SDRC/CPP Project # 6

Request for Proposals (RFP)
Community Crisis Group Home
San Diego Regional Center
Community Placement Plan
For Fiscal Year 2019-2020

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 transitioning from and Institution for Metal Disease (IMD), other emergency facilities, and/or community settings to a less restrictive environment. This project will be in collaboration with a Non-Profit Ownership (NPO). **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
erik.peterson@sdrc.org

Copies of the proposals must be *received* at the above e-mail address **no later than 4:00 p.m. on March 9, 2020.** 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 if you **do not** receive confirmation.

PROJECT DESCRIPTION

San Diego Regional Center has identified the need to create a Community Crisis Group Home (CCH) to serve 4 Foster Dual Agency children. The facility will be owned by a Non-Profit Ownership (NPO) and leased to a service provider who will be selected through this Request for Proposal (RFP) process. The service provider's development team will work with the NPO and Regional Center staff to develop renovation designs for the physical plant structure to support the anticipated behavioral, physical, security and supervision needs of the individuals who will reside at the home.

A children's CCH means a group home residential facility certified by the Department of Developmental Services (DDS) and licensed by the Department of Social Services (DSS) that provides 24-hour nonmedical care to individuals with developmental disabilities receiving regional center services and in need of crisis intervention services, and individuals who are transitioning from and/or at risk of entering into a more restrictive environment. A Community Crisis Home is eligible for, and must meet all the requirements for vendorization as a residential facility by a Regional Center.

The service provider will be expected to:

- Provide intensive behavioral and mental health services for dually diagnosed clients.
- Have an administrator who provides a highly structured environment and program to serve individuals in crisis with behavioral challenges such as aggression, property destruction, self-injury, and elopement.
- Stabilize individuals in crisis with challenging needs and assist in transitioning to a less restrictive environment.
- Provide a specific plan for achieving stabilization with respect to crisis home exit plan (30, 60, 90 day plan).

Start-up funding Available: $250,000

FORMAT AND APPLICATION REQUIREMENTS

Proposals must comply with the instructions, format, and time lines 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: **Please refer to** Welfare and Institutions Code, starting in section 4698 and in Title 17 emergency regulations, starting with Section 59000 for regulations.

1. **Service Description Summary (12 pages maximum):** Please include all headings and information requested below and provide in the same order in your document.

    a. **Mission, Vision, and Value Statements:** Provide agency MVV statements related to the proposed project.

    b. **Agency Outcomes:** Describe anticipated outcomes of proposed service for people residing the homes and how achievement of outcomes will be measured.

    c. **Assessment and Planning:** Briefly describe the planning process. How will individuals' goals/objectives be determined and progress measured? How will individuals' supports and services be determined prior to moving into a facility? Please include a description of the entry criteria for individuals who will be served by the project.

    d. **Staff Training:** Describe the topics to be covered in staff training, types of training that will occur (e.g., pre-service, on-the-job training, continuing education), who will provide the training, roles of in-house vs. contract consultants, and the specific types of crisis prevention training (e.g., Crisis Prevention Institute or Professional Crisis Management Association) that will be included. Initial and ongoing training, including required certifications. Include any specialized training for providing mental health treatment, behavior support and crisis intervention to individuals who may have a dual diagnosis (mental health diagnosis and intellectual/developmental disability) and may potentially have danger behaviors.

    e. **Program Plan requirements:** Include the following:

        i. CCH shall have a facility program plan which is approved by DDS. Describe the components of this plan.

        ii. Describe the pre-admissions procedures and identify staff responsible for admissions.

        iii. Describe how the facility will ensure appropriate services and supports at the time of admission to meet the client's immediate needs pending the development of the individual behavioral support plan.

        iv. Describe the services to be provided for the clients residing in the home.

v. Staff requirements: Please list the qualifications and educational requirements for administrator, consultants including but not limited to: psychiatrist, BCBA, psychologist, recreational therapist and nutritionist), direct care lead staff and direct care professionals. Describe staff training.

