to Records

Subject to the provisions of Title 17, California Code of Regulations, Section 54311 and Code of Federal Regulations, Title 42, Part 455.105, an applicant or vendored provider agrees to provide access for the review of any and all ownership disclosure information and/or documentation upon written request by the vendoring regional center, the Department of Developmental Services, the State Medicaid Agency, Department of Health Care Services, any State survey team, the Secretary of the United States Department of Health and Human Services, or any duly authorized representatives of the above named entities.

Privacy Statement

All information requested on the application and the disclosure statement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department of Developmental Services pursuant to 26 USC 6041. This information is required by the authority of Welfare and Institutions Code, Section 4648.12 and Title 17, California Code of Regulations, Section 54311. The consequences of not supplying the mandatory information requested are denial of vendorization as a regional center vendor or termination of vendorization. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, or licensing programs in other states.

BUDGET AND FINANCIAL INFORMATION

Applicant/Agency Name _____ CPP Project # _____

FINANCIAL STATUS AS OF _____, 20____

Line of Credit Available? 0 Yes LI No Amount _____

ASSETS

Cash on hand and in commercial and savings accounts _____

Notes and Receivables _____

Inventory, Equipment, Furniture and Furnishings _____

Real Estate (Market Value) _____

Other Assets: _____

TOTAL ASSETS _____

LIABILITIES

Accounts and Notes Payable (Balance Due) _____

Salaries and Wages Payable _____

Real Estate Loans or Mortgages (Balance Due) _____

Payroll and Real Estate Taxes Payable _____

Other Liabilities: _____

TOTAL LIABILITIES _____

Reference who may be contacted regarding applicant's/agency's qualifications and experience in financial management:

Name/Title _____ Agency/Company _____

Address _____ Phone _____

Budget/Financial Information Submitted by _____
Name Date

BUDGET FOR PROJECT START-UP

PERSONNEL SERVICES (Staff and Consultants)

Job Title	Number (or %) FTE	FTE Monthly Salary with Fringe Benefit	Number of Months	TOTAL
2 .				
3 .				
4 .				
5 .				
Employee Fringe Benefits (_____ % of Salaries)				
START-UP PERSONNEL SERVICES SUBTOTAL				

OPERATING EXPENSES

	Monthly Amount	Number of Months	TOTAL
Office and/or Facility Lease			
Insurance			
Utilities			
Travel			
Purchased Equipment and Supplies (list)			
2 .			
3 .			
4 .			
5 .			
Other-			
Administrative Overhead			
START-UP OPERATING EXPENSES SUB-TOTAL			

TOTAL START-UP
BUDGET

Submitted by

Name

Date

COMMUNITY PLACEMENT PLAN REQUEST FOR PROPOSAL

PROPOSAL REVIEW/SELECTION CRITERIA

(The minimum requirement will be 70% of the total possible points)

Project Number _____ Applicant /Agency _____

	Maximum Score	Initial Proposal Score	Final Score
A. Agency Description			
1. The applicant/agency has prior relevant experience and credentials in the developmental disabilities and/or mental health field.	10		
2. The applicant/agency’s philosophy is positive, consumer oriented and appropriate to the goals of the proposed project.	5		
3. The applicant/agency’s history indicates the capability of developing, managing, and operating the proposed project in San Diego County.	10		
B. Project Description			
1. The expected service outcomes are clear and consistent with the goals of the proposed project.	5		
2. The proposed use of personnel (direct care staff and consultants), including the selection, management and training of staff should ensure quality outcomes in the project.	15		
3. The plan for providing services, including the description of the needs of the consumers who will be served, is consistent with the goals of the project.	5		
C. Work Plan/Timelines			
1. The work plan indicates a thorough knowledge of the processes and procedures needed to complete the project.	10		
2. The timeline for project development is realistic and meets deadlines.	10		
D. Budget/Finances			
1. The applicant/agency’s financial statement reflects sound fiscal practices. Assets are sufficient to undertake the proposed project.	5		
2. The start-up budget is reasonable and demonstrates a good appraisal of actual costs involved in completing the project.	5		
3. The estimate for on-going service rate is cost-effective and consistent with funding for similar programs.	5		
E. Proposal Responsiveness			
1. The overall proposal indicates an ability to follow directions and is an appropriate response to the RFP	10		
2. The proposal provides evidence of innovative practices in providing services.	5		
TOTAL	100		

