HAMILTON COUNTY
JOB & FAMILY SERVICES

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August 23, 2013

HCJFS/BCCS REQUEST FOR PROPOSAL
GROUP HOME SERVICES RFP#SC0913-R

ADDENDUM 1

To All Potential Proposers:

Corrections to RFP

As read:

Outside front cover states Location: Butler County Youth's Services

Change to read:

Location: Butler County Children Services

As read:

A. HCJFS and BCCS anticipate services will begin approximately January 1, 2014. Provider must submit a Budget and a calculation of the Unit Rate for the initial contract term (Contract Year 1) that Provider understands will be used to compensate Provider for services provided. Budget for each County and Unit Rates must be submitted in the form provided as Attachment C. Contracts will be written for the initial term of one (1) year with two (2) one year options for renewal.

Change to read:

A. HCJFS and BCCS anticipate services will begin approximately January 1, 2014. Provider must submit a Budget and a calculation of the Unit Rate for the initial contract term (Contract Year 1) and each renewal year that Provider understands will be used to compensate Provider for services provided. Budget for each County and Unit Rates must be submitted in the form provided as Attachment C. Contracts will be written for the initial term of one (1) year with two (2) one year options for renewal.

Insertion:

Attachment C should also include Contract Budget Instructions.

Replace:

Current Table of Contents with updated Table of Contents.

Questions Received prior to RFP Conference

Q1. Does Hamilton County anticipate the release of a residential treatment RFP within the next 6 months?

A: Yes. If you are on the bidder's list, you will receive notification when it is released.

Q2. Please provide a range of daily rates being paid to current Group Home providers.

A: This is a public record request. You must complete a public record request form to have your request honored.

Q3. The RFP indicates a limit of 14 for the size of a group home. Are there any exceptions to this?

A: We are always open to discussions.

Q4. Are step-down services (separate from the group home services) required in order to meet the independent living requirements?

A: Clarification is needed to answer.

Q5. Please provide specific requirements for clothing, including direction on how the funds are to be managed and maintained.

A: Please refer to Section 1.2.2 – Section 5 regarding requirements. There are different intake and individual contract requirements.

Q6. Can the standard issue program clothing be included as part of the supply when a child exists?

A: Yes if clothing still fits and in good condition. Please refer to Section 1.1.2 Question 24.

Q7. Can county issued vouchers be used toward purchase of standard issue program clothing?

A: Please clarify what is meant by "standard issue program clothing."

Q8. Do Providers have the right of refusal for placements who do not meet program criteria?

A: Yes, Providers may refuse placement at the point of referral; not during placement.

Q9. Section 1.2.2 #13 references dedicating discretionary dollars toward an allowance. Please clarify allowance expectations and requirements.

A: Providers must have dollars available to support youth's participation in social, recreational, sports and other extra-curricular activities. If an allowance is provided to a youth, it is not to be used for purchase of basic needs including hygiene, personal care and grooming supplies.

Q10. May the Hamilton County group home children be mixed with placement from out-of-state?

A: Yes.

Q11. The budget forms were provided in pdf format. Are they available as Excel spreadsheets?

A: The budget will be sent as an addendum in an Excel format to all Providers who registered for the RFP.

Q12. If the applicant does not have a IV-E rate issued a for group home but does have a IV-E rate for another type of residential program, should they use those percentages on Attachment A to break out the IV-E Admin and Maintenance Ceilings? Or should they just leave those fields blank?

A: Only provide IV-E Rates if they are approved by ODJFS. If you have submitted rates to ODJFS for review but they are not yet approved, provide those and state they are being reviewed by ODJFS and an approval letter will be forwarded once it is received.

Q13. The RFP reads that providers must certify that they are or will become a provider, but the Hamilton County contract indicates that you must be a IV-E provider. Please clarify.

A: Hamilton County has waived this requirement on a case by case basis with providers. It is the goal and expectation that all providers who could be a IV-E reimbursable provider would have taken the necessary steps to do so, or would be in the process of becoming IV-E reimbursable.

Q14. The last paragraph of page 22 reads, "cover sheet must also include the proposed unit rate(s) for each service provider is proposing." What is meant by "each service"? Is this a separation in order to break out therapy and education for IV-E purposes?

A: The provider is to include rates for each discrete service being proposed by the provider, i.e., Residential Group Home, Residential Group Home Special Needs, or Individual Aid.

Q15. What percentage of anticipated placements have Medicaid for medical services?

A: Nearly 100% of youth in placement receive Medicaid. Approximately 82% of youth in placement are IV-E eligible.

Q16. Please describe the selection process for and composition of the RFP award panel.

A: Please refer to Section 4.6 – Evaluation and Award of Agreement for details of the selection process and composition of the Review Committee.

TABLE OF CONTENTS

CONTRACT BUDGET INSTRUCTIONS

When contracting with the Hamilton County Department of Job & Family Services (HCJFS), it is required that a budget be completed for each program/service being proposed. In order to facilitate the process, HCJFS requests that the attached budget be used.

These instructions are designed to assist in the completion the budget. Should you have any questions, please submit them to the HCJFS Contact Person in one of the following ways:

1) Fax:

   Fax: (513) 946-2384

2) E-mail:

   HCJFS_RFP_COMMUNICATIONS@jfs.hamilton-co.org

3) Mail:

   Contract Services
   Hamilton County Department of Job & Family Services
   222 East Central Parkway, 3rd Floor
   Cincinnati, OH 45202

PAGE 1 - SUMMARY PAGE

Page 1 is the summary page for all information entered on pages 2 through 9. If you are not using the Excel spreadsheet for the budget, the summary page should be completed after all other budget pages (pages 2 through 9) are finalized. The total amounts for each expense type on this page (A through J) should equal the total amounts of each section on pages 2 through 8.

