

DEPARTMENT OF SOCIAL & HEALTH SERVICES
DEPARTMENT OF VOCATIONAL REHABILITATION

OPEN ENROLLMENT IL Vendors

Solicitation #0115-0102
DVR Job Services

Solicitation Opens: January 1, 2015
Solicitation Closes: December 31, 2015

Solicitation documents and supporting exhibits for eligible IL Vendors.

**OPEN ENROLLMENT – IL SERVICES
SOLICITATION # 0115-0102**

Project Title: DVR Job Services (a.k.a. “IL” Services)

Estimated Contract Period: Effective Date through June 30, 2016.

Application Due Date: This solicitation is an OPEN ENROLLMENT. Contracts will be prepared on a case-by-case basis and executed within 60 days of receipt of a responsive application packet.

All Application Packets must be mailed or hand-delivered by no later than 4:00 p.m. Pacific Standard time, December 31, 2015. Postmarks will NOT be accepted. Applications packets received after this time will be returned as rejected.

Submit Application To:

Application Packets Delivered by Mail:

Contracts Unit
Department of Social and Health Services
Division of Vocational Rehabilitation
PO BOX 45340
Olympia, WA 98504-5340

Application Packets delivered by Express / Hand Delivery, Or Courier:

Contracts Unit
Department of Social and Health Services
Division of Vocational Rehabilitation
4565 7th Avenue SE
Lacey, WA 98503

**Faxed bids WILL NOT be accepted.
E-mailed bids WILL NOT be accepted.**

**OPEN ENROLLMENT – IL SERVICES
SOLICITATION #0115-0102
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Section A-1. SUMMARY OF PROJECT

1. Purpose of Solicitation

The Washington State Department of Social and Health Services (DSHS), Division of Vocational Rehabilitation (DVR) wishes to contract with eligible applicants (see section 4) to provide specific employment-related services, known as Independent Living (IL) Services.

2. Background

DVR's mission is to empower people with disabilities to achieve a greater quality of life by obtaining and maintaining employment.

3. Project Scope

- a. The contract period begins as soon as January 1, 2015, and expires June 30, 2016. The actual contract start date (effective date) will be noted in the executed agreement.
- b. Independent Living Services purchased from ILs include:
 - (1) IL Evaluations;
 - (2) IL Work-Related Systems Access; and,
 - (3) IL Skills Training.
- c. DVR will consider submitted Application Packets for any of the services in Exhibit H.
- d. Applicants who will receive consideration must be able to:
 - (1) Provide Services, as defined in "Section A-2. Scope of IL Services," of this Invitation; and
 - (2) Meet all required qualifications.
- e. Applicants may submit their Application Packets to provide services in more than one county.
- f. An organization may be providing services to DVR Customers while also serving them under another State Contract. The organization must keep separate client files and billings for each contract and must not bill on more than one contract for the services provided to an individual.
- g. Any contract awarded is contingent upon availability of funding and service needs.

- h. Any contract awarded does not guarantee DVR will purchase IL services from your organization.

4. Minimum Qualifications

This solicitation is open to all eligible Applicants. To be eligible, an Applicant must:

- a. If a returning contractor (any state contract), the vendor must meet the following conditions:
 - (1) Has not had a Washington State DSHS contract terminated for default;
 - (2) Is not currently subject of a DSHS/DVR, or other State agency, investigation regarding performance of a criminal act, abridgement of human rights, or improper billing practices; and,
 - (3) Has not been the subject of any finding(s) due to a DSHS/DVR, or other State agency, investigation regarding the performance of a criminal act, abridgement of human rights, or improper billing practices.
- b. Be able to serve all eligible individuals in a manner and setting that meet the requirements of the [Americans with Disability Act](#) (ADA).
- c. Be able to provide services through alternative formats, methods, and languages as needed per the ADA and the Civil Rights Act of 1964.
- d. Possess a current State of Washington Master Business License.
- e. Be able to serve individuals providing the services selected in Exhibit H.
- f. Have key personnel who are able to pass a DSHS Background Check.
- g. Meet all uniform requirements. Pursuant to [WAC 388-892-0300](#), Such qualifications shall include but not be limited to, qualifications regarding conformance to:
 - (1) Federal, state and local laws and DSHS regulations and policies;
 - (2) Accessibility;
 - (3) Safety and health;
 - (4) Liability insurance coverage;
 - (5) Having a system in place to report the effectiveness and efficiency of the provider's DVR services;
 - (6) Having a system in place to gather and report DVR customer satisfaction;
 - (7) DVR code of ethics and standards of practice;

- (8) Having a complaint and dispute resolution process in place for DVR customers;
- (9) Having current background checks in place for personnel serving DVR customers.

5. Minimum Personnel (Provider) Qualifications:

Contractors being granted a subsequent contract must meet all qualifications listed below (as applicable):

a. Personnel Qualifications for IL Evaluation Services

Your response must include copies of educational degrees, diplomas, or official transcripts and resume of paid employment experience showing each staff member providing IL Evaluations has met the following qualifications:

- (1) A Bachelor's Degree in human or social services (Counseling, Vocational Rehabilitation, Social Work, Education, Psychology, Occupational / Physical Therapy, etc.), from an accredited college or university, **and**
 - (a) Two (2) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.
 - (b) One (1) of the two years must involve performing individual evaluations and writing reports regarding individuals' cognitive, psycho/social, life skills and interpersonal abilities, either directly or under the supervision and sign-off authority of a person who meets DVR's qualifications for IL Evaluation, **OR**
- (2) A Bachelor's Degree, in any field, from an accredited college or university, **and**
 - (a) Three (3) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.
 - (b) One (1) of the three years must involve performing individual evaluations and writing reports of individuals' cognitive, psycho/social, life skills and interpersonal abilities, either directly or under the supervision and sign-off authority of a person who meets DVR's qualifications for IL Evaluation, **OR**
- (3) Ninety (90) quarter or sixty (60) semester hours of human or social services coursework (Counseling, Vocational Rehabilitation, Social Work, Education, Psychology, Occupational / Physical Therapy, etc.), from an accredited college or university, **and**
 - (a) Four (4) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with

disabilities.

- (b) One (1) of the four years must involve performing individual evaluations and writing reports of individuals' cognitive, psycho/social, life skills and interpersonal abilities, either directly or under the supervision and sign-off authority of a person who meets DVR's qualifications for IL Evaluation, **OR**

(4) A High School Diploma or GED **and**

- (a) Six (6) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.
- (b) One (1) of the six years must involve performing individual evaluations of and writing reports regarding individuals' cognitive, psycho/social, life skills and interpersonal abilities, either directly or under the supervision and sign-off authority of a person who meets DVR's qualifications for IL Evaluation.

b. Personnel Qualifications for IL Work Related Systems Access and IL Skills Training Services

Your response must include copies of educational degrees, diplomas, official transcripts and resume of paid employment experience showing each staff member providing IL Work Related Systems Access Services and IL Skills Training Services has met the following qualifications:

- (1) A Bachelor's Degree, in any field, from an accredited college or university, **and**
 - (a) One (1) year Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities, **OR**
- (2) Ninety (90) quarter or sixty (60) semester hours of coursework, in any field, from an accredited college or university, **and**
 - (a) Two (2) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities, **OR**
- (3) A High School Diploma or GED **and**
 - (a) Four (4) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

An Applicant must meet minimum qualifications in order to be considered for an award under this Invitation. Applicants not meeting minimum qualifications will be disqualified.

6. Funding

Independent Living (IL) services are purchased on a Fee for Service basis. Fees are standard statewide and set by DVR.

Any contract awarded does not guarantee DVR will purchase IL services from your organization.

7. Auxiliary Aids and Services

DSHS will provide access to this Solicitation document to individuals with disabilities. Please contact the Contracts Unit Supervisor to request auxiliary aids and services for this Solicitation.

If an individual believes that the department has discriminated on the basis of a disability, please contact the DSHS Investigations Unit (IU) for the Nondiscrimination Policy Brochure and complaint process. The brochure can be found at <http://www.dshs.wa.gov/pdf/Publications/22-171.pdf>.

8. Minority & Women's Business Enterprises (MWBE)

In accordance with the legislative findings and policies set forth in RCW 39.19, the State of Washington encourages participation in all of its contracts by Minority & Women's Business Enterprises (MWBE) firms either self-identified or certified by the Office of Minority & Women's Business Enterprises (OMWBE). While the State does not give preferential treatment, it does seek equitable representation from the minority and women's business community.

Participation by MWBE contractors may only be on a direct basis in response to this Solicitation. However, no preference will be given in the evaluation of Application Packets, no minimum level of MWBE participation shall be required, and submissions will not be evaluated, rejected or considered non-responsive on that basis.

Applicants may contact the Office of Minority & Women's Business Enterprises (OMWBE) at <http://www.omwbe.wa.gov/index.shtml> to obtain information on how to become certified.

Nothing in this section is intended to prevent or discourage participation from non MWBE firms, as well as MWBE firms.

9. Definitions.

The following terms which appear in this Solicitation have the meaning that is defined below for the purposes of this Solicitation:

- a. ADA – [Americans with Disabilities Act](#).

- b. Applicant - An individual, organization, public or private agency, or other entity submitting an Application Packet, in response to this Solicitation.
- c. Application Packet - All materials prepared and assembled by an Applicant, and which the Applicant submits in response to this Solicitation.
- d. Agency – The Department of Social and Health Services is the agency of the State of Washington that is issuing this Solicitation.
- e. CFR – Code of Federal Regulations (All references to CFR chapters or sections shall include any successor, amended, or replacement regulation).
- f. Contractor – Individual or Company’s Application Packet has been accepted by the Agency and is awarded a fully executed, written contract.
- g. Contracts Unit Supervisor – Management contact for the Contracts Unit; primary contact for applicant protect actions.
- h. Independent Living (IL) – A program that provides vocational rehabilitation services to individuals with disabilities to enable those individuals to maximize their opportunities for employment.
- i. Issue - To mail, post or otherwise release this Solicitation as a public document to interested parties.
- j. Key Personnel - Staff being proposed to do the work under this Solicitation.
- k. Protest - An objection by the Applicant, in writing, protesting the results of this Solicitation, and which complies with all requirements of this Solicitation.
- l. RCW - Revised Code of Washington. (All references to RCW chapters or sections shall include any successor, amended, or replacement statute.)
- m. Statement of Work - A statement of the work or services (a.k.a. “scope of work” or “scope of services”) which the Contractor is to perform under any contract awarded, and which is generally in the form of an exhibit attached to the contract.
- n. Submit - To deliver to the Contracts Unit all required documents and materials, as described and in the manner specified in this Solicitation.
- o. WAC - Washington Administrative Code. (All references to WAC chapters or sections shall include any successor, amended, or replacement regulation.)
- p. WEBS – Washington’s Electronic Business Solution. DSHS encourages all Applicants to register with WEBS at <http://www.ga.wa.gov/Webs/>.

Section A-2. SCOPE OF IL SERVICES

IL Evaluations

1. Definition:

Identification of an individual's IL strengths, limitations and needs for IL Skill Training or

IL Work-related Access services as a means to access community resources related to home and community life that could impact participation in the DVR VR process and attainment of competitive employment.

2. Two types:

a. **Partial** will consist of up to five of the IL Evaluation topics below.

b. **Comprehensive** will consist of all ten of the IL Evaluation topics below.

