New Provider Application

PROVIDER APPLICATION PACKET

Background

Community Partnership for Children is the non-profit lead agency overseeing Community Based Care in Circuit 7, which encompasses Volusia, Flagler and Putnam Counties. CPC is responsible for the provision of services for children who have been abused and/or neglected. These services include foster care, case management, independent living and adoption.

Community Partnership for Children has been in operation in the community implementing the new System of Care to better service children and families that are in need of support and services to prevent child abuse and neglect getting help to families before harm occurs through our prevention efforts.

As the Child Welfare Lead Agency, Community Partnership for Children is concerned with the safety and well being of children in our community. CPC currently oversees on a daily basis the care of 1200 children who have experienced abuse and / or neglect right here in our community. CPC is charged with the responsibilities of ensuring that the children in Circuit 7 (Volusia, Flagler, and Putnam Counties) are safe from abuse/neglect and are receiving services for their mental health and physical well being.

Mission

The mission of Community Partnership for Children is to design, implement, and manage a quality child protection system for the citizens of Volusia, Flagler and Putnam Counties.

Vision

- Community Partnership for Children will operate a service delivery system that will achieve excellence in providing quality services that assure the safety, well-being, and life permanency of children and the stability of families.
- Community Partnership for Children will foster community investment in the lives of children and families by not only participating in, but also being a catalyst of, community partnerships in improving the lives of local children.
- Community Partnership for Children will be a premier employer by demonstrating that staff are valued, fairly compensated, and given abundant opportunity for personal and professional development.

Community Partnership for Children Contact

Chief of QA and Contracted Services
Community Partnership for Children
160 North Beach Street
Daytona Beach, Florida 32114
(386) 238-4900

Karin.Flostiz@cbcvf.org

Application Instructions:

Please complete the application in its entirety and submit the following documents along with any additional supporting documentation your agency feels would be beneficial in Community Partnership for Children's review. Incomplete applications will not be considered. Final determinations will be mailed to the applicant within sixty (60) days of receipt of a completed application packet and all required documentation.

- ☐ General Affidavit (Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion)
- ☐ Certification Regarding Lobbying
- ☐ Designation of Contracting Authority
- ☐ Designation of Invoicing Authority
- ☐ Copies of Liability and Workman's Compensation insurance showing coverage limits and effective dates
- ☐ Organizational Structure
- ☐ Conflict of Interest Certification
- ☐ W-9
- ☐ IRS 501(c) 3 letter (Non-profit agencies only)
- ☐ Articles of Incorporation
- ☐ Program description narrative that includes a history of the agency, mission statement, core values, clients to be served, and services to be provided
- ☐ Program budget and budget narrative that includes a projection of monthly income, funding sources, and expenditures
- ☐ Policies and Procedures associated with proposed service
- ☐ Most recent financial audit
- ☐ Copy of the agency's license and licensing summary (if applicable)
- ☐ Copy of any monitoring reports or accreditation reports
- ☐ Civil Rights Checklist
- ☐ Security Awareness Agreement
- ☐ Affidavit of Compliance with Background Screening
- ☐ Copies of any consultant or management company agreements
- ☐ Emergency preparedness plan
- ☐ Single Point-of-Contact (Deaf & Hard of Hearing Settlement Agreement)

A. Type of Services:

Please indicate all that apply:

- ☐ Case Management Organization
- ☐ Family Builders/Transitions
- ☐ Child Caring Agency
  - ☐ Residential Group Home
  - ☐ Maternity Home Care
  - ☐ Emergency Shelter
  - ☐ Independent Living
  - ☐ Therapeutic/BHOS
  - ☐ Developmental Disabilities
- ☐ Child Placing Agency (Please indicate all that apply)
  - ☐ Adoption Services
  - ☐ Foster Care Services
  - ☐ Other
- ☐ Independent Contractor
  - ☐ Child Welfare Consultant
  - ☐ Special Projects
  - ☐ Prevention
  - ☐ Ancillary Services (IT, Courier, Maintenance, etc…)
  - ☐ Other (Please Describe) _____