As the amounts are entered on pages 2 through 9, the total amounts on the summary page will be populated, if using the Excel spreadsheet to complete the budget.

Mgmt Indirect Cost

A rationale or basis for the allocation of Mgmt Indirect cost which details how the amount charged to the proposed service was determined must be included. Some agencies allocate these types of costs on staff salaries, total personnel costs, total direct cost of service proposed, and/or time studies. Records substantiating development of the means of these costs must be provided with your budget submittal and also maintained by your agency. Mgmt Indirect costs, allocated to the proposed service(s) should not exceed 15% of the total proposed service(s) cost. After allocating Mgmt Indirect costs between Other Direct Services and the proposed service(s), total program expenses for Mgmt Indirect should equal zero.

The Summary Page, once completed, should give a total budget for the service being proposed as well as a picture of your agency's total budget.

HCJFS CONTRACT BUDGET

AGENCY: (Enter legal name of your agency) BUDGET PREPARED FOR PERIOD

NAME OF CONTRACT PROGRAM: (Enter name of program, e.g. Foster Care) (Enter Begin Date of Budget) **TO** (Enter End Date of Budget)

INDICATE NAME OF SERVICE IN APPROPRIATE COLUMN BELOW

(1) EXPENSES BY PROGRAM SERVICES	(2) (Enter Name of Proposed Service)	(3) (Enter Name of Add'l Proposed Service, if needed)	(4) (Enter Name of Add'l Proposed Service, if needed)	(5) MGMT INDIRECT	(6) OTHER DIRECT SER	(7) TOTAL EXPENSE
A. STAFF SALARIES						
B. EMPLOYEE PAYROLL TAXES & BENEFITS						
C. PROFESSIONAL & CONTRACTED SERVICES						
D. CONSUMABLE SUPPLIES						
E. OCCUPANCY						
F. TRAVEL						
G. INSURANCE						
H. EQUIPMENT						
I. MISCELLANEOUS						
J. PROFIT MARGIN						
K SUB-TOTAL OF EXPENSES BEFORE MGMT INDIRECT ALLOCATION						
ALLOCATION OF MGT/INDIRECT COSTS						
TOTAL PROGRAM EXPENSES						

1

**ESTIMATED TOTAL UNITS OF SERVICE TO BE PROVIDED: _____ _____ _____ **UNIT= (Define unit - day, hour, trip, etc…)

****TOTAL PROGRAM EXPENSES / TOTAL UNITS OF SERVICE = UNIT RATE: $_____ $_____ $_____

**If the proposed service is Cost Reimbursement, do not complete.

TOTAL REVENUE*						

*As the amounts for revenue are entered on page 9 of the budget, total revenue will be populated here.

Instructions:

Column 1: Description of expenses by type.

Columns 2-4: Totals of the direct costs entered for each section on pages 2 through 8. **Direct costs** are those that can be identified specifically to the service being proposed.

Column 5: Totals of management, administrative, and indirect costs for each section on pages 2 through 8. **Indirect costs** are those costs incurred for a common or joint purpose benefiting more than one service area or cost center. It is not possible to specify the types of costs which may be considered as indirect cost in all situations due to the diverse characteristics and accounting practices of nonprofit organizations. However, typical examples of indirect cost for many nonprofit organizations may include the costs of operating and maintaining facilities, personnel administration, salaries and expenses of executive officers, and accounting functions such as payroll, and accounts payable.

Column 6: Totals for all other direct and indirect costs of your agency not associated with the service being proposed to HCJFS on pages 2 through 8. For example, if your agency provides both Traditional and Therapeutic Foster Care and Residential Treatment and you are responding to a Request For Proposals (RFP) for Traditional and Therapeutic Foster Care, all costs associated with Residential Treatment would be entered under "Other Direct Serv".

Column 7: Column 7 is the sum of Columns 2 through 6.

PAGE 2 - SECTION A - STAFF SALARIES

This section is used to list all positions by position title, number of staff per position, hours per week per position, annual salary per position, and salaries per position included in the proposed service. All management and administrative positions indirectly associated with the service being proposed should be listed with their corresponding salaries listed under the column, "Mgmt Indirect". All other positions **not** directly or indirectly associated with the service being proposed may be grouped together and listed as "All Other Positions" with their total salaries listed under the column "Other Direct Ser".

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
POSITION TITLE	# STAFF	HRS WEEK	ANNUAL COST	(Enter Name of Proposed Service)	(Enter Name of Add'l Proposed Service, if needed)	(Enter Name of Add'l Proposed Service, if needed)	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
TOTAL SALARIES									

Instructions:

Column 1: List all position titles of staff that will be associated with the service being proposed. All other positions not associated with the proposed service may be grouped together and labeled as "Other Personnel".

Column 2: Indicate the number of staff for the position title identified in Column 1.

Column 3: Indicate the number of hours each staff will work each week for the proposed service.

Column 4: Enter the annual salary for each position listed in Column 1. For the positions grouped as "Other Personnel", you may enter the sum of the salaries.

Columns 5-7: List the salary costs that are directly associated with the position titles for the proposed service.

