

# REQUEST FOR STATEMENT OF QUALIFICATIONS #DMH021121B1

## EATING DISORDERS SERVICES AND ELECTROCONVULSIVE THERAPY SERVICES STATEMENT OF QUALIFICATIONS (SOQ) APPLICATION

### 1. Proposer's Information:

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| Proposer's Name and Doing Business As (DBA), if applicable:                        |  |
| Type of Entity:<br>Choose an Item  | Headquarters (HQ) Address:                                     |
| LAC Supervisorial District of HQ Address:<br>Choose an Item                        | LAC Service Area of HQ Address:<br>Choose an Item              |
| Director, President, or Chief Executive Officer<br>(include telephone and e-Mail): | Contact Person for this SOQ<br>(include telephone and e-Mail): |
| WebVen ID Number:  | Proposed Services:<br>Choose an Item                           |

### 2. Please check all those that apply if you are currently contracted with LACDMH.

- |  |                       |
|--|-----------------------|
| <input type="checkbox"/> Legal Entity (LE) Mental Health Services  | Contract Number _____ |
| <input type="checkbox"/> LE Institution for Mental Disease (IMD)   | Contract Number _____ |
| <input type="checkbox"/> Fee-for-Service Individual or Group       | Contract Number _____ |
| <input type="checkbox"/> Other Provider – describe: _____          | Contract Number _____ |
| <input type="checkbox"/> N/A – not currently contracted by LACDMH. |                       |

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**3. Please check the appropriate box pertaining to a Settlement Agreement with LACDMH.**

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- ☐ No, I do not have a current Settlement Agreement with LACDMH.
- ☐ Yes, I do currently have a Settlement Agreement with LACDMH 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.

**4. Please check all target age groups that you have the capacity to serve.**

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- ☐ Children (0-5) ☐ Adults (26-59)
- ☐ Transition Age Youth (16-25) ☐ Older Adults (60+)

**5. Please check all the Service Areas where you currently have the capacity to serve.**

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- ☐ Service Area 1 (Antelope Valley) ☐ Service Area 5 (West Los Angeles)
- ☐ Service Area 2 (San Fernando Valley) ☐ Service Area 6 (South Los Angeles)
- ☐ Service Area 3 (San Gabriel Valley) ☐ Service Area 7 (East Los Angeles)
- ☐ Service Area 4 (Metro) ☐ Service Area 8 (South Bay/Harbor)

**6. For ED Services Only – please check those service categories that apply to your agency:**

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☐ ACUTE INPATIENT CARE

- ☐ Children (0-15)
- ☐ Transition Age Youth (16-25)
- ☐ Adults (26-59)
- ☐ Older Adults (60+)

☐ PARTIAL HOSPITALIZATION PROGRAM (PHP)

- ☐ Children (0-15)
- ☐ Transition Age Youth (16-25)
- ☐ Adults (26-59)
- ☐ Older Adults (60+)

☐ SPECIALIZED FOLLOW-UP TREATMENT

☐ INTENSIVE OUTPATIENT PROGRAM (IOP)

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**RESIDENTIAL TREATMENT CENTER (RTC)**

☐ Children (0-15)

☐ Transition Age Youth (16-25)

☐ Adults (26-59)

☐ Older Adults (60+)

☐ Children (0-15)

☐ Transition Age Youth (16-25)

☐ Adults (26-59)

☐ Older Adults (60+)

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☐ 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 Sample Master Agreement for Eating Disorders Services and/or Electroconvulsive Therapy Services should a contract be awarded by the County to provide services. Neither the RFSQ nor this SOQ constitutes a Request for Proposals, Request for Services, or Work Order Solicitation or an offer of a contract.

On behalf of \_\_\_\_\_  
Proposer's Name

I, \_\_\_\_\_, certify that all statements made in  
Name of Proposer's Authorized Official  
this SOQ 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