



**THRIVING MIND**  
**SOUTH FLORIDA®**

A network of exceptional mental health and  
substance use treatment providers.

7205 Corporate Center Drive, Suite 200  
Miami, Florida 33126  
(305) 858-3335  
[ThrivingMind.org](http://ThrivingMind.org)

# **Request for Qualified Behavioral Health Services Providers (RFQ)**

**Release Date: September 30, 2022**

**Thriving Mind/SEBHN Administrative Offices**  
**7205 Corporate Center Drive, Suite 200**  
**Miami, Florida 33126**  
**(305) 858-3335**

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Contracting As South Florida  
Behavioral Health Network, Inc.

## I. REQUEST FOR QUALIFICATIONS

The South Florida Behavioral Health Network, Inc. d.b.a. Thriving Mind South Florida (“SFBHN”) seeks qualified and accredited behavioral health organizations who wish to sub-contract with SFBHN to provide behavioral health (Substance Abuse and/or Mental Health) treatment, and prevention services. Funding is made available to SFBHN primarily through the Florida Department of Children and Families, Office of Substance Abuse and Mental Health. Interested parties are invited to complete the application included in this Request for Qualification. A Request for Qualifications (RFQ) refers to the pre-qualification stage of the procurement process. Only those applicants who successfully respond to the RFQ and meet the qualification criteria will be eligible to enter into a contractual agreement with SFBHN should funds become available. This application is designed to evaluate the applicant’s ability to comply with the service, administrative, fiscal, and data requirements of SFBHN. Applicants may apply to be pre-qualified for one service, or for a full continuum of care. An approved, pre-qualified organization is not guaranteed a contract with SFBHN; however, it does qualify the organization to be considered for a contract should funds become available within the period that the organization is pre-qualified. **Organizations are pre-qualified for no more than three years or as otherwise determined by SFBHN.**

## II. BACKGROUND

The Pre-Qualification of agencies to provide behavioral health services will allow SFBHN to negotiate with entities most suitable to deliver the services it funds through an efficient and effective process and meet the needs of the community served through SFBHN. Through Pre-Qualification, SFBHN identifies direct service agencies that possess the administrative and programmatic infrastructure that present reasonable likelihood of an Applicant’s ability to successfully comply with SFBHN’s contractual requirements. The current SFBHN Provider Network includes over 45 agencies delivering an array of services. The criteria are indicative of an entity’s viability, competencies, and capabilities and, when present, result in a reasonable likelihood the successful applicant will achieve or exceed SFBHN’s standardized contract requirements; quality service delivery expectations; appropriately utilize public funds; and protect vulnerable persons served by SFBHN. A committee will independently review each application in three (3) key areas:

1. program services;

2. administrative capacity; and
3. financial viability.

Applicants are advised that additional documents submitted in response to this RFQ may be requested by SFBHN.

### **III. MAJOR PROGRAM GOALS AND ACTIVITIES**

SFBHN requires all its contracted providers to utilize evidence-based practices (EBP), evidence-based intervention, science informed, research based, science based, and evidence informed strategies; implement continuous quality assurance/improvement plans; utilize an Electronic Healthcare Record (EHR); and deliver a wide array of behavioral health prevention, treatment, and recovery services in Miami Dade and Monroe Counties.

SFBHN will establish a network of Pre-Qualified entities that may be eligible to respond to solicitations consistent with the SFBHN procurement process. Further eligibility requirements may be contained in future solicitations issued to such Pre-Qualified entities in the SFBHN network. Through the Pre-Qualification process, SFBHN identifies network members that are able to provide community-based Substance Abuse and Mental Health (SAMH) services for a consumer-centered and family-focused coordinated system by qualified, direct service, community-based professionals as authorized by §394.9082, Florida Statutes, consistent with Chapters 394, 397, 916, §985.03, Florida Statutes, as applicable and in the Prime Contract (contract between the Florida Department of Children and Families and SFBHN).

The primary goal is to promote the reduction of substance use disorders and improve the mental health and lives of the people of Miami Dade and Monroe Counties by making substance use and mental health treatment, prevention, and support services available through a comprehensive, integrated community-based System of Care and to engage and encourage persons with or at risk of substance use and/or mental illness to live, work, learn, and participate fully in their community. SFBHN's Pre-Qualification process enables SFBHN to appropriately identify entities ready to provide service delivery throughout its network of providers. It also identifies those providers across systems resulting in systematic access to a full continuum of care for all children, adolescents and adults who enter the publicly-funded behavioral health services systems. Goals include improving co-occurring capability, trauma informed care, and expertise in all programs, as well as promoting and improving the behavioral health of Miami-Dade and Monroe Counties by strategically funding or implementing substance use prevention programs and environmental strategies relevant to the community's needs.

## IV. GENERAL DESCRIPTION

SFBHN will only contract with agencies it determines Pre-Qualified through a successful response to this RFA and future RFAs. Furthermore, SFBHN seeks to contract with agencies that utilize innovative and evidence-based approaches that address the needs of youth and/or adults which may seek to address the needs of an underserved population and which possesses highly skilled, trained, and credentialed staff. Applicants will have a history of delivering services in the community. In addition to the implementation of evidence-based practices, evidence-based intervention, science informed, research based, science based, and evidence informed strategies, SFBHN seeks applications from entities with expertise and training utilizing well developed, integrated, and appropriate design/methods consistent with the mission, goals, and vision of SFBHN. Services to meet the needs of consumers with mental health and substance use disorder diagnoses, which also address grief and the impact of trauma, are strongly desired.

Quality of services are assessed by SFBHN through regular monitoring of contractual requirements, quality improvement reviews, and ongoing analysis of data. Successful applicants shall maintain quality assurance/improvement practices as part of its Quality Assurance/Improvement Plan, to ensure the successful and sustained delivery of prevention, treatment, and other services, for which the successful applicant is qualified, that will result in achieving the minimum Performance Measures and Outcomes established by SFBHN, which may be reviewed at:

<https://www.myflfamilies.com/service-programs/samh/managing-entities/2022-contract-docs.shtml>

SFBHN also seeks applicants with comprehensive training programs of highly educated staff who enhance the delivery of evidence-based and innovative treatment approaches; applicants who employ self-monitoring of adherence to its policies, procedures, program models, and contracts; applicants with fidelity monitoring practices and reporting and analysis functions; applicants with procedures for receipt of an investigation of critical incidents that have the potential to impact the safety, security, health, and welfare of consumers, employees, or the public; applicants with effective grievances and compliance programs.

Applicants shall demonstrate in its Application its ability and methods to deliver behavioral health services led by a Board of Directors that includes person served representation and has a clear mission, vision, and value statement that is supported by a Strategic Plan. This will be evidenced through a Table of Organization that includes professionals with documented experience and credentials (education, licensure, certification); comprehensive policies and procedures; current applicable licenses and certifications; accounting procedures consistent with Generally Accepted Accounting Principles (GAAP); documentation of sound accounting and finance systems; development and implementation of Sliding Fee Scale; Client Trust Fund, Incident Reporting, Grievance, Financial Eligibility Screening, Informed Consent, Emergency Planning procedures; the

organization’s Code of Ethics; and ensure services recognize cultural, linguistic differences, and sensitive to the unique needs of persons with disabilities. To be eligible for consideration as a treatment Provider, the Applicant must utilize, or provide assurances that it will utilize, an Electronic Healthcare Record (EHR) system compatible with SFBHN’s requirements contained in PAM 155-2 Version 14 by the start date of any future contract award. For Prevention Services, Providers will utilize the Florida Department of Children and Families’ (“Department”) Performance Based Prevention System “PBPS,” that collects data related to community assessments and plans and substance use prevention programs and activities.

## V. CONTACT PERSON

This application is issued by SFBHN. The single point of contact for communication regarding this Application is:

Stephanie Feldman, RFQ Coordinator  
7205 Corporate Center Drive – Suite 200  
Miami, Florida 33126  
[E-mail: sfeldman@thrivingmind.org](mailto:sfeldman@thrivingmind.org)

During the application period, questions regarding this application can only be submitted in writing to the single point of contact. All questions submitted will be included in Q&A (Question and Answer) documents compiled and posted for review by all applicants on the SFBHN website by the date listed in the Schedule of Activities.

## VI. APPLICANT

The roles and responsibilities of the applicant staff are as follows:

- **Authorized Organizational Official (AOO).** The AOO is the designated representative of the applicant organization in matters related to the RFQ. In signing an application, this individual certifies that the applicant organization will comply with all applicable assurances and certifications referenced in the application. This individual’s signature on the RFQ application further certifies that the applicant organization will be accountable for the accuracy of the information provided.
- **Contact Person.** The designated Authorized Organizational Official (AOO) will assign and specify in their application an alternate contact person. This individual is responsible for responding to any additional information requests made by SFBHN, for the submission of the desk review materials, and for coordinating SFBHN’s on-site review when the AOO is unavailable.

NOTE: SFBHN will conduct official business only with the designated Authorized Organizational Official (AOO) and Contact Person.

## **VII. APPLICATION AND REVIEW PROCESS**

This subsection provides an overview of SFBHN’s RFQ support mechanisms, types of entities eligible to receive contracts, types of applications, types of funding opportunities, application submission (including application forms, application receipt points and deadlines, legal implication, and proprietary information), and the application evaluation process. It includes publications and SFBHN websites that can be accessed for additional information concerning the SFBHN pre-qualification process.

### **(1) ELIGIBILITY OF APPLICANTS**

Eligible Applicants are organizations that are domestic, private nonprofit organizations eligible to conduct business in the State of Florida. Eligible applicants must have a registered physical location in Miami-Dade and/or Monroe Counties at the time of submission of an application.

SFBHN is committed to ensuring provision of the highest quality services to the persons served by its network. Accordingly, SFBHN has expectations that accreditation is generally accepted nationwide as a clear indicator of quality service, that Applicants, at the time of submission of the RFQ applications, are fully accredited. Nationally recognized behavioral health accrediting bodies such as: Green Apple Accreditation of Children’s Services, Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), Joint Commission, International Center for Clubhouse Development (ICCD), or Council on Accreditation of Peer Recovery Support Services (CAPRSS) are accepted by SFBHN. Eligible behavioral health care organizations include local governments, hospitals, and nonprofit community-based organizations. SFBHN may waive this requirement for Prevention Providers.

### **(2) PROGRAMS AND SERVICES**

There is a commitment to ensure that publicly funded behavioral health services and supports to be available, accessible, and accountable. Supports and services are provided to respond to people's needs, build on their strengths, and be outcome based. SFBHN awards contracts for a wide range of services. A list of these services along with their description are grouped into four (4) programs (Adult Mental Health, Children’s Mental Health, Adult Substance Abuse and Children’s Substance Abuse). For a list of approved services description click on the link below:

<https://www.flrules.org/gateway/ChapterHome.asp?Chapter=65E-14>

### **(2a) TREATMENT**

SFBHN provides funding for therapeutic interventions and activities that help to eliminate, reduce, or manage symptoms or distress for persons who have severe emotional distress, a mental illness and/or co-occurring substance use disorder with the use of evidence-based practices, evidence-based

intervention, science informed, research based, science based, evidence informed strategies, recovery-oriented, and peer involved approaches in accordance with priorities established by the SFBHN and the Department for substance use, mental health treatment, and/or co-occurring disorders.

SFBHN funds a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and community to improve the health, wellness, and quality of life for those with behavioral health conditions.

### **Treatment for Mental Health**

SFBHN provides funding for the treatment of mental health through a coordinated system that offers treatment, rehabilitation, and support services for children, adolescents and adults affected by mental health disorders.

The process of treatment and recovery is highly personal and occurs via many pathways. It may include assessment and clinical treatment, therapy, medications, crisis intervention, psychiatric hospitalization, rehabilitation, support services, peer and family supports, among other approaches.

Rehabilitative services are intended to reduce or eliminate the disability that is associated with mental illness. Rehabilitative services may include assessment of personal goals and strengths, readiness preparation, specific skill training, and assistance in designing environments that enable individuals to maximize their functioning and community participation.

Support services include services that assist individuals in living successfully in environments of their choice. Such services may include income supports, social supports, housing supports, vocational supports, or accommodations related to the symptoms or disabilities associated with mental illness. Support services include culturally and linguistically appropriate services that assist individuals and families working toward recovery from mental health conditions.

Services may be delivered in a variety of settings, such as inpatient, residential, partial hospital, day treatment, outpatient, club house, or a drop-in or self-help center, as well as in other community settings, such as the individual's residence or workplace. The types and intensity of services provided shall be based on the clinical status of the individual and goals, community resources, and preferences. Services such as assertive community treatment involve all four types of services which are delivered by a multidisciplinary treatment team that is responsible for identified individuals who have a serious mental illness.

The term also includes those preventive interventions and activities that reduce the risk for or delay the onset of mental disorders. The term includes the mental health promotion and prevention at the core of a public health approach to children, youth, and adult mental health which addresses the mental health of all individuals, focusing on the balance of optimizing positive mental health as well

as preventing and treating mental health problems.<sup>1</sup>

### **Treatment for Substance Use**

SFBHN provides funding for the treatment of substance use through a coordinated system that offers detoxification, treatment, and recovery support for adolescents and adults affected by substance misuse, abuse, or dependence.

Detoxification Services: Detoxification focuses on the elimination of substance use. Specifically, detoxification services utilize medical and clinical procedures to assist individuals as they withdraw from the physiological and psychological effects of substance abuse. Detoxification may occur in either a residential or outpatient setting, depending on the needs of the individual.

Treatment Services: Treatment services include a wide array of assessment, counseling, case management, medication-assisted treatment, combined with counseling and behavioral health therapies, and support provided in residential and non-residential (outpatient) settings. Treatment services are designed to help individuals and their families who have lost their abilities to control the substance use on their own and require formal, structured intervention and support. Services include various levels of residential, outpatient, and recovery support based on the severity of the addiction.

Recovery Support: Recovery Support is offered during and following treatment to further assist individuals in their development of the knowledge and skills necessary to maintain their recovery. These services include transitional housing, life skills training, parenting skills, and peer-based individual and group counseling.

## **(2b) PREVENTION AND COALITIONS**

SFBHN provides funding for coalitions and evidence-based programs, practices, or strategies supported by research that reduce the prevalence and consequences of underage drinking and other substance use/abuse related problem behaviors, as well as promoting positive mental health. The basis for the State's prevention strategy is the Strategic Prevention Framework (SPF), which uses a five-step process known to promote youth development, reduce risk-taking behaviors, build assets, build resilience, and prevent problem behaviors across the life span, using the information from the six SAMHSA-CSAP strategies. SFBHN requires the use of evidence-based practices, evidence-based intervention, science informed, research based, science based, and evidence informed strategies, according to the focus of the services/strategies to be implemented. Evidence-based practices are well integrated with the SPF.

SFBHN funds high quality prevention programs and coalitions that integrate with community prevention efforts and currently have formal partnerships in the community, based on a public health model and prevention science informed comprehensive strategies that include the entire community. Applicants must have a structured design of activities and outcomes, grounded in prevention science

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<sup>1</sup> <https://youth.gov/youth-topics/youth-mental-health/mental-health-promotion-prevention>

informed programs and strategies that work in partnership to leverage prevention efforts for positive community level change.

Direct service applicants must have the basis of programming, , practices, or strategies supported by research and prevention science. It is the responsibility of the applicant to ensure that the selected program/strategy is still currently considered as founded in prevention science based on the criteria of SFBHN and the State of Florida Department of Children and Families.

Prevention science and research-based prevention refers to a set of prevention activities that evaluation research has shown to be effective. Some of these prevention activities help individuals develop the intentions and skills to act in a healthy manner. Others focus on creating an environment that supports healthy behavior. SFBHN encourages practitioners to consider "fit" when choosing an intervention.

SFBHN requires partnerships between direct service programs and coalitions in the community that the direct service provider offers its services. If there is no coalition in the direct service provider's community, then SFBHN expects the direct service provider to modify the CCAPs and the Logic Models to fit the needs of their target population and its community based on the approved CCAPs and Logic Models found on the SFBHN website, [www.thrivingmind.com](http://www.thrivingmind.com), and the identified community's risk and protective factors.

SFBHN funds only programs that provide services year-round (12 months of service provision) and not just during the school year, preferably outside of instructional school time. Creative strategies using science based prevention are encouraged for year-round uninterrupted prevention services that meet the community's needs.

A coalition is defined as a community-based entity for cooperation and collaboration among sectors representative of the community in which the group retains its identity with the common goal of building a safe, healthy, drug-free, and productive community.

At the time of this application, coalitions must have been in existence for a minimum of twelve (12) months as a formal coalition to be considered an applicant.

Coalitions must have a defined plan to work with the SFBHN Prevention Evaluation entity, led by Behavioral Science Research Institute (BSRI), to create a comprehensive approach to evaluation using a system to measure and report outcomes for the stated outcomes in the CCAP and Logic Model and using the SPF and consistent with the SFBHN Prevention goals and outcomes for the Prevention System of Care.

### **(3) FUNDING OPPORTUNITIES**

When funds are available, SFBHN will notify all contracted and pre-qualified organizations for an opportunity to apply for the funding in accordance with SFBHN's established policies and procedures.

#### **(4) CATEGORIES OF FUNDING**

The funding that SFBHN receives from DCF to provide behavioral health services can be divided into these types of funding sources: State General Revenue, Temporary Assistance to Needy Families (TANF), Federal Community Mental Health Block Grant, Substance Abuse Prevention and Treatment Block Grant, and other grants, contracts, or awards. Each of the funding sources is met with special conditions and/or restrictions that must be complied with.

#### **(5) LOCAL MATCH REQUIREMENTS**

Local match regulations are applied to certain Department of Children and Families Substance Abuse and Mental Health Program funding. Contracted service providers are responsible for meeting matching requirements for substance abuse and mental health funds as specified in Chapter 394, Part IV, F.S. based on the total amount of contracted funds. Chapter 65E-14, Florida Administrative Code contains the standards for service providers to satisfy State requirements for matching.

<https://www.flrules.org/gateway/ChapterHome.asp?Chapter=65E-14>

#### **(6) SLIDING FEE**

Uniform Schedule of Discounts and Sliding Fee Scale: The Federal Poverty Guidelines and applies to individuals receiving treatment services that are paid for by state, federal, or local matching fund annual uniform schedule of discounts and sliding fee scale, as specified in Section 394.674(4)(a), F.S. and in conjunction with the Federal Poverty Guidelines, and applies to individuals receiving services that are paid for by state, federal, or local matching funds.

The service provider shall request a sliding fee payment from persons not eligible for Medicaid or receiving services ineligible under Medicaid; and whose household income is less than 150 percent of the federal poverty income guidelines in accordance with Section 409.9081, F.S. Nominal co-payments for the following substance abuse and mental health services shall apply:

1. Outpatient treatment services – \$3 per day.
2. Residential treatment services – \$2 per day.

The service provider shall require persons meeting the criteria listed below to contribute to their treatment costs consistent with the provisions of Section 409.212, F.S.:

The service provider shall make a determination of ability to pay in accordance with the sliding fee scale for all individuals seeking substance abuse or mental health services. Payment of fees shall not be a pre-requisite to treatment or the receipt of services. The sliding fee scale shall not apply to services provided under the following Covered Services as defined in Rule 65E-14.021. F.A.C.

It is not the intent of Rule 65E-14, FA.C. to prohibit or regulate the collection of fees on behalf of an individual from third party payers and commercial insurers such as Workers' Compensation, TRICARE, Medicaid, or Medicare. However, service providers shall make every reasonable effort

to identify and collect benefits from third party payers for services rendered to eligible individuals.

<https://www.flrules.org/gateway/RuleNo.asp?title=COMMUNITY%20SUBSTANCE%20ABUSE%20AND%20MENTAL%20HEALTH%20SERVICES%20-%20FINANCIAL%20RULES&ID=65E-14.018>

## **(7) EMPLOYMENT SCREENING**

The pre-qualified provider shall ensure that prior to entering into a contract with SFBHN, all staff that are required by Florida law and by CFOP 60-25, Chapter 2, to be screened in accordance with chapter 435, F.S., are of good moral character and meet the Level 2 Employment Screening standards specified by sections 435.04, 110.1127, and subsection 39.001(2), F.S., as a condition of initial and continued employment that shall include but not be limited to:

- 1) Employment history checks.
- 2) Fingerprinting for all criminal records checks.
- 3) Statewide criminal and juvenile delinquency records checks through the Florida Department of Law Enforcement (FDLE)
- 4) Federal criminal records check for the Federal Bureau of Investigation via the Florida Department of Law Enforcement and
- 5) Security background investigation, which may include local criminal record checks through local law enforcement agencies.
- 6) Attestation by each employee, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant to chapter 435 F.S. and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.

## **(8) SUBMISSION OF THE MANDATORY NON-BINDING LETTER OF INTENT TO APPLY**

- a. A mandatory non-binding letter of intent to apply must be received by the specific date and time as in **Section VIII. Schedule of Activities** to continue to Phase I. This letter shall be submitted to the RFQ Coordinator, Stephanie Feldman to the following e-mail address: [sfeldman@thrivingmind.org](mailto:sfeldman@thrivingmind.org) . The RFQ Coordinator will send an e-mail confirmation of receipt to the applicant as well as a link to a SharePoint folder where a sample contract can be accessed. It is the responsibility of the prospective applicant to ensure that the letter was electronically submitted and received by the RFQ Coordinator.
- b. This letter is non-binding and will not require that the applicant apply for this RFQ. However, this letter is required for any applicant to be considered for funding through this solicitation.

The letter must state:

- i. The name of the organization that is applying with appropriate identifying information: address, telephone number, a contact email address, website address, name of President/CEO/Executive Director, tax ID information, two contacts for this application, signed by an individual approved to conduct business with SFBHN, on the organization letterhead. The letter must also identify the Authorized Organizational Official and Contact Person as defined previously.
- ii. The described intent to apply.
- c. Failure to submit the Mandatory Non-Binding Letter of Intent to Apply shall be deemed a fatal flaw and the application will be rejected and disqualified for further consideration for this RFQ.

## **(9) SUBMISSION OF APPLICATION**

To be considered a pre-qualified provider; an applicant must submit a complete application in accordance with established dates and, through an evaluation process, be determined by SFBHN to meet pre-qualifying criteria. Information to be submitted includes organizational capabilities, including but not limited to, data processing, quality assurance, human resources, training, prior behavioral health services experience, a program description of all services to be provided, unit cost budget and budget justification, biographical sketches of key personnel, accreditation, and other information specified in the application instructions. SFBHN reserves the right to request and evaluate additional information from any applicant after the submission deadline as SFBHN deems necessary.

Applicants should consult the cost principles and general administrative requirements for DCF contracts specified in Chapter 65E-14, F.A.C. Applicants may be required to provide proof of organizational eligibility (such as proof of nonprofit status) or other eligibility information.

Applications also must demonstrate compliance (or intent to comply), through certification or other means, with the applicable state and federal requirements as specified in **Appendix C, Mandatory Assurances SFBHN**.

## **(10) RECEIPT OF APPLICATION (ACCEPTANCE/REJECTION)**

### **1) Proposal Deadline**

An application will be considered to be on time if it is received on or before the published receipt date (See Schedule of Activities).

## 2) **Receipt Statement**

A confirmation e-mail acknowledging receipt of the application will be sent by the RFQ Coordinator or their designee. Proposals received after the deadline will be rejected via an email notification, and the application will not be reviewed.

It is the applicant's responsibility to communicate with the RFQ Coordinator should the applicant not receive an e-mail acknowledgement within twenty-four (24) business hours after the submission of the application.

## 3) **Right to Reject or to Waive Minor Irregularities Statement**

SFBHN reserves the right to reject any and all applications received with respect to this RFQ at any time.

## 4) **Request for Additional Information**

SFBHN reserves the right to request from an applicant additional information as deemed necessary to evaluate the proposal more fully.

## 5) **Fatal Flaw**

- a) Failure to submit the Mandatory Non-Binding Letter of Intent to Apply on or before the deadline indicated on the Schedule of Activities shall be deemed a fatal flaw and the application will be rejected and disqualified for further consideration for this RFQ.
- b) Failure to submit an application on or before the deadline indicated on the Schedule of Activities will constitute a fatal flaw and will result in the application not being considered.

## **(11) ASSURANCES**

The signature of an Authorized Organizational Official (AOO) on the application (**Appendix A, General Information**) certifies that the organization will comply with all applicable assurances and certifications referenced in the application. The applicant organization is responsible for verifying the accuracy, validity, and conformity with the most current organizational guidelines of all the administrative, fiscal, data, and programmatic information in the application. The AOO's signature further certifies that the applicant organization will be accountable for the appropriate use of any funds and for the performance of the contract, if awarded.

Recipients of SFBHN contract funds are responsible for and must adhere to all applicable state and federal statutes, regulations, and policies, and SFBHN policies and requirements. The applicant also is expected to be in compliance with applicable local laws and ordinances.

Anyone who becomes aware of the existence (or apparent existence) of fraud, waste, or abuse

related to SFBHN contract funds is encouraged to report this information to the SFBHN's President and CEO. Some examples of fraud, waste, and abuse that should be reported include, but are not limited to, embezzlement, misuse, or misappropriation of contract funds, and false statements, whether by organizations or individuals. This includes theft of contract funds for personal use; charging SFBHN for the services of "ghost" individuals; charging inflated building rental fees for a building owned by the contractor; and submitting false financial reports.

SFBHN may use administrative remedies if a contractor deliberately withholds information or submits fraudulent information or does not comply with applicable requirements including removal from pre-qualification for funding list, the withholding of payments, reducing payments for services, terminating the contract, and legal intervention. Additionally, if the contract is funded with state funds, SFBHN may assess financial penalties in accordance with Section 402.73(7), F. S., and Section 65-29.001 F.A.C.

## **(12) CONFIDENTIALITY OF INFORMATION (PROPRIETARY INFORMATION)**

Applicants are discouraged from submitting information considered proprietary unless it is deemed essential for proper evaluation of the application. If the application contains information that the applicant organization considers to be trade secrets, information that is commercial or financial, or information that is privileged or confidential, the pages containing that information should be identified.

When such information is included in the application, it is furnished to SFBHN in confidence, with the understanding that the information will be used or disclosed only for evaluation of the application. The information contained in an application will be protected by SFBHN from unauthorized disclosure. However, if a contract is awarded as a result of or in connection with an application, SFBHN shall have the right to use or disclose the information to the extent authorized by law. This restriction does not limit SFBHN's right to use the information if it is obtained without restriction from another source.

## **(13) ADDENDA**

An RFQ opportunity may have addenda documents issued while the application period is still open. These may describe application updates, include question and answer (Q&A) documents generated by inquiries from other applicants, and/or revisions to the RFQ opportunity. If addenda documents have been issued for the RFQ opportunity, they will be available on the SFBHN website.

Other requirements, certifications, applicable standards, and assurances may be found on the SFBHN website and in the SFBHN standard contract and rules, laws, policies, and regulations which it references.

It is the responsibility of the applicant to regularly check the SFBHN website for addenda, notices of decisions, and other information or clarifications to this RFQ.

## (14) EVALUATION PROCESS

The evaluation process consists of two phase process: a Screening for Compliance with Necessary Required Documents and an Onsite Monitoring Review. The purpose, scope, process, and criteria of each of these components are described below.

### 1) Screening for Compliance with Necessary Required Documents

Applicants will be screened for compliance with submission of the application per instructions and necessary required documents requested. This screening will qualify the application to proceed to the substantive reviews. All proposed services must take place within Miami-Dade and Monroe Counties, and applicants must meet all eligibility criteria described in this RFQ.

### 2) The Onsite Review

SFBHN staff will schedule an onsite review. The duration of this review will depend on the number of activities, programs, and services that are being pre-qualified. The applicant is required to submit supporting documentation with their application, refer to **Appendix B, Narrative and Appendix E, Documentation**. The documentation will be used to provide background on the applicant's administrative, fiscal, and programmatic policies and procedures, determine financial stability, current certification status, licenses, and corporate status.

Reviewers will:

- (a) Interview administrative, data, and/or clinical staff.
- (b) Validate the **Administrative and Fiscal Self-Evaluation Form (Appendix D)**.
- (c) Conduct a walk-through of the facility.
- (d) Review mock personnel and clinical files including, but not limited to, treatment and service plans, psychosocial evaluation, eligibility determination, assessment, intake information, and case notes. ANY IDENTIFYING INFORMATION OF THE INDIVIDUAL'S BEING SERVED MUST BE REDACTED BY THE APPLICANT.
- (e) Verify the information in the Application (**Appendix B, Narrative**); and,
- (f) Determine compliance with rules and regulations applicable to the services, which the organization is requesting to be pre-qualified.

### 3) Suspension of Review

If at any time during the review process a finding is revealed that would result in an applicant not being pre-qualified, the review process may be immediately suspended at the discretion of the President and CEO without completing all three review components. The application will be determined to be not qualified and returned to the applicant as such.

## (15) APPEALS AND DISPUTE RESOLUTION

To preserve and underscore the fairness of the SFBHN review process, SFBHN has a review appeal

system to provide applicants the opportunity to seek reconsideration of the review results if, after review of the summary statement, they believe the review process was procedurally flawed.

The applicant should discuss concerns about the review with the RFQ Coordinator; the RFQ Coordinator will attempt to resolve the applicant's concerns. If, after discussion with the RFQ Coordinator, the applicant still has concerns, the Authorized Organizational Official (AOO) may submit a formal letter of appeal to the RFQ Coordinator within ten (10) business days (Saturdays, Sundays, and SFBHN holidays excluded) after notice of the decision.

If the RFQ Coordinator and the AOO are unable to reach a mutually satisfactory resolution, the RFQ Coordinator will present the applicant's formal letter of appeal and consult with SFBHN's President/CEO. This process may result in a decision to re-review the application if it is found that there was a procedural flaw or it may result in a meeting between SFBHN's President/CEO, the RFQ Coordinator, and the AOO to amicably resolve the issue. Should the decision be to re-review the application, the re-review consists of a review of the same application, not a revised version, by the same or another review group without access to the summary statement of the disputed process. If the parties cannot reach a satisfactory resolution, the dispute shall be presented, at the discretion of SFBHN's President/CEO, either to the Executive Committee to the Board of Directors for final resolution. The decision of SFBHN shall prevail.

## **(16) TYPES OF RECOMMENDATIONS**

As a result of the evaluation process there are three (3) possible recommendations:

1. Pre- Qualified,
2. Conditionally Pre-Qualified, and
3. Not Pre-Qualified.

A Pre-Qualified status indicates that the applicant's organizational administrative, fiscal, and data processing capabilities, facilities and services are substantially in compliance with state and federal regulations or have the ability to be in compliance within thirty (30) days if awarded a contract.

Conditionally Pre-qualified means that there are one or more minor deficiencies, which can be corrected. With evidence that the deficiencies have been corrected, the applicant's recommendation can be upgraded to Pre- Qualified.

A Not Pre-Qualified recommendation is made when the applicant's administrative, fiscal, and data processing capabilities and services are determined to be significantly out of compliance with SFBHN's and state and federal regulations. If an applicant fails to become pre-qualified after three (3) continuous attempts, they must wait a minimum of three (3) years to request to become pre-qualified.

## **(17) REVIEW AND FINAL APPROVAL BY THE SFBHN BOARD'S EXECUTIVE COMMITTEE**

Summary statements for those applications recommended for pre-qualification or conditionally pre-qualified are presented to the SFBHN Board's Executive Committee for approval. The Executive Committee may concur with the recommendation, may decide not to recommend an application on the basis of program or policy considerations, or may recommend deferral of an application and refer it back for re-review. Applications, which are deemed significantly deficient to be pre-qualified, may be notified of such without review of the Executive Committee.

## **(18) APPLICANT NOTIFICATION OF RECOMMENDATION**

Within fifteen (15) working days of receiving the Executive Committee's approved recommendations, the RFQ Coordinator sends an e-mail to the applicant notifying them of the Executive Committee's decision. If the Executive Committee of the Board made either a Conditionally Pre-Qualified or Not Pre-Qualified recommendation, the notification will also include a list of the deficiencies and an explanation of why they were not pre-qualified. In addition, for conditionally pre-qualified applicants, the necessary corrective action will be described as well as the steps to take for reconsideration by SFBHN.

## **(19) DISPOSITION OF APPLICATIONS**

All incomplete applications, non-compliant applications, and applications determined to be nonresponsive to application requirements will be returned to the applicant by the RFQ Coordinator without further action.

## **(20) DURATION OF PRE-QUALIFICATION CERTIFICATION**

New organizations that have been pre-qualified will remain pre-qualified for up to three (3) years from the date of the notification or unless otherwise noted by SFBHN in writing to the pre-qualified organization. The actual duration will be set at the discretion of the leadership staff of SFBHN. An applicant is required to update their application if any of the required information in the application has changed and to send it to the RFQ Coordinator, Stephanie Feldman. Additionally, the applicant will be asked to sign an affidavit certifying that their application is not materially different prior to contracting.

## **(21) ELIGIBILITY CRITERIA FOR RECIPIENTS OF SERVICES**

The organization and its subcontractors, if applicable, shall be knowledgeable of the eligibility criteria for services for which they are applying. All persons meeting the target population descriptions in the list below are eligible for services based on the availability of resources. A detailed description of each target population is contained in s. 394.674, Florida Statutes.

**A. Treatment Services Target Populations**

1. Adult Mental Health-Severe & Persistent Mental Illness
2. Adult Mental Health-Serious & Acute Episodes of Mental Illness
3. Adult Mental Health-Mental Health Problems
4. Adult Mental Health-Forensic Involvement
5. Children’s Mental Health-Serious Emotional Disturbances
6. Children’s Mental Health-Emotional Disturbances
7. Children’s Mental Health-At Risk of Emotional Disturbances
8. Adult Substance Abuse (includes Prevention)
9. Children’s Substance Abuse (includes Prevention)

**B.** State of Florida Department of Children and Families Pamphlet 155-2, Substance Abuse and Mental Health Measurement and Data may be found on the State of Florida Department of Children and Families, Substance Abuse Mental Health website:

[FASAMS - Florida Department of Children and Families \(myflfamilies.com\)](http://myflfamilies.com)

**C.** Section 394.674, F.S., Eligibility for publicly funded substance abuse and mental health services; fee collection requirements is found on the Florida Legislature Official Internet Site below:

[http://www.leg.state.fl.us/STATUTES/index.cfm?App\\_mode=Display\\_Statute&URL=0300-0399/0394/0394.html](http://www.leg.state.fl.us/STATUTES/index.cfm?App_mode=Display_Statute&URL=0300-0399/0394/0394.html)

**(22) PERFORMANCE MEASURES**

The Florida Legislature has established specific performance measures applicable to state supported behavioral health services. There are two types of performance measures: outputs, which are quantitative, and outcomes, which are qualitative. See **Appendix F, Substance Abuse and Mental Health Required Performance Outcomes and Outputs** for a reference to the outputs and outcomes related to each program. Though this document is not required for submission in the RFQ, Network Providers who contract with SFBHN are required to meet the measures included in the tables. Prevention Providers will have different performance measures which will be negotiated at the time of contracting.

**VIII. SCHEDULE OF ACTIVITIES**

The following is the schedule of activities related to the current pre-qualification process.

Activity	Estimated Timeframe
----------	---------------------

1. Posting RFQ	September 30, 2022, By 5:00 PM [EST]
2. All written inquiries due to SFBHN	On or before October 17, 2022 By 12:00 P.M. [EST]
3. Posting of responses to written inquiries	On or before October 27, 2022 By 12:00 P.M. [EST]
4. Mandatory Non-Binding Letter of Intent to Apply	October 31, 2022 By 3:00 PM
5. Submission of applications	On or before December 1, 2022 By 12:00 Noon [EST]
6. Review of Applications: signed and dated by authorized person, signed and dated assurances; complete application; and required supporting documentation	Beginning December 5th, 2022 -January 31, 2023
7. Evaluation: Screening for Compliance with Necessary Required Documents, Desk Review of Supplemental Information, and Onsite Monitoring Review	Beginning February 6, 2023 – March 31, 2023
8. Recommendations submitted to Executive Committee for approval	2 weeks after evaluation of all Applications is finalized
9. List of pre-qualified agencies submitted to the Florida Department of Children and Families.	1 week after SFBHN Executive Committee approves the recommendations
10. Notification of Results	E-mail notification within fifteen (15) working days after Executive Committee of Board approval, excluding weekends and legal holidays.

## IX. INSTRUCTIONS FOR THE SUBMISSION OF AN APPLICATION

- (a) Electronic submission of the applications must be received by the date as set forth in the above Schedule of Activities. Late applications will not be accepted.
- (b) Table of Contents
- (c) **Appendix A, General Information** must be completed, signed.

- (d) The application must be sent electronically to the RFQ Coordinator at: [sfeldman@thrivingmind.org](mailto:sfeldman@thrivingmind.org). The RFQ Coordinator will send an E-mail confirmation receipt to the applicant, to the e-mail address that it was sent from, confirming receipt of the application. It is the responsibility of the applicant to ensure that the application was electronically submitted and received by SFBHN.

## (1) FORMAT AND INSTRUCTIONS

- (a) Table of Contents: A table of contents is required.
- (b) Applications must be submitted in the following format:
- be written in English (avoiding jargon),
  - Times New Roman, and
  - unreduced 12-point font and 1" margins.
- (c) Label and number the pages, sections and/any supporting documentation.
- (d) A completed application consists of the documents listed below and must be submitted in the order presented below:
- i. **Table of Contents**
  - ii. **Appendix A:**
    - Cover Page, Applicant General Information and Three (3) Reference Letters
  - iii. **Appendix B:**
    - Part 1 – Narrative
    - Part 2 – Program Description – Service Delivery Site
  - iv. **Appendix C:** Mandatory Assurances Form
  - v. **Appendix D:** Administrative and Fiscal - Self-Evaluation Form
  - vi. **Appendix E** –Documentation

*Remainder of page left blank intentionally*

## (2) APPENDIX A -GENERAL INFORMATION FORM

### Applicant General Information

RFQ Submission to: South Florida Behavioral Health Network, Inc.,  
d.b.a. Thriving Mind South Florida

I. Legal Name of Applicant Agency: \_\_\_\_\_

II. Contact Information for the Authorized Organization Official (AOO)

Contact Name (AOO): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone 1: \_\_\_\_\_

Telephone 2: \_\_\_\_\_

Email Address: \_\_\_\_\_

III. Alternate Contact Person

Contact Name (AOO): \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Telephone 1: \_\_\_\_\_

Telephone 2: \_\_\_\_\_

Email Address: \_\_\_\_\_

IV. Applying for (Select all that apply)

- Adult Mental Health Services
- Children's Mental Health Services
- Adult Substance Abuse Services
- Children's Substance Abuse Services
- Substance Use Prevention Services

Substance Use Prevention Coalition

Signature of Authorized Organization Official (AOO): \_\_\_\_\_

Print Name of AOO: \_\_\_\_\_

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

*This signature attests that as an authorized representative the submission has been reviewed and all sections of the application have been completed*

**APPLICANT GENERAL INFORMATION CONTINUED**

1. **Legal Name of Applicant Agency:** \_\_\_\_\_
  
2. **Address of Corporation's Administrative Offices or Principal Business Site:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
3. **Federal Employer Number:** \_\_\_\_\_
  
4. **Unique Entity Identifier used in SAM.gov(12 character alpha numeric ID assigned by SAM.gov):**
5. **NPI Number:**
6. **Medicaid Number:**
  
7. **Contract Information**
  - a. **Chief Executive Officer:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_
  
  - b. **Chief Financial Officer:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_
  
  - c. **Data Security Officer:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_
  
  - d. **Authorized Organizational Official (AOO):** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_
  
  - e. **Contact Person Assigned by AOO:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_
  
  - f. **Clinical Director:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_  
**E-mail:** \_\_\_\_\_
  
8. **Corporate Status per IRS Designation:** \_\_\_\_\_

9. Annual Operating Budget (Include all revenue sources): \_\_\_\_\_

10. Number of Employees: \_\_\_\_\_

11. Major Funders: \_\_\_\_\_

12. Corporate Mission Statement: \_\_\_\_\_

13. Provide three (3) reference letters for your organization. Ensure that the letters describe your relationship and collaboration with these partners.

14. Accreditation. Note that all mental health and/or substance use treatment providers, mental health clubhouses and recovery community organizations under contract with SFBHN must be accredited. If your agency is applying to become a pre-qualified agency through this application for any mental health and/or substance use treatment service, mental health clubhouse and/or recovery community organization, your agency must be fully accredited at the time of submission of this application. For Prevention Providers, SFBHN may wave this requirement.

Please provide a list of all of the services that have been accredited in the table below.

As part of the documentation requested in **Appendix E, Documentation**, submit a copy of the certificate of accreditation.

If the service(s) provided by your organization does not fall under the above criteria, provide a statement indicating so.

Accrediting Body	Services Accredited	Expiration Date

### (3) APPENDIX B - NARRATIVE

#### PART I – ORGANIZATIONAL CAPABILITIES

Please provide a narrative of the information requested in each of the sections below. Answer completely, but concisely. Include exceptions to your statements when appropriate. Your responses should reflect your organization as a whole.

##### A. Organization Structure

1. Table of Organization: Provide a Table of Organization indicating lines of authority and supervision as an appropriate attachment, and label appropriately. Include short biographical sketches for key staff (CEO, CFO, COO, Medical Director, Clinical Director, Program Director, Information Technology Director, and Quality Assurance Director).
2. Philosophy and Mission of the Organization: Provide your organization's philosophy in the provision of services as well as your mission.
3. Management Structure: Describe the organization's top management structure, including key positions and functions.

##### B. Service Array-Treatment Services

1. Target Population: Describe the target populations you currently serve. Describe service recipients in terms of age, sex, ethnicity, language, disabilities, children, youth, young adults at risk of substance use, parents, caregivers of children, youth, young adults at risk of substance use and any special populations as listed below. Explain exclusions.

Special Populations, if applicable. Check all that apply:

- 1.1.  Children at risk of residential services or juvenile justice involvement
- 1.2.  Pregnant/Post-partum Women
- 1.3.  Individuals Involved with the Forensic or Criminal Justice System
- 1.4.  Individuals with co-occurring disorders
- 1.5.  Individuals with HIV
- 1.6.  Individuals with Child Welfare Involvement
- 1.7.  Homeless Youth and Adults
- 1.8.  Individuals admitted and discharged from a State Mental Health Treatment Facility
- 1.9.  Injecting Intravenous Drug User
- 1.10. Others: (describe): \_\_\_\_\_

2. Services Provided: Describe your current array of services provided to the target population you listed above.
3. Peer Services:
  - 1) Describe the agency's use and employment of Peers throughout the service array.
  - 2) Describe the support, training and supervision provided to the Peers and how many are certified or seeking certification.
4. Recovery-Oriented System of Care (ROSC): Describe how your agency is implementing the Recovery-Oriented System of Care (ROSC) principles.
5. Telehealth Services: Describe the use of technology your organization utilizes in your services continuum, i.e., do you utilize an Electronic Health Record (EHR)?
6. Cultural and Linguistic Competence: Describe your strategy to assure that your services are provided in a culturally and linguistically competent manner.
7. Trauma Informed Care: Many individuals with behavioral health issues have experienced trauma that affects their development and adjustment. Describe your strategy to assure that your services are trauma focused.
8. Integration of Behavioral Health and Primary Health Care: Many individuals with behavioral health issues have chronic health conditions and may have neglected their primary health needs.
  - 1) Describe your agency's strategy to ensure that individuals are receiving proper medical care.
  - 2) Describe formal or informal agreements you may have with other entities, or individuals, from whom you receive referrals and who make referrals to you. Provide any collaborative agreements or memorandum of understanding (MOU) currently in effect.
9. Service and/or Treatment Planning:
  - 1) Describe the process used to determine an individual's service and/or treatment plan. At a minimum, your description should specify who participates in the planning, who signs off and when, how frequently the

plan is reviewed, and how changes are made. Describe how these fits with the system of care. Attach a copy of your service plan and service plan manual as an appropriately labeled attachment.

- 2) Address the admission and discharge criteria.
- 3) What is the average length of participation in treatment for a person served?
- 4) Describe the processes employed to match individuals and families to services and ensure that services are consistent with the individuals' and families' individual recovery and resiliency needs.
- 5) Individual and Family Participation Strategies. Discuss how the organization promotes family participation in services and practices for the development of natural supports. Discuss how the organization involves individuals and families in the planning, development, implementation, and evaluation of service delivery systems.

10. Describe the organization's specific individual identification, outreach, and engagement strategies applicable to the array of covered services provided. Explain how referrals are received and the process between referral and admission.

11. Identify the major continuing care strategies for individuals and families completing services. Address placement and referral activities specific to the general target populations served and any Special Populations. This description should address: The processes by which individuals and families are prepared for and transitioned to continuing care services, The major continuing care strategies, best practice models, and community housing/living options alternatives for individuals and families completing services in this activity (within the organization and within the community system of care).

12. Responding to individuals in crisis

- 1) Adult: Describe your agency's process in responding to an adult in crisis including services, linkages and supports (including natural supports, long acting injectables, etc.)

- 2) Children: Describe your agency’s process in responding to a child in crisis including services, linkages and supports (including natural supports, work with the school system, etc.)

### 13. Child Welfare System/Involvement

- 1) Does your agency screen for this during your intake process? If so, describe how the agency identifies individuals that are involved in the child welfare system including services, coordination/staffing’s with the Community Based Organization, linkages and supports provided. Additionally, describe the agency’s training activities to increase staff competency in child welfare.
- 2) Describe your agency’s relationship with child welfare system stakeholder’s such as the Miami Dade Community Based Care Alliance.

### 14. Case Management

- 1) Describe how your agency provides Case Management Services to the community, i.e., home-based and/or community-based services.
- 2) How many Targeted Case Managers does your agency have on staff?
- 3) Describe whether you provide case management services to forensic populations and your experience with the justice system, if applicable.

### 15. Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) Outreach, Access, and Recovery (SOAR)

- 1) Describe your knowledge of the SOAR process and if your agency currently has SOAR Certified staff who are providing these services to individuals served.

### 16. Housing

- 1) Provide a description of how housing needs are identified and what services, supports and linkages are provided.
- 2) What steps are taken when an individual is identified as “homeless”?
- 3) Describe the agency’s relationship with housing agencies such as Miami-Dade County’s Homeless Trust, CARRFOUR, Camillus House, etc.
- 4) Does your agency have access to HMIS or a process to link individuals

to permanent supportive housing services?

17. Children Programs – collaborating with local schools, Department of Juvenile Justice (DJJ), courts for the children receiving behavioral health services

- 1) Describe your agency’s relationship with other community organizations such as the local school system, Department of Juvenile Justice.
- 2) Describe best practices your agency uses in working with LGBTQ youth.

18. Continuous Quality Improvement Program

Describe the Continuous Quality Improvement Program utilized to include:

- 1) the name and a description of each of the evidence-based practices/treatment modalities in your agency’s delivery of behavioral health services
- 2) the applicable target population;
- 3) fidelity monitoring activities;
- 4) data reporting and analysis related to assessment of the quality of services; and
- 5) the methods of measuring achievement of outcomes achieved through service delivery.

19. Clinical Records

Describe your agency’s method of keeping client records. Provide any policies or procedures, if applicable. Include how you maintain HIPAA compliance and practices. Describe any qualitative or quantitative reviews that take place to ensure that files are maintained in a complete and accurate manner.

**C. Substance Use Direct Prevention Services**

1. Describe the youth substance use problems and any other prioritized issues in the in the identified community. Describe if these are consistent with the State consumption priorities.
2. Describe the unique local conditions that contribute to these problems.
3. State the substances or related, concomitant issues, that will be addressed and describe the specific programming related to those substances.. Describe if these are consistent with the State consumption priorities.

4. How will the Strategic Prevention Framework (SPF) steps be implemented in the basis of the programming/services?
5. Describe how the programming will be integrated with Environmental Strategies implemented to affect community level change by the community coalition, consistent with the agency and or SFBHN's goals and outcomes
6. Continuous Quality Improvement Program  
Describe the Continuous Quality Improvement Program utilized to include:
  - 1) The name and a description of each of the practice/strategies in your agency's delivery of prevention services and the designation as prevention science or research based;
  - 2) The applicable target population;
  - 3) Fidelity monitoring activities;
  - 4) Data reporting and analysis related to assessment of the quality of services;
  - 5) The methods of measuring achievement of outcomes achieved through service delivery; and
  - 6) The required collaboration with the evaluation entity.

#### **D. Community Coalition Services**

The coalition must have been in existence as a coalition for a minimum of twelve (12) months at time of the submission of this application is to be considered as an applicant. Coalitions are expected to respond how they will affect and sustain community level change through work with leaders within their community using the Strategic Prevention Framework (SPF) and selected environmental strategies and community based processes.

1. Describe the history of the coalition and how it currently operates to work together toward with its key stakeholders for the common goal of a safe, healthy, and drug-free community.
2. Describe the coalition's accomplishments in developing a viable coalition.
3. Describe the leadership structure of the coalition (i.e., roles and responsibilities, workgroups, coalition by-laws, etc.)
4. Describe how each of the twelve (12) sector representatives is the best fit for the assigned sector and how the coalition identifies the sector priority membership based on the coalition's Community Needs Assessment.

5. Describe how the coalition will increase its capacity through the recruitment of new key stakeholder members for task forces and committees to expand the work based on the coalition's Community Needs Assessment.
6. Describe how the coalition will retain members to increase its ability to meet its objectives based on the coalition's Community Needs Assessment.
7. Provide the MOUs/MOAs, letters of agreement you have with the key stakeholder direct service providers and identify and describe the strategies you are currently working on.

#### **E. Administrative**

1. Clinical Record Keeping: Except for agencies that are currently licensed by the Department of Children and Families, Agency for Health Care Administration or are accredited by Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), Joint Commission, International Center for Clubhouse Development (ICCD), or Council on Accreditation of Peer Recovery Support Services (CAPRSS) provide, as an appropriately labeled attachment, an example of the clinical portion only of a clinical record, including all clinical forms, consent for treatment forms, assessments, progress note forms, clinical instruments used, treatment plans, treatment plan reviews, etc. *(Please be sure to redact any identifying information.)*
2. Clinical Outcomes: Describe how your organization determines how much an individual has improved or benefited from a course of treatment. Explain your process and differentiate between processes used for diverse types of individuals served by demographic characteristics, if applicable, or programs. Describe how these relate to the organization's performance measures, outputs, and outcomes. Specify instruments used, if any, and attach copies as an appropriately labeled attachment.
3. Information Technology and Service Data Reporting: Describe your data system and how the system captures and its ability to report demographic information assessment and placement information, services and units of service provided, and outcome data. In addition, address HIPAA and HITECH compliance. What procedures do you currently use to combat data breaches and what occurs if a data breach takes place? Attach your organizations Information Technology policy and procedure/manual and label it appropriately.

#### **F. Workforce Development**

1. Staff Development and Training: Describe your staff development and training

- program. Attach a list of trainings you currently provide to staff internally and that staff receive externally.
2. Include any organizational supports such as tuition reimbursement, sponsored training, paying for CEU's, etc.
  3. The American with Disabilities Act (ADA) requires businesses in the private and public sector to make reasonable accommodations for individuals with recognized disabilities. Describe how your organization complies with ADA requirements including ensuring effective communication with deaf or hard-of-hearing customers or companions. Include a copy of your Accessibility Plan (as an appropriately labeled attachment) or explain your plan to provide access to persons with disabilities.

*Remainder of page left blank intentionally*

**PART 2 – PROGRAM DESCRIPTION – SERVICE DELIVERY SITES**

**Service Delivery Sites**

Complete this table for each location at which services would be provided.  
Add rows or tables as needed.

<p><b>Agency Name</b> Location Name, if applicable Address Contact Person (Name and Title) Phone # Email</p>					
<p><b>Program Type</b> Mental Health, Substance Abuse, Direct Prevention Services, Community Coalition</p>	<p><b>Client or Non-Client</b></p>	<p><b>List Service and Program Name, if applicable</b></p>	<p><b>Days and Hours of Operation</b></p>	<p><b>Target Population(s) Served (Adults or Children)</b></p>	<p><b>List Facility Licenses Numbers</b> <i>(Attach a copy of all applicable licenses as requested in Appendix E, Administrative Documentation)</i></p>


*Remainder of page left blank intentionally*

#### (4) APPENDIX C- MANDATORY ASSURANCES

<p><b><u>Infrastructure:</u></b> The Applicant shall possess equipment and Internet access necessary to participate fully in this solicitation.</p>	<p>_____</p> <p><b>Initial</b></p>
<p><u>History in the community.</u> The applicant has a history of providing services in the community.</p>	<p>_____</p>
<p><u>Infrastructure:</u> The applicant shall possess equipment and Internet access necessary to participate fully in this Request for Qualification</p>	<p>_____</p>
<p><u>Site Visits:</u> The applicant will cooperate fully with SFBHN in coordinating site visits.</p>	<p>_____</p>
<p><u>Non-discrimination:</u> The applicant agrees that no person will, on the basis of race, color, national origin, creed or religion be excluded from participation in, be refused the benefits of, or be otherwise subjected to discrimination pursuant to the Act governing these funds or any project, program, activity or sub-grant supported by the requirements of, (a) Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended which prohibits discrimination the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended which prohibits discrimination in employment or any program or activity that receives or benefits from federal financial assistance on the basis of handicaps; (d) Age Discrimination Act 1975, as amended which prohibits discrimination on the basis of age, (e) Equal Employment Opportunity Program (EEOP) must meets the requirements of 28 CFR 42.301.</p>	<p>_____</p>
<p><u>Lobbying:</u> The applicant is prohibited by Title 31, USC, Section 1352, entitled “Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,” from using Federal funds for lobbying the Executive or Legislative Branches of the federal government in connection with a specific grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal funds if grants and/or cooperative agreements exceed \$100,000 in total costs (45 CFR Part 93).</p>	<p>_____</p>
<p><u>Drug-Free Workplace Requirements:</u> The applicant agrees that it will, or will</p>	<p>_____</p>

continue to, provide a drug-free workplace in accordance with 45 CFR Part 76.	
<u>Smoke-Free Workplace Requirements:</u> Public Law 103-227, Part C- Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library projects to children under the age of 18, if the projects are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children’s projects provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary of up to \$1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.	_____
<u>Pricing:</u> The applicant certifies as to its own organization that (a) the prices proposed have been arrived at independently, without consultation, communication, or agreement for the purpose of restricting competition as to any matter relating to such prices with any other applicant or with any competitor and (b) unless otherwise required by law, the prices quoted have not been knowingly disclosed by the applicant prior to award, whether directly or indirectly, to any other applicant or competitor.	_____
<u>Confidentiality &amp; HIPAA:</u> The applicant certifies to meet Confidentiality and HIPAA requirements as required by applicable laws, rules, regulations and policies including but not limited to, the Health Insurance Portability Act of 1996 (HIPAA), FS 397 and CFR 42 Part 2 and applicable state laws and regulations.	_____
<u>Certification of Non-supplanting:</u> The applicant certifies that funds awarded under this process will not be used for programs currently being paid for by other funds or programs where the funding has been committed.	_____
<b><u>Submission of Data:</u></b> The Applicant agrees to provide data and other information requested by SFBHN.	_____ <b>Initial</b>
<b><u>Submission of Reports:</u></b> The Applicant agrees to submit progress reports and any fiscal reports to SFBHN.	_____ <b>Initial</b>
<b><u>Annual Appropriation:</u></b> The SFBHN’s performance and obligation to pay under the resulting contract is contingent upon an annual appropriation by the Florida Department of Children and Families.	_____ <b>Initial</b>

**By signing and submitting this agreement, the Applicant certifies that it will comply with all the above requirements.**

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

## (4) APPENDIX D - ADMINISTRATIVE AND FISCAL - SELF EVALUATION FORM

This certification is to assure SFBHN that the applicant has adequate administrative internal control procedures in place to ensure that funds disbursed by SFBHN will be safeguarded as outlined in Chapter 287, Florida Statutes.

Please answer all questions by checking off the applicable box. For those items that are not applicable to your organization, check N/A. For example, if you do not have any subcontracts, you should check N/A for each item in Section II, Subcontracts/Professional Agreements. If you need to provide additional information, please attach an explanation on a separate page. If you have questions send your questions in writing to the RFQ Coordinator by the date specified in the Schedule of Activities.

**Please provide a brief explanation for any negative response on a separate sheet.**

### I. SEGREGATION OF DUTIES

1. Someone other than the timekeeper and persons who deliver paychecks to employees prepares the payroll.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
2. The duties of record keeper are separated from any cash related functions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
3. Check signing is limited to those authorized to make disbursements and whose duties exclude posting and recording of cash received.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
4. Personnel performing the disbursement function are excluded from purchasing, receiving, inventory, and general ledger functions.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
5. Mail receipts are opened and listed by someone not involved in posting, deposit preparation and deposit making.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
6. The person making the deposit is different from the person who prepares the deposit.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
7. An official who is not responsible for its preparation and is outside the payroll department approves the payroll.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

**II. WRITTEN POLICIES AND PROCEDURES**

1. Record Retention	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
2. Travel and Entertainment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
3. Purchasing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
4. Asset acquisition, inventory, and disposal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
5. Cash management (payables, receivables, deposits, petty cash, reconciliations, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
6. Credit cards	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
7. Subcontractors	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
8. Bad debt write-offs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
9. Disaster plan, including recovery	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
10. Personnel	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
11. Employee loans	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
12. Client trust funds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
13. Computer back-up	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
14. Recycling	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
15. Data Security	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

**III. CASH**

**A. Cash Handling Procedures**

1. a. All revenue is deposited into one operating account.  b. Deposits are made on a daily; weekly; other (be specific) basis.	<b>a.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A  <b>b.</b> Daily _____ Weekly _____ Other _____
2. The organization maintains a cash receipts journal	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
3. Revenue received that is not deposited on the same day is stored in a locked and secure location.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4. The person receiving the monthly bank statement in the mail is not the same person responsible for performing the monthly account reconciliation.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5. The bank statements and paid checks are received unopened from the bank by the person reconciling the account.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

6. Checks received in the mail are restrictively endorsed immediately upon opening the mail.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
7. Cash received from fund raising events are properly controlled, accounted, and reported.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
8. Bank reconciliations are performed monthly, reviewed, and signed by the next level of management.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

**B. Petty Cash**

1. A specific employee is designated, in writing, as custodian.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
2. Petty cash is not commingled with other funds and is used for small, emergency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
3. expenses			
4. Cash fund is kept in a locked, secure location.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
5. Payments are made through vouchers that are completely and accurately filled out.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
6. Payments are supported by invoices or receipts.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
7. Payments made are under \$50 (for small incidental purchases).	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
8. Travel payments are not made from petty cash.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
9. Documents are effectively canceled (marked paid) when expense is paid.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
10. The size of the petty cash fund is adequate to meet emergency expenses.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

**IV. ACCOUNTS RECEIVABLE**

1. A detailed accounts receivable aging schedule is maintained by accounting.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
2. The accounts receivable aging schedule is reconciled to the general ledger monthly.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

<p>3. The organization has established accounts receivable write off procedures that:</p> <p><b>a.</b> Are promptly documented</p> <p><b>b.</b> Are approved by the President/CEO and the Board of Directors</p>	<p><b>a.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>b.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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**V. ACCOUNTS PAYABLE**

**A. Disbursements**

<p>1. The organization maintains an accounts payable ledger (checkbook) for its operating account</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. During the payment process, the following are verified by management:</p> <p><b>a.</b> Checks are issued in sequence</p> <p><b>b.</b> Voids are clearly documented and accounted for</p> <p><b>c.</b> Multiple payments made to one payee during the month are researched</p> <p><b>d.</b> Payments are based on original invoices</p> <p><b>e.</b> Payments are approved by appropriate levels of management</p> <p><b>f.</b> Back-up is effectively canceled upon payment (help prevent duplicate payments)</p> <p><b>g.</b> The check amount and invoice amount agree</p> <p><b>h.</b> Bills are timely paid</p> <p><b>i.</b> Payments to the Executive Director are countersigned by a Board member</p> <p><b>j.</b> Goods and services with a cost of \$1,500 or more are supported with a cost analysis price quotation or competitive bid unless the organization's policies and procedures require another level</p> <p>For tax exempt providers:</p>	<p><b>a.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>b.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>c.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>d.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>e.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>f.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>g.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>h.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>i.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p><b>j.</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

k. Sales tax is not being paid on purchases of goods or services.	k. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
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**B. Employee Expense Transactions**

1. Expense reports/vouchers are utilized.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. All expenses are supported with original receipts.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. The business purpose of the expenses is clearly stated.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. All conference expenses are pre-authorized and supported with an agenda	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5. A mileage sheet is used to calculate and reimburse mileage expenses.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6. The mileage sheet contains information to include beginning and ending odometer readings, purpose, and destination	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
7. All travel expenses reimbursed from state funding sources are paid in accordance with state rates (s. 112.061, F.S.).	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

**C. Credit Card Transactions**

1. The organization maintains a listing of who has credit cards and the corresponding credit card numbers.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
2. The organization performs monthly reconciliations of credit card statements.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
3. The organization has review procedures that are used to track and pay balances.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4. The cardholder or designee is not making personal purchases.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5. Corporate credit cards that are loaned to employees are controlled through a log indicating the date, person's name, purchase amount, and description.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

**D. Tax Payments**

1. 941s and UCTs are completed, submitted, and paid timely.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**VI. FINANCIAL REPORTING**

<p>1. Monthly financial statements are prepared. These include the following:</p> <p><b>a.</b> A statement of activities (income statement) listed by covered service.</p> <p><b>b.</b> A statement of financial condition/position (balance sheet)</p> <p><b>c.</b> Budget variance report</p>	<p><b>a.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</p> <p><b>b.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</p> <p><b>c.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</p>
<p>2. Support documentation for all journal entries made is retained.</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</p>
<p>3.</p> <p><b>a.</b> The organization performs a monthly closing and</p> <p><b>b.</b> Prepares/prints a complete set of accounting books (general ledger, accounts payable journal, accounts receivable journal, etc.)</p>	<p><b>a.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</p> <p><b>b.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</p>
<p>4. The organization maintains a current chart of accounts which:</p> <p><b>a.</b> Allows for covered service center accounting</p> <p><b>b.</b> Tracks administration as a covered service</p> <p><b>c.</b> Has a methodology to allocate indirect cost including administration</p>	<p><b>a.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</p> <p><b>b.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</p> <p><b>c.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</p>
<p>5. An independent audit has been performed and the report submitted to the department within 180 days from the organization's fiscal year end or within 30 days of the organization's receipt of the audit report, whichever occurs first.</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</p>
<p>6. The organization has an adequate record keeping system. The records are kept in a central location and are neat and organized.</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
<p>7. Organization management submits monthly financial statements to the Board of Directors</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</p>
<p>8. The organization has an operating budget that was approved by the Board of Directors.</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</p>

**VII. ASSETS AND PROPERTY**

1. An annual asset inventory is taken and recorded in writing.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
2. Property records are reconciled to the general ledger at least annually.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
3. Property / capital assets are recorded on an asset ledger with the following information:  a. Sequential item number b. Description c. Funding source d. Purchase date and amount e. Cost f. Location g. Condition h. Asset tag number (capital assets of \$1000 or more)	3.  a. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A b. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A c. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A d. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A e. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A f. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A g. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A h. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4. Acquisitions and disposals are documented in writing.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5. If any leases for property and equipment exist, they are current and properly executed.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

**VIII. LOANS**

1. If loans are made to employees, formal, signed agreements are secured and contain the following:  a. Date loan made, amount, and maturity  b. Terms and conditions regarding repayment  c. Approval by the Executive Director/President & CEO  d. Disclosure to the Board of Directors through an aging schedule or other report	a. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A b. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A c. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A d. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
2. If loans are being granted to officers and/or directors of the organization, please explain on separate attachment or scan your agency's Ledger  <p style="text-align: right;">Attached # included</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**IX. PERSONNEL MANAGEMENT / PAYROLL**

<p><b>1.</b> All personnel files contain the following:</p> <ul style="list-style-type: none"> <li><b>a.</b> I-9 Forms</li> <li><b>b.</b> W-4 Forms</li> <li><b>c.</b> Annual evaluations (if required)</li> <li><b>d.</b> Pay rates and changes are clearly documented and agree with the latest payroll register</li> <li><b>e.</b> Reference checks</li> <li><b>f.</b> Security agreement forms (CF 114), if applicable.</li> </ul> <p><b>(1)</b> All employees with access to DCF data through computer-related media have read and signed the CF 114.</p> <p><b>(2)</b> The custodian (NAME) for all CF 114 forms at the provider's location is:</p> <p><b>(3)</b> The forms are stored at the following sites:</p>	<ul style="list-style-type: none"> <li><b>a.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No</li> <li><b>b.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No</li> <li><b>c.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No</li> <li><b>d.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No</li> <li><b>e.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No</li> <li><b>f.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> N/A</li> </ul> <p><b>(1)</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No</p> <p><b>(2)</b> Name of Custodian (Print Clearly):</p> <p>_____</p> <p><b>(3)</b> _____</p> <p>_____</p> <p>_____</p>
<p><b>2.</b></p> <ul style="list-style-type: none"> <li><b>a.</b> Employees document their work hours through a time sheet or punch clock.</li> <li><b>b.</b> The employee signed the time records.</li> <li><b>c.</b> The supervisor reviewed and signed the time records.</li> </ul>	<p><b>2.</b></p> <ul style="list-style-type: none"> <li><b>a.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No</li> <li><b>b.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No</li> <li><b>c.</b> <input type="checkbox"/> Yes      <input type="checkbox"/> No</li> </ul>
<p><b>3.</b> Non-exempt employees receive time and a half for all hours in excess of 40 per week.</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
<p><b>4.</b> Do any of your employees also have a contract with your organization? If yes, please explain in separate attachment.</p> <p style="text-align: right;">Attachment # included</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>

**X. INDIVIDUAL CLIENT TRUST ACCOUNTS FOR FEDERAL BENEFIT PROGRAMS (SSAI, SSA, VA)**

1. An individual account is established and managed for each client with adequate procedures in place to track all transactions and reconcile at least monthly.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
2. Written proof that client deposits are made timely (within one to two days).	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
3. Receipts for expenditures are maintained and approved by an appropriate level of management with documentation of such purchases.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
4. All transactions are supported with receipts that are kept in the client's file.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
5. Documentation is maintained for  a. Transaction dates b. Deposits c. Withdrawals d. Interest earned e. Service charges (only bank account charges permitted)	  a. <input type="checkbox"/> Yes b. <input type="checkbox"/> Yes c. <input type="checkbox"/> Yes d. <input type="checkbox"/> Yes e. <input type="checkbox"/> Yes	  <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	
6. If any client's bank account/trust fund is in excess of \$2,000, please explain how it is handled in a separate attachment. Attachment # included	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. Client trust funds are maintained in interest bearing accounts.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
8. Client trust funds are established in an insured bank, credit union or savings & loan association.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

**XI. INSURANCE**

1. The organization has comprehensive liability insurance.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Policies are in effect.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**XII. DECLARATIONS TO BE COMPLETED**

1. Please list any and all family relationships that exist between your board of directors, your organization's principal officers, your organization's employees and independent contractors.

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- 2. Please list any civil litigations pending against your organization. Include a statement as to the amount of each claim and whether such potential for loss is covered by insurance.**

- 3. Are there any amounts or reports due to the Internal Revenue Service and any other taxing organization that have not been paid or filed? Specify amounts, reports, and due dates.**

- 4. Please list all persons and their titles currently authorized to sign contract(s) with the South Florida Behavioral Health Network on behalf of your organization.**

- 5. Please list your Independent Auditor and contact person's office address, telephone number, and e-mail address.**

- 6. Has there been any change in structure/operations of your programs in the past twelve months? If yes, please describe in detail.**

- 7. Has staff turnover occurred in key managerial or clinical positions during the past twelve months? If yes, what are the affected positions and reasons for the turnover?**

**8. Has there been any client grievances / complaints filed against your Agency? If yes, what was the nature of the grievances, dates, and other pertinent information? Explain in detail.**

**9. Do you operate satellite sites? If so, how many locations? Is the management of the satellite offices decentralized or centralized?**

**CERTIFICATION:**

**I hereby certify that the responses provided in this self-monitoring document are true and accurate to the best of my knowledge.**

\_\_\_\_\_  
**Signature – Executive Director/President &CEO**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name – Executive Director/ President & CEO**

**OR**

\_\_\_\_\_  
**Signature – President or Chairperson of the Board**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name – President or Chairperson of the Board**

## (5) APPENDIX E –DOCUMENTATION

Applicants are required to submit the following documentation. Please provide explanations if any are missing or indicate if not applicable. **Provide a table of contents, label the documents according to their number in the list below and title each submission as appropriate for ease of reference.**

1. Mandatory Non-Binding Letter of Intent to Apply by October 31<sup>st</sup>, 2022
2. Internal Revenue Service designation (non-profit status).
3. Certificate of Good Standing from the Florida Department of State, Division of Corporations:  
<https://services.sunbiz.org/Filings/CertificateOfStatus/StandaloneCertificateStart>
4. Articles of Incorporation. The applicant must submit a copy of current of Articles of Incorporation for the organization.
5. Copy of current By Laws.
6. Last filed Annual Report and Copy of current Certificate of Status from the Florida Department of State Division of Corporations.
7. 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.
8. Copy of current list of Board of Directors, including individual term of office, address, phone number and e-mail address of each board member.
9. Copy of Board Minutes from the last Board of Directors Meeting –the most current minutes from the last board of directors meeting.
10. Copy of a Table of Organization.
11. Copy of the Organization’s Accessibility Plan.
12. 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.
13. Organization Statement (letter addressed to SFBHN’s CEO), explaining current Indirect Cost Allocation Methodology.
14. 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.
15. 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.
16. For agencies that do not withhold income taxes, social security tax, or Medicare tax:

- submit a copy of the most recent 1096.
17. Proof of enrollment as a Medicaid Provider - including Medicaid Provider number.
  18. Copy of National Provider Identifier (NPI) number.
  19. Unique Entity Identifier used in SAM.gov (12 character alpha numeric ID assigned by SAM.gov).
  20. Proof of registration in [www.SAM.gov](http://www.SAM.gov).
  21. Name and contact information of the Quality Assurance Officer or Compliance Officer.
  22. Name and contact information of the Privacy Officer.
  23. 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. For Prevention Providers that are not accredited, provide a letter indicating as such.
  24. 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.
  25. Copies of any Corrective Action Plans issued by any funder, government entity, and/or accrediting body issued in the last 2 years
  26. 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)
  27. Examples of instruments used to measure client progress in treatment, if applicable.
  28. 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 individuals 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, procedures for a pandemic, and a recovery plan that will allow the applicant to continue functioning in the event of an emergency.
  29. Organizations Information Technology policy and procedure/manual.
  30. List of the organization's internal and external trainings for staff.
  31. 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 to subcontract with SFBHN as the Managing Entity.

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## (6) APPENDIX F- SUBSTANCE ABUSE AND MENTAL HEALTH REQUIRED PERFORMANCE OUTCOMES AND OUTPUT

\*This document is for information purposes only and is not required for application submission.

<b>Table 1 -Network Provider Measures</b>				
Target Population and Measure Description	Annual Target	Minimum Acceptable Performance	Performance This Period	Year to Date Performance
<b>Adults Community Mental Health</b>				
<b>a. MH003-</b> Average annual days worked for pay for adults with severe and persistent mental illness	40	38		
<b>b. MH703-</b> Percent of adults with serious mental illness who are competitively employed	24%	22.8%		
<b>c. MH742 -</b> Percent of adults with severe and persistent mental illnesses who live in stable housing environment	90%	85.5%		
<b>d. MH743 -</b> Percent of adults in forensic involvement who live in stable housing environment	67%	63.7%		
<b>e. MH744 -</b> Percent of adults in mental health crisis who live in stable housing environment	86%	81.7%		
<b>Adult Substance Abuse</b>				
<b>a. SAA73 -</b> Percentage change in clients who are employed from admission to discharge	10%	9.5%		
<b>b. SA754 -</b> Percent change in the number of adults arrested 30 days prior to admission versus 30 days prior to discharge	15%	14.3%		
<b>c. SA755 -</b> Percent of adults who successfully complete substance abuse treatment services	51%	48.5%		
<b>d. SA756 -</b> Percent of adults with substance abuse who live in a stable housing environment at the time of discharge	94%	89.3%		
<b>Children’s Mental Health</b>				
<b>a. MH012 -</b> Percent of school days seriously emotionally disturbed (SED) children attended	86%	81.7%		
<b>b. MH377 -</b> Percent of children with emotional disturbances (ED) who improve their level of functioning	64%	60.8%		
<b>c. MH378 -</b> Percent of children with serious emotional disturbances (SED) who improve their level of functioning	65%	61.8%		
<b>d. MH778 -</b> Percent of children with emotional disturbance (ED) who live in a stable housing environment	95%	90.3%		
<b>e. MH779 -</b> Percent of children with serious emotional disturbance (SED) who live in a stable housing environment	93%	88.4%		
<b>f. MH780 -</b> Percent of children at risk of emotional disturbance (ED) who live in a stable housing environment	96%	91.2%		
<b>Children’s Substance Abuse</b>				
<b>a. SA725 -</b> Percent of children who successfully complete substance abuse treatment services	48%	45.6%		
<b>b. SA751 -</b> Percent change in the number of children arrested 30 days prior to admission versus 30 days prior to discharge	20%	19.0%		
<b>c. SA752 -</b> Percent of children with substance abuse who live in a stable housing environment at the time of discharge	93%	88.4%		

<b>Table 2</b>		
<b>Network Service Provider Output Measures – Persons Served</b>		
	<b>Service Category</b>	<b>FY Target</b>
<b>Adult Mental Health</b>	<b>Residential Care</b>	
	<b>Outpatient Care</b>	
	<b>Crisis Care</b>	
	<b>State Hospital Discharges</b>	
	<b>Peer Support Services</b>	
<b>Children's Mental Health</b>	<b>Residential Care</b>	
	<b>Outpatient Care</b>	
	<b>Crisis Care</b>	
<b>Adult Substance Abuse</b>	<b>Residential Care</b>	
	<b>Outpatient Care</b>	
	<b>Detoxification</b>	
	<b>Women's Specific Services</b>	
	<b>Injecting Drug Users</b>	
	<b>Peer Support Services</b>	
<b>Children's Substance Abuse</b>	<b>Residential Care</b>	
	<b>Outpatient Care</b>	
	<b>Detoxification</b>	
	<b>Prevention</b>	

**(7) APPENDIX G-FATAL FLAW AND APPLICATION CHECKLIST**

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

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

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

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

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

**Section I:**

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

**Section II:**

	Requirement	Requirement Met Y/N	Comments	Reviewer Initials
1.	Appendix A - completed, signed and placed as covers sheet (pp. 23- 25)  a. Cover Page - General Information  b. Applicant General Information Form			

	c. References (3 References)			
2.	Table of Contents (p.21)			
3.	Format Times New Roman, unreduced 12-point font, 1" margin (p.21)			
4.	Pages labeled and numbered (p.21)			
5.	Appendix B Part I – Organizational Capabilities  Part II – Program Description – Service Delivery Site			
6.	Appendix C – Mandatory Assurances Form (Completed, initialed, signed and dated)			
7.	Appendix D – Administrative and Fiscal Self-Evaluation Form (all questions must be answered)			
8.	Appendix E – Administrative Documentation			
<b>(1)</b>	Internal Revenue Service designation (non-profit status).			
<b>(2)</b>	Certificate of Good Standing from Florida			

	Department of State, Division of Corporations (www.sunbiz.org)			
<b>(3)</b>	Articles of Incorporation			
<b>(4)</b>	By-Laws			
<b>(5)</b>	Last filed Annual Report and Copy of current Certificate of Status from the Florida Department of State Division of Corporations.			
<b>(6)</b>	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.			
<b>(7)</b>	Copy of current list of Board of Directors, including individual term of office, address, phone number and e-mail address of each board member.			
<b>(8)</b>	Copy of Board Minutes from the last Board of Directors Meeting –the most current minutes from the last board of directors meeting.			
<b>(9)</b>	Copy of a Table of Organization.			
<b>(10)</b>	Copy of the Organization’s Accessibility Plan.			

<b>(11)</b>	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.			
<b>(12)</b>	Organization Statement (letter addressed to SFBHN's CEO), explaining current Indirect Cost Allocation Methodology.			
<b>(13)</b>	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.			
<b>(14)</b>	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.			
<b>(15)</b>	For agencies that do not withhold income taxes, social security tax, or Medicare tax: submit a copy of the most recent 1096.			
<b>(16)</b>	Proof of enrollment as a Medicaid Provider - including Medicaid Provider number.			
<b>(17)</b>	National Provider Identifier (NPI) number.			
<b>(18)</b>	Unique Entity Identifier used in SAM.gov (12 character alpha numeric ID assigned by SAM.gov.			
<b>(19)</b>	Proof of registration in www.SAM.gov.			
<b>(20)</b>	Name and contact information of the Quality Assurance Officer or Compliance Officer.			

<b>(21)</b>	Name and contact information of the Privacy Officer.			
<b>(22)</b>	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.			
<b>(23)</b>	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.			
<b>(24)</b>	Copies of any Corrective Action Plans issued by any funder, government entity, and/or accrediting body issued in the last 2 years			

<b>(25)</b>	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)			
<b>(26)</b>	Examples of instruments used to measure client progress in treatment, if applicable.			
<b>(27)</b>	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.			
<b>(28)</b>	Organizations Information Technology policy and procedure/manual.			
<b>(29)</b>	List of the organization's internal and external			

	trainings for staff.			
(30)	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:

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**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: \_\_\_\_\_

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## (8) APPLICATION FORMS

The table below delineates the sections that must be completed in this RFQ and where the information is located. These forms and associated instructions are available electronically on the SFBHN website. Questions about application forms and instructions may be directed by e-mail to RFQ Coordinator.

Stephanie Feldman, RFQ Coordinator  
 7205 Corporate Center Drive – Suite 200  
 Miami, Florida 33126  
 E-mail: [sfeldman@thrivingmind.org](mailto:sfeldman@thrivingmind.org)

<b>Required Forms for Completing Pre-Qualification Applications</b>		
<b>Application Section Title</b>	<b>Form number</b>	<b>Information</b>
Cover Page, General Information and References	Appendix A	All new applicants complete this form. It contains information regarding the applicant’s official name, address, contact persons, and the types of programs and behavioral health services they are requesting to be pre-qualified for and references. See <b>Appendix A</b> .
Narrative	Appendix B	All new applicants must submit responses to the questions provided in Part 1 of Appendix B. In addition to the completion of Part 2, Program Description which captures a description of the services to be provided staffing patterns, service delivery sites and licensure information. See <b>Appendix B</b> .
Mandatory Assurances	Appendix C	To be used by all new applicants for assuring compliance with state and federal contracting regulations. See <b>Appendix C</b> .
Administrative and Fiscal Self-Evaluation Form	Appendix D	To be used to assess the capabilities of the applicant to comply with state and federal regulations. See <b>Appendix D</b> .
Documents	Appendix E	<b>See Appendix E.</b>

## **(9) LIST OF APPENDICES**

- 1. Appendix A – General Information Form**
- 2. Appendix B – Narrative**
- 3. Appendix C – Mandatory Assurances Form**
- 4. Appendix D – Administrative and Fiscal - Self-Evaluation Form**
- 5. Appendix E –Documents**
- 6. Appendix F- Substance Abuse and Mental Health Required Performance Outcomes and Outputs**
- 7. Appendix G-Fatal Flaw and Application Checklist**