Proposal review completed by: _____ Signature _____ Date _____

APPLICANT/AGENCY INFORMATION

Applicant/Agency Name _____ CPP Project # _____

Address: _____ Phone: _____

- Non-Profit Corporation For-Profit Corporation
- Educational Institution
- Local Government Agency Individual
- Other(_____)

Contact Person's Name and Job Title: _____ Phone _____

E-Mail: _____

A. List up to four current or previous services implemented by the applicant/agency that provide evidence of experience related to your proposal. Include the service name, the dates that services started (and ended if not currently being provided), and a one sentence description of the type/purpose of the indicated service:

- 1. _____

- 2. _____

- 3. _____

- 4. _____

B. List two references that can be contacted in regards to applicant's experience, qualifications and ability to implement this proposal:

- 1. _____
Name and Title Agency Affiliation
_____ Address Phone
- 2. _____
Name and Title Agency Affiliation
_____ Address Phone

Application submitted by _____
Signature Date

APPLICANT/VENDOR DISCLOSURE STATEMENT

GENERAL INSTRUCTIONS

Every applicant or vendor must complete and submit a current Applicant/Vendor Disclosure Statement, DS 1891 (disclosure statement) as part of a complete application packet for vendorization or upon request of the vendoring regional center. The following instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. See 42 CFR 455.101 for additional definitions.

Overall Authority: Code of Federal Regulations (CFR), Title 42, Part 455; California Code of Regulations, Title 17, Section 54311. Welfare and Institutions Code, Section 4648.12.

Important:

- **IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.**
- **Parents and consumers of Vouchers, Participant-Directed Services, or Purchase Reimbursements:** Complete Part 1 on page 2 and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date.
- Failure to disclose complete and accurate information will result in a denial of enrollment and/or may be cause for termination of vendorization.
- Read **ALL** instructions when completing the disclosure statement.
- Type or print clearly in ink.
- If applicant or vendor must make corrections, please line through, date, and initial in ink. Do not use correction fluid.
- Answer all questions as of the current date.
- If additional space is needed, attach a sheet referencing the part and question being completed.
- Return this completed statement with the complete application package to the regional center to which you are applying.

Part 1: Identifying Information

- A. Specify name of the applicant or vendor, agency, facility or organization, vendor number and service code, business address, and telephone number of applicant or vendor submitting the vendor application.
- B. Specify in what capacity the applicant or vendor is doing business. For example: The name of the corporation under which they are doing business. This name must match the license name, if applicable.
- C. List the National Provider Identifier, of the applicant or vendor, if any.
- D. List the Social Security Number, Date of Birth, and/or the Federal Employer Identification Number (EIN) of the applicant or vendor, if any. Enter Vendor's nine-digit EIN assigned by the IRS in the following format: XX-XXXXXXX.
 - An EIN is used to identify the accounts of employers and certain others who have no employees.
 - For more information about an EIN, please check <http://www.irs.gov> for "Employer Identification Numbers" or "EIN". Whenever this Disclosure Statement requests an EIN about an individual or entity, it has the same meaning.
- E. Check the entity type that best describes the structure of your organization.

Part 2: Ownership and Control Interests. Use the following definitions to identify the individuals you should enter in A, B and C of this section. See 42 CFR 455.101 for additional definitions.

- "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in the applicant or vendor. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or vendor;
- "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, agency or business entity;
- "Ownership Interest" means the possession of equity in the capital, the stock, or the profits of the applicant or vendor.
- "Person with an Ownership or Control Interest" means a person or corporation that:
 - A) Has an ownership interest totaling 5 percent or more in an applicant or vendor;
 - B) Has an indirect ownership interest equal to 5 percent or more of an applicant or vendor;
 - C) Has a combination of direct or indirect ownership interests equal to 5 percent or more in an applicant or vendor;
 - D) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or vendor if that interest equals at least 5 percent of the value of the property or assets of the applicant or vendor;
 - E) Is an officer or director of an applicant or vendor that is organized as a corporation; or
 - F) Is a partner in an applicant or vendor that is organized as a partnership.
- "Significant Business Transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of an applicant or vendor's total operating expenses.

- “Subcontractor” means an individual, agency, or organization to which an applicant or vendor has contracted or delegated some of the management functions or responsibilities of providing services.
- “Wholly Owned Supplier” means a supplier whose total ownership interest is held by an applicant or vendor or by a person, persons, or other entity with an ownership or control interest in an applicant or vendor.

