

Established Provider Pre-Negotiation Packet

FISCAL YEAR 2010-2011

PROVIDER PRE-NEGOTIATION PACKET

Dear Provider:

This letter is to thank you for your continued interest in partnering with us as we continue to enhance the quality of life for the children and families of Volusia, Flagler and Putnam Counties. We greatly value your role as a Network Provider and recognize the work that you do as critical to achieving our goal and mission. Most importantly, we thank you for your decision to provide services for the children and families of Volusia, Flagler, and Putnam Counties.

Community Partnership for Children (CPC) foster care redesign system allows the DCF Protective Investigator to report, assess child safety, and identify the best approach address findings through an integrated, multidisciplinary decision process.

The CPC system of care strives to provide a seamless continuum of services from entry to exit with emphasis upon continuity of care; capacity building and developing evidence based promising practice program models.

Thank you for your commitment and willingness to provide services for the children and families we serve. It is our mission to protect children, strengthen families and change lives. We are deeply grateful for your devoted service and for joining us in partnership.

Sincerely,

Mark Jones, CEO

Community Partnership for Children

In an effort to streamline the negotiation and contracting process, Community Partnership for Children has developed this Provider Pre-Negotiation/Application Packet. Completion of this packet will serve as a request from the Provider to remain a member of the Community Partnership for Children Provider Network and will provide essential information to assist in negotiations and contract development for the upcoming fiscal year.

Directions:

Please complete the application below and submit the following documents along with any additional supporting documentation you or your agency feels would be beneficial in Community Partnership for Children’s review:

- Copies of Professional Liability and Workman’s Compensation Insurance showing coverage limits and effective dates
- Copy of the agency’s organizational structure
- Copies of the program’s license(s) and licensing summary(ies)
- Copies of external monitoring reports or accreditation reports
- Emergency Preparedness Plan
- Program budget and budget narrative that includes a projection of monthly income, funding sources, and expenditures
- Certification Regarding Lobbying Form
- Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion
- Affidavit of Compliance (Background Screening Requirements)
- Single Point-of-Contact (Deaf & Hard of Hearing Settlement Agreement)
- Security Agreement Form
- Civil Rights Checklist (Programs/providers/facilities that employ 15 or more persons)

A. Program/Service Information (Attach additional sheets for each program)

Program/Service Name:
Location(s):
Services Description (Please provide detailed information, if necessary, you may reference and attach additional supporting documents):

Accreditation/License(s):
Identify any Lead Community Based Care Organizations or any other governmental or private organization that your agency has contract agreements with for this program/service:
Proposed Method of Payment: <div style="text-align: right;"> <input type="checkbox"/> Unit Rate <input type="checkbox"/> FTE <input type="checkbox"/> Cost Reimbursement <input type="checkbox"/> Rate/Cost Reimbursement </div>
Proposed Rate: <div style="text-align: right;"> _____ per <input type="checkbox"/> Hour <input type="checkbox"/> Day <input type="checkbox"/> FTE <input type="checkbox"/> Other _____ </div>
Proposed Performance Measures/Outcomes:
Proposed Contract Additions/Changes:
Identify the Name and Services Provided by Any Subcontractors, Management Company, or Consultant Agreements:
Has This Program Been the Subject of Disciplinary Action or Corrective Action by any Regulatory Agency, Lead Agency, or Accrediting Organization Within the Last Year? (Explanation Required if Yes)

B. 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 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 REGARDING LOBBYING

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 its 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:

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.

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

(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



SECTION 504 and AMERICANS WITH DISABILITIES ACT

SINGLE POINT OF CONTACT

The Office of 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, brailled 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://www.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 Addresses:

Sincerely,

(Your Name)