Column 8: Enter the salary costs that are indirectly associated with the service being proposed.

Column 9: Enter the total salaries for staff employed by your agency but are **not** directly or indirectly associated with the proposed service.

Column 10: Column 10 is the sum of Columns 5 through 9.

PAGE 3 – SECTION B – EMPLOYEE PAYROLL TAXES & BENEFITS

This section is used to calculate the employee payroll taxes and benefits.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
B. PAYROLL TAXES	(Enter Name of Proposed Service)	(Enter Name of Add'l Proposed Service, if needed)	(Enter Name of Add'l Proposed Service, if needed)	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
FICA _____ %						
WORKER'S COMP. _____%						
UNEMPLOYMENT _____ %						
BENEFITS						
RETIREMENT _____ %						
HOSPITAL CARE						
OTHER (SPECIFY)						
TOTAL EMPLOYEE PAYROLL TAXES & BENEFITS						

3

Instructions:

Column 1: List the percents used to calculate the amounts withheld for payroll taxes and benefits. Please list separately any other employee deduction not listed under "Other".

Columns 2-4: Calculate the payroll taxes and benefits by multiplying the percent listed in Column 1 by the Total Salary in the corresponding columns on Page 2. **Please Note:** Unemployment taxes should only be calculated up to the first $9,000.00 of an employee's salary.

Column 5: Calculate the payroll taxes and benefits by multiplying the percent listed in Column 1 by the Total Salary for Mgmt Indirect on Page 2.

Column 6: Calculate the payroll taxes and benefits by multiplying the percent listed in Column 1 by the Total Salary for Other Dir Serv on Page 2.

Column 7: Column 7 is the sum of Columns 2 through 6.

PAGE 3 - SECTION C – PROFESSIONAL FEES & CONTRACTED SERVICES

This section is used to list any contracted services such as janitorial, pest control, and security; as well as any professional fees such as consultants and auditors. Also, if you have any contracted employees from a temporary agency who are performing duties either directly or indirectly related to the service proposed; those costs should be entered here. Foster care agencies should enter their Foster Parent fees here. Any subcontractor's costs should be entered here.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
C. PROFESSIONAL FEES & CONTRACTED SERVICES	(Enter Name of Proposed Service)	(Enter Name of Add'l Proposed Service, if needed)	(Enter Name of Add'l Proposed Service, if needed)	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
TOTAL PROFESSIONAL FEES & CONTRACTED SERVICES						

3

Instructions:

Column 1: List all professional fees and contracted services.

Columns 2-4: Enter the costs that are directly associated with the service proposed.

Column 5: Enter the costs that are **indirectly** associated with the service proposed.

Column 6: Enter the costs that are not associated (directly or indirectly) with the service proposed.

Column 7: Column 7 is the sum of Columns 2 through 6.

PAGE 4 - SECTION D – CONSUMABLE SUPPLIES

This section is used to enter costs for items that will be directly used or consumed in the proposed service. These items must be used or consumed within one (1) Consumable supplies that are more of a general supply used within your agency should be entered in the "Mgmt Indirect" column. Examples of some of these costs are janitorial supplies (cleaning supplies, paper towels, floor cleaner, mops, brooms, etc.). Program supplies such as pamphlets, text books, and computer software directly related to the proposed service should be entered in this section as well.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
EXPENSES BY PROGRAM SERVICES	(Enter Name of Proposed Service)	(Enter Name of Add'l Proposed Service, if needed)	(Enter Name of Add'l Proposed Service, if needed)	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
D.CONSUMABLE SUPPLIES						
OFFICE						
CLEANING						
PROGRAM						
OTHER (SPECIFY)						
TOTAL CONSUMABLE SUPPLIES						

4

Instructions:

Column 1: List of consumable supplies by expense type. List any other consumable supplies separately under "Other".

Columns 2-4: Enter the costs that are directly associated with the service proposed.

Column 5: Enter the costs that are **indirectly** associated with the service proposed.

Column 6: Enter the costs that are not associated (directly or indirectly) with the service proposed.

Column 7: Column 7 is the sum of Columns 2 through 6.

PAGE 4 - SECTION E – OCCUPANCY COSTS

This section is used to enter occupancy costs that will be associated with the proposed service. If your agency is renting the entire building and using all of the space for the proposed service, enter the total rental amount for the building. If your agency is renting the entire building and not using all of the space for the proposed service, the rental cost for the proposed service is calculated by multiplying the Cost per Square Foot by the total Square Footage of the space used for the proposed service. The remaining rental cost should be entered under "Other Direct Ser".

If your agency owns the building, a charge for depreciation **or** usage allowance is allowable. Depreciation or usage allowance should be applied to the original acquisition cost of the building. Depreciation should be calculated using the straight-line method. The lifespan of a nonresidential building is 31.5 years for property placed in service before May 13, 1993. If the property was placed in service after May 13, 1993 the lifespan is 39 years per the Internal Revenue Service (IRS) (Publication 946). If the building has been fully depreciated, the usage allowance method should be used. The usage allowance is limited to 2% of the original acquisition cost.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
EXPENSES BY PROGRAM SERVICES	(Enter Name of Proposed Service)	(Enter Name of Add'l Proposed Service, if needed)	(Enter Name of Add'l Proposed Service, if needed)	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
E. OCCUPANCY COSTS						
RENTAL @ _____ PER SQ. FT. SQ. FT. _____						
USAGE ALLOWANCE OF BLDG. OWNED @ 2% OF ORIGINAL ACQUISITION COST						
MAINTENANCE & REPAIRS						
UTILITIES (MAY BE INCLUDED IN RENT) HEAT & ELECTRICITY _____ WATER _____						
TELEPHONE						
OTHER (SPECIFY)						
TOTAL OCCUPANCY COSTS						

4

Instructions:

Column 1: Rental – Enter the amount per square foot and the total square footage used for the proposed service.