3. IL Evaluation Topics

a. Disability:

(1) How the individual understands their disability and related limitations.

(2) Individual's ability to manage their physical, emotional and mental health.

b. Residential issues:

(1) Accessibility;

(2) Mobility within the home;

(3) Environmental management;

(4) Home safety;

(5) Level of independence; and

(6) Need for housing benefit program or residential support services, etc.

c. Community mobility:

(1) Mobility outside of the living environment;

(2) Transportation ability and needs; and

(3) Safety issues in the community.

d. Financial issues:

- (1) Individual's ability to budget, pay bills and manage money;
- (2) Need for public benefits;
- (3) Problems with current benefit programs;
- (4) Need for guardian or protective payee;
- (5) Significant debt;
- (6) Use of payday lenders; and
- (7) Other legal issues related to financial issues.

e. Home management issues:

Basic skills of home management that could impact ability to work, i.e. cooking, cleaning, shopping, family issues, and need for adaptive equipment or caregiver services to assist in home management.

f. Social skills:

- (1) How the individual relates to family and others socially;
- (2) Ability to appropriately interact with others in an employment setting;
- (3) Identification of any social and/or family support system;
- (4) Use of free time;
- (5) Involvement with recreational activities; and
- (6) Problems with abuse and/or neglect.

g. Support Systems:

- (1) Ability to access all appropriate benefit programs, i.e. mental health, Division of Developmental Disabilities (DDD), food stamps, medical programs, housing assistance, etc.;
- (2) Understanding of why the person is accessing benefit programs and who the contact is for the programs;
- (3) Ability to manage benefit programs and community resources independently;
- (4) Understanding of rights and responsibilities for benefits programs;
- (5) Identification of significant problems with any benefit programs;
- (6) Identification of need and eligibility for long-term employment supports through a community resource or if natural supports are available.

h. Communication:

- (1) Ability to read, write and take messages;
- (2) Understanding and response to verbal and written communication;
- (3) Ability to express oneself verbally and non-verbally; and
- (4) Ability to access and use telephone, TTY, computer, etc.

i. Self care:

Management of personal health care, (i.e. bathing; dressing; grooming; toileting; medication management; doctor appointments; routine preventative health care measures; and need for personal care assistance.

j. Education and employment:

- (1) Educational background / history with special education services;
- (2) Learning difficulties and styles;
- (3) Employment history;
- (4) Understanding of DVR process, vocational goals, plans, etc. and
- (5) Criminal / legal issues that may impact employment.

4. Expected Outcome:

Individualized written report identifying all of the following:

- a. Individual's abilities and limitations in each specified IL Evaluation topic;
- b. Individual's IL barriers to competitive employment;
- c. IL Evaluator's summary impressions;
- d. IL Evaluator's name; and
- e. Specific recommendations regarding what IL skill training, natural supports and/or community resources may mitigate or eliminate the individual's IL barriers to competitive employment.

5. Fees:

a. Partial IL Evaluation:

Uniform outcome-based all-inclusive flat-fee of \$430

b. Comprehensive IL Evaluation:

Uniform outcome-based all-inclusive flat-fee of \$715

- (1) Travel Time - Reimbursement for travel time shall be provided for round-trip travel time paid at a fixed rate of \$35 per hour in quarter-hour increments and shall be paid only if service delivery occurs at a location more than fifty (50) miles from the Contractor's nearest staffed office location.
- (2) Mileage - If service delivery occurs more than fifty (50) miles from the Contractor's nearest staffed office location mileage shall be paid at the current rate according to the Office of Financial Management (OFM) State Administrative and Accounting Manual (SAAM), Section 10.90.20. <http://www.ofm.wa.gov/policy/10.90.htm#10.90.20>
- (3) Other Transportation Expenses - A DVR Counselor may authorize other transportation expenses, such as State Ferry System fees or toll fares.

6. IL Evaluation Services – Minimum Personnel Qualifications Required:

- a. A Bachelor's Degree in human or social services (Counseling, Vocational Rehabilitation, Social Work, Education, Psychology, Occupational / Physical Therapy, etc.), from an accredited college or university, and
- b. Two (2) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.
 - (1) One (1) of the two years must involve performing individual evaluations and writing reports regarding individuals' cognitive, psycho/social, life skills and interpersonal abilities, either directly or under the supervision and sign-off authority of a person who meets DVR's qualifications for IL Evaluation, OR
 - (2) A Bachelor's Degree, in any field, from an accredited college or university, and
 - (3) Three (3) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.
 - (a) One (1) of the three years must involve performing individual evaluations and writing reports of individuals' cognitive, psycho/social, life skills and interpersonal abilities, either directly or under the supervision and sign-off authority of a person who meets DVR's qualifications for IL Evaluation, OR
 - (b) Ninety (90) quarter or sixty (60) semester hours of human or social services coursework (Counseling, Vocational Rehabilitation, Social Work, Education, Psychology, Occupational / Physical Therapy, etc.), from an accredited college or university, and
 - (c) Four (4) years Full Time Equivalency (FTE) paid employment

experience in the direct provision of social services to individuals with disabilities.

- i. One (1) of the four years must involve performing individual evaluations and writing reports of individuals' cognitive, psycho/social, life skills and interpersonal abilities, either directly or under the supervision and sign-off authority of a person who meets DVR's qualifications for IL Evaluation, OR
- ii. A High School Diploma or GED and
- iii. Six (6) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

(A) One (1) of the six years must involve performing individual evaluations of and writing reports regarding individuals' cognitive, psycho/social, life skills and interpersonal abilities, either directly or under the supervision and sign-off authority of a person who meets DVR's qualifications for IL Evaluation.

IL Work-Related Systems Access

1. Definition:

Direct services to assist a person in accessing and utilizing public support systems, including but not limited to:

- a. Income – Social Security, TANF, GAU, etc.
- b. Personal care – Medicaid Personal Care, COPES, etc.
- c. Housing – Section 8, Public Housing, Adult Family Homes, etc.
- d. Medical coverage – Medicaid, Medicare, Basic Health, Healthcare for Workers with Disabilities, etc.

2. Expected Outcome:

Individualized written report(s) detailing:

- 1 All service delivery activity, as identified in the IL Service Delivery Outcome Plan (SDOP), provided to reach the Customer's IL Work-related Systems Access goal(s);
- 2 Dates and hours of all activities provided;
- 3 Name of staff person providing services;
- 4 Specific results achieved by the customer for each IL Work-Related Systems Access services topic as identified in the SDOP;

5 Specific recommendations, if any, for further services.

3. Fees:

- a. Hourly unit-of-service fee of \$72 per hour.
- b. Billable hours directly pertain to the delivery of services for the Customer. No payment will be made for time involved in report writing.
- c. Travel Time - Reimbursement for travel time shall be provided for round-trip travel time paid at a fixed rate of \$35 per hour in quarter-hour increments and shall be paid only if service delivery occurs at a location more than fifty (50) miles from the Contractor's nearest staffed office location.
- d. Mileage - If service delivery occurs more than fifty (50) miles from the Contractor's nearest staffed office location mileage shall be paid at the current rate according to the Office of Financial Management (OFM) State Administrative and Accounting Manual (SAAM), Section 10.90.20. <http://www.ofm.wa.gov/policy/10.90.htm#10.90.20>
- e. Other Transportation Expenses - A DVR Counselor may authorize other transportation expenses, such as State Ferry System fees or toll fares.

IL Skills Training

1. Definition:

Direct training to develop an individual's skills and abilities to mitigate or eliminate their IL barriers to employment:

- a. Use of transportation services:

Development of an individual's ability to:

- i. Explore, understand and utilize different transportation options;
- ii. Utilize direct bus use training;
- iii. Identify community resources for bus training;
- iv. Get to work and to feel safe obtaining transportation services, etc.

- b. Decision making:

Development of an individual's ability to:

- i. Identify a problem;
- ii. Collect data on potential solutions;
- iii. Weigh alternatives;

- iv. Develop a wise plan of action;
- v. Implement the plan of action;
- vi. Assess the success of the plan; and
- vii. Make adjustments as needed, etc.

c. Money management:

Development of an individual's ability to:

- i. Track income and expenses;
- ii. Budget for upcoming expenses;
- iii. Shop wisely;
- iv. Pay bills on time;
- v. Balance a checkbook;
- vi. Avoid bad debt;
- vii. Learn about deceptive financial practices;
- viii. Know where to get assistance if financial difficulties arise, etc.

d. Use of communication access services:

Development of an individual's ability to explore, identify, and access effective communication options, such as interpreters, Braille services, assistive technology, etc.

e. Organizational abilities:

Development of an individual's ability to identify and develop specific strategies, systems and tools to increase their efficiency and independence at home, in daily living, and in employment.

Examples include use of day planner, Personal Digital Assistants (PDAs), charts, checklists, filing systems, other memory aids, and work station arrangement.

f. Interpersonal and social relationships:

Development of an individual's ability to understand effective interpersonal and social relationships and how they may affect one's personal life, judgment, decision making, functional behavior, common ground, teamwork skills, etc. Examples include work relationships, family, friendships, intimate/romantic love, nonfamilial brother and sisterhoods, platonic love, internet relationships, spiritual groups, social groups, activism, etc.

g. Time management:

Development of an individual's ability and techniques to:

- i. Plan, schedule and manage time related to employment, personal life, and home activities;
- ii. Acknowledge one's personal time needs; and
- iii. Manage personal priorities, goals and life skill needs, etc.

h. Self-advocacy:

Development of an individual's ability to:

- i. Learn strategies and knowledge to resolve one's own problems;
- ii. Speak for one's self;
- iii. Exercise civil rights; and
- iv. Make decisions affecting one's life.

i. Accessing community resources and benefit programs:

Development of an individual's ability to independently obtain services or financial assistance through available support systems. Examples include Social Security, TANF, Healthcare for Workers with Disabilities, Section 8 and Public Housing, etc.

j. Attendant management:

Development of an individual's ability to self-manage:

- i. Personal care providers including, but not limited to how to recruit, hire, train, schedule, supervise, dismiss (if necessary), manage payroll, problem solve and develop a plan for when a personal care attendant is ill or stops working; and/or
- ii. Personal care needs, i.e. time required for assistance, ability to explain how assistance is to be given, having all supplies on hand, being organized, using time effectively, etc.

k. Self care:

Development of an individual's ability to manage basic independent life skills including, but not limited to:

- i. Grooming and hygiene (toileting, bathing and dressing);
- ii. Health management (setting up doctor appointments; getting routine physical and preventative care; accessing medical,

psychological, and other professional services as needed);

- iii. Medication management (setting up a system to take medications on-time, keeping doctors informed of changes in medication, getting prescriptions refilled, etc.).