Part 3: Excluded Individuals or Entities. (See page 3. Must be disclosed if applicable.)

“Excluded Individuals or Entities” means those individuals and entities that have been placed on either the U.S. Department of Health and Human Services Office of Inspectors’ General (OIG) List of Excluded Individuals/Entities or the Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible Provider List of persons, or individuals and entities that have been convicted of a criminal offense related to involvement in any program under Medicare, Medicaid or the Title XX services program, or those individuals and entities that meet the criteria included in Title 17, Section 54311(a)(6).

**Title 17, California Code of Regulations, Section 54311(a)(6)
(Criteria for Excluded Individuals or Entities)**

The name, title and address of any person(s) who, as applicant or vendor, or who has ownership or control interest in the applicant or vendor, or is an agent, director, members of the board of directors, officer, or managing employee of the applicant or vendor, has within the previous ten years:

- (A) Been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of an elder or dependent adult or child, or in any connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse; or
- (B) Been found liable any civil proceeding for fraud or abuse involving any government program; or
- (C) Entered into a settlement in lieu of conviction involving fraud or abuse in any government program.

PLEASE FILL OUT

Part 1. Applicant/Vendor Information

A. Name of applicant or vendor, entity, agency, facility, or organization as reported to IRS:

Vendor Number and Service Code:

Business Address:

Telephone number (with area code):

B. Name registered with California Secretary of State, if any:

C. National Provider Identifier (NPI), if any:

D. Social Security Number (SSN), Date of Birth (DOB), and/or Federal Employer Identification Number (EIN), if any:

E. Check the entity type that best describes the structure of the applicant or vendor individual, business entity, agency, facility or organization: Check **only one** box:

- Parent or Consumer for Vouchers, Participant-Directed Services, or Purchase Reimbursements** (Complete Part 1 above and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date).
- Sole Proprietor (Unincorporated)**
- General Partnership** **Limited Partnership** **Limited Liability Partnership**
- Limited Liability Company:** **State of formation:** _____
- Governmental**
- Corporation:** **Corporate number:** _____ **State incorporated:** _____
- Nonprofit – Check One:** **Unincorporated Association** **Religious/Charitable**
 Corporation **Other (specify):** _____

Part 2. Ownership, indirect ownership, and managing employee interests (If not applicable, please indicate.)

A. List the name(s), title(s), address(es), SSNs, and DOBs of individuals for organizations having direct or indirect ownership interests, and/or managing employees in the applicant/vendor (see instructions for definitions). Also list all members of a group practice. Attach additional pages as necessary to list all officers, owners, management and ownership individuals and entities.

Name	Title	Address	SSN	DOB

B. List those persons named in ‘A’ above or ‘Part 4. A’ below, that are related to each other as spouse, parent, child, or sibling.

Name	Relationship	Address

C. List the name, address, vendor number and service code, SSN, NPI and/or EIN of any other applicant or vendor in which a person with an ownership or controlling interest in the applicant or vendor also has an ownership or control interest of at least 5 percent or more. For example: Are any owners of the applicant or vendor also owners of Medicare or Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.)

Name	Address	Vendor Number and Service Code	SSN, NPI and/or EIN

Part 3. Excluded Individuals or Entities (If not applicable, please indicate.)

List the name, title, and address of any person, as applicant or vendor, or entity with an ownership or control interest, any agent, director, officer, or managing employee of the applicant or vendor who is an excluded individual or entity, as defined on page 2.

Name	Title	Address

Part 4. Subcontractor (If not applicable, please indicate.)

A. List the name, title, address, SSN, NPI and/or EIN of each person or entity with an ownership or control interest in any **subcontractor** in which the applicant or vendor has direct or indirect ownership of 5 percent or more. State percentage.

Name	Title	Address	Percentage	SSN, NPI and/or EIN

B. List the name, title, address, SSN, NPI and/or EIN of each **subcontractor or wholly owned supplier** in which the applicant or vendor has had any significant business transactions within 5 years of the application or request.

Name	Title	Address	SSN, NPI, and/or EIN

APPLICANT/VENDOR SIGNATURE

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become vendored, or if the service provider already is vendored, a termination of its vendorization.

By signing this disclosure statement, you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform the vendoring Regional Center, in writing, within 30 days of any changes or if additional information becomes available.