B. Agency Information:

Agency Legal Name:	**Mailing Address:**
Phone Number:	**Fax Number:**
Federal Tax Identification Number:	**Medicaid Provider Number:**

Type of Entity: (Check all That Apply)	**Currently Licensed:**
☐ For Profit ☐ Not for Profit ☐ Corporation	☐ Yes ☐ No
☐ LLC ☐ Partnership ☐ Sole Proprietor	☐ If no, date of licensure application

C. Agency Representatives:

1. Agency Executive Director/CEO (Attach additional sheets as necessary.)

Name:	**Title:**
Address:	
Phone Number:	**Fax Number:**
Email Address:	**Tenure With the Agency:**
Cities and States of Residence Within the Last Five Years:	
Description of Child Welfare Experience Including Titles, Time Frames, Duties, and Locations (May attach a resume)**:**	
Educational Level (Please include school and type of degree earned)**:**	
Have you ever had disciplinary action or revocation of a professional license, resigned a professional license in lieu of disciplinary action, or been the subject of pending or legal action in the last five (5) years? (Explanation required if yes)	

2. Board of Directors/Advisory Board (If Applicable) Attach additional sheets as necessary

Name:	**Title:**
Address:	

Phone Number:	**Fax Number:**
Email Address:	**Occupation:**
Tenure of Board Membership:	**Term Length:**
Have you ever had disciplinary action or revocation of a professional license, resigned a professional license in lieu of disciplinary action, or been the subject of pending or legal action in the last five (5) years? (Explanation required if yes)	

D. Contract Representatives

AGENCY OFFICAL AUTHORIZED TO SIGN CONTRACTS	
Name:	
Title:	
Address:	
Phone Number:	
Fax Number:	
Email:	
AGENCY OFFICIAL RESPONSIBLE FOR CONTRACT ADMINISTRATION	
Name:	
Title:	
Address:	
Phone Number:	
Fax Number:	
Email:	
AGENCY OFFICIAL RESPONSIBLE FOR DISPUTE RESOLUTION	
Name:	
Title:	

Address:	
Phone Number:	
Fax Number:	
Email:	
AGENCY OFFICIAL AUTHORIZED TO RECEIVE PAYMENTS	
Name:	
Title:	
Address:	
Phone Number:	
Fax Number:	
Email:	

E. Agency Ownership (For Profit Agencies) Attach additional sheets as necessary.

Name:	**Title:**
Address:	
Phone Number:	**Fax Number:**
Email Address:	**Percentage of Ownership:**
Cities and States of Residence Within the Last Five Years:	
Agency Involvement:	
Have you ever had disciplinary action or revocation of a professional license, resigned a professional license in lieu of disciplinary action, or been the subject of pending or legal action in the last five (5) years? (Explanation required if yes)	

F. Agency Investor Relationships (For Profit Agencies) Attach additional sheets as necessary.

Name:	**Title:**
Address:	
Phone Number:	**Fax Number:**
Email Address:	**Agency Involvement:**
Method of Compensation:	
Cities and States of Residence Within the Last Two Years:	

G. Program/Service Information (Attach Additional Sheets For Each Program.)

Program/Service Name:	**Service Description:**
Location(s):	
License Information: _____ Licensing Body _____License Type _____ License Number _____ Expiration Date	**Accreditation Information:** _____ Accrediting Body _____Accreditation Status _____ Expiration Date _____ Date of Most Recent Survey
Primary Contact Individual and Position:	**Phone Number(s):** Office: _____ Cell: _____
Proposed Method of Payment: ☐ Unit Rate ☐ FTE ☐ Cost Reimbursement ☐ Combination Unit Rate/Cost Reimbursement	**Proposed Rate:** **$**_____ **per** ☐ Hour ☐ Day ☐ FTE ☐ Other Comments**:**_____
Proposed Performance Measures/Outcomes:	

*** For Agencies Providing Direct Child Services Only:**

*** Staffing Pattern:**

☐ House Parent (Residential Providers Only)

☐ 24 Hr. Awake (Residential Providers Only) Please indicate shift times

_____

☐ FTE (Please indicate hours of staff availability)

_____

☐ Other Staffing Pattern (Please provide explanation)

_____

*** Program Capacity:**

*** Client Eligibility and Referral Process:** (Please include referral contact information and times referrals are accepted)

*** Admission Process:**

*** Discharge Criteria:**

***Identify the Name and Services Provided by any Management Company or Consultant Agreements:**

*** Other Lead Agencies That Have Contract Agreements With This Program/ Service:**

*** Please provide the names, addresses, and telephone numbers of three (3) individuals who can provide references as to the quality of work/services provided by your organization:**

1.