I. Self protection:

Development of an individual's ability around personal awareness and skills to be safe when:

- i. In the home or community (how to respond to an emergency, contacting 911, escaping during a fire, etc.);
- ii. Interacting with others (being taken advantage of financially, sexually or in other ways); or
- iii. Using public transportation or technology (internet "scams", identify theft, online sexual predators); etc.

m. Expected Outcome:

Individualized written report(s) detailing the:

- i. All service delivery activity provided, as identified in the IL Service Delivery Outcome Plan (SDOP), to reach the Customer's IL Skills Training goal(s);
- ii. Dates and hours of all activities provided;
- iii. Specific results achieved for each IL Skill Training topic as identified in the SDOP;
- iv. Name of staff person providing services; and
- v. Specific recommendations, if any, for further services.

n. Fee:

- i. Hourly unit-of-service fee of \$72 per hour.
- ii. Billable hours directly pertain to the delivery of services for the Customer. No payment will be made for time involved in report writing.
- iii. Travel Time - Reimbursement for travel time shall be provided for round-trip travel time paid at a fixed rate of \$35 per hour in quarter-hour increments and shall be paid only if service delivery occurs at a location more than fifty (50) miles from the Contractor's nearest staffed office location.
- iv. Mileage - If service delivery occurs more than fifty (50) miles from

the Contractor's nearest staffed office location mileage shall be paid at the current rate according to the Office of Financial Management (OFM) State Administrative and Accounting Manual (SAAM), Section 10.90.20.

<http://www.ofm.wa.gov/policy/10.90.htm#10.90.20>

- i. Other Transportation Expenses - A DVR Counselor may authorize other transportation expenses, such as State Ferry System fees or toll fares.

Section B. SOLICITATION PROCESS

1. Solicitation Contact Information

Upon release of this Solicitation, all communications concerning this Solicitation must be directed **only** to the contact listed below. Any communication directed to DSHS staff or consultants, other than as identified below, may result in disqualification, rejection/return of materials, and/or a continued expired and ineligible status.

Contact: Contracts Unit
Department of Social & Health Services
Division of Vocational Rehabilitation

Mailing Address: P.O. Box 45340
Olympia, WA 98504-5811

Physical Address: 4500 7th Ave SE
Lacey, WA 98503

Telephone: (360) 725-3652

E-mail Address: dvrcontractsunit2@dshs.wa.gov

2. Acceptance of Solicitation Terms

The Applicant acknowledges that the submission of an Application Packet, which includes a signed *Bidder's Certification and Assurances* form, attached as Exhibit A, constitutes a binding offer.

3. Enrollment Schedule

The Enrollment Schedule is a clear outline of the timetable for this contract opportunity. As this is a short-term, very specifically targeted contract, the schedule will be strictly adhered to, and any application action occurring after the noted deadline will be rejected.

Figure 1. **ENROLLMENT SCHEDULE**

Item	Action	Date
1.	DSHS Issues Open Enrollment – IL Services	January 1, 2015
2.	Applicant may submit their Open Enrollment Application Packet anytime, prior to 4:00 p.m. Pacific Time	December 31, 2015
3.	<p>DSHS notifies Applicant of missing/incorrect documents. Incomplete and/or inaccurate Application Packets will be rejected* (in their entirety) as unacceptable. Application materials must be complete, accurate and received as one submission. DVR will not accept “piecemealed” submissions. Materials will be date and time stamped at receipt, and processed in the order received.</p> <p><i>*=rejected packets will NOT be returned, as submitted documents and materials are subject to public disclosure laws and requirements.</i></p>	<p><i>Usually within 10 business days of receipt date/time stamp. The identified Contract Contact will be notified, in cases of delay.</i></p>
4.	<p>Contract Execution – contracts will be prepared for complete and responsive application packets only, in the order they are physically received and accepted as responsive. Unsigned contracts will be e-mailed to only the identified contact person (not necessarily the signing authority) for approval. Once received back, the contract will be executed by DVR and an electronic copy emailed back to the vendor, as a part of the solicitation close-out.</p>	<p>Contracts will be executed within 2 business days of receipt of the vendor-signed agreement (<i>not including the date of receipt</i>).</p>
5.	<p>Contract Close Out – executed contracts will be updated in the STARS system, files created, and electronic copies of the final agreement will be emailed to the identified contract contact.</p> <p>NOTE: Although the process will not be “complete” prior to this point – Vendors may accept assignments immediately following execution of the agreement.</p>	<p><i>Usually within 10 business days of execution. The Identified Contract Contact will be notified, in cases of delay.</i></p>

4. Contract

DSHS intends to award **multiple contract(s)** to provide the services described in this Solicitation.

The term of the Contract will be **up to** 18 months in length, commencing upon the effective start date, as noted on the executed agreement. Amendments extending the period of performance, if any, shall be at the sole discretion of DSHS.

Additional services that are appropriate to the scope of this Solicitation, as determined by DSHS, may be added to the resulting contract by a written amendment mutually agreed to and executed by both parties.

5. Ethics

Specific restrictions apply to contracting with current or former state employees pursuant to chapter 42.52 of the Revised Code of Washington. Applicants should familiarize themselves with the requirements prior to submitting an Application Packet.

Additionally, Exhibit O – “*Code of Ethics and Standards of Practice*” form is required as a part of the Application Packet; failure to include a completed and signed document may result in disqualification.

6. Insurance

Successful Applicants must comply with insurance requirements.

7. Proprietary information/public disclosure

Materials submitted in response to this Solicitation shall become the property of DSHS and the Application Packets shall be deemed public records as defined by RCW 42.56.

The Application Packet must include a statement on the Letter of Submittal identifying the pages of the Application Packet, if any, which contain information the Applicant considers proprietary. Each page claimed to be proprietary must be clearly marked by printing the word “Proprietary” on the lower right hand corner. Applicants may not mark their entire Application Packet proprietary.

If DSHS receives a request to view or copy an Application Packet, DSHS will respond according to applicable law and DSHS’ policy governing public disclosure. DSHS will not disclose any information marked “Proprietary” in an Application Packet without giving the Applicant ten (10) days notice to seek a relief in superior court per RCW 42.56.540.

8. Communications

All communications concerning this Solicitation must be directed only to the Contracts Unit—as specified in Section B, item #1, *Solicitation Contact*

Information. Any communication directed to DSHS staff or consultants, other than the Contracts Unit Supervisor, may result in disqualification. Application Packets should be based on the material contained in this Solicitation, any related addendum(s), and any questions and answers directed through the Contracts Unit Supervisor.

9. Questions and Answers

Vendors are expected to read, fully understand, and agree to all conditions of this service contract. All questions must be submitted, in writing, prior to submission of the Application Packet and/or contract execution. Submit solicitation/contract inquiries to: dvrcontractsunit2@dshs.wa.gov for review and response.

10. Solicitation Addendums

DSHS reserves the right, at any time before execution of a contract, to amend all, or a portion, of this Solicitation. Addendums will be posted on the DSHS Procurements website and/or WEBS. In the event of a conflict, addendum language shall supersede this solicitation.

11. Retraction of this Solicitation

DSHS reserves the right to retract this Solicitation in whole, or in part, at any time without penalty.

12. Submission and Contents of Application Packets

a. Submission of Application Packets.

Application Packets must be prepared and submitted no later than the submission date and time specified in the Enrollment Schedule. The Application Packet is to be sent to the Contracts Unit, either by mail or hand delivery, at the address specified in Section B.1, Solicitation Contact Information. **DSHS will not accept any Proposal submitted by fax. DSHS will not accept any Proposal submitted by email.**

Applicants should allow sufficient time to ensure timely receipt by the Contracts Unit; postmarks will NOT be accepted. Applicants assume the risk for the method of delivery and for any delay in the mailing or delivery of the Proposal. DSHS will disqualify any Application Packet and withdraw it from consideration if it is received after the proposal submission due date and time.

All Application Packets and any accompanying documentation and material become the property of DSHS and will not be returned.

b. Format of Application Packet.

(1) The Applicant must Submit Application Packets on standard eight and one-half by eleven inch (8 ½" x 11") white paper.

- (2) The Applicant must use a font size of 12 or larger.
- (3) The Applicant may submit Application Packets in a securely bound method of their choice; examples include a three-ring binder, pronged report folder, or binder clip, as specified in Section C, *Application Packet Contents*. DVR assumes no liability for the rejection of incomplete Application Packets, due to inadequately secured presentations.
 - (a) The Applicant must provide tabs separating the major sections of the Application Packet, and must note the name of their company/organization on the front cover.

c. Contents of Application Packets.

The Applicant must submit one binder of the identified and required application materials. The Applicant must identify the procurement as **Solicitation # 0115-0102** and entitle the Application Packet, “**Open Enrollment—IL Services**”

Application Packets must address the sections of this Solicitation in the same order as presented here, and with the same headings. *Failure to meet this requirement may result in a “non-responsive” designation, and the rejection of the Application Packet.*

- (1) Table of Contents
- (2) Section 1: Administrative Requirements.
- (3) Section 2: Technical Requirements
- (4) Section 3: Management/Experience and Qualification Requirements

13. Non-responsive Application Packets

All Application Packets will be reviewed by Contracts Unit staff to determine compliance with administrative requirements and instructions specified in this Solicitation. DSHS may reject or withdraw an Application Packet at any time, as nonresponsive for any of the following reasons:

- a. Incomplete Application Packet;
- b. Submission of an Application Packet that proposes services that deviate from the technical requirements set forth in this document;
- c. Failure to comply with any part of this Solicitation or any exhibit to this Solicitation; or
- d. Submission of incorrect, misleading, or false information.

14. Minor Irregularities

DSHS retains the right to waive minor administrative irregularities related to any Application Packet.

15. Cost to Prepare Proposal

DSHS will not be liable for any costs incurred by the Applicant in preparing, submitting, or presenting an Application Packet for this Solicitation.

16. Withdrawal of Application Packets

After an Application Packet has been submitted, an Applicant may withdraw its Application Packet at any time up to the submission deadline specified in the Enrollment Schedule (and prior to execution of contract). A written request to withdraw the Application Packet, signed by an authorized representative of the Applicant, must be submitted to the Contracts Unit Supervisor*. After withdrawing an Application Packet, the Applicant may submit another Application Packet at any time up to the submission deadline.

**= withdrawal will NOT be returned, as submitted documents and materials are subject to public disclosure laws and requirements.*

17. Protest

In order to Submit a Protest under this Solicitation, an Applicant must have submitted an Application Packet for this Solicitation. **This protest process is the sole administrative remedy available within DSHS.** The following is the process for filing a Protest:

a. Grounds for Protest. A Protest may be made based on these grounds only:

- (1) DSHS failed to follow the procedures established in this Solicitation document, or to follow applicable State or federal laws or regulations; or
- (2) Bias, discrimination, or conflict of interest on the part of a DSHS staff member.

b. Protest Form and Content.

A Protest must state all of the facts and arguments upon which the Protest is based, and the grounds for the Protest. It must be in writing and signed by a person authorized to bind the Applicant to a contractual relationship. At a minimum, the Protest must include:

- (1) The name of the protesting Applicant, mailing address and phone number, and the name of the individual responsible for submission of the Protest—including an active email account, in which to deliver the receipt acknowledgement.
- (2) The Solicitation number and title;

- (3) A detailed and complete statement of the specific action(s) by DSHS under protest;
- (4) The grounds for the Protest;
- (5) Description of the relief or corrective action requested.

Applicants may attach to their Protest any documentation they have to offer in support.

c. Submitting a Protest

Protests must be in writing and must be signed. Applicants must mail or hand-deliver their Protest to the Contracts Unit Supervisor. Protests may not be submitted by fax or email. DSHS must **receive** (*date and time stamped*) the written Protest within ten (10) business days closure of the protested issue event. ***Under no circumstances, will a protest be given consideration after the specified timeframe.***

d. The Contracts Unit Supervisor will acknowledge receipt within two (2) business days, to the email address provided in the written Protest, and forward all Protest documentation to the DSHS designated Protest Coordinator with copies of the following:

- (1) This Solicitation and any addendums,
- (2) The protesting Applicant's Application Packet, and
- (3) Any other documents showing evaluation of the Application Packet in question.

DSHS will follow these procedures in reviewing a Protest:

- (1) DSHS will conduct an objective review of the Protest, based on the contents of the written Protest and the above materials provided by the Contracts Unit Supervisor.
- (2) DSHS will send the Protestor a written decision within five (5) business days after DSHS receives the Protest, unless more time is required to review the Protest and make a determination. The protesting Applicant will be notified by the Contracts Unit Supervisor if additional time is necessary.

DSHS will make a final determination of the Protest and will either:

- (1) Find that the Protest lacks merit and uphold DSHS's actions;
- (2) Find that any errors in the Solicitation process or in DSHS's conduct did not influence the outcome of the Invitation, and uphold DSHS's actions; or

- (3) Find merit in the Protest and provide options for corrective action by DSHS which may include:
 - (a) That DSHS correct any errors and re-evaluate all Application Packets affected by its determination of the Protest;
 - (b) That DSHS reissue the Solicitation document; or
 - (c) That DSHS make other findings and take such other action as may be appropriate.

18. Execution of the Contract

Successful Applicants are expected to sign a contract with DSHS and any subsequent amendments that may be required to address specific work or services as needed.

DSHS reserves the right to negotiate the specific wording of the Statement of Work, based on the requirements of this Solicitation and the terms of the awarded Application Packet(s).

If a Successful Applicant fails or refuses to sign the contract or any subsequent amendment within ten (10) business days of delivery, DSHS may elect to cancel the individual Contractor awards.

Section C. APPLICATION PACKET CONTENTS

The Applicant must answer all questions and must include all items, in the order requested for the Solicitation to be considered responsive. **Failure to address every section of the Solicitation may result in a non-responsive determination and disqualification from continuing the contract process.**

1. Administrative Requirements

(Section 1 of Application Packet Binder)

Responsive Application Packets: In order to be considered a “responsive” application packet, this section of your submission **MUST** address the following:

The Applicant must respond to each item in the same order in which they appear in this solicitation.

a. Letter of Submittal.

Applicants must include a signed Letter of Submittal on Applicant’s official business letterhead stationery as the first page of Section 1. Signing the Letter of Submittal indicates that the Applicant accepts the terms and conditions of *Solicitation #0115-0102*.

The Applicant’s Letter of Submittal must include the following:

- (1) Name, address, principal place of business, telephone number, fax number, and e-mail address of legal entity or individual with whom contract would be written;
- (2) The name of the contact person for this Solicitation (*this is the SOLE person who will be contacted with solicitation questions and who will receive the contract documents for signature*);
 - (a) **It is HIGHLY recommended that the email and phone number provided as contact methods, be accessible to multiple contractor representatives—in the case of vacation, illness, or staff changes. ONLY the person identified as the “Contact” will be notified of contract activities and status. It is the Contractor’s responsibility to ensure that accurate and current contact information is ALWAYS on file with DSHS/DVR.**
- (3) A detailed list of all materials and enclosures included in the Solicitation;
- (4) A statement substantiating that the person who signs the letter is authorized to contractually bind the Applicant’s firm;
- (5) Identification of the page numbers on the Application Packet that are marked “Proprietary or Confidential” Information; and

(6) Any statements describing variations between the Application Packet and the requirements of this Solicitation.

b. Bidder Certification and Assurances Form.

Applicants must submit a completed *Bidder Certification and Assurances Form*, (Exhibit A). Please sign and include any attachments that are necessary.

c. Contractor Intake Forms.

Applicants must submit completed and signed Contractor Intake forms, (Exhibit B). All applicable documents listed under Contractor Intake form(s) in the Administrative Section of the Applicant's Checklist must be submitted with the Contractor Intake form to be considered complete.

d. Contract Employees to Provide IL Services and Service(s) Approved (Exhibit P).

This form must be completed and included in the Application Packet to be considered responsive. The top portion is ONLY for employees who have already gone through the background check process and have been approved to provide specific IL services. The lower portion is for new/oncoming providers that need to be added, following the standard screening process.

e. Washington State Master Business License (Exhibit C).

f. Statewide Payee Registration.

The Department of Social and Health Services is now processing all vendor payments through the Office of Financial Management (OFM) Statewide Vendor Registration system. In order for you to receive payment for your invoices, you must complete and submit the Statewide Vendor Registration/Direct Deposit Authorization form AND the IRS W-9 form (Exhibit E) to the Office of Financial Management.

The State of Washington strongly encourages vendors to register for Electronic Funds Transfer (EFT). This process, also known as Direct Deposit, is cost-effective for both the State and the vendor. Direct Deposit:

- (1) Saves your organization the time and cost of manually processing and depositing checks;
- (2) Helps you manage your cash balances because notification payments can be sent two days before the date of deposit; and
- (3) Eliminates the worry of checks getting delayed or lost in the mail. *No special software is required for direct deposit – all you need is a bank account.*

If you elect not to receive payments by Electronic Funds Transfer, you are still required to complete the top portion of the Statewide Vendor Registration form and the IRS form W-9. Both forms must be completely filled out, signed, and returned to the address on the registration form or **faxed to (360) 664-3363** before submitting this Solicitation.

To assist DVR with setting up apparently successful Applicant(s) in the DSHS Service Tracking and Reporting System (STARS), please complete, sign, and submit the Statewide Payee Registration Status Form (Exhibit F)

g. Ethics.

The applicant must complete and remit Exhibit O, "*Code of Ethics and Standards of Practice.*"

h. Insurance.

The Applicant must provide proof of Commercial General and Business Auto insurance by submitting a Certificate of Insurance, (Exhibit G – Sample COI).

Insurance must include the minimum dollar amounts, additional insured language, and certificate.

i. Reference Section.

The Applicant must provide a list of at least three (3) references of entities for which the Applicant has performed similar services. The references should include the names, telephone numbers, dates of services, and a brief description of the similar services the Applicant provided them in the past.

References may not include DVR employees.

2. Technical Requirements

(Section 2 of Application Packet Binder)

General Requirements: In this section of the Application Packet, the Applicant is to provide a list of services they wish to provide; required certification, licensure, or accreditation for each service selected; correctly completed background authorization forms for all applicable personnel with other required documentation.

Application Packet Template(s): The Applicant is required to use all forms supplied to respond to this section of the Solicitation. A reference to another section will not suffice, each answer must stand alone.

Numbering of Responses. Please number each response so that it corresponds to the question number. The response must begin with a restatement of the question followed by the Applicant's response to the question. A reference to another section will not suffice, each answer must stand alone.

Attachments. Attachments must be labeled and tabbed and the question number to which it responds must be indicated.

Responsive Application Packets: In order to be considered a “responsive” application packet, this section of your submission MUST address the following:

- a. Services - Using the *IL Services and Qualifications Form* (Exhibit H), indicate the IL services your organization will provide and what certification, licensure, or accreditations currently held by your organization.
- b. Qualifications - Provide copies of your applicable certificate, license, or **full** CARF accreditation report, as appropriate.
- c. Background Checks
 - (1) Your response must include a fully completed DSHS Background Check Authorization form (Exhibit I) for each of your organization’s employees, volunteers, interns, or board members who may have unsupervised access to DVR clients.

DVR will conduct the background check through the DSHS Background Check Central Unit and return all authorizations and results to the identified contact.

NOTE: For this solicitation only, we will accept Background Check Authorizations and Approvals issued within 30 days of the “opening date.” *Applicants must, instead, provide a simple bullet list of applicable employees, who have already undergone and passed the background check process with DVR (within 30 days of the opening date). Employees not included on this list must authorize the investigation as described above.*

- (2) The Contractor shall designate an employee or employees authorized to process confidential background check authorization forms and accept results of the background checks of its personnel, interns, volunteers, or board members.

The Contractor shall provide DVR the following information (Exhibit J) on each employee authorized to receive confidential information available on background checks and their results:

- (a) Employee(s) name;
- (b) Employee(s) job title;
- (c) Employee(s) area code(s) and telephone number(s); and
- (d) Employees business location(s) including street address, city, state, and zip+4.

The Contractor is required to notify DVR in writing within fourteen (14) calendar days when an employee(s) is no longer authorized to process and receive confidential background checks and results.

Any employee designated by the contractor to send and receive confidential background check authorization forms and related information shall sign a Background Check Confidentiality Agreement (Exhibit K). The Contractor shall maintain the original agreement in the employee's personnel file and provide copies to the employee and DVR with this Solicitation.

3. Management, Experience, and Qualification Requirements

(Section 3 of Application Packet Binder)

General Requirements: In this section of the Application Packet, the Applicant is to discuss written policies and procedures of the organization.

Application Packet Template(s): The Applicant is required to use the *IL Contract Information Form* (Exhibit L) to respond to section 3.a. of the Solicitation. Forms are attached as exhibits.

Questions beginning with section 3.c. must follow the numbering guidelines listed below with each separate response. A reference to another section will not suffice, each answer must stand alone.

Numbering of Responses. Please number each response so that it corresponds to the question number. The response must begin with a restatement of the question followed by the Applicant's response to the question. A reference to another section will not suffice, each answer must stand alone. Any questions left unanswered will be considered unresponsive.

Attachments. Attachments must be labeled and tabbed and the question number to which it responds must be indicated.

Responsive Application Packets: In order to be considered a "responsive" application packet, this section of your submission MUST address the following:

a. Contract Information.

Complete in full, sign, and submit the IL Contract Information Form (Exhibit L) answering questions and identifying counties where the vendor will provide services.

b. Fire/Safety Inspection.

Your response must include a copy of an **approved** Fire/Safety Inspection certificate for all premises owned, leased, or rented by your organization where you will provide IL services for DVR clients.

Such inspections must be conducted within the previous twenty-four (24) months of the date of your Solicitation response and performed by a recognized external authority, e.g. State Fire Marshall, OSHA, WISHA, liability insurance carrier, etc.

If you will provide services in a public setting such as a library, etc. you must submit a letter stating such and the types of locations you may provide services at.

c. Safety.

- (1) Explain your procedures on how you have immediate access to each of the following:
 - (a) First aid expertise;
 - (b) First aid equipment and supplies; and
 - (c) Emergency information on personnel and DVR clients.
- (2) Explain procedures for reporting critical incidents involving DVR clients. For example, abuse or neglect, injuries, communicable diseases, violence or aggression, transportation, weapons, or illicit substances, etc.
- (3) Explain your Emergency plans for each of the following:
 - (a) Fires;
 - (b) Bomb threats;
 - (c) Natural disasters;
 - (d) Power failures;
 - (e) Medical emergencies; and
 - (f) Safety during violent or other threatening situations.

d. Confidentiality.

- (1) What are your written policies and procedures for safeguarding the confidentiality of all information regarding DVR Clients?
- (2) What are your written policies and procedures for release of any confidential information regarding DVR Clients?

e. Information Management and Performance Improvement.

- (1) Describe your Information Management system and specific measures you will use to track **effectiveness** (results) of your future DVR IL services.

