Tri-Counties Regional Center
SAN LUIS OBISPO • SANTA BARBARA • VENTURA

COVER PAGE
FEBRUARY 2013 REQUEST FOR PROPOSALS
Purchase of Services Projects (POS)

County to be served: ☐ Santa Barbara ☐ San Luis Obispo ☐ Ventura

Proposed / Existing Agency Name: _____

Proposed Service Type and Service Code: _____

Name of person or organization submitting proposal: _____

Business physical address:

_____

Mailing address (if different from above):

_____

Telephone number: _____

Cell phone number (optional): _____

Fax number: _____

E-mail address: _____

Contact person: _____

Author of proposal: _____

Author's Title & Contact Info _____

Date proposal submitted: _____

Important note: Consultants <u>cannot</u> be used to write this initial RFP proposal summary. The summary must be written by the applicant. Any proposals found to be written by a consultant will be disqualified.

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STATEMENT OF EXPERIENCE AND QUALIFICATIONS
FEBRUARY 2013 REQUEST FOR PROPOSALS

1. Are you now, or have you ever been a vendor of Tri-Counties Regional Center or any other regional center in California? ☐ No ☐ Yes

If yes, please identify which Regional Center(s) and list the vendor number(s), beginning and ending dates of service, and service code(s). If you need additional room, attach a separate sheet of paper.

Regional Center	Vendor Number(s)	Beginning and Ending Dates of Service	Service Code(s)

2. Have you ever been an employee of or associated with any organization that serves persons with a Developmental Disability? ☐ No ☐ Yes

   If yes, provide name of agency(s), location, position(s) held, dates of service and a professional reference and phone number from that agency. (Use the back of this page or an additional page if needed.)

3. <u>As a separate attachment</u>, submit résumé for the director(s) and all other positions above direct staff that are listed on the organizational chart with all relevant qualifications, work experience, education, licenses and certifications for at least the past five years.

4. Applicants responding to this RFP who are currently vendored providers for TCRC or any other regional center must have services in good standing. Providers with Substantial Inadequacies (SI) or Type A CCL deficiencies in the past 12 months and providers who have had numerous SI's, deficiencies and/or other disciplinary actions taken against them historically shall not be considered for this service. Applicants must disclose any past, present, or pending licensure revocation, probation or denials, including, but not limited to Community Care Licensing, Public Health Licensing, or any other agency providing services to people with disabilities, children, or the elderly. <u>If you are a current vendor with a facility, you must include a letter of reference from CCL that you are in good standing and have had no SI's or Type A deficiencies in the past 12 months.</u>

5. If you currently operate, or have previously operated, one or more licensed Residential Facilities or Day Programs please provide the location of the facility(s) and name of the Licensing Program Analyst(s) (LPA) assigned to your facility, the location of the office having responsibility for each facility and the phone number for the LPA. Enter "N/A" if not applicable.

License Number	Location (City)	LPA Name, Office & Phone Number

6. Are you currently in the proposal or vendorization process with any other Regional Center?
☐ No ☐ Yes

If yes, please use the table below to identify which Regional Center(s) you are currently working on proposals with and describe the service(s).

Regional Center:	Type of Proposed Service and Service Code:

7. Provide a detailed account of your credentials and experience that qualify you and your staff to provide this service. Use additional pages as necessary.

8. Are you planning to develop the proposed service using a funding source other than Tri-Counties Regional Center during Fiscal Year 2012-2013? ☐ No ☐ Yes

If yes, indicate funding source and scope of grant program, if any.

9. Do you have any non-regional center professional/business operations that provide services to developmentally disabled persons and/or their families? ☐ No ☐ Yes

If yes, provide details of each service including business name, location, type, and time commitment of each obligation. (Use back of this page or additional page if needed.)

10. As an additional attachment, include an organizational chart for your agency or the proposed agency showing all positions and any affiliated organizations.

Acknowledgements

By my signature below I attest that the information provided above and on any attachments hereto is true and complete to the best of my knowledge and belief. I understand that if any information is found to be incorrect or incomplete, my proposal will be disqualified from consideration.

Signature of Person Authorized for Agency Contract Approval

_____ _____
Signature *Printed Name & Title*

_____
Date