**ANNUAL**
**REQUEST FOR QUALIFICATION (RFQ)**
**FOR SERVICE PROVIDERS**

**NOTICE IS HEREBY GIVEN** that pursuant to a fair and open process, sealed submissions will be received by The Lackawanna-Susquehanna Behavioral Health / Intellectual Disabilities / Early Intervention Program ("Program') at its offices at 507 Linden Street, 8th Floor, Scranton, Pennsylvania 18503 for provision of services to eligible individuals served by our Program. This RFQ will be used in applying funds for Fiscal Year 2012-2013.

## A. PURPOSE:

The purpose of this RFQ for service providers is to solicit interest from qualified agencies and/or individuals to provide professional services for the Program. A qualified agency and/or individual will be selected through a competitive, quality-based, fair and open process at the sole discretion of the Program.

## B. PROCEDURES FOR RESPONDING TO REQUEST FOR PROPOSAL:

1. Interested providers will submit a Letter of Intent to the Project Officer, c/o James Martin, 507 Linden Street, 8th Floor, Scranton, Pennsylvania 18503 by the close of business on March 24, 2011.

2. RFQ submissions will include four (4) copies and contain all information required within Section D. Proposals must be submitted to the Project Officer, c/o James Martin, 507 Linden Street, 8th Floor, Scranton, PA 18503 by the close of business on **Tuesday, April 12, 2011.** Submissions must be submitted in a sealed envelope with the name of the agency or individual submitting the proposal clearly marked on the outside of the envelope. It is recommended that each submission package be hand-delivered. The Program assumes no responsibility for delays in any form of carrier, mail, or delivery service causing the submission to be received after the above-referenced due date and time. Submission by fax, telephone, or email is not permitted.

3. All questions regarding this RFQ should be made in writing to the Project Officer, c/o James Martin, 507 Linden Street, 8th Floor, Scranton, PA 18503- All questions will be received by the Program by Tuesday, March 22, 2011. All responses to questions will be posted on both the Lackawanna County website at www.Lackawannacounty.org and the Lackawanna-Susquehanna BH/ID/EI Program's website at www.lsbhidei.org by Tuesday, March 29, 2011.

4. **Submission Format:** Submissions should adhere to the following outline:
   a. Cover letter
   b. Qualification Requirements (Section D)
      i. Agency Summary (Form A)
      ii. Scope of Services – Qualification statements (Form B-1, B-2, B-3)
      iii. Other Service Contracts (Form C)
      iv. Facilities – Office Locations (Form D)

   c. Appendix –Additional Supporting Documents

**C. CRITERIA FOR EVALUATION OF QUALIFICATION:**

The Program will independently evaluate each submission and selection will be made upon the following criteria:

1. Experience and reputation in the field;

2. Knowledge of Pennsylvania's Department of Public Welfare and the Lackawanna-Susquehanna Behavioral Health / Intellectual Disabilities / Early Intervention Program's *philosophy and approach* to the delivery of specific services identified within Form A

3. The administrative and programmatic capacity to manage the volume of work;

4. Availability to accommodate any required meetings of the Program;

5. Compliance with (a) established licensed requirements by the Commonwealth, (b) *Provider Qualification* (for Office of Developmental Programs [ODP] funded agencies), (c) *Provider Monitoring* (for ODP and Office of Child Development and Early Learning [OCDEL] funded agencies) and/or (d) specific requirements defined by the Program.

**D. QUALIFICATION REQUIREMENTS:**

The Program is requesting agencies and individuals to qualify to provide Behavioral Health, Intellectual Developmental Disabilities and Early Intervention Services within the Joinder Program by providing the following:

1. Agency Summary

2. Scope of Services, including a listing of services provided by your agency identified in Form B, in the following service areas:

   B-1 Behavioral Health Services
   B-2 Intellectual Disabilities Services
   B-3 Early Intervention Services

3. Other Service Contracts

4. Facilities and locations where services are provided.

The following explains what the Program expects in each of the Qualification Requirements listed above:

1. **Scope of Services** – The Lackawanna-Susquehanna Behavioral Health / Intellectual Disabilities / Early Intervention Program is requesting qualification statements to provide professional services for the Program. Your response should detail the agencies or individual's proposal to provide that type of service.

   Qualified agencies and individuals will provide services as described in the following three (3) service delivery areas:

a) *Behavioral Health Services* as defined by The Office of Mental Health and Substance Abuse Services
b) *Intellectual Disabilities Services* as defined by the Office of Developmental Programs
c) *Early Intervention Services* as defined by The Office of Child Development and Early Learning

2. **Résumé (Agency Summary)** – All summaries submitted to the Program shall include the following:

   a) Name and address of your agency and the corporate officer authorized to execute agreements. (Form B)

   b) A brief description of your agencies history, ownership and organizational structure. (Form B)

   c) The names, experience, proposal, and applicable licenses held by the individual primarily responsible for servicing the Program and any other person(s), whether as employees or subcontractors, with specialized skills that would be assigned to service the Program.