2.

3.

*** Has This Program Been the Subject of Disciplinary Action by any Regulatory Agency, Lead Agency, or Accrediting Agency Within the Last Five Years or the subject of current pending or legal actions in the last five (5) years?** (Explanation Required if Yes)

***Please Indicate the Program's Success With the Target Population. Include Quantifiable Data From Performance Measures, QA/QI Studies, Etc…**

Authorized Signature

I attest to the fact that the answers given by me are true and correct to the best of my knowledge and ability. I understand that any omission (including any misstatement) of material fact on this application or on any document can be grounds for rejection of this application or termination of any contract awards.

Name	**Title**
Signature	**Date**

GENERAL AFFIDAVIT

State of Florida
County of _____

BEFORE ME, the undersigned Notary, _____
[name of Notary before whom affidavit is sworn], on this _____ *[day of month]* day of _____ *[month]*, 20____, personally appeared _____ *[name of affiant]*, known to me to be a credible person and of lawful age, who being by me first duly sworn, on _____ *[his or her]* oath, deposes and says:

The following conditions do not exist for myself or my employer (Name of Entity):

a) is barred, suspended, or otherwise prohibited from doing business with any government entity, or has been barred, suspended, or otherwise prohibited from doing business with any government entity within the last 5 years;
b) is under investigation or indictment for criminal conduct, or has been convicted of any crime which would adversely reflect on their ability to provide services to vulnerable populations, including, but not limited to, abused or neglected children, or which adversely reflects their ability to properly handle public funds;
c) is currently involved, or has been involved within the last 5 years, with any litigation, regardless of whether as a plaintiff or defendant, which might pose a conflict of interest to the Florida Department of Children and Families, the State of Florida or its subdivisions, or a federal entity providing funds to the department;
d) has had a contract terminated by the Department of Children and Families for a failure to satisfactorily perform or for cause; or
e) has failed to implement a corrective action plan approved by the department or any other governmental entity, after having received due notice.

_____
[signature of affiant]

_____
[typed name of affiant]

_____
[address of affiant, line 1]

_____
[address of affiant, line 2]

State of Florida
County of _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____, _____ (year), by _____ (name of person making statement).

_____
(Signature of Notary Public - State of Florida)

_____
(Print, Type, or Stamp Commissioned Name of Notary Public)

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, “Disclosure Form to Report Lobbying,” in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

_____ _____

Signature Date

_____ _____

Name of Authorized Individual Application or Contract Number

_____

Name of Organization

_____

Address of Organization

CONFLICT OF INTEREST CERTIFICATION FORM

All applicants must disclose the name of any officer, director, or agent who is also an employee of Community Partnership for Children or member of the board of directors. Further, all Applicants must disclose the name of any CPC employee or member of the reviewing board of directors who owns, directly or indirectly, any interest in the Applicant's agency or any of it's branches.

I certify that I understand the above and that no conflict of interest exists between my agency and CPC.

_____ I am in compliance with the policy.

_____ I am reporting the following potential conflicts.

I understand that I am expected to report promptly any changes in my affairs that might affect compliance with this policy.

_____	_____	_____
Name (print)	Signature	Date

Disclosures required above are as follows:

_____
_____
_____
_____
_____
_____

Community Partnership for Children
protecting children . . . fostering family stability

AFFIDAVIT OF COMPLIANCE

Background Screening Requirements for Child Caring Agencies and Child Placing Agencies

DESIGNATE EMPLOYEE BACKGROUND SCREENING STATUS AS:

C – CLEARED = Clearance Letter on File S – SUBMITTED = Results Pending

T – TRANSFER = Transfer From Other Facility

Incomplete forms will be returned and will delay the contracting process.

