**APPENDIX G- Fatal Flaw and Application Checklist**

Applicant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Review Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section I:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Fatal Flaw | Requirement Met  Y/N | Comments | Reviewer Initials |
|  | Mandatory Non-Binding Letter of Intent to Apply submitted by October 31st, 2022 (p. 15) |  |  |  |
|  | Application submitted on time (p. 15) |  |  |  |

**Section II:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Requirement | Requirement Met  Y/N | Comments | Reviewer Initials |
|  | Appendix A - completed, signed and placed as covers sheet (pp. 23- 25)   1. Cover Page - General Information 2. Applicant General Information Form 3. References (3 References) |  |  |  |
|  | Table of Contents (p.21) |  |  |  |
|  | Format Times New Roman, unreduced 12-point font, 1” margin (p.21) |  |  |  |
|  | Pages labeled and numbered (p.21) |  |  |  |
|  | Appendix B  Part I – Organizational Capabilities  Part II – Program Description – Service Delivery Site |  |  |  |
|  | Appendix C – Mandatory Assurances Form (Completed, initialed, signed and dated) |  |  |  |
|  | Appendix D – Administrative and Fiscal Self-Evaluation Form (all questions must be answered) |  |  |  |
|  | Appendix E – Administrative Documentation |  |  |  |
|  | Internal Revenue Service designation (non-profit status). |  |  |  |
|  | Certificate of Good Standing from Florida Department of State, Division of Corporations (www.sunbiz.org) |  |  |  |
|  | Articles of Incorporation |  |  |  |
|  | By-Laws |  |  |  |
|  | Last filed Annual Report and Copy of current Certificate of Status from the Florida Department of State Division of Corporations. |  |  |  |
|  | Copy of the board of director’s resolution, signed by the Chairperson of the Board, granting authority to a named individual to complete and sign the application and negotiate and sign a contract, should it be awarded. |  |  |  |
|  | Copy of current list of Board of Directors, including individual term of office, address, phone number and e-mail address of each board member. |  |  |  |
|  | Copy of Board Minutes from the last Board of Directors Meeting –the most current minutes from the last board of directors meeting. |  |  |  |
|  | Copy of a Table of Organization. |  |  |  |
|  | Copy of the Organization’s Accessibility Plan. |  |  |  |
|  | Organization’s negotiated rate (Indirect Cost) from a federal cognizant organization, if applicable - a current copy of your federally awarded Indirect Cost Rate must be submitted if the organization has one. |  |  |  |
|  | Organization Statement (letter addressed to SFBHN’s CEO), explaining current Indirect Cost Allocation Methodology. |  |  |  |
|  | Copy of the most recent annual financial statement audit performed by a Certified Public Accounting (CPA) firm that is licensed and registered with the Florida Department of Business and Professional Regulation to conduct business in Florida. If an audit is not applicable, submission of the most recent financial statements for the agency’s most recent fiscal year prepared by the agency and approved by the board of directors. These statements must be in conformance with generally accepted accounting principles (GAAP) and standards contained in Government Auditing Standards issued by the Comptroller General of the United States. Applicant organizations with an audit will be scored more favorably. |  |  |  |
|  | For agencies that withhold income taxes, social security tax, or Medicare tax: attestation indicating that the 941 has been filed timely and any taxes due have been paid timely to the IRS was submitted, submitted on the agency’s letterhead and signed by the CEO/Executive Director. |  |  |  |
|  | For agencies that do not withhold income taxes, social security tax, or Medicare tax: submit a copy of the most recent 1096. |  |  |  |
|  | Proof of enrollment as a Medicaid Provider - including Medicaid Provider number. |  |  |  |
|  | National Provider Identifier (NPI) number. |  |  |  |
|  | DUNS Number |  |  |  |
|  | Proof of registration in www.SAM.gov. |  |  |  |
|  | Name and contact information of the Quality Assurance Officer or Compliance Officer. |  |  |  |
|  | Name and contact information of the Privacy Officer. |  |  |  |
|  | Accreditation. Provide a copy of the certificate and the most current monitoring report from the accrediting body. If the monitoring resulted in corrective action, provide a copy of the corrective action plan and proof of successful implementation of the plan as evidenced by a letter/report from the accrediting body. |  |  |  |
|  | Proof of successful past performance of the applicant with funders as evidenced by monitoring reports and program audits for the last two (2) years. If monitoring reports are not available, the applicant must provide an explanation for the absence of such monitoring reports. Failure to provide an explanation will in the absence of such explanation, SFBHN may decide will deem the application non-responsive. |  |  |  |
|  | Copies of any Corrective Action Plans issued by any funder, government entity, and/or accrediting body issued in the last 2 years |  |  |  |
|  | Example of a clinical file including all clinical forms, consent for treatment forms, assessments, progress note forms, clinical instruments used, treatment plans, treatment plan reviews, etc. (Non-Accredited Agencies Only) |  |  |  |
|  | Examples of instruments used to measure client progress in treatment, if applicable. |  |  |  |
|  | Emergency Preparedness Plan. The applicant is to submit a copy of their emergency preparedness plan. At a minimum this plan shall include provisions for records protection, alternative accommodations for clients in substitute care alternate facilities for the 24 hour facilities in case those facilities are incapacitated by the disaster and the expectation for returning exceeds emergency sheltering capabilities and time allowances supplies, and a recovery plan that will allow the applicant to continue functioning in the event of an emergency. |  |  |  |
|  | Organizations Information Technology policy and procedure/manual. |  |  |  |
|  | List of the organization’s internal and external trainings for staff. |  |  |  |
|  | Copy of all current Florida Department of Children and Families, and if applicable, Agency for Health Care Administration issued licenses for State of Florida funded services, or applications for these in order to subcontract with SFBHN as the Managing Entity. |  |  |  |

Overall Reviewer Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section III:**

Recommended for On-Site Visit:

☐ Yes

☐ No

Reviewer Name (Print and Signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Name (Print and Signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section III:**

Recommendation:

☐ Pre-Qualified

☐ Conditionally Pre-Qualified

☐ Not Pre-Qualified

Reviewer Name (Print and Signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Name (Print and Signature): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_