Usage Allowance of Building – Should be used when building has been fully depreciated. Usage Allowance is limited to 2% of the original acquisition cost.

Maintenance & Repairs – Enter any projected building maintenance and repair costs.

Utilities – Enter the projected utility costs on the appropriate lines. If heat and electricity is included in the rent, write "included" on this line. If water is included in the rent, write "included" on this line.

Telephone – Enter the projected telephone costs including long distance. Cell phone costs should be entered on this line, also.

Other – List separately any other costs associated with occupancy.

Columns 2-4: Enter the costs that are directly associated with the service proposed.

Column 5: Enter the costs that are **indirectly** associated with the service proposed.

Column 6: Enter the costs that are not associated (directly or indirectly) with the service proposed.

Column 7: Column 7 is the sum of Columns 2 through 6.

PAGE 5 - SECTION F – TRAVEL COSTS

This section is used to enter the costs of operation, maintenance, and repairs of agency vehicles when relevant to the delivery of the proposed service. Such costs may be charged on an actual cost basis, a per diem or mileage basis in lieu of actual costs incurred, or a combination of the two, provided the method used is applied to an entire trip and not to selected days of the trip, and results in charges consistent with those normally allowed in like circumstances in the non-profit organization's non-federally sponsored activities. The amount paid for mileage reimbursement should not exceed HCJFS' reimbursement rate, which is the rate determined by the IRS. The reimbursement rate can be found on the IRS website.

Conference and meeting costs are allowable if the primary purpose is the dissemination of technical information relating to the proposed service. Purchased transportation is allowable if required for the delivery of the proposed service.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
EXPENSES BY PROGRAM SERVICES	(Enter Name of Proposed Service)	(Enter Name of Add'l Proposed Service, if needed)	(Enter Name of Add'l Proposed Service, if needed)	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
F. TRAVEL COSTS						
GASOLINE & OIL						
VEHICLE REPAIR						
VEHICLE LICENSE						
VEHICLE INSURANCE						
OTHER (PARKING)						
MILEAGE REIMBURSE. @ PER MILE						
CONFERENCES & MEETINGS, ETC.						
PURCHASED TRANSPORTATION						
TOTAL TRAVEL COSTS						

5

Instructions:

Column 1: List of travel costs by expense type. List any other travel costs separately under, "Other".

Columns 2-4: Enter the costs that are directly associated with the service proposed.

Column 5: Enter the costs that are **indirectly** associated with the service proposed.

Column 6: Enter the costs that are not associated (directly or indirectly) with the service proposed.

Column 7: Column 7 is the sum of Columns 2 through 6.

PAGE 5 - SECTION G – INSURANCE COSTS

This section is used to enter insurance costs relevant to the delivery of the proposed service. Some agencies allocate all insurance costs to the Mgmt Indirect column of their budgets, and then allocate them along with all the other shared type of costs. If one service operated by the agency has disproportionate insurance costs (either higher or lower) than the other agency services, then a more appropriate method would be to show the insurance costs in the column for that service. Records substantiating development of the means of allocating must be provided with your budget submittal and also maintained in your agency.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
EXPENSES BY PROGRAM SERVICES	(Enter Name of Proposed Service)	(Enter Name of Add'l Proposed Service, if needed)	(Enter Name of Add'l Proposed Service, if needed)	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
G. INSURANCE COSTS						
LIABILITY						
PROPERTY						
ACCIDENT						
OTHER						
TOTAL INSURANCE COSTS						

5

Instructions:

Column 1: List of insurance costs by expense type. List any other insurance costs separately under, "Other".

Columns 2-4: Enter the costs that are directly associated with the service proposed.

Column 5: Enter the costs that are **indirectly** associated with the service proposed.

Column 6: Enter the costs that are not associated (directly or indirectly) with the service proposed.

Column 7: Column 7 is the sum of Columns 2 through 6.

PAGE 6 - SECTION H – EQUIPMENT COSTS

This section is used to enter small equipment (items costing under $5,000.00 and will be purchased during the budget period); equipment maintenance and repair; equipment lease costs; and depreciation costs for capital equipment (any item or group of like items costing $5,000.00 or more) relevant to the delivery of the proposed service. Leased equipment in excess of $5,000.00 must be depreciated. If your agency has, or acquires equipment costing $5,000.00 or more with an anticipated useful life in excess of one (1) year a charge for depreciation is allowable.

Depreciation should be calculated using the straight-line method. Refer to IRS guidelines to determine the useful life of equipment. Follow the instructions on Page 7 of Budget Form to calculate depreciation.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
EXPENSES BY PROGRAM SERVICES	(Enter Name of Proposed Service)	(Enter Name of Add'l Proposed Service, if needed)	(Enter Name of Add'l Proposed Service, if needed)	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
H. EQUIPMENT COSTS						
SMALL EQUIPMENT (items costing under $5,000.00, which are to be purchased during budget period should be listed)						
TOTAL SMALL EQUIPMENT COSTS						
EQUIPMENT MAINTENANCE & REPAIR (DETAIL)						
TOTAL EQUIPMENT & REPAIR						
EQUIPMENT LEASE COSTS (DETAIL)						
TOTAL LEASE COSTS						
TOTAL COST DEPRECIATION OF LARGE EQUIPMENT ITEMS (detail on page 7)						
TOTAL EQUIPMENT COSTS						

6

Instructions:

Column 1: List of equipment costs by expense type.

Columns 2-4: Enter the costs that are directly associated with the service proposed.

Column 5: Enter the costs that are **indirectly** associated with the service proposed.

Column 6: Enter the costs that are not associated (directly or indirectly) with the service proposed.

Column 7: Column 7 is the sum of Columns 2 through 6.

PAGE 7 - LARGE EQUIPMENT DEPRECIATION COSTS

Any individual equipment item costing $5,000 or more at time of purchase may be included in the budget and must be depreciated. The exception to the "individual equipment item" is for computer components which are purchased as a group, e.g. hard drive, monitor, keyboard, printer, etc. If the total cost for all the components is $5,000 or greater, the equipment must be depreciated. Any items of equipment used by the Management Indirect activities of the Agency for which costs are included in this budget must also be itemized on this sheet. If needed, extra copies may be made and numbered 7A, 7B, & 7C, etc.

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Item(s) To Be Depreciated	New or Used	Date of Purchase	Total Actual Cost	Salvage Value	Total To Depreciate	Useful Life	Chargeable Annual Depreciation	Percent Used By Service Proposed	Amount Charged to Service Proposed	Which Service Proposed
Total										

7

Instructions:

Column 1: Enter item to be depreciated.

Column 2: Enter "N" for new equipment or "U" for used equipment.

Column 3: Enter date of purchase.

Column 4: Enter acquisition cost of item.

Column 5: Enter salvage value.

Column 6: Subtract value entered in Column 5 from the value entered in Column 4.

Column 7: Enter useful life per IRS guidelines.

Column 8: Divide value in Column 6 by value in Column 7.

Column 9: Enter percent item will be used in the service proposed.

Column 10: Multiply value in Column 8 by percent in Column 9.

Column 11: Enter name of service proposed.

PAGE 8 – SECTION I - MISCELLANEOUS COSTS

This is the section to enter anticipated miscellaneous costs incidental to the delivery of the service proposed. Allowable miscellaneous include costs such as printing, advertising, postage, FBI background checks, and drug testing.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
EXPENSES BY PROGRAM SERVICES	(Enter Name of Proposed Service)	(Enter Name of Add'l Proposed Service, if needed)	(Enter Name of Add'l Proposed Service, if needed)	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
I. MISCELLANEOUS COSTS						
TOTAL MISCELLANEOUS COSTS						

8

Instructions:

Column 1: List miscellaneous costs separately.

Columns 2-4: Enter the costs that are directly associated with the service proposed.

Column 5: Enter the costs that are **indirectly** associated with the service proposed.

Column 6: Enter the costs that are not associated (directly or indirectly) with the service proposed.

Column 7: Column 7 is the sum of Columns 2 through 6.

PAGE 8 – SECTION J - PROFIT MARGIN

This section is for for-profit entities only. Enter the amount of anticipated profit being charged to the service proposed. The profit margin will be negotiated during contract negotiations.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
EXPENSES BY PROGRAM SERVICES	(Enter Name of Proposed Service)	(Enter Name of Add'l Proposed Service, if needed)	(Enter Name of Add'l Proposed Service, if needed)	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
J. PROFIT MARGIN (For profit entities only- indicate the amount)						

8

PAGE 8 – SECTION K – SUB-TOTAL OF EXPENSES BEFORE MGMT INDIRECT ALLOCATION

This is the grand total of Sections A through J for each column. The values on this line should equal Sub-Total of Expenses Before Mgmt Indirect Allocation on Page 1 - Summary Page.

(1)	(2)	(3)	(4)	(5)	(6)	(7)
EXPENSES BY PROGRAM SERVICES	(Enter Name of Proposed Service)	(Enter Name of Add'l Proposed Service, if needed)	(Enter Name of Add'l Proposed Service, if needed)	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
K. SUB-TOTAL OF EXPENSES BEFORE MGMT INDIRECT ALLOCATION						

8

PAGE 9 – REVENUE BY PROGRAM SERVICES

Projected revenues of your agency should be entered for the same time period of the budget for expenses. Government contracts, including revenues expected to be received from HCJFS, should be listed separately (e.g. HCJFS, Butler County, etc.). "Fees From Clients" should only represent monies received directly from clients. These are not fees paid by third parties (insurance, Medicaid, contracts). Contributions from individual benefactors need not be listed individually unless they represent a significant proportion or amount of donated funds.

Total revenues shown MUST equal or exceed the total expenses shown on Page 1 – Summary Page.

REVENUE PREPARED FOR PERIOD
(Enter Begin Date of Budget) **TO** (Enter End Date of Budget)

(1)	(2)	(3)	(4)	(5)	(6)	(7)
REVENUE BY PROGRAM SERVICES	(Enter Name of Proposed Service)	(Enter Name of Add'l Proposed Service, if needed)	(Enter Name of Add'l Proposed Service, if needed)	MGMT INDIRECT	OTHER DIRECT SER	TOTAL REVENUE
A. GOVERNMENTAL AGENCY FUNDING (specify agency)						
HCJFS						
B. OTHER FUNDING						
Fees From Clients						
Contributions						
Awards & Grants						
Other (specify)						
TOTAL REVENUE						

Instructions:

Column 1: List funding sources.

