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March 3, 2017

HCJFS REQUEST FOR PROPOSAL
INDEPENDENT LIVING SERVICES

ADDENDUM 1

RFP Conference Attendees:

Hearne House
Kelly Youth Services
Lighthouse Youth Services
Momma's Place
Necco
Nella's Place
Pro Foundation, The
St. Joseph Orphanage
Trinit-D Network Services
Independent Providers (4)

Questions asked during RFP Conference:

Q1. Do you want the Service Grid to be part of the proposal?

A. Yes.

Q2. Where in proposal do you want Providers to put Attachment A-1?

A. Attachment A-1, Program Component Checklist should be placed after Attachment A – Cover Sheet.

Q3. Excel version of budget will be sent to us, correct?

A: Yes, Excel budget is attached along with Addendum 1, Cover Sheet (Attachment A), Program Component Checklist (Attachment A-1), and Service Grid.

Q4. Provider outcome measures: Is there an HCJFS reporting format?

A: The invoice is the reporting format. When the invoice is submitted we will determine the accuracy of the information.

Q5. Provider outcome measures: Is there an HCJFS invoice format?

A: Refer to Question 4.

Q6. Provider outcome measures: Whom should the reports be sent to at HCJFS?

A: Jane Huesman.

Q7. Provider outcome measures: When is each report due?

A: Time frames are outlined in RFP Attachment I – SORC Performance Outcomes Measures.

Q8. Will the 6-month review to determine if a placement should be extended happen every 6 months?

A: No, it will be determined every month during the 1st 6 months services are intensified and working on goals to move the child into scattered site apartment. After 6 months it is then decided to extend the time. There needs to be specific goals that they are working on during the 30 day period. Again, provider is intensifying the services during that period so that the child knows what needs to happen during that time. The child needs to be part of the meetings. Meetings after the initial 6 months needs to occur monthly. During the 6 months anyone can request meetings occur more frequently. There has to be specific goals that the child is working on that justifies the child being in Semi longer than 6 months.

Q9. If a youth has more than one child, how many bedrooms are required?

A: It depends on the age and sex of the children.

Q10. At what age does a child of the youth placed require his/her own bedroom?

A: It is our belief that any child past 1 year old needs a room of their own.

Q11. On page 24, question 8, there is an added part to address independent living. Do we address it here or under question 5?

A: The questions are different. One addresses the Daniel Memorial and the other question is about education.

Q12. On page 26, question 24 appears to duplicate question 15 on page 25.

A: You are correct. Please respond to question 15 and remove question 24.

EXHIBIT II

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: $_____ $_____ $_____

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
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.

NOTE: You must list the percentage amount on the FICA, Worker's Comp and Unemployment lines. Remember - Unemployment Taxes are based ONLY on the first $9,000 of the employees' salary.

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

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.

	EXHIBIT II		
RENEWAL YEAR ESTIMATED COST SHEET			
PROGRAM	**RENEWAL YEAR 1 EXPENSE**	**RENEWAL YEAR 1 UNIT RATE**	**NARRATIVE - Please describe in detail the reasons for increased costs/expenses. This narrative will be used to help determine the amount of increase Provider may receive if HCJFS awards increases in renewal years 1 and 2.**
PROGRAM 1			
PROGRAM 2			
PROGRAM 3			
PROGRAM 4			
PROGRAM	**RENEWAL YEAR 2 EXPENSE**	**RENEWAL YEAR 2 UNIT RATE**	**NARRATIVE - Please describe in detail the reasons for increased costs/expenses. This narrative will be used to help determine the amount of increase Provider may receive if HCJFS awards increases in renewal years 1 and 2.**
PROGRAM 1			
PROGRAM 2			
PROGRAM 3			
PROGRAM 4			

Renewal years 1, 2, and 3

ATTACHMENT A
Cover Sheet for Independent Living Proposals
Bid No: RFP #SC03-16R

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.

Person(s) authorized to negotiate with HCJFS:

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

Name:_____ **Title:** _____

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

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

Service/Year	Total Cost	For years 2 and 3 only, please list % increase from previous year
IL/Year 1		
IL/Year 2		
IL/Year 3		
IL-B/Year 1	$12.00	
IL-B/Year 2	TBD	Not to exceed 3%
IL-B/Year 3	TBD	Not to exceed 3%
IL-SN/Year 1		
IL-SN/Year 2		
IL-SN/Year 3		
Individual Aid/Year 1	$21.50 per hour	
Individual Aid/Year 2	TBD	
Individual Aid/Year 3	TBD	
Other/Year 1		
Other/Year 2		
Other/Year 3		

***** If you intend to bid for "Other" ancillary services your agency may provide to assist with keeping a child in placement, a brief service description must be included in the proposed services section of the RFP.**

*****The Individual Aid rate is an hourly rate set by HCJFS. Please indicate if your agency is capable and willing to provide individual aid services if needed.**
Yes ____ No_____

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**

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 March 7, 2017?	3.3	
Will your Proposal be submitted by 11:00 a.m. on March 28, 2017?	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 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?	2.8	

RFP# SC03-16R - Independent Living RFP

Program Component Checklist

Please ensure all questions in Section 2.2.1 are answered and page numbers are listed by using checklist below.

Proper Answer: If YES - list page number where response can be found. If NO - list reason for not responding.

QUESTION #	YES	PAGE #(s)	NO	REASON FOR NOT RESPONDING
Question 1				
Question 2				
Question 3				
Question 4 (A through L)				
Question 5				
Question 6				
Question 7				
Question 8				
Question 9				
Question 10				
Question 11				
Question 12				
Question 13				
Question 14				
Question 15				
Question 16				
Question 17				
Question18				
Question 19 (A through F)				
Question 20				
Question 21				
Question 22				
Question 23				
Question 24				
Question 25				
Question 26				
Question 27				
Question 28				
Question 29				
Question 30				
Question 31				
Question 32				
Question 33				
Question 34				
Question 35				
Question 36				
Question 37				
Question 38				
Question 39				
Question 40				
Question 41				
Question 42				
Question 43				
Question 44 (A through K)				

Attachment H – Independent Living Service Grid

Category:	**Independent Living**	**Independent Living**
Discrete Service	Independent Living Diagnostic Assessment Individual/Family Therapy	Diagnostic Assessment Individual/Family Therapy
Program Name	**Independent Living**	**Independent Living – Special Needs**
Location		
Ages		
Gender		
Admission Criteria		
Exclusion Criteria		
Admissions Process		
Intake Contact Person:		
Intake telephone #		
Clinical Director Contact		
Clinical Director Telephone #		
After Hours telephone #		
Ability to accept ER admissions? [4 hour admission]		
Estimated projected # slots		
Projected ALOS		
Estimated # fixed vacancies a month		
Staffing Ratios:		