

**REQUEST FOR STATEMENT OF QUALIFICATIONS
MENTAL HEALTH SERVICES ACT
STATEMENT OF QUALIFICATIONS (SOQ) CHECKLIST
RFSQ No. DMH030719B1**

Proposer Name and Doing Business As (DBA) (if applicable):	
Headquarter (HQ) Address:	
Supervisory District of HQ Address:	Service Area of HQ Address:
Name of Director, President or Chief Executive Officer:	Contact Number:
	E-mail Address:
Date SOQ Submitted:	WebVen ID Number:

This serves as an application for the Mental Health Services Act Master Agreement. All details about this Request For Statement of Qualifications are available at:

- LACDMH - <https://dmh.lacounty.gov/contract-opportunities/>
- LA County Doing Business With Us - <http://camisvr.co.la.ca.us/lacobids/BidLookUp/BidOpenStart.asp>

To complete the Statement of Qualifications (SOQ), please check off all applicable boxes.

1. Please check the appropriate box if you are currently a DMH provider as a:

- | | |
|---|--------------------|
| <input type="checkbox"/> Legal Entity/Mental Health Services provider | Contract No. _____ |
| <input type="checkbox"/> Legal Entity/Institution for Mental Disease (IMD) provider | Contract No. _____ |
| <input type="checkbox"/> Fee-For-Service Individual or Group provider | Contract No. _____ |
| <input type="checkbox"/> Consultant provider - please describe: _____ | Contract No. _____ |
| <input type="checkbox"/> Other provider or N/A - please describe: _____ | Contract No. _____ |

2. Please check the appropriate box pertaining to a Settlement Agreement with DMH:

- ☐ **No, I do not** have a current Settlement Agreement with DMH.
- ☐ **Yes, I do** have a current Settlement Agreement with DMH and am aware that there is a moratorium on expansion and/or implementation of any new programs during the Settlement Agreement's repayment period and that any exemption from this penalty requires justification that this restriction will negatively impact planned program services.

3. Please check the appropriate box for your agency:

- ☐ For Profit ☐ Nonprofit ☐ For Profit with a Nonprofit parent company or affiliate

4. Please check all target age groups with whom you have three (3) years' experience within the last five (5) years. You will be considered only for the target age groups checked below.

- | | |
|---|--|
| <input type="checkbox"/> Children (0-15) | <input type="checkbox"/> Adults (26-59) |
| <input type="checkbox"/> Transition Age Youth (16-25) | <input type="checkbox"/> Older Adults (60 Years +) |

5. Please check all Service Areas where you provide services and those Service Areas where you do not currently provide services, but have an interest in providing services. You will be considered only for Service Areas checked below.

- | | |
|---|---|
| <input type="checkbox"/> Service Area 1 (Antelope Valley) | <input type="checkbox"/> Service Area 5 (West Los Angeles) |
| <input type="checkbox"/> Service Area 2 (San Fernando Valley) | <input type="checkbox"/> Service Area 6 (South Los Angeles) |
| <input type="checkbox"/> Service Area 3 (San Gabriel Valley) | <input type="checkbox"/> Service Area 7 (East Los Angeles) |
| <input type="checkbox"/> Service Area 4 (Metro) | <input type="checkbox"/> Service Area 8 (South Bay/Harbor) |

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6. As referenced in the RFSQ, Section 2.1. (Scope of Work), below are the following MHSA Service Components and MHSA Infrastructure Components. Please check all categories of service where you have three (3) years' experience within the last five (5) years.

MHSA Service Component						
Community Services and Supports (CSS)						
The CSS Plan Consists of the following Six (6) Focal Areas						
Focal Areas	Full Service Partnerships	Outpatient Care Services	Alternative Crisis Services	Planning, Outreach and Engagement	Linkage	Housing
Service Categories	<input type="checkbox"/> Full Service Partnerships (FSP)	<input type="checkbox"/> Transitional Age Youth (TAY) Drop-In Centers	<input type="checkbox"/> Residential and Bridging	<input type="checkbox"/> Outreach and Engagement at the Service Area level	<input type="checkbox"/> Linkage to County Operated Functions/ Programs	<input type="checkbox"/> MHSA Housing program and other MHSA funded housing
		<input type="checkbox"/> Field-based mental health services and supports and clinic-based mental health services and supports	<input type="checkbox"/> Urgent Care Centers	<input type="checkbox"/> Outreach and Engagement of Underserved and Cultural Communities		<input type="checkbox"/> Enhanced Emergency Shelter Program
		<input type="checkbox"/> TAY Supported Employment Services	<input type="checkbox"/> Enriched Residential Services			
		<input type="checkbox"/> Integrated Care Outpatient Programs				
		<input type="checkbox"/> Peer Run Centers, including Peer Run Respite Housing				
	<input type="checkbox"/> Wellness Services					
	<input type="checkbox"/> Probation Camp Services					

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<u>MHSA Service Component</u>		
Prevention and Early Intervention (PEI)		
The PEI Plan Consists of the following Six (6) Focal Areas		
<input type="checkbox"/> Prevention	<input type="checkbox"/> Early Intervention	<input type="checkbox"/> Suicide Prevention
<input type="checkbox"/> Stigma and Discrimination Reduction	<input type="checkbox"/> Outreach for Increasing Recognition of Early Signs of Mental Illness	<input type="checkbox"/> Access and Linkage to Treatment

<u>MHSA Service Component</u>	
Innovations (INN)	
<input type="checkbox"/> Innovations (INN)	

<u>MHSA Infrastructure Components</u>	
<input type="checkbox"/> Capital Facilities and Technological Needs	<input type="checkbox"/> Workforce Education and Training

<u>Evaluation</u>	
<input type="checkbox"/> Evaluation of MHSA Funded Programs	

Please sign and attach to this SOQ Short Form the Settlement Agreement justification (if applicable) and all required forms listed under the RFSQ's Section 7.5 (Preparation and Format of the SOQ) and Section 7.6 (SOQ Submission). Incomplete forms or forms lacking necessary documentation will not be considered.

- ☐ I hereby acknowledge and confirm understanding that the submission of this SOQ constitutes acknowledgement and acceptance of, and willingness to comply with all terms and conditions of Appendix A – MHSA Master Agreement should a contract be eventually awarded by the County to provide services. Neither the RFSQ nor this SOQ constitutes a Request for Proposal, Request for Services/Work Order solicitation or an offer of a contract.

On behalf of _____,
(Proposer's Name)

I, _____, certify that all statements made in this SOQ
(Name of Proposer's Authorized Official)

submitted by my organization are true and complete to the best of my knowledge and belief. I understand that any false statement(s) of material facts or omissions may be subject to disqualification.

Submitted by: _____
Print Name and Title of Authorized Agency Representative

Signature of Authorized Agency Representative

SOQ Submission Date