**LOS ANGELES COUNTY-DEPARTMENT OF MENTAL HEALTH**

**QUESTIONNAIRE**

**STATEMENT OF ELIGIBILITY AND INTEREST**

**FOR PREVENTION AND EARLY INTERVENTION SERVICES FOR ELIGIBLE UNFUNDED INDIVIDUALS BY FEDERALLY QUALIFIED HEALTH CENTERS AND FEDERALLY QUALIFIED HEALTH CENTERS LOOK-ALIKES**

**Bid #DMH011818B1**

Initial Responses Due: 3:00 p.m., Pacific Standard Time, on February 22, 2018

1. Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Address of Agency Headquarters: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Address of site(s) where services will be provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Name of Chief Executive Officer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name of Agency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Title of Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number: \_\_\_\_\_\_\_\_\_\_

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

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**Note:** Respondent’s completion of the Questionnaire in response to this SEI does not bind, nor purport to bind, the County or respondent in any way. A legally binding contract shall be executed only after formal approval by and/or authorization of the County of Los Angeles Board of Supervisors.

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| **QUESTIONNAIRE** | **Yes** | **No** |
| 1. Is your agency presently a non-profit organization?
 |  |  |
| 1. Is your agency presently a Master Agreement contractor under DMH’s MHSA Master Agreement list?
 |  |  |
| 1. Does your agency presently have documentation to confirm its designation as either an FQHC or an FQHC Look-Alike?
 |  |  |
| 1. Does your agency presently have a Legal Entity Agreement with the County of Los Angeles DMH?
 |  |  |
| 1. As of the date of release of this SEI **(January 18, 2018) and each day since then**, does your agency have a site(s) certified as an FQHC or FQHC Look-Alike within the boundaries of the County of Los Angeles?
 |  |  |
| 1. As of the date of release of this SEI **(January 18, 2018) and each day since then,** does your agency currently provide outpatient mental health services through one or more licensed clinical staff? For purposes of this question, outpatient mental health services means treatment for the remediation of a diagnosis found in the DSM 5, but which is not medication management by a primary care physician.
 |  |  |
| 1. Does your agency presently have a working Electronic Health Record (EHR) that supports the ability to claim electronically through DMH?
 |  |  |
| 1. Is your agency presently current with all licenses, permits, registrations, accreditations and certificates required by Federal, State and local laws, ordinances, rules, regulations, guidelines and directives, which are applicable to your facility(ies) and/or services?
 |  |  |
| 1. Assuming that a contract for PEI is awarded, will you ensure your agency will employ and/or contract with licensed clinical staff (PhD, PsyD, LMFT, LCSW, and/or PMHNP) who have either been trained, or who will get registered to be trained in one or more Evidence-Based Practices (EBP) approved by DMH? *(See approved PEI EBP Matrix – Attachment I to Appendix A)*
	1. DMH will verify which staff have already met required minimum necessary training standards per EBP, and/or which trainings staff may elect to register for that shall meet required minimum necessary training standards per EBP.
 |  |  |
|  |  |
| 1. Assuming that a contract for PEI is awarded, will your agency be able to comply after contract execution with all PEI Data Collection and Outcomes requirements set forth in the Agreement and any associated PEI guidelines and/or protocols?
 |  |  |
| 1. Does your agency presently have staff qualified to provide medication services?
 |  |  |
| 1. Assuming that a contract for PEI is awarded, at the time a contract is executed, will your agency be able to provide an initial appointment for PEI services within 15 business days of a referral request from the primary care physician, or within 15 business days of a direct patient request?
 |  |  |
| 1. Does your agency presently have, or will be able to obtain before contract execution, assuming that a contract is awarded, one or more operational agreements, Memorandum of Understanding (MOU), and/or other type of written documentation demonstrating a formal relationship between your agency and another party(ies) for specialty mental health services to clients that meet DMH’s criteria for severe and persistent mental illness?
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| --- | --- | --- |
| **QUESTIONNAIRE** | **Yes** | **No** |
| 1. Can you presently attest that neither your agency nor any of its staff who will be claiming to DMH for PEI services are listed on the Medi-Cal Suspended and Ineligible Provider List (S&I List) and/or the Office of the Inspector General’s List of Excluded Individuals and Entities (LEIE) database for exclusion from participation in any federally qualified programs?
 |  |  |

**All responses are subject to verification by DMH and your agency may be required to provide further documentation to substantiate your responses.**

**I hereby acknowledge that the foregoing response to this Statement of Eligibility and Interest Questionnaire for PREVENTION AND EARLY INTERVENTION SERVICES FOR ELIGIBLE UNFUNDED INDIVIDUALS BY FEDERALLY QUALIFIED HEALTH CENTERS AND FEDERALLY QUALIFIED HEALTH CENTERS LOOK-ALIKES is truthful and accurate.**

 Submitted by: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Print Name of Agency

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Signature of Authorized Agency Representative

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Print Name of Authorized Agency Representative

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Date