Name of Applicant/Vendor or Authorized Representative **Title**

Signature **Date**

Recordkeeping and Access to Records

Subject to the provisions of Title 17, California Code of Regulations, Section 54311 and Code of Federal Regulations, Title 42, Part 455.105, an applicant or vendored provider agrees to provide access for the review of any and all ownership disclosure information and/or documentation upon written request by the vendoring regional center, the Department of Developmental Services, the State Medicaid Agency, Department of Health Care Services, any State survey team, the Secretary of the United States Department of Health and Human Services, or any duly authorized representatives of the above named entities.

Privacy Statement

All information requested on the application and the disclosure statement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department of Developmental Services pursuant to 26 USC 6041. This information is required by the authority of Welfare and Institutions Code, Section 4648.12 and Title 17, California Code of Regulations, Section 54311. The consequences of not supplying the mandatory information requested are denial of vendorization as a regional center vendor or termination of vendorization. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, or licensing programs in other states.

BUDGET AND FINANCIAL INFORMATION

Applicant/Agency Name _____ CPP Project # _____

FINANCIAL STATUS AS OF _____, 20____

Line of Credit Available? 0 Yes LI No Amount _____

ASSETS

Cash on hand and in commercial and savings accounts _____

Notes and Receivables _____

Inventory, Equipment, Furniture and Furnishings _____

Real Estate (Market Value) _____

Other Assets: _____

TOTAL ASSETS _____

LIABILITIES

Accounts and Notes Payable (Balance Due) _____

Salaries and Wages Payable _____

Real Estate Loans or Mortgages (Balance Due) _____

Payroll and Real Estate Taxes Payable _____

Other Liabilities: _____

TOTAL LIABILITIES _____

Reference who may be contacted regarding applicant's/agency's qualifications and experience in financial management:

Name/Title _____ Agency/Company _____

Address _____ Phone _____

Budget/Financial Information Submitted by _____
Name Date

BUDGET FOR PROJECT START-UP

PERSONNEL SERVICES (Staff and Consultants)

Job Title	Number (or %) FTE	FTE Monthly Salary with Fringe Benefit	Number of Months	TOTAL
2 .				
3 .				
4 .				
5 .				
Employee Fringe Benefits (_____ % of Salaries)				
START-UP PERSONNEL SERVICES SUBTOTAL				

OPERATING EXPENSES

	Monthly Amount	Number of Months	TOTAL
Office and/or Facility Lease			
Insurance			
Utilities			
Travel			
Purchased Equipment and Supplies (list)			
2 .			
3 .			
4 .			
5 .			
Other-			
Administrative Overhead			
START-UP OPERATING EXPENSES SUB-TOTAL			

TOTAL START-UP
BUDGET

Submitted by

Name

Date

COMMUNITY PLACEMENT PLAN REQUEST FOR PROPOSAL

PROPOSAL REVIEW/SELECTION CRITERIA

(The minimum requirement will be 70% of the total possible points)

Project Number _____ Applicant /Agency _____

	Maximum Score	Initial Proposal Score	Final Score
A. Agency Description			
1. The applicant/agency has prior relevant experience and credentials in the developmental disabilities and/or mental health field.	10		
2. The applicant/agency’s philosophy is positive, consumer oriented and appropriate to the goals of the proposed project.	5		
3. The applicant/agency’s history indicates the capability of developing, managing, and operating the proposed project in San Diego County.	10		
B. Project Description			
1. The expected service outcomes are clear and consistent with the goals of the proposed project.	5		
2. The proposed use of personnel (direct care staff and consultants), including the selection, management and training of staff should ensure quality outcomes in the project.	15		
3. The plan for providing services, including the description of the needs of the consumers who will be served, is consistent with the goals of the project.	5		
C. Work Plan/Timelines			
1. The work plan indicates a thorough knowledge of the processes and procedures needed to complete the project.	10		
2. The timeline for project development is realistic and meets deadlines.	10		
D. Budget/Finances			
1. The applicant/agency’s financial statement reflects sound fiscal practices. Assets are sufficient to undertake the proposed project.	5		
2. The start-up budget is reasonable and demonstrates a good appraisal of actual costs involved in completing the project.	5		
3. The estimate for on-going service rate is cost-effective and consistent with funding for similar programs.	5		
E. Proposal Responsiveness			
1. The overall proposal indicates an ability to follow directions and is an appropriate response to the RFP	10		
2. The proposal provides evidence of innovative practices in providing services.	5		
TOTAL	100		

Proposal review completed by: _____ Signature _____ Date _____