**ATTACHMENT II**

**MOBILE CRISIS OUTREACH TEAMS PROPOSAL**

**1.0 INSTRUCTIONS**

Provide your organization’s complete responses in the following text entry fields below.

**2.0 PROPOSER CONTACT**

Proposer shall identify a primary point of contact as part of its Proposal as follows: Organization Name: Click or tap here to enter text.

Headquarters

Address: Click or tap here to enter text.

Click or tap here to enter text.

Organization

Website: Click or tap here to enter text. Principal Point of Contact:

Name: Click or tap here to enter text.

Title: Click or tap here to enter text.

Mailing Address: Click or tap here to enter text.

Click or tap here to enter text. Email Address: Click or tap here to enter text. Phone Number: Click or tap here to enter text.

* 1. **PROPOSAL**

# Proposer's Minimum Mandatory Qualifications (MMQ)

# Failure to substantiate all MMQs will immediately disqualify the proposal from further review.

* + 1. Must have a minimum of five years’ experience (within the last seven years) delivering field-based, face-to-face behavioral health care services (suicide, mental health, and/or substance use related) in community-based settings (i.e. non-facility). At least one clinician team member must be Lanterman-Petris-Short (LPS) certified or be able to become LPS certified prior to beginning work under the Contract.

Narrative:

Click or tap here to enter text.

**Please provide a brief description of experience and provide business documentation, contracts, and/or service pamphlets that substantiate this requirement.**

* + 1. Must have an electronic health record (eHR).

**Please provide a copy of eHR/IT contract, including its term.**

* + 1. Must have at least one licensed mental health care professional capable of billing/claiming Medi-Cal crisis intervention services.

**Please provide a listing of licensed professional(s) and copies of their licensure to substantiate this requirement.**

* + 1. Must have medical consultation support staff.

**Please provide a staff roster with licensure information.**

* + 1. If Proposer’s compliance with a County contract has been reviewed by the Department of the Auditor-Controller within the last 10 years, Proposer must not have unresolved questioned costs identified by the Auditor-Controller, in an amount over $100,000, that are confirmed to be disallowed costs by the contracting County department, and remain unpaid for six months or more from the date of disallowance, unless such disallowed costs are the subject of current good faith negotiations to resolve the disallowed costs, in the opinion of the County.

**Submission is not necessary. DMH will verify this requirement.**

G. The Department will review the County’s Contractor Alert Reporting Database (CARD), reflecting past performance history on County contracts. This review may result in disqualification if there are current, uncured/outstanding items on CARD.

**Submission is not necessary. DMH will verify this requirement.**

* 1. **References**

Please provide three signed letters of references where the same or similar scope of services were provided as referenced in the Statement of Work, Mobile Crisis Outreach Teams. The Department of Mental Health shall not be used a reference. Letters shall not exceed one page.

Proposer will be evaluated on the verification of references provided.

# Work Plan

Provide a work plan with detailed specific tasks as noted in the Statement of Work. Provide a conceptual project plan and schedule. Describe how Proposer will minimize costs and maximize resources, including utilization of project management resources in a cost- effective manner, assessment of alternatives, delivery methods, streamlining project and work tasks, quality control methods, etc.

Narrative:

Click or tap here to enter text.

# Facilities, Resources, and Staffing

Describe the organization's resources, which are advantageous to the successful provision of the services. Items to be considered include the capabilities and experience of the Proposer and principal participants, such as ability to transport clients, capacity to perform psychiatric consultation, current relationships with law enforcement and fire, etc. Please include the name, position (including qualification), phone number and email, certifications, and licenses of the individual(s) that will be assigned to provide the services. Please outline how many agreements, of similar scope, the organization has been obligated to perform and the approximate dollar value of each project in the last five years, including current commitments. Please provide an organizational chart.

Narrative:

Click or tap here to enter text.

# Cost Proposal

Using the attached budget template (Attachment II – Proposal Budget Template), provide an estimated annual budget for the provision of MCOT services included in the Statement of Work.

The maximum number of possible points will be awarded to the lowest estimated annual budget. All other proposals will be compared to the lowest cost and points awarded accordingly.

The maximum allowable indirect costs is 15% of the direct costs.

* 1. **Financial Viability**

Attach copies of the organization's most current and prior two years' financial statements (for example 2019 and 2020). Financial statements should include the company’s assets, liabilities, and net worth. At a minimum, include the Balance Sheet (Statement of Financial Positions), Income Statement (Statement of Operations), and the Retained Earnings Statement. If audited statements are available, these should be submitted. Do not submit Income Tax Returns to meet this requirement. Financial statements will be kept confidential if so stamped on each page.

**Proposer's Declaration and Signature**

Proposer acknowledges that if any false, misleading, incomplete, or deceptively unresponsive statements are made in connection with this proposal, the proposal may be rejected. The evaluation and determination in this area shall be at the Department Head's sole judgment, which shall be final.

**DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.**

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **PROPOSER NAME:** | | | | | | | **COUNTY WEBVEN NUMBER:** |
| **ADDRESS:** | | | | | | | |
| **PHONE NUMBER:** | | | **E-MAIL:** | | | | |
| **INTERNAL NUMBER:** | **REVENUE** | **SERVICE** | | **EMPLOYER** | **IDENTIFICATION** | **CALIFORNIA BUSINESS LICENSE NUMBER:** | |
| **PROPOSER OFFICIAL NAME AND TITLE (PRINT):** | | | | | | | |
| **SIGNATURE** |  |  | |  |  |  | **DATE** |