Columns 2-4: Enter the revenues that are directly associated with the service proposed.

Column 5: Enter revenue such rental of facilities, interest income, investment income, contributions, etc.

Column 6: Enter all other revenues that are not associated with the service proposed.

Column 7: Column 7 is the sum of Columns 2 through 6.

EXHIBIT II

EXPENSES BY PROGRAM SERVICES				MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
B.PAYROLL TAXES						
FICA %						0.00
WORKER'S COMP. %						0.00
UNEMPLOYMENT %						0.00
BENEFITS						
RETIREMENT						0.00
HOSPITAL CARE						0.00
OTHER (SPECIFY)						0.00
						0.00
TOTAL EMPLOYEE PAYROLL TAXES & BENEFITS	0.00	0.00	0.00	0.00	0.00	0.00

Employee Payroll Taxes & Benefits Narrative.

Please type narrative here.

C. PROFESSIONAL FEES & CONTRACTED SERVICES (Indicate type, function performed, and				MGMT INDIRECT	OTHER DIRECT SERVICES	TOTAL EXPENSE
						0.00
						0.00
						0.00
						0.00
TOTAL PROFESSIONAL FEES & CONTRACTED SERVICES	0.00	0.00	0.00	0.00	0.00	0.00

Professional Fees & Contracted Services Narrative

Please type narrative here.

EXHIBIT II

CONTRACT BUDGET

AGENCY: **BUDGET PREPARED FOR PERIOD**

NAME OF CONTRACT PROGRAM: _____ **TO** _____

INDICATE NAME OF SERVICE IN APPROPRIATE COLUMN BELOW

EXPENSES BY PROGRAM SERVICES				MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
A. STAFF SALARIES	0.00	0.00	0.00	0.00	0.00	0.00
B. EMPLOYEE PAYROLL TAXES & BENEFITS	0.00	0.00	0.00	0.00	0.00	0.00
C. PROFESSIONAL & CONTRACTED SERVICES	0.00	0.00	0.00	0.00	0.00	0.00
D. CONSUMABLE SUPPLIES	0.00	0.00	0.00	0.00	0.00	0.00
E. OCCUPANCY	0.00	0.00	0.00	0.00	0.00	0.00
F. TRAVEL	0.00	0.00	0.00	0.00	0.00	0.00
G. INSURANCE	0.00	0.00	0.00	0.00	0.00	0.00
H. EQUIPMENT	0.00	0.00	0.00	0.00	0.00	0.00
I. MISCELLANEOUS	0.00	0.00	0.00	0.00	0.00	0.00
J. PROFIT MARGIN	0.00	0.00	0.00	0.00	0.00	0.00
K. SUB-TOTAL OF EXPENSES BEFORE MGMT INDIRECT ALLOCATION	0.00	0.00	0.00	0.00	0.00	0.00
ALLOCATION OF MGT/INDIRECT COSTS						0.00
TOTAL PROGRAM EXPENSES	0.00	0.00	0.00	0.00	0.00	0.00

ESTIMATED TOTAL UNITS OF SERVICE TO BE PROVIDED:				**UNIT =**
TOTAL PROGRAM COST/TOTAL UNITS OF SERVICE = UNIT COST:	#DIV/0!	#VALUE!	#VALUE!	

TOTAL REVENUE	0.00	0.00	0.00	0.00	0.00	0.00

EXHIBIT II

A. STAFF SALARIES - Attach Extra Pages for Staff, if needed.

POSITION TITLE	# STAFF	HRS WK	Annual Cost				MGMT INDIRECT	OTHER DIRECT	TOTAL EXPENSE
									0.00
									0.00
									0.00
									0.00
									0.00
									0.00
									0.00
									0.00
									0.00
									0.00
									0.00
									0.00
									0.00
									0.00
									0.00
									0.00
TOTAL SALARIES			0.00	0.00	0.00	0.00	0.00	0.00	0.00

Salaries Narrative. Describe how each position relates to the service proposed.
Please type narrative here.

EXHIBIT II

EXPENSES BY PROGRAM SERVICES				MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
D.CONSUMABLE SUPPLIES						
OFFICE						0.00
CLEANING						0.00
PROGRAM						0.00
OTHER (SPECIFY)						0.00
						0.00
						0.00
TOTAL CONSUMABLE SUPPLIES	0.00	0.00	0.00	0.00	0.00	0.00

Consumable Supplies Narrative

Please type narrative here.

EXPENSES BY PROGRAM SERVICES				MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
E. OCCUPANCY COSTS						
RENTAL @ PER SQ. FT.						0.00
USAGE ALLOWANCE OF BLDG. OWNED @2% OF ORIG. ACQUISITION COST						0.00
MAINTENANCE & REPAIRS						0.00
UTILITIES (MAY BE INCLUDED IN RENT) HEAT & ELECTRICITY WATER						0.00
TELEPHONE						0.00
OTHER (SPECIFY)						0.00
						0.00
						0.00
TOTAL OCCUPANCY COSTS	0.00	0.00	0.00	0.00	0.00	0.00

Occupancy Costs Narrative

Please type narrative here.