				Status (Check One)			
Name	SS#	Date of Hire	Date Screening Submitted	C	S	T	5yr Re-screen Date

(Attach additional sheets if necessary)

I, _____, Applicant of _____ Child Caring Agency / Child Placing Agency do hereby affirm under penalty of perjury that all child care personnel meet the statutory requirements for background screening.

Sworn to and subscribed before me this _____ day of_____,_____.

_____Notary Public, State of Florida

My Commission Expires _____

_____

Signature of Affiant

Community Partnership for Children

protecting children . . . fostering family stability

SECTION 504 and AMERICANS WITH DISABILITES ACT

SINGLE POINT OF CONTACT

The Office or Civil Rights (OCR) within the U.S. Department of Health and Human Services (DHHS) is responsible for enforcing the nondiscrimination requirements of Section 504 of the Rehabilitation Act of 1973, and Title II of the Americans with Disabilities Act (ADA) of 1990, involving health care and human service providers and institutions.

Specific Requirements

Covered entities must not:

- Establish eligibility criteria for receipt of services or participation in programs or activities that screen out or tend to screen out individuals with disabilities, unless such criteria are necessary to meet the objectives of the program.
- Provide separate or different benefits, services, or programs to individuals with disabilities, unless it is necessary to ensure that the benefits and services are equally effective.

Covered entities must:

- Provide services and programs in the most integrated setting appropriate to the needs of qualified individuals with disabilities.
- Make reasonable modifications in their policies, practices, and procedures to avoid discrimination on the basis of disability, unless it would result in a fundamental alteration in their program or activity.
- Ensure that buildings are accessible.
- Provide auxiliary aids to individuals with disabilities, at no additional cost, where necessary to ensure effective communication with individuals with hearing, vision, or speech impairments. (Auxiliary aids include such services or devices as: qualified interpreters, assistive listening headsets, television captioning and decoders, telecommunications devices for the deaf (TDDs), videotext displays, readers, taped texts, brailed materials, and large print materials).

CPC Compliance

As part of the compliance with all the provisions of Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act (ADA) of 1990, subcontractors with 15 or more employees are required to fulfill the following:

- Appoint a Single-Point-of-Contact to ensure effective communication with the deaf or hard-of-hearing.
- Post the flyers at all entrances that may be used by anyone who is deaf or hard-of-hearing. (Flyers can found at http://eww.dcf.state.fl.us/aspe/civilrights_HHS.shtml.
- Complete the attached verification letter and return it to Community Partnership for Children.
- Ensure that all staff have read and understand the Americans with Disabilities Policy and the Rehabilitation Act of 1973, Section 504. (An attestation form should be signed by each employee and included in their personnel file)

For more information regarding Section 504 and the Americans with Disabilities Act: U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW-Room 506-F, Washington, D.C. 20201.Hotlines: 1-800-368-1019 Email: ocrmail@hhs.gov

[**Your Name**]
[**Street Address**]

[**City, ST ZIP Code**]
[Date]

Contract Department
Community Partnership for Children
160 North Beach Street
Daytona Beach, Florida 32114

Re: Compliance with Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act (ADA) of 1990

Dear CPC:

We have reviewed Community Partnership for Children's contract requirements directing our organization to complete the following tasks:

1. Appoint a Single-Point-of-Contact to ensure effective communication with the deaf or hard-of-hearing.

2. Post the designated flyer at all entrances that may be used by anyone who is deaf or hard-of-hearing.

3. Ensure that all employees have read and understand the Americans with Disabilities Policy and the Rehabilitation Act of 1975, Section 504.

4. Include a signed attestation form in each employee personnel file.

This letter verifies that we have posted the flyer at all entrances of our buildings and assigned a single point of contact. Listed below are addresses of our buildings where the required posters are displayed. We have also listed our designated point of contact along with his/her contact information.

Single-Point-of-Contact: _____ Title: _____

Facility/Building Address(es):

_____

_____

_____

_____

Sincerely,

(Your Name)