vi. Each resident will have an "individual behavior supports plan" developed by the "individual's behavior supports team". Describe and address the components of the plan and the members of the "individual's behavior supports team".

vii. Describe the monitoring process of the home as required by law. Include the roles of Regional Center and DDS.

viii. Describe the facilities Continuous Quality Improvement system.

f. **Staff Recruitment and Retention:** Describe your plan to recruit and retain quality staff.

g. **Staffing Schedule:** Provide a sample one-week staffing schedule including Administrator/Assistant Administrator, direct support professionals, consultants, and program prep time.

h. **Transportation:** Describe how transportation will be provided for day/school services, therapy, medical appointments, recreation, legal appointments and other activities.

i. **Community Outreach:** Describe how your county agency collaboration will engage the local community and community agencies to engender support for this project. List which groups or agencies (e.g., city council, probation, judicial, law enforcement, mental health, etc.) you will approach, how you will approach them, and how you will address their objections or ambivalence to ensure successful collaboration for this project.

j. **Equity and Diversity:** Each proposal will include a section on issues of equity and diversity. The plan will address diverse population, including, but not limited to, culturally and linguistically diverse populations. You must also include examples of your commitment in addressing the needs of those diverse populations, and include any relevant issues you deem relevant to equity and diversity. Projects developed specifically for identified clients will only require plans to provide culturally and linguistically competent services and supports to those specific clients.

2. **Development Team:** List the members of the proposed Project Development Team including the name, qualifications and title of the team members. At a minimum, this team should include the lead staff that will develop the response to the RFP, the

service design, and the individuals with the expertise to hire skilled consultants and staff to assist the provider in developing the project. **If the applicant's mailing address is outside of San Diego/Imperial County area, the name and qualifications of the person who will be physically located in San Diego/Imperial County area and responsible for managing the proposed project must be included**. (1 page)

3. **Applicant/Agency Information Form:** 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)

4. **Applicant Disclosure Statement:** A completed and signed Applicant/Vendor Disclosure Statement **(Appendix B).** (4 pages)

5. **Financial Information:** Include: **(Appendix C (C(a), C(b) DS6023, DS6024, 4 pages total)** (a) 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 C. (b) Budget and Financial Information, and (c) **Proposed Rate Structure:** The rate structure for an EBSH will be established for a facility cost (which is fixed) and an individual cost which is based on the client's need. Include a sample on the forms DS 6023 and DS 6024).

6.

7. **Community Placement Plan** For reference, **Appendix D** (Proposal Review/Selection Criteria) will be used to evaluate the proposal. **This does not need to be submitted with your proposal.**

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 D, 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, 2022.

Key Objectives of this project:
1. Acquisition of property and development of the facility - NPO responsibility.
2. Submit licensing application to Community Care Licensing.
3. Submit a full program design for the facility to SDRC.
4. Assess clients who are being referred to project.
4. Hire and train staff.
5. Obtain the services of appropriate licensed consultants.
6. Obtain appropriate licensure for the facility.
7. Admit four (4) residents identified by San Diego Regional Center by 6/30/21.

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

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

State of California—Health and Human Services Agency Department of Developmental Services
DS 1891 (7/2011)

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.ciov 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 (01G) 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:

O 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 C)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 ApplicantNendor 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.

Appendix C (b)

BUDGET AND FINANCIAL INFORMATION

Applicant/Agency Name _____CPP Project # _____

FINANCIAL STATUS AS OF _____, 20____

Line of Credit Available? ☐ Yes ☐ 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

Proposed BUDGET Start Up Costs

ITEM	PROJECTED COSTS
Salaries/Wages	
Fringe Benefits	
Administrative Overhead	
Consultant(s)	
General Expenses	
Rent	
Staff Training	
Utilities	
Equipment	_____
Office Supplies	
Travel	
Other (Specify)	_____
	$_____
	Total Projected Costs
	_____
	_____
	_____
	_____

In addition to the projected cost for each line item, be sure to include a narrative detailed breakdown (on a separate sheet of paper) of how <u>each</u> line item was constructed.

RATE DEVELOPMENT - FACILITY COSTS

DS 6023 (Rev 10/2016)

Reset Form

A. FACILITY TYPE

☐ Enhanced Behavioral Supports Home ☐ Community Crisis Home ☐ Other_____

B. CONTACT INFORMATION

Vendor Name:	Vendor #
Address:	
City:	State: Zip:

C. CATEGORIES AND DESCRIPTIONS OF COSTS

	Total Monthly Cost	Notes
1. Payroll Costs		
a. Administrator Salary		
b. Administrator Payroll Taxes		
c. DSP Lead Salary (168 Hours/Week)		
d. DSP Lead Payroll Taxes		
e. Workers Compensation		
f. Benefit Allowance: Medical, Dental, etc.		
g. Other Costs: Describe in notes		
Total Administrator Payroll Costs	$ 0.00	
2. Facility Related		
a. Rental, Lease, or Mortgage, include Homeowner's Assoc. Dues		
b. Property Taxes		
c. Combined Utilities: Gas, Electric, Water, Garbage		
d. Janitorial Service, Gardening		
e. Transportation: Vehicle, Maintenance, Fuel (not DP/School)		
f. Telephone: Long Distance, Cell Phones, Pagers		
g. Office Supplies		
h. Insurance: Business Liability, Auto		
i. Fees for Licenses and Memberships		
j. Other Costs: Repairs/Maintenance/Modifications		
k. Other Costs: Cable and Internet		
l. Other Costs: Describe in notes		
Total Facility Related Costs	$ 0.00	
TOTAL FACILITY COSTS	$ 0.00	

D. SIGNATURES

Vendor Signature: **Date:**

Print Name:

Regional Center Representative Signature: **Date:**

Print Name:

RATE DEVELOPMENT - INDIVIDUAL COSTS ASSOCIATED WITH RESIDENCY

DS 6024 (REV 10/2016)

Reset Form

A. FACILITY TYPE

☐ Enhanced Behavioral Supports Home ☐ Community Crisis Home ☐ Other_____

B. CONTACT INFORMATION

Consumer Name:		UCI #
Vendor Name:		Vendor #
Vendor Address:		
City:	State:	Zip:

C. CATEGORIES AND DESCRIPTIONS OF COSTS

	Unit Cost	Total Monthly Cost	Notes
1. Salaries and Wages			
a. Total Wages – Hourly Direct Care Staff			
1) Direct Care Staff			
2) Behaviorist			
3) Relief Time/Staff			
4) Other Costs: Describe in Notes			
Total Salaries and Wages Costs		**$ 0.00**	
2. Payroll Taxes, Workers Compensation, and Fringe Benefits			
a. Payroll Taxes			
b. Workers Compensation			
c. Benefit Allowance: Medical, Dental, etc.			
d. Other Costs: Describe in Notes			
Total Taxes and Benefits Costs		**$ 0.00**	
Total Personnel Costs (Combine Totals from Section 1 and 2 above)		**$ 0.00**	
3. Program Costs – Per Consumer			
a. Snacks/Food			
b. Combined Utilities - Additional			
c. Consultant (Non-Behaviorist)			
d. Training			
e. Transportation: Vehicle, Maintenance, Fuel (not DP/School)			
f. Other Costs: Repairs and Maintenance - Additional			
g. Office Supplies - Additional			
h. Other Costs: Outside Activities Expenses			
i. Other Costs: Activity Supplies			
j. Other Costs: Describe in Notes			
Total Program Costs		**$ 0.00**	
TOTAL INDIVIDUAL COSTS		**$ 0.00**	

D. SIGNATURES

Vendor Signature:	**Date:**
Print Name:	
Regional Center Representative Signature:	**Date:**
Print Name:	