   d) A statement of your agencies insurance coverage. Agencies need not provide an insurance certificate specific to the Program in responding to this RFQ. An insurance certificate will be required prior to commencing work after selection of an agency to provide services relative to a specific project. (form b)

   e) A statement of assurance that your agency is not currently in violation of any regulatory rules and regulations set forth by the Pennsylvania Department of Public Welfare (DPW) that may have any impact on your agencies operations. (form b)

3. **Other Service Contracts**
   A listing of all like or similar service contracts with other county programs or Mutually Agreed upon Written Arrangement (MAWA) to provide Behavioral Health, Intellectual Developmental Disabilities and Early Intervention Services. Include the name, address and telephone number of the contact person. (Form C)

4. **Facilities – Office Locations**
   a) For your agencies facilities which will service this project:
      i. The location

      ii. Agency personnel assigned to this location (Administrative and Professional)

      iii. Activities of the agency performed at this location. Please list services provided by program type (i.e. Behavioral Health, Intellectual Disabilities and Early Intervention).

   For those facilities and activities located elsewhere, please explain the activities performed elsewhere and why these are best performed at a different office. Agencies where all activities are performed at one location should clearly indicate there is only one location.

**E. RESERVATION OF RIGHTS:**

The Program reserves the right to reject any and all submissions, in whole or in part; to waive any immaterial defect or informality in any proposal as may be permitted by law.

## AGENCY SUMMARY

## FORM A

This form should be completed and submitted with the Request for Qualification by the submission date noted in the Annual Request for Qualification for Service Providers.

| I. GENERAL INFORMATION | | |
|---|---|---|
| Agency Name: | | |
| Corporate Address: | | |
| City: | State: | Zip Code: |
| Services Provided: ☐ Behavioral Health | ☐ Intellectual Disabilities | ☐ Early Intervention |
| *Corporate Officer's Name: | Title: | |
| Corporate Officer's Signature: | | |

* Person authorized to execute agreements

| II. DESCRIPTION |
|---|
| In the space below, please provide a brief description of your agencies history, ownership and organizational structure. Please attach any supporting documents. |
| |

| III. EMPLOYEE DETAILS |
|---|
| In the space below, please provide the names, experience, proposal, and applicable licenses held by the individual primarily responsible for servicing the Program and any other person(s), whether as employees or subcontractors, with specialized skills that would be assigned to service the Program. |
| |

☐ **I ATTEST** that [TYPE NAME OF AGENCY] currently carries the following types of insurance coverage:

- ☐ Workers' Compensation Insurance
- ☐ Commercial General Liability Insurance
- ☐ Professional Liability Insurance
- ☐ Automobile Insurance

☐ **I ATTEST** that [TYPE NAME OF AGENCY] is not currently in violation of any regulatory rules and regulations set forth by the Pennsylvania Department of Public Welfare (DPW) that may have any impact on your agencies operations.

☐ **I ATTEST** that [TYPE NAME OF AGENCY] does create/have a *conflict of interest* with the submission of this Request for Qualification.

## SCOPE OF SERVICES

### FORM B-1
### Behavioral Health Services

**Instructions:** In the space below, please list all Behavioral Health service and the address of service delivery provided by your agency.

This form should be completed and submitted with the Request for Qualification by the submission date noted in the Annual Request for Qualification for Service Providers.

| BEHAVIORAL HEALTH SERVICES | |
|---|---|
| **Service Name** | **Address** |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## SCOPE OF SERVICES

### FORM B-2
### Services to Individuals with Intellectual Disabilities

**Instructions:** In the space below, please list all Intellectual Disabilities service and the address of service delivery provided by your agency.

This form should be completed and submitted with the Request for Qualification by the submission date noted in the Annual Request for Qualification for Service Providers.

| INTELLECTUAL DISABILITIES | |
|---|---|
| **Service Name** | **Address** |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## SCOPE OF SERVICES

### FORM B-3
### Early Intervention Services

**Instructions:** In the space below, please list all Early Intervention service and the address of service delivery provided by your agency.

This form should be completed and submitted with the Request for Qualification by the submission date noted in the Annual Request for Qualification for Service Providers.

| EARLY INTERVENTION | |
|---|---|
| **Service Name** | **Address** |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## OTHER SERVICE CONTRACTS

## FORM C

**Instructions:** In the space below, please provide a listing of all like or similar service contracts with other county programs or Mutually Agreed Upon Written Arrangement (MAWA) to provide Behavioral Health, Intellectual Disabilities and Early Intervention Services. Include the name, address and telephone number of the contact person. If no other service contracts exist, please mark N/A in the first space.

This form should be completed and submitted with the Request for Qualification by the submission date noted in the Annual Request for Qualification for Service Providers.

| OTHER SERVICE CONTRACTS | | | |
|---|---|---|---|
| Name | Address | Telephone Numbers | Contact Person |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## FACILITIES AND OFFICE LOCATIONS

**FORM D**

**Instructions:**

This form should be completed and submitted with the Request for Qualification by the submission date noted in the Annual Request for Qualification for Service Providers.

| FACILITIES AND OFFICE LOCATIONS | | | | |
|---|---|---|---|---|
| **County** | **Address** | **City** | **State** | **Zip Code** |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |