APPENDIX A

***HEALTH AGENCY***

***REQUIRED FORMS***

***FOR A***

***REQUEST FOR STATEMENT OF QUALIFICATIONS***

***(RFSQ)***

***FOR***

***SUPPORTIVE AND/OR HOUSING SERVICES MASTER AGREEMENT***

***Available only as electronic fillable forms in the DHS***

***Contracts and Grants Portal at http://cg.dhs.lacounty.gov/***

**REQUIRED FORMS EXHIBIT 1**

**AGENCY’S ORGANIZATION QUESTIONNAIRE AND AFFIDAVIT**

Please complete, date and sign this form in its entirety. The person signing the form must be authorized to sign on behalf of the Agency and to bind the applicant in an Agreement.

1. If your firm is a corporation or limited liability company (LLC), state its legal name (as found in your Articles of Incorporation) and State ofincorporation:

|  |  |  |
| --- | --- | --- |
| **Name** | **State** | **Year Inc.** |
|  |  |  |
| **Address** | | |
|  | | |

2. The Agency must be registered with the California Secretary of State in order to do business with the County. Provide the following:

|  |  |
| --- | --- |
| **Name** | **CA Secretary of State**  **Entity Number** |
|  |  |

3. All Agencies must register on the County’s WebVen. Provide Agency’s County WebVen Number:

4. If your firm is a limited partnership or a sole proprietorship, state the name of the proprietor or managing partner:

5. If your firm is doing business under one or more DBA, please list all DBA names and the County(ies) of registration:

|  |  |  |
| --- | --- | --- |
| **Name** | **County of Registration** | **Yr. became DBA** |
|  |  |  |
| **Name** | **County of Registration** | **Yr. became DBA** |
|  |  |  |

6. Is your firm wholly or majority owned by, or a subsidiary of, another firm?  No  Yes **If yes,**

**Name of parent firm:**

State of incorporation or registration of parent firm:

**COMPLIANCE WITH SPECIFIC COUNTY PROVISIONS**

Agency acknowledges and certifies compliance with all terms and conditions outlined in Appendix C, Master Agreement, and the following specific Los Angeles County codes and provisions:

|  |  |  |  |
| --- | --- | --- | --- |
| 1. | Appendix C, Master Agreement, Paragraph 8.4 – Certification Regarding Debarment, Suspension, Ineligibility & Voluntary Exclusion – Lower Tiered Covered Transactions (2 C.F.R. Part 376). | Yes | No |
| 2. | The Los Angeles County Code, Chapter 4.32.010 and Appendix C, Master Agreement, Paragraph 8.7 – Compliance with Civil Rights Laws, Anti-Discrimination and Affirmative Action Laws. | Yes | No |
| 3. | Appendix C, Master Agreement, Paragraph 8.8 – Compliance with County’s Jury Service Program. | Yes | No |
| 4. | The Los Angeles County Code, Section 2.180.010 and Appendix C, Master Agreement, Paragraph 8.9 – Conflict of Interest. | Yes | No |
| 5. | Appendix C, Master Agreement, Paragraph 8.11 – Consideration of Hiring GAIN/GROW Participants. | Yes | No |
| 6. | The County of Los Angeles Defaulted Property Tax Reduction Program, Los Angeles County Code Chapter 2.206 and Appendix C, Master Agreement, Paragraph 8.16 – Contractor’s Warranty of Compliance with County’s Defaulted Property Tax Reduction Program. | Yes | No |
| 7. | Appendix C, Master Agreement, Paragraph 8.28 – General Provisions for All Insurance Coverage and Paragraph 8.29 – Insurance Coverage. **Agency shall submit proof of insurability prior to execution of a Work Order.** | Yes | No |
| 8. | Appendix C, Master Agreement, Paragraph 8.60 – Compliance with County’s Zero Tolerance Policy on Human Trafficking. | Yes | No |
| 9. | Appendix C, Master Agreement, Paragraph 8.61 – Compliance with Fair Chance Employment Hiring Practices Certification. | Yes | No |
| 10. | The County of Los Angeles Lobbyist Ordinance, Los Angeles Code Chapter 2.160. | Yes | No |

Agency further acknowledges that if any false, misleading, incomplete, or deceptively unresponsive statements in connection with this SOQ are made, the SOQ may be rejected. The evaluation and determination in this area shall be at the Director’s sole judgment and his/her judgment shall be final.

**DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION PROVIDED IN THIS EXHIBIT 1 IS TRUE AND ACCURATE.**

|  |
| --- |
| **Agency’s Name** |
|  |

On behalf of       (Agency’s name), I       (Name of Agency’s authorized representative), certify that the information contained in this Appendix A - Exhibit 1, Agency’s Organization Questionnaire and Affidavit, is true and correct to the best of my information and belief.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title Date

\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address Telephone Number

**COMPLETE THIS SECTION BELOW FOR AGENCIES WITH CURRENT DPH, DMH, AND/OR DHS AGREEMENTS UNDER RFSQ, SECTION 1.4.3, 1.4.4, or 1.4.5**

**DPH Agreement/Contract Number:**

Indicate the type of service(s):

Substance Use Disorder  Residential  Case Management

**DMH Agreement/Contract Number:**

Indicate the type of service:

Full Service Partnership

**DHS Agreement/Contract Number:**

Indicate the type of service:

My Health LA

1. **FIRM/ORGANIZATION INFORMATION:** The information requested below is for statistical purposes only. On final analysis and consideration of award, contractor/Agency will be selected without regard to race/ethnicity, color, religion, sex, national origin, age, sexual orientation or disability.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Business Structure:**  Sole Proprietorship  Partnership  Corporation  Non-Profit  Franchise  Other (Please Specify) | | | | | | |
| **Number of California Employees:** | | | | | | |
| **Total Number of Employees of Firm** (including owners)**:** | | | | | | |
| **Race/Ethnic Composition of Firm.** Please distribute the **total number of employees** **of the Firm** into the following categories: | | | | | | |
| **Race/Ethnic Composition** | **Owners/Partners/**  **Associate Partners** | | **Managers** | | **Staff** | |
|  | Male | Female | Male | Female | Male | Female |
| Black/African American |  |  |  |  |  |  |
| Hispanic/Latino |  |  |  |  |  |  |
| Asian or Pacific Islander |  |  |  |  |  |  |
| American Indian |  |  |  |  |  |  |
| Filipino |  |  |  |  |  |  |
| White |  |  |  |  |  |  |

**II. PERCENTAGE OF OWNERSHIP IN FIRM:** Please indicate by percentage (%) how ownership of the firm is distributed.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Black/African American** | **Hispanic/ Latino** | **Asian or Pacific Islander** | **American Indian** | **Filipino** | **White** |
| Men | % | % | % | % | % | % |
| Women | % | % | % | % | % | % |

**III. CERTIFICATION AS MINORITY, WOMEN, DISADVANTAGED, AND DISABLED VETERAN BUSINESS ENTERPRISES:** *If your firm is currently certified as a minority, women, disadvantaged or disabled veteran owned business enterprise by a public agency, complete the following and attach a copy of your proof of certification. (Use back of form, if necessary.)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Agency Name** | **Minority** | **Women** | **Disadvantaged** | **Disabled Veteran** | **Other** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**REQUIRED FORMS - EXHIBIT 3**

**CHARITABLE CONTRIBUTIONS CERTIFICATION**

**Company Name:**

**Address:**

**Internal Revenue Service Employer Identification Number:**

The Agency or Contractor is exempt from the California Nonprofit Integrity Act.

**California Registry of Charitable Trusts “CT” number (if applicable):**

The Nonprofit Integrity Act (SB 1262, Chapter 919) added requirements to California’s Supervision of Trustees and Fundraisers for Charitable Purposes Act which regulates those receiving and raising charitable contributions.

If the Agency or Contractor is not exempt, **check the Certification below that is applicable to your company.**

The Agency or Contractor has examined its activities and determined that it does not now receive or raise charitable contributions regulated under California’s Supervision of Trustees and Fundraisers for Charitable Purposes Act. If Agency engages in activities subjecting it to those laws during the term of a County contract, it will timely comply with them and provide the County a copy of its initial registration with the California State Attorney General’s Registry of Charitable Trusts when filed.

**OR**

The Agency or Contractor is registered with the California Registry of Charitable Trusts **as required by Title 11 California Code of Regulations, sections 300-301 and Government Code sections 12585-12586** under the CT number listed above and is in compliance with its registration and reporting requirements under California law. Contractor shall be listed in good standing and is required to **annually** renew its registry with the Attorney General’s Registry of Charitable Trusts.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature** **Date:**   -  -

**Name of Signer:**

**Title:**

**Agency’s Name:**

List three (3) References where any of the same or similar services in Appendix B – Supportive and/or Housing Services, were provided within the past three (3) years. New Agencies responding under the COO or CEO experience may provide references who can speak upon the COO’s or CEO’s experience. Agencies qualifying under RFSQ, Section 1.4.3, 1.4.4, or 1.4.5 do not need to complete this Exhibit.

|  |  |  |
| --- | --- | --- |
| 1. **Name of Firm:** | **Address of Firm:** | **Contact Person:** |
| **Telephone #:**     -   - | **E-mail Address:** | **Specific Date of Contract – From - To**    -  -     -   -  - |
| **Name or Contract No.** | **Type of Service:** | **Annual Dollar Amount:**  $ |
|  | | |
| **2. Name of Firm:** | **Address of Firm:** | **Contact Person:** |
| **Telephone #:**     -   - | **E-mail Address:** | **Specific Date of Contract – From - To**    -  -     -   -  - |
| **Name or Contract No.** | **Type of Service:** | **Annual Dollar Amount:**  $ |
|  | | |
| 1. **Name of Firm:** | **Address of Firm:** | **Contact Person:** |
| **Telephone #:**     -   - | **E-mail Address:** | **Specific Date of Contract – From - To**    -  -     -   -  - |
| **Name or Contract No.** | **Type of Service:** | **Annual Dollar Amount:**  $ |