EXHIBIT II

EXPENSES BY PROGRAM SERVICES				MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
F.TRAVEL COSTS						
GASOLINE & OIL						0.00
VEHICLE REPAIR						0.00
VEHICLE LICENSE						0.00
VEHICLE INSURANCE						0.00
OTHER (PARKING)						0.00
MILEAGE REIMBURSE.@ _____ PER MILE						0.00
CONFERENCES & MEETINGS, ETC.						0.00
PURCHASED TRANSPORTATION						0.00
TOTAL TRAVEL COSTS	0.00	0.00	0.00	0.00	0.00	0.00

Travel Costs Narrative

Please type narrative here.

EXPENSES BY PROGRAM SERVICES				MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
G. INSURANCE COSTS						
LIABILITY						0.00
PROPERTY						0.00
ACCIDENT						0.00
OTHER						0.00
TOTAL INSURANCE COSTS	0.00	0.00	0.00	0.00	0.00	0.00

Insurance Costs Narrative

Please type narrative here.

EXHIBIT II

EXPENSES BY PROGRAM SERVICES				MGMT INDIRECT	OTHER DIRECT SERV	TOTAL EXPENSE
H.EQUIPMENT COSTS						
SMALL EQUIPMENT (items costing under $5,000.00, which are to be purchased during budget period should be listed)						
						0.00
						0.00
						0.00
TOTAL SMALL EQUIPMENT COSTS	0.00	0.00	0.00	0.00	0.00	0.00
EQUIPMENT MAINTENANCE & REPAIR (DETAIL)						0.00
						0.00
						0.00
						0.00
TOTAL EQUIPMENT & REPAIR	0.00	0.00	0.00	0.00	0.00	0.00
EQUIPMENT LEASE COSTS (DETAIL)						
						0.00
						0.00
						0.00
TOTAL LEASE COSTS	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL COST DEPRECIATION OF LARGE EQUIPMENT ITEMS (detail on page 7)	0.00	0.00	0.00	0.00	0.00	0.00
TOTAL EQUIPMENT COSTS	0.00	0.00	0.00	0.00	0.00	0.00

Total Equipment Costs Narrative (Small Equipment, Equipment Maintenance & Repair, Equipment Lease, Equipment Depreciation)

Please type narrative here.

EXHIBIT II

LARGE EQUIPMENT DEPRECIATION COSTS

Any individual equipment item costing $5,000 or more at time of purchase may be included in the budget and must be depreciated. The exception to the "individual equipment item" is for computer components which are purchased as a group, I.e. hard drive, monitor, keyboard, printer, etc. If the total cost for all the components is $5,000 or greater, the equipment must be depreciated. Any item which was full depreciated on the agency's books prior to the beginning date of the contract may not be used as a basis for determining costs of the program proposed for a contract, even though that item of equipment is used by the program. Any items of equipment used by the Management and Indirect activities of the Agency for which costs are included in this budget must also be itemized on this sheet. If needed, extra copies may be made and numbered 7A, 7B, & 7C.

ITEM(S) TO BE DEPRECIATED	NEW OR USED	DATE OF PURCHASE	TOTAL ACTUAL COST	SALVAGE VALUE	TOTAL TO DEPRECIATE	USEFUL LIFE	CHARGEABLE ANNUAL DEPRECIATION	*PERCENT USED BY CONTRACT PROGRAM	AMOUNT CHARGED TO CONTRACT PROGRAM	WHICH CONTRACTED PROGRAM
			0.00	0.00	0.00	0	0.00	100.00%	0.00	
			0.00	0.00	0.00	0	0.00			
			0.00	0.00	0.00	0	0.00			
			0.00	0.00	0.00	0	0.00			
			0.00	0.00	0.00	0	0.00			
Total			0.00		0.00		0.00		0.00	

EXHIBIT II

EXPENSES BY PROGRAM SERVICES				MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
I.MISCELLANEOUS COSTS						
						0.00
						0.00
						0.00
						0.00
						0.00
TOTAL MISCELLANEOUS COSTS	0.00	0.00	0.00	0.00	0.00	0.00
J. PROFIT MARGIN (For profit entities only)						0.00
K. SUB-TOTAL OF EXPENSES BEFORE MGMT INDIRECT ALLOCATION	0.00	0.00	0.00	0.00	0.00	0.00

Miscellaneous Costs Narrative.
Please type narrative here.

A rationale or basis for the allocation of Mgmt Indirect cost which details how the amount charged to the proposed service was determined must be included. Some agencies allocate these types of costs on staff salaries, total personnel costs, total direct cost of service proposed, and/or time studies. Records substantiating development of the means of these costs must be provided with your budget submittal and also maintained by your agency.

Mgmt/Indirect Cost Narrative.
Please type narrative here.

Profit Margin Narrative (for profit entities only).
Please type narrative here.

EXHIBIT II

REVENUES BY PROGRAM SERVICES				MGMT INDIRECT	OTHER DIRECT SER	TOTAL REVENUES
A. GOVERNMENTAL AGENCY FUNDING (specify agency & type)						
						0.00
						0.00
						0.00
B.OTHER FUNDING						
FEES FROM CLIENTS						0.00
CONTRIBUTIONS						0.00
						0.00
						0.00
						0.00
						0.00
AWARDS & GRANTS						0.00
						0.00
OTHER (specify)						0.00
						0.00
TOTAL REVENUE	0.00	0.00	0.00	0.00	0.00	0.00

Revenue Narrative

Please type narrative here.

ATTACHMENT E

Declaration of Property Tax Delinquency

(ORC 5719.042)

I, _____, hereby affirm that the Proposing Organization herein, _____, is ____ / is not ____ **(check one)** charged at the time of submitting this proposal with any delinquent property taxes on the general tax list of personal property of the County of Hamilton.

If the Proposing Organization is delinquent in the payment of property tax, the amount of such due and unpaid delinquent tax and any due and unpaid interest is $_____.

State of Ohio
County of Hamilton

Before me, a notary public in and for said County, personally appeared _____, authorized signatory for the Proposing Organization, who acknowledges that he/she has read the foregoing and that the information provided therein is true to the best of his/her knowledge and belief.

IN TESTIMONY WHEREOF, I have affixed my hand and seal of my office at _____, Ohio this _____ day of _____ 20____.

_____
Notary Public

G:/Masters/Declaration of Property Tax Delinquency (Rev. 0505)

HAMILTON COUNTY JOB & FAMILY SERVICES

222 East Central Parkway • Cincinnati, Ohio 45202-1225
General Information: (513) 946-1000
General Information TDD: (513) 946-1295
FAX: (513) 946-2250
www.hcjfs.org
www.hcadopt.org
www.hcfoster.org

Employer Name:			
Employee Name:			
Employee Address:			
Authorization Date:		Expiration Date:	

RELEASE OF PERSONNEL RECORDS AND CRIMINAL RECORD CHECKS

Whereas R.C. 2151.86 requires the Hamilton County Department of Job and Family Services (HCJFS) to obtain a criminal records check on each employee and volunteer of a HCJFS Provider who is responsible for a consumer's care during service delivery, and

Whereas HCJFS, and HCJFS' funding organizations, may be required to audit the records of Providers to ensure compliance with provisions relating to criminal record checks of Providers' employees who are responsible for a consumer's care during service delivery, and

NOW THEREFORE

I authorize HCJFS, and those entitled to audit its records, to review my personnel records, including, but not limited to, criminal records checks. This authorization is valid for this, and the three subsequent fiscal years of HCJFS.

Signature_____ Date _____

A. Criminal Record Check

Provider shall comply with R.C. Sections 2151.86 and 5153.111. Generally these require that every employee or volunteer of Provider who has contact with a Consumer have an effective criminal record check. Notwithstanding the aforesaid, an employee or volunteer, without an effective criminal record check, may have contact with a Consumer if he/she is accompanied by an employee with an effective criminal record check. As used in this section an "effective criminal record check" is a criminal record check performed by the Ohio Bureau of Criminal Identification and Investigation, done in compliance with ORC 2151.86, which demonstrates that the employee or volunteer has not been convicted of any offense listed in R.C. Section 2151.86(C).

ATTACHMENT A
Cover Sheet Group Home Proposals
Bid No: SC0913-R

Name of Provider _____

Provider Address:_____

Telephone Number: _____ **Fax Number:** _____

Contact Person:_____
(Please Print or type)

Phone Number: _____**(ext)**_____**E-Mail Address:**_____

Additional Names: Provider must include the names of individuals authorized to negotiate with HCJFS/BCCS.

Person(s) authorized to negotiate with HCJFS and BCCS:

Name:_____ **Title:** _____
(*Please Print)*
Phone Number: _____ **Fax Number:**_____**E-Mail:**_____

Name:_____ **Title:** _____

Phone Number: _____ **Fax Number:**_____ **E-Mail:** _____

Please Place an "X" next to each county for which you are submitting a proposal:

County	Place an X if submitting for the County
Hamilton County	
Butler County	

Please Complete Rate Grid located on page 2 of this form.

Service/Year	Proposed Unit Rates	IV-E Admin Ceiling	IV-E Maintenance Ceiling	For years 2 and 3 only, please list % increase from previous year
RGH/Year 1				
RGH/Year 2				
RGH/Year 3				
RGH-SN/Year 1				
RGH-SN/Year 2				
RGH-SN/Year 3				
Other/Year 1				
Other/Year 2				
Other/Year 3				

Certification: I hereby certify the information and data contained in this proposal are true and correct. The Provider's governing body has authorized this application and document, and the Provider will comply with the attached representation if the contract is awarded.

_____ _____ _____

Signature - Authorized Representative **Title** **Date**

By signing and submitting this proposal Cover Sheet, Provider certifies the proposal and pricing will remain in effect for 180 days after the proposal submission date.

Please complete the back of this form containing a checklist to verify that everything required to be submitted as part of your proposal is included.

RFP Submission Checklist

Pursuant to Section 4.6 of the RFP, the following items are to be included in your proposal in order for it to be deemed qualified. Please indicate that the items are included by checking the corresponding column.

Action Required	RFP Section	Included
Did you register for the RFP process by September 6, 2013?	3.3	
Will your Proposal be submitted by 11:00 a.m. on September 27, 2013?	4.4	
Did you include all the Contact Information on the Cover Sheet?	2.1	
Did you include the Unit Rate for the Initial Term on the Cover Sheet?	2.1	
Did you include the Unit Rate for the First and Second Renewal Terms on the Cover Sheet?	2.1	
Did you sign the Cover Sheet?	2.1	
Is a response to each Program Component included?	2.2.1	
Is a response to each System and Fiscal Administration Component included?	2.2.2	
Are three (3) Customer Reference Letters enclosed or is there a written explanation why a reference(s) is not included?	2.4	
Are required Personnel Qualifications enclosed?	2.5	
Did you submit 1) a report to include all of the Outcome Measures for the last twelve (12) months; 2) a narrative description of data sources for the Objective Measures; and 3) a narrative description of reporting methodology to produce the Outcome Measures report?	2.6	