

**REQUEST FOR STATEMENT OF QUALIFICATIONS
EATING DISORDERS and ELECTROCONVULSIVE THERAPY SERVICES
STATEMENT OF QUALIFICATIONS (SOQ) CHECKLIST
RFSQ No. DMH021121B1**

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:	Phone Number: E-mail Address:
Date SOQ Submitted:	WebVen ID Number:

This serves as an application for the Eating Disorders and Electroconvulsive Therapy Services 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 contracted 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) |
| <input type="checkbox"/> Out of County | |

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6. As referenced in the Exhibit F, SOW 1.0 (Scope of Work), below are the following Eating Disorders Service Components. Please check all categories of service where you have three (3) years' experience within the last five (5) years.

<input type="checkbox"/> Acute Inpatient Care <input type="checkbox"/> Children (0-15) <input type="checkbox"/> Transition Age Youth (16-25) <input type="checkbox"/> Adults (26-59) <input type="checkbox"/> Older Adults (60+ Years)	<input type="checkbox"/> Specialized Follow-Up Residential Treatment Center (RTC) <input type="checkbox"/> Children (0-15) <input type="checkbox"/> Transition Age Youth (16-25) <input type="checkbox"/> Adults (26-59) <input type="checkbox"/> Older Adults (60+ Years)
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<input type="checkbox"/> Partial Hospitalization Program (PHP) <input type="checkbox"/> Children (0-15) <input type="checkbox"/> Transition Age Youth (16-25) <input type="checkbox"/> Adults (26-59) <input type="checkbox"/> Older Adults (60+ Years)	<input type="checkbox"/> Intensive Outpatient Program (IOP) <input type="checkbox"/> Children (0-15) <input type="checkbox"/> Transition Age Youth (16-25) <input type="checkbox"/> Adults (26-59) <input type="checkbox"/> Older Adults (60+ Years)
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☐ **ELECTROCONVULSIVE THERAPY SERVICES (ECT)**

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 2.6 (Preparation and Format of the SOQ) and Section 2.7 (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 H – Eating Disorders and Electroconvulsive Therapy Services 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