- (2) Describe your Information Management system's specific methods of measuring **efficiency** (the relationship between results and resources used to produce results) of your future DVR IL services.
 - (3) Describe your Information Management system's specific methods of measuring **DVR Client Satisfaction**.
- f. DVR Client Rights.
- (1) What are your written policies for promoting the rights of DVR Clients' freedom from abuse, exploitation, retaliation, humiliation, and neglect?
 - (2) What are your written policies for promoting the rights of DVR Clients' access to and the release of their personal records to others and for their own use?
 - (3) What are your written policies for promoting the rights of DVR Clients' informed consent and expression of choice regarding service delivery?
 - (4) What are your written policies for promoting the rights of DVR Clients' access to legal entities for appropriate representation if needed?
 - (5) What are your written policies for promoting the rights of DVR Clients' regarding investigation and resolution of alleged infringement of rights?
- g. DVR Client Grievance Procedures.
- (1) Describe your written procedures to ensure a DVR Client may make a formal complaint, file a grievance, or appeal a decision made by your organization's personnel.

Section D. EVALUATION

1. Evaluation Procedure

DSHS will initially screen each Application Packet to determine if the Applicant has complied with the stated Administrative Requirements and Submittal Instructions. If the Application Packet does not meet all requirements for this Solicitation, DSHS may consider the submission non-responsive and may withdraw it from further contracting activities.

DSHS program staff and/or management may conduct a final review of the submitted Application Packets to consider past or current performance and experience of any DSHS contracts by Applicants.

Applications meeting the requirements of this Solicitation will be offered a contract for approval and execution. Applicants deemed non-responsive or ineligible to contract will be notified by email of this determination. Non-responsive applicants will be permitted to resubmit application materials, if the revised presentation meets the established enrollment deadline and other specified requirements.

An "*Applicant's Checklist*" (Exhibit M) has been provided for the Applicant's convenience.

Please note: DSHS has made every attempt to ensure a complete and accurate checklist. It is, however, the Applicant's responsibility to fully read, understand, and comply with ALL terms and requirements of this solicitation. DSHS assumes no liability for incomplete, non-responsive, and/or rejected Application Packets, resulting from an inadvertent omission of information from the supplied checklist.

Section E. EXHIBITS

1. Exhibits

Exhibits to this Solicitation are:

- Exhibit A Bidder Certification and Assurances Form
- Exhibit B Contractor Intake Form
- Exhibit C Washington State Master Business License – Sample
- Exhibit D Statewide Payee Instructions
- Exhibit E OFM Statewide Payee Registration and W-9 Forms
- Exhibit F Statewide Vendor Registration Status Form
- Exhibit G Certificate of Insurance – Sample
- Exhibit H IL Services and Qualifications Form
- Exhibit I Background Authorization Form
- Exhibit J Background Check Contractor Designated Contact Form
- Exhibit K Background Check Confidentiality Agreement
- Exhibit L IL Contract Information
- Exhibit M Applicant's Checklist
- Exhibit N Map for Physical Delivery of Proposals
- Exhibit O Code of Ethics and Standards of Practice Form
- Exhibit P Contract Employees to Provide IL Services and Service(s) Approved

Solicitation #0115-0102—Exhibit A

Bidder Certification and Assurances Independent Living Services

Under the penalties of perjury of the State of Washington, we make the following certifications and assurances as a required element of our Application Packet for *Solicitation #0115-0102*. We affirm the truthfulness of these facts and acknowledge our current and continued compliance with these certifications and assurances as part of our Proposal and any resulting contract award with DSHS.

1. We declare that all answers and statements made in the Application Packet are true and correct.
2. Our Application Packet is a firm offer for a period of 180 days following receipt, and it may be accepted by DSHS without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 180-day period. In the case of a protest, the Bidder's Proposal will remain valid for 210 days or until the protest is resolved, whichever is later.
3. We have not been assisted by any current or former DSHS employee whose duties relate (or did relate) to this procurement and who assisted in other than his or her official, public capacity.

If there are any exceptions to these assurances or we have been assisted, we will identify on a separate page attached to this document each individual by: (a) name, (b) current address and telephone number, (c) current or former position with DSHS, (d) dates of employment with DSHS, and (e) detailed description of the assistance provided by that individual.

4. We acknowledge that DSHS will not reimburse us for any costs incurred in the preparation of our Proposal. All Proposals become the property of DSHS and we claim no proprietary right to the ideas, writings, items or samples.
5. We acknowledge that any resulting contract awards will incorporate Special Terms and Conditions, Statement of Work, and General Terms and Conditions substantially similar to the sample contract attached to the procurement document.
6. We will comply with these or substantially similar Special Terms and Conditions, Statement of Work, and General Terms and Conditions if awarded a contract, and will negotiate in good faith any changes or modifications.
7. We acknowledge that if awarded a contract with DSHS, we are required to comply with all applicable state and federal civil rights and other laws. Failure to comply may result in contract termination. We agree to submit additional information about our nondiscrimination policies, at any time, if requested by DSHS.
8. We certify that we have a current Washington State Business License, and agree to promptly provide a copy of the license with this proposal.

9. We made no attempt, nor will make any attempt, to induce any other person or firm to submit, or not submit, a proposal for the purpose of restricting competition.
10. We acknowledge and authorize DSHS to conduct a financial assessment and/or background check of our organization if DSHS considers such action necessary or advisable.
11. We acknowledge our obligation to notify DSHS of any changes in the certifications and assurances above.

Signature

Date

Title

Organization Name

Telephone Number

Email Address

Contractor Intake Instructions

All New DSHS Contractors must:

- Complete, sign and submit the **Intake Form** to the **Department of Social and Health Services (DSHS)**.
- Register in the **Statewide Payee Registration System**. This system is maintained by the Washington State Office of Financial Management (OFM) to process payments for **all** Washington state agencies. To register, **follow the online instructions at <http://www.ofm.wa.gov/isd/vendors.asp>**. You must complete this step in order to be paid.
Please **do not** return this DSHS Contractor Intake Form to OFM; they will **not** process it.

All Existing DSHS Contractors who have changed their business name or business organization, or experienced other significant changes, **must:**

- Update their information in the **Statewide Payee Registration System** by following the instructions at <http://www.ofm.wa.gov/isd/vendors.asp>.
- Complete, sign and submit a new **Contractor Intake** form to the **Department of Social and Health Services (DSHS)**.

Section One: Contractor Name/Business Organization

1. **Contractor name.**

- For an Individual or Sole Proprietor, enter your name as shown on your Social Security card on the "Name" line. Sole Proprietors provide Last Name, First Name, Middle Name, and Suffix.
- Other entities. Enter your business name as shown on the legal document creating the entity.

2. **Business Organization.** Please mark only one.

- If you are a nonresident alien foreign person or a business entity established in another state or country, the IRS may require you to complete Form W-8.
- If you are a Non-profit Corporation or a Faith-Based Non-Profit Corporation **attach a copy of your 501(c) status**.

3. **Taxpayer Identification Number (TIN).**

- Individual or Sole Proprietor - If you are a sole proprietor you may enter either your Social Security Number (SSN), or if you have one, your federal Employer Identification Number (EIN).
- Other Business Entities - Enter the entity's Employer Identification Number (EIN). If the entity does not have an EIN, enter the SSN of the owner of the business.
- Resident alien. - If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the SSN box.

4. **Default Reported, Fiscal Year, UBI Number, and Business License**

- List any contracts that you have had with the state that have been terminated for default.
- Provide your fiscal year end date.
- Provide your Washington State Uniform Business Identifier (UBI) Number.
- **Attach a copy of your State Master Business License**. You may be exempt from registering with the State of Washington under certain circumstances. For more information review: <http://www.dol.wa.gov/business/faqlicense.html>

Section Two: Contractor Primary Address Enter the primary address information of your business. If you are completing this form for a new DSHS contract, and you want to provide a contract-specific address in addition to your primary one, please do so in Section Five.

Section Three: Contractor Ownership Check those that, in your opinion, apply to your organization. If you have a certification number, please provide that also.

Section Four: Contractor Contact Person(s) Enter the primary contact information, and job title, for your business. If you are completing this form for a new DSHS contract, and you want to provide a contract-specific contact person other than your primary one, please do so in Section Five.

Section Five: Additional Information

1. **Contractor Additional Addresses.** If applicable, provide additional addresses used for DSHS Contracts.
2. **Contractor Additional Staff.** If applicable, provide additional staff information for DSHS Contracts. Additional staff may include those who have authority to sign a DSHS contract on behalf of the business, and are referred to as a signatory.

Section Six: Contractor Certification You must sign, date, and return this form before DSHS will issue a contract.

Contractor Intake

Section One: Contractor Name/Business Organization		(DSHS staff enter on ACD Intake Detail screen)			
1. CONTRACTOR NAME		DBA OR FACILITY NAME			
2. BUSINESS ORGANIZATION					
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> Individual or Sole Proprietor <input type="checkbox"/> Non-Profit Corporation (Attach a copy of 501(c) status) <input type="checkbox"/> For Profit Corporation <input type="checkbox"/> Faith Based (FBO) Non-Profit Corporation <input type="checkbox"/> Faith Based (FBO) Unincorporated <input type="checkbox"/> Governmental Entity <input type="checkbox"/> Foreign Person or Entity </td> <td style="width: 50%; vertical-align: top; padding: 5px;"> <input type="checkbox"/> General Partnership <input type="checkbox"/> Limited Liability Partnership (LLP) <input type="checkbox"/> Limited Liability Limited Partnership (LLLLP) <input type="checkbox"/> Limited Liability Company, filing as a Corporation <input type="checkbox"/> Limited Liability Company, filing as a Partnership <input type="checkbox"/> Limited Liability Company, filing as a Sole Proprietor </td> </tr> </table> <p style="text-align: center; padding: 5px;">If your business is NOT a sole proprietorship, attach a list of the partners, members, directors, officers, and board members.</p>				<input type="checkbox"/> Individual or Sole Proprietor <input type="checkbox"/> Non-Profit Corporation (Attach a copy of 501(c) status) <input type="checkbox"/> For Profit Corporation <input type="checkbox"/> Faith Based (FBO) Non-Profit Corporation <input type="checkbox"/> Faith Based (FBO) Unincorporated <input type="checkbox"/> Governmental Entity <input type="checkbox"/> Foreign Person or Entity	<input type="checkbox"/> General Partnership <input type="checkbox"/> Limited Liability Partnership (LLP) <input type="checkbox"/> Limited Liability Limited Partnership (LLLLP) <input type="checkbox"/> Limited Liability Company, filing as a Corporation <input type="checkbox"/> Limited Liability Company, filing as a Partnership <input type="checkbox"/> Limited Liability Company, filing as a Sole Proprietor
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3. TAXPAYER IDENTIFICATION NUMBER (TIN) Enter your TIN in the appropriate box.		Social Security Number OR Employer Identification Number			
<ul style="list-style-type: none"> For individuals, this may be your Social Security Number (SSN). For other entities, it is your Employer Identification Number. 		<p style="text-align: center;">_____</p> <p style="text-align: center;">(Enter all 9 numbers, NO DASHES)</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">(Enter all 9 numbers, NO DASHES)</p>			
4. DEFAULT REPORTED, FISCAL YEAR, UBI NUMBER, AND BUSINESS LICENSE					
<p>Have you had any contract with the state terminated for default? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">If yes, attach a list of terminated contracts with an explanation why each contract was terminated.</p> <p>Is your fiscal year end the same as the calendar year (January 1 through December 31)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">If the answer is no, what is your fiscal year end date? _____</p> <p>What is your Washington State Uniform Business Identifier (UBI) Number? _____ (Enter all 9 numbers, NO DASHES)</p> <p>Attach a copy of your current Washington State Master Business License.</p> <p>If you do not have a Washington State Master Business License, explain below why you are exempt from registering your business with the State of Washington. (See page 1 for information on exemptions.)</p>					
Section Two: Contractor Primary Address		(DSHS staff enter on ACD Intake Detail screen)			
CONTRACTOR PRIMARY ADDRESS (NUMBER, STREET, AND APARTMENT OR SUITE NUMBER)					
CITY, STATE, AND ZIP CODE					
EMAIL ADDRESS		COUNTY WHERE PRIMARY ADDRESS IS (FOR OUT-OF-STATE CONTRACTORS)			
PHONE NUMBER (INCLUDE AREA CODE) ()		FAX NUMBER (INCLUDE AREA CODE) ()			

Section Three: Contractor Ownership Type		(DSHS staff enter, as applicable, on ACD Intake Detail screen)																		
<p>In your opinion, do you consider your business to be one or more of the following? If so, please check the boxes that apply.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 80%;"></td> <td style="text-align: center; width: 10%;">YES</td> <td style="text-align: center; width: 10%;">NO.</td> </tr> <tr> <td>Disadvantaged Business Enterprise</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Woman Owned Business Enterprise</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Minority Owned Business Enterprise</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Veteran Owned Business Enterprise</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Community Based Organization</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		YES	NO.	Disadvantaged Business Enterprise	<input type="checkbox"/>	<input type="checkbox"/>	Woman Owned Business Enterprise	<input type="checkbox"/>	<input type="checkbox"/>	Minority Owned Business Enterprise	<input type="checkbox"/>	<input type="checkbox"/>	Veteran Owned Business Enterprise	<input type="checkbox"/>	<input type="checkbox"/>	Community Based Organization	<input type="checkbox"/>	<input type="checkbox"/>	<p>If your business is Certified by Washington State's Office of Minority and Women Owned Business Enterprises (OMWBE) http://www.omwbe.wa.gov, or Department of Veterans Affairs (DVA), enter the certification number.</p> <hr/> <hr/> <hr/> <hr/>	
	YES	NO.																		
Disadvantaged Business Enterprise	<input type="checkbox"/>	<input type="checkbox"/>																		
Woman Owned Business Enterprise	<input type="checkbox"/>	<input type="checkbox"/>																		
Minority Owned Business Enterprise	<input type="checkbox"/>	<input type="checkbox"/>																		
Veteran Owned Business Enterprise	<input type="checkbox"/>	<input type="checkbox"/>																		
Community Based Organization	<input type="checkbox"/>	<input type="checkbox"/>																		

Section Four: Contractor Primary Contact Person		(DSHS staff enter on ACD Intake Detail screen)
<p>Primary contact person is a(n):</p> <p><input type="checkbox"/> Owner <input type="checkbox"/> Officer or Board Member <input type="checkbox"/> Partner <input type="checkbox"/> Staff Member <input type="checkbox"/> Elected Official</p> <p><input type="checkbox"/> Other (please identify) _____ (DSHS staff enter as applicable on ACD)</p> <p>Is the primary contact person authorized to sign contracts? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
PRIMARY CONTACT NAME AND JOB TITLE	PHONE NUMBER (INCLUDE AREA CODE) ()	
FAX NUMBER (INCLUDE AREA CODE) ()	PRIMARY CONTACT EMAIL ADDRESS	
PAGER NUMBER (INCLUDE AREA CODE) ()	CELLULAR PHONE NUMBER (INCLUDE AREA CODE) ()	

Section Five: Additional Information		(DSHS staff enter on Intake Detail – Sub Information Summary screens)
<p>1. ADDITIONAL CONTRACTOR ADDRESSES: IF YOU HAVE MORE THAN TWO ADDITIONAL ADDRESSES, YOU MAY <u>ATTACH</u> A LISTING OF ADDITIONAL ADDRESSES.</p>		
<p>ADDRESS DESCRIPTION</p> <p><input type="checkbox"/> Billing address</p> <p><input type="checkbox"/> Facility address</p> <p><input type="checkbox"/> Mailing address</p>	<p>ADDITIONAL ADDRESS (NUMBER, STREET, AND APARTMENT OR SUITE NUMBER)</p> <hr/> <p>CITY, STATE, AND ZIP CODE</p>	
PHONE NUMBER (INCLUDE AREA CODE) ()	COUNTY WHERE PRIMARY ADDRESS IS (FOR OUT-OF-STATE CONTRACTORS)	
FAX NUMBER (INCLUDE AREA CODE) ()	EMAIL ADDRESS	
<p>ADDRESS DESCRIPTION</p> <p><input type="checkbox"/> Billing address</p> <p><input type="checkbox"/> Facility address</p> <p><input type="checkbox"/> Mailing address</p>	<p>ADDITIONAL ADDRESS (NUMBER, STREET, AND APARTMENT OR SUITE NUMBER)</p> <hr/> <p>CITY, STATE, AND ZIP CODE</p>	
PHONE NUMBER (INCLUDE AREA CODE) ()	COUNTY WHERE PRIMARY ADDRESS IS (FOR OUT-OF-STATE CONTRACTORS)	
FAX NUMBER (INCLUDE AREA CODE) ()	EMAIL ADDRESS	

2. ADDITIONAL STAFF: IF YOU HAVE MORE THAN TWO ADDITIONAL STAFF (LISTED BELOW), WHO ARE ALSO RELEVANT TO YOUR DSHS CONTRACTS, PLEASE PROVIDE INFORMATION ABOUT THOSE STAFF ON A SEPARATE PAGE.

Additional staff person is a(n):

- Officer or Board Member
 Partner
 Staff Member
 Elected Official
 Other (please identify) _____ (DSHS staff enter as applicable on ACD)

Is the additional staff authorized to sign contracts? Yes No

Is the additional staff a contact for DSHS contracts? Yes No

ADDITIONAL STAFF NAME	PHONE NUMBER (INCLUDE AREA CODE) ()
FAX NUMBER (INCLUDE AREA CODE) ()	ADDITIONAL STAFF EMAIL ADDRESS
PAGER NUMBER (INCLUDE AREA CODE) ()	CELLULAR PHONE NUMBER (INCLUDE AREA CODE) ()

Additional staff person is a(n):

- Officer or Board Member
 Partner
 Staff Member
 Elected Official
 Other (please identify) _____ (DSHS staff enter as applicable on ACD)

Is the additional staff authorized to sign contracts? Yes No

Is the additional staff a contact for DSHS contracts? Yes No

ADDITIONAL STAFF NAME	PHONE NUMBER (INCLUDE AREA CODE) ()
FAX NUMBER (INCLUDE AREA CODE) ()	ADDITIONAL STAFF EMAIL ADDRESS
PAGER NUMBER (INCLUDE AREA CODE) ()	CELLULAR PHONE NUMBER (INCLUDE AREA CODE) ()

Section Six: Contractor Certification (DSHS staff enter on ACD Intake Detail as Intake Form Date)

You must sign, date, and return this form.

I certify, under penalty of perjury as provided by the laws of the State of Washington, that all of the foregoing statements are true and correct, and that I will notify DSHS of any changes in any statement.

SIGNATURE	DATE	PRINTED NAME
		TITLE

ATTACHED SUPPORTING DOCUMENTATION CHECKLIST

- Copy of your W-9 - Request or Taxpayer Identification Number and Certification
- Copy of statement showing non-profit 501(c) status (if applicable)
- List of partners, members, directors, officers, and board members (not applicable to sole proprietors)
- Copy of your Washington State Master Business License or proof of exemption
- List of any contracts you have had with the state that have been terminated for default, including a brief explanation (if applicable)
- List of Additional Addresses (if applicable)
- List of Additional Staff (if applicable)
- Copy of your Certificate of Insurance (if applicable)



STATE OF WASHINGTON

MASTER LICENSE SERVICE
REGISTRATIONS AND LICENSES

UNIFIED BUSINESS ID #: 123 456 789
BUSINESS ID #: 001
LOCATION: 0001

ORGANIZATION TYPE
DOMESTIC PROFIT CORPORATION

CREATE-A-CORP, INC.
CREATIVE BUSINESS OWNERS
1234 MAIN ST
ANYTOWN WA 12345-6789

UNEMPLOYMENT INSURANCE INDUSTRIAL INSURANCE
TAX REGISTRATION

REGISTERED TRADE NAMES:
CREATIVE BUSINESS OWNERS

The above entity has been issued the business registrations or licenses listed
DEPARTMENT OF LICENSING, BUSINESS & PROFESSIONS DIVISION,
P.O. BOX 9034 OLYMPIA, WA 98507-9034 (360) 964-1400

Leah Stephens
Director, Department of Licensing

Instructions for the Statewide Payee Registration Form

The term 'payee' refers to an individual or business that received payments from the State of Washington. This form is intended to be used for payees to register with the State of Washington, indicate how they would like to receive payments, and change their registration information.

For prompt payment, it is important that we receive complete and accurate information. **We must return any form that is not complete, so please be sure to read and follow these instructions carefully.**

Step 1: Is this a new registration or a change to an existing registration?

Select **NEW REGISTRATION** if:

- You have never completed the Statewide Payee Registration Form.
- You are changing the legal name of a payee already registered.
- You are changing the EIN (Employer Identification Number) or SSN (Social Security Number) of a payee already registered
- You are changing the reporting type (sole proprietor, corporation, etc) on an existing registration.

Select **CHANGE TO EXISTING REGISTRATION** for all other changes to an existing registration, and check the items that have changed. Be sure to **COMPLETE the ENTIRE form**, even if you are only changing one item. This will help us keep your account up to date and accurate. If you know your SVN number, please enter it on the form.

Step 2: Payee & contact information

Legal name of payee – enter the name as it appears on federal tax forms.

Business name – “doing business as” name. Enter only if different from legal name.

Mailing address – enter the PO Box or street address where you want information sent to you. If you choose to have checks mailed to you, this is the address where they will be sent.

Primary business –

Enter the primary occupation of the payee.

EIN or SSN – enter the EIN or SSN you use with the IRS for the legal name entered.

Contact person – the person we can contact with questions about your registration.

Title of contact person – title of the contact person.

Telephone number for contact person – telephone number of the contact person

Fax number – fax number of the contact person

Email for contact person - enter the email address we should use to communicate with you about your registration and your payments. We will use the email address to:

- Notify you when your account has been set up.
- Notify you when changes you submitted have been made

- Notify you when your payment has been processed, if you have signed up for direct deposit

NOTE: For larger organizations we recommend that you use the email address for a distribution list to ensure that our notifications are received and processed quickly.

Step 3: Payment options

Indicate if you want to receive your payments via Direct Deposit or via US Mail.

Step 4: Direct deposit information

Financial institution name & phone number – enter the name and phone number of the financial institution where you want your funds deposited. This **must** be a US institution.

Routing number – this is the 9 digit Bank Identification Number assigned by the American Banking Association. The routing number is the first 9 numbers at the bottom of your check. See example on form. Do not use the routing number from a generic deposit slip – these begin with the number '5.'

Account number – this is your bank account number, and can vary in length. It usually follows the routing number on the check

Account type – select the kind of account your payment will be deposited into. If you do not make a selection, funds will be transferred into the checking account.

Authorization Signature – in order for us to process the Direct Deposit, we need the signature of the person on file with the bank.

Step 5: W-9

The IRS has issued new regulations governing how we report payments and calculate withholding. **We need a complete, signed W-9 in order to process your registration and verify any changes to it.**

1. **Legal name of payee** – enter the name as it appears on federal tax forms.
2. **Business name** – “doing business as” name. Enter only if different from legal name.
3. **Check one box for your IRS reporting type** – you must check ONLY one box to indicate if you are an individual, corporation, non-profit organization, etc.
4. **Check if the business is medical or legal** - If you are a corporation, S-corporation, partnership or LLC, and your business is medical or legal, you must check the appropriate box. See the W-9 instructions for more information about reporting types.
5. **Mailing address** – enter the PO Box or street address
6. **City, State and ZIP**
7. **Taxpayer Identification Number** – enter the Employer Identification Number (EIN) **OR** Social Security Number (SSN) you use with the IRS for the legal name entered. **DO NOT ENTER BOTH.** Enter **ONLY** the one that you use with the IRS for the legal name.
8. **SIGN the W-9**

Step 6: For fastest service, scan and email both pages to PayeeForms@ofm.wa.gov. If you do not have scanning ability, you may fax it to 360-664-3363, or mail to the Statewide Payee Desk, PO Box 43113, Olympia, WA 98504-3113

Statewide Payee Registration Washington State

STEP 1: Is this a NEW registration or CHANGE to an existing registration (check one)?

- NEW REGISTRATION** (also includes changing the LEGAL NAME, SSN, EIN or reporting type)
- CHANGE to EXISTING REGISTRATION** – complete the **ENTIRE** form and check below what is updated:
- Business Name/DBA Business Address Contact Information Bank, Routing or Account Numbers Payment Options

If you know your Statewide Vendor Number, enter it here: **SWV:** _____ - _____

STEP 2: Enter information about the payee and contact person

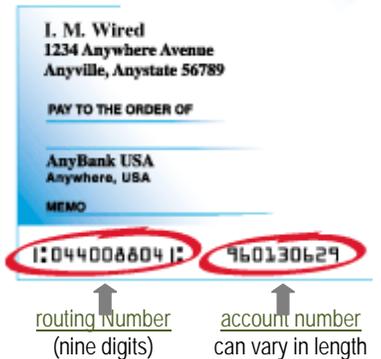
_____			_____		
Legal Name of Payee as it appears on federal tax forms			EIN or SSN for the Legal Name at left		
_____			_____		
Business Name, if different from Legal Name above – eg. Doing Business As (DBA) Name			Contact Person		
_____			_____		
Mailing Address for us to send notifications or payments – PO Box or Street Address			Title of Contact person		
_____			() - Ext.		
_____			_____		
Mailing Address – Suite or Office Number			Telephone Number for Contact Person		
_____			() -		
_____			_____		
City	State	Zip + 4	Fax Number for Contact Person		
_____			_____		
Email for us to use ONLY to send you notifications about your account			Primary Business		

STEP 3: Select Payment Option:

- Direct Deposit to bank (recommended) or Check in US mail

STEP 4: For Direct Deposit, complete all fields below and sign

_____		_____	
Financial Institution Name – must be a US institution		Financial Institution Phone Number	
_____		_____	
Routing Number – see example at right		Account Number – see example at right	
You may also attach a voided check if you are unsure which number to enter above			
Account Type: <input type="checkbox"/> Checking or <input type="checkbox"/> Savings (Checking will be used if neither box is marked.)			



Authorization for Direct Deposit:

I hereby authorize and request the Office of Financial Management (OFM) and the Office of the State Treasurer (OST) to initiate credit entries for payee payments to the account indicated above, and the financial institution named above is authorized to credit such account. I agree to abide by the National Automated Clearing House Association (NACHA) rules with regard to these entries. Pursuant to the NACHA rules, OFM and OST may initiate a reversing entry to recall a duplicate or erroneous entry that they previously initiated. I understand that, if a reversal action is required, OFM will notify this office of the error and the reason for the reversal. This authority will continue until such time OFM and OST have had a reasonable opportunity to act upon written request to terminate or change the direct deposit service initiated herein.

_____		_____	
Authorization Name on Account		Title	
_____		_____	
SIGNATURE of Authorization Name on Account		Date	

STEP 5: Complete and sign the Request for Taxpayer Identification Number (W-9)

Substitute Form W-9	Request for Taxpayer Identification Number and Certification																		
1. Legal Name (as shown on your income tax return)																			
2. Business Name, if different from Legal Name above – eg. Doing Business As (DBA) Name																			
3. Check ONLY ONE box below (see W-9 instructions for additional information)																			
<input type="checkbox"/> Individual or Sole Proprietor <input type="checkbox"/> LLC filing as a sole proprietor <input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation <input type="checkbox"/> S-Corp																		
<input type="checkbox"/> LLC filing as Corporation <input type="checkbox"/> LLC filing as Partnership <input type="checkbox"/> LLC filing as S-Corp	<input type="checkbox"/> Non Profit Organization <input type="checkbox"/> Volunteer <input type="checkbox"/> Board /Committee Member																		
<input type="checkbox"/> Local Government <input type="checkbox"/> State Government <input type="checkbox"/> Federal Government (including tribal)	<input type="checkbox"/> Tax-exempt organization <input type="checkbox"/> Trust/Estate																		
4. For Corporation, S-Corp, Partnership or LLC, check one box below if applicable: <input type="checkbox"/> Medical <input type="checkbox"/> Attorney/Legal																			
5. If exempt from backup withholding, check here: <input type="checkbox"/> (see instructions for W-9 to determine if you are exempt from backup withholding)																			
6. Address (number, street, and apt. or suite no.)	For office use																		
7. City, state, and ZIP code																			
7. Taxpayer Identification Number (TIN) Enter your EIN <u>OR</u> SSN in the appropriate box to the right (do not enter both) For individuals, this is your social security number (SSN). For other entities, it is your employer identification number (EIN).																			
<table border="1" style="margin-left: auto;"> <tr><td colspan="9" style="text-align:center;">Social security number</td></tr> <tr><td> </td><td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td></tr> </table>		Social security number												-			-		
Social security number																			
			-			-													
OR																			
<table border="1" style="margin-left: auto;"> <tr><td colspan="9" style="text-align:center;">Employer identification number</td></tr> <tr><td> </td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>		Employer identification number												-					
Employer identification number																			
			-																
<p><i>NOTE: The EIN or SSN must match the Legal Name as reported to the IRS. For a resident alien, sole proprietor, or disregarded entity, or to find out how to get a Taxpayer Identification Number, see the W9 Instructions. If the account is in more than one name, see the W9 Instructions for guidelines on whose number to enter.</i></p>																			
8. Certification Under penalty of perjury, I certify that:																			
<ul style="list-style-type: none"> • The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and • I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and • I am a U.S. person (including a U.S. resident alien). <p><i>(For additional information about the W-9 see the W-9 Instructions.)</i></p>																			
SIGNATURE of U.S. PERSON	Date																		

STEP 6: Submit

For fastest service, PRINT, SIGN, SCAN and EMAIL to PayeeForms@ofm.wa.gov

If you do not have scanning ability, you may fax to: 360-664-3363
 or mail to: Statewide Payee Desk PO Box 41434 Olympia, WA 98504-1434



Washington State
Department of Social
& Health Services

Division of Vocational Rehabilitation
STATEWIDE VENDOR STATUS
Solicitation #0115-0102
Exhibit F

Please PRINT clearly in all boxes, except for signature box.

CONTRACTOR NAME AS REGISTERED WITH THE IRS

CONTRACTOR DBA (IF ANY) FOR THIS CONTRACT

NAME OF PERSON COMPLETING FORM

PHONE NUMBER

() - Extension:

EMAIL ADDRESS

Statewide Vendor (SWV) Registration Status

I already have a Statewide Vendor Number Yes No

My Statewide Vendor Number is: SWV

I do not have a SWV Number. I submitted SWV Registration and W-9 to OFM on

Contractor Signature

CONTRACTOR SIGNATURE

DATE

PRINTED NAME

TITLE

ACORD™ CERTIFICATE OF LIABILITY INSURANCE	
PRODUCER	THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.
	INSURERS AFFORDING COVERAGE
INSURED	INSURER A:
	INSURER B:
	INSURER C:
	INSURER D:
	INSURER E:

COVERAGES

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

CO LTR	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
A	GENERAL LIABILITY				GENERAL AGGREGATE \$ 2,000,000.
	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY				PRODUCTS - COMP/OP AGG \$ 2,000,000.
	<input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR				PERSONAL & ADV INJURY \$ 1,000,000.
	<input type="checkbox"/> OWNER'S & CONTRACTOR'S PROT				EACH OCCURRENCE \$ 1,000,000
					FIRE DAMAGE (Any one fire) \$ 100,000.
					MED EXP (Any one person) \$ 5,000.
	GENL AGGREGATE LIMIT APPLIES PER:				
B	AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT \$ 1,000,000
	<input checked="" type="checkbox"/> ANY AUTO				BODILY INJURY (Per person) \$
	<input type="checkbox"/> ALL OWNED AUTOS				BODILY INJURY (Per accident) \$
	<input type="checkbox"/> SCHEDULED AUTOS				PROPERTY DAMAGE \$
	<input type="checkbox"/> HIRED AUTOS				
	<input type="checkbox"/> NON-OWNED AUTOS				
	GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT \$
	<input type="checkbox"/> ANY AUTO				OTHER THAN AUTO ONLY:
					EACH ACCIDENT \$
					AGGREGATE \$
	EXCESS LIABILITY				EACH OCCURRENCE \$
	<input type="checkbox"/> UMBRELLA FORM				AGGREGATE \$
	<input type="checkbox"/> OTHER THEN UMBRELLA FORM				\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				WC STATU-TORY LIMITS OTH-ER
	<input type="checkbox"/> THE PROPRIETOR/PARTNERS/EXECUTIVE OFFICERS ARE				E.L. EACH ACCIDENT \$
	<input type="checkbox"/> INCL <input type="checkbox"/> EXCL				E.L. DISEASE - EA EMPLOYEE \$
					E.L. DISEASE - POLICY LIMIT \$
A	OTHER				

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/EXCLUSIONS ADDED BY ENDORSEMENT/SPECIAL PROVISIONS

The State of Washington, Department of Social & Health Services (DSHS), its elected and appointed officials, agents, and employees of the state, shall be named as additional insureds.

CERTIFICATE HOLDER	CANCELLATION
DEPARTMENT OF SOCIAL AND HEALTH SERVICES PO BOX 45340 OLYMPIA WA 98504-5340	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 45 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.
	AUTHORIZED REPRESENTATIVE



DIVISION OF VOCATIONAL REHABILITATION INDEPENDENT LIVING SERVICES AND FEES FOR SERVICE

Organization Name:

Please do the following:

- 1) Check only those boxes for services you will provide;
- 2) Attach copies of transcripts and resumes of all staff who will provide services showing they meet the educational and experience requirements;
- 3) Enter proposed FEE you will charge for IL Services during the life of this contract.

IL Evaluations:

- A Bachelor's degree in human or social services (Counseling, Vocational Rehabilitation, Social Work, Education, Psychology, Occupational/Physical Therapy, etc), from an accredited college or university; AND
Two (2) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

One (1) of the two years must involve performing individual evaluations and writing reports regarding individuals' cognitive , psycho/social, life skills and interpersonal abilities, either directly or under the supervision and sign-off authority of a person who meets the Washington DVR qualifications for IL Evaluation; OR

- A Bachelor's degree, in any field, from an accredited college or university; AND
Three (3) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

Once (1) of the three years must involve performing individual evaluations and writing reports of individuals' cognitive, psycho/social, life skills and interpersonal abilities, either directly or under the supervision and sign-off authority of a person who meets the Washington DVR qualifications for IL Evaluation; OR

- Ninety (90) quarter or sixty (60) semester hours of human or social services coursework (Counseling, Vocational Rehabilitation, Social Work, Education, Psychology, Occupational/Physical Therapy, etc.) from an accredited college or university; AND
Four (4) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

One (1) year of the four years must involve performing individual evaluations and writing reports of individuals' cognitive, psycho/social, life skills and interpersonal abilities, either directly or under the supervision and sign-off authority of a person who meets the Washington DVR qualifications for IL Evaluation, OR

- A High School Diploma or GED; AND
Six (6) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

One (1) of the six years must involve performing individual evaluations of and writing reports regarding individuals' cognitive, psycho/social, life skills and interpersonal abilities, either directly or under the supervision and sign-off authority of a person who meets the Washington DVR qualifications for IL Evaluation.

Fee for IL Evaluations	
Comprehensive IL Evaluation	Partial IL Evaluation
\$715	\$430

IL SERVICES

IL Work-related Systems Access related to barriers to employment

- A Bachelor's degree, in any field, from an accredited college or university; AND

One (1) year Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities; OR

- Ninety (90) quarter or sixty (60) semester hours of coursework, in any field, from an accredited college or university; AND

Two (2) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities; OR

- A High School diploma or GED; AND

Four (4) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

IL Skills Training related to barriers to employment

- A Bachelor's degree, in any field, from an accredited college or university; AND

One (1) year Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities; OR

- Ninety (90) quarter or sixty (60) semester hours of coursework, in any field, from an accredited college or university; AND

Two (2) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities; OR

- A High School diploma or GED; AND

Four (4) years Full Time Equivalency (FTE) paid employment experience in the direct provision of social services to individuals with disabilities.

IL Fee for Services

The fee you enter below is the fee for IL Services (both Work-related Systems Access and IL Skills Training) that you commit to for the life of this contract. The maximum fee you are allowed to charge is \$70 per hour; however, you may propose a lesser fee if you choose.

Fee for IL SERVICES
\$72 per hour

PRINTED Name of Person Completing form:

Date:

SIGNATURE of Person Completing form: _____

I certify, under penalty of perjury as provided by the laws of the State of Washington, that all of the foregoing statements are true and correct, that I commit to the proposed service fee through the life of this contract and that I will notify DSHS of any changes in any statement.

INSTRUCTION SHEET FOR FILLING OUT THE BACKGROUND AUTHORIZATION FORM

Background Authorization Instructions – Page 1 of 2

You MUST fill in ALL boxes on this form as instructed. READ the instructions for each Section and each box.

You MUST put an answer in the box. You can put NO, NOT APPLICABLE (N/A), OR NONE– except BOX number 3 –

DO NOT answer any question by putting UNKNOWN or a QUESTION MARK in the box. If you do, the form will be sent back.

Print clearly with black ink.

Read each question carefully.

Check with your DSHS program to find out if you must fill in boxes marked "SEE INSTRUCTIONS"

_____ (This box allows your program to insert their requirements.)

You MUST put an answer in every box and return this form to: _____ (This box allows the person, program, or entity to insert the address or fax number where the form is to be returned.)

Most background authorization forms are sent back to the requester for the following reasons:

- Wrong form.
- Blank boxes.
- Bad handwriting.
- Missing or wrong BCCU account number.
- Person under 18 signs the form without a parent or guardian signature.
- Date signed is older than three (3) months from the date BCCU received the form.

SECTION 1: This section must be completed by the person or entity requesting this background check. An entity may be a facility, business, organization, or agency such as a Nursing Home, a Rehabilitation Center, or a DSHS Office.

If you are applying to be a licensed Adult Family Home, Boarding Home, or Nursing Home, **SKIP SECTION 1.** GO directly to SECTION 2.

- A. You MUST** put the name of the entity or person asking for the background check. An entity may be a DSHS office. A person may be someone applying for a license or a service provider contract. Ask your DSHS program to tell you what person's name or the name of the entity that is required for this box.

_____ (This box allows your program to insert requirements.)

B. Ask your DSHS program if you are required to fill in the address of the entity or person asking for the background check. Put N/A in this box if NOT required by your program.

_____ (This box allows your program to insert requirements.)

C. This box is ONLY for Children's Administration. Children's Administration: Fill in the name of the facility or foster home.
- You MUST** print and sign your name if you are the person asking for the background check. The person who is being checked signs in box 19.
- DO NOT WRITE ANYTHING IN THESE BOXES UNLESS** you are an employee of Children's Administration, Economic Services Administration, Adult Protective Services or a DSHS hiring authority.

D. Personnel ID Number is the permanent number assigned to every staff person by the Department of Personnel (DOP).
- You MUST** put your BCCU account number in this box. You can find your BCCU account number at <http://www1.dshs.wa.gov/msa/bccu/index.htm>. If this form is part of your application for **license** as an Adult Family Home, Boarding Home or Nursing Home, you **DO NOT** need to give the BCCU account number. You **MUST** do the following:

 - Adult Family home – Put an **A** in front of your license number.
 - Boarding home– Put a **B** in front of your license number.
 - Nursing home– Put an **N** in front of your license number.
- A.** You **MUST** ask your DSHS program if they require you to have an ID number or a name in this box. Put N/A in this box if NOT required by your program.

_____ (This box allows your program to insert requirements.)

B. DSHS ONLY – Put N/A if you are NOT a DSHS staff person using Web Service for fingerprint background checks. This ID number is for DSHS staff to track background checks. Any program may use this box for their own tracking purposes.

SECTION 2: You **MUST** fill out this section if you are the person we are checking. **Note:** A DSHS employee asking for a background check for an Adult Protective Services (APS) or Child Protective Services (CPS) investigation **MUST** fill out this section as best he or she can.

6. You **MAY** put your social security number (SSN) in this box. Your SSN is not required to conduct a background check.
_____ (This box allows your program to insert requirements.)
7. You **MUST** fill in your date of birth.
- 8A. You **MUST** put your whole name. If you do not have a name to put in this box, you **MUST** put **NONE**.
SEE EXAMPLE BELOW.

EXAMPLE:

PRINT YOUR LAST NAME AS IT IS NOW <i>NONE</i>	PRINT YOUR FIRST NAME AS IT IS NOW <i>"Prince"</i>	PRINT YOUR MIDDLE NAME AS IT IS NOW <i>NONE</i>
--	---	--

- B. You **MUST** put your whole birth name. You **MUST** put **SAME** if any of your names are the same as the names you put in box 8A.
9. You **MUST** put last names you have used or have been known by. You **MUST** put **NONE** if you have NOT used or been known by any other last names.
10. You **MUST** put any nicknames you have used. You **MUST** put **NONE** if you have NOT used any nicknames.
11. You **MUST** answer **YES** or **NO**. If your answer is **YES** to A. or B., you **MUST** fill in your conviction and pending charge information.
12. You **MUST** answer **YES** or **NO**.
13. You **MUST** answer **YES** or **NO**.
14. You **MUST** answer **YES** or **NO**. Put **YES** if the protection order lasted longer than 30 days and it was for the protection of a vulnerable adult, juvenile or child.
15. You **MUST** put your driver's license or state identification number in the box. You **MUST** put the name of the state in the box. You **MUST** put **NONE** if you do not have a driver's license or state identification number.
16. You **MUST** put the number of years and months you have lived in Washington State without living in another state or country. If you have moved out of Washington to another state or country, you **MUST** start counting the years and months from the date you moved back to Washington State. **Note:** You **MUST** ask your program if you have to get a fingerprint check.
17. A. You **MUST** fill in the address where you live now.
B. Your program may require you give your old address. Ask your DSHS program. Put N/A in this box If NOT required by your program.
_____ (This box allows your program to insert requirements.)
C. Ask your program if your telephone number is required. You **MUST** put **NONE** if you do not have a telephone number.
_____ (This box allows your program to insert requirements.)
18. You **MUST** read the statement in this box. Your signature under number 19 means you have read and agree to the statements in number 18. This background authorization form does NOT take the place of a public disclosure request for records about a founded finding. Founded finding means a state agency has taken a legal action against someone after an investigation and notice of a decision about abuse, sexual abuse, neglect, abandonment or exploitation or financial exploitation of a vulnerable adult, juvenile or child.
19. You **MUST** sign your name here. If you are NOT 18 years old, your parent or guardian **MUST** sign here.
20. You **MUST** fill in the date you signed this form.

ATTENTION APPLICANTS:

If you want to know the status of your background check form or need information about the BCCU background check process, contact BCCU at: bccuinquiry@dshs.wa.gov

ATTENTION ENTITIES AND DSHS STAFF: You **MUST** report errors in your address, telephone number or fax number to BCCU at bccuinquiry@dshs.wa.gov or (360) 902-0299. Put your BCCU account number in your email.



Division of Vocational Rehabilitation
Background Check Contractor Designated Contact(s)
RFQ 1213-0101
Exhibit J

Please PRINT clearly in all boxes, except for signature box.

This form is for the staff person(s) who deals with confidential information in your organization.

CONTRACTOR NAME AS REGISTERED WITH THE IRS

CONTRACTOR DBA (IF ANY) FOR THIS CONTRACT

NAME OF PRIMARY PERSON DESIGNATED TO SEND/RECEIVE CONFIDENTIAL BACKGROUND CHECK INFORMATION

TITLE:

PRIMARY PERSON'S PHONE NUMBER

() - Extension:

PRIMARY PERSON'S EMAIL ADDRESS

PHYSICAL/MAILING ADDRESS OF PRIMARY PERSON

STREET:

CITY:

STATE: ZIP: -

NAME OF BACKUP PERSON DESIGNATED TO SEND/RECEIVE CONFIDENTIAL BACKGROUND CHECK INFORMATION

TITLE:

BACKUP PERSON'S PHONE NUMBER

() -

BACKUP PERSON'S EMAIL ADDRESS

PHYSICAL/MAILING ADDRESS OF BACKUP PERSON

STREET:

CITY:

STATE: ZIP: -

I have designated the above staff to process confidential background information. Each designated employee listed above has read and signed a background check confidentiality agreement. A copy of the agreement has been provided to the employee and DVR Contracts Unit.

I will notify DVR within fourteen (14) calendar days of changing designated contacts.

CONTRACTOR SIGNATURE

DATE

PRINTED NAME

TITLE

DSHS Division of Vocational Rehabilitation
Contractor Background Check Confidentiality Agreement for Designated Employees Who Process Checks

Confidentiality of all information received and generated through the DSHS Background Central Unit (BCCU) or BCCU's web-based application used by the Division of Vocational Rehabilitation (DVR) is of the highest importance. Each DVR contractor handling background checks is expected to abide by the following instructions. Violations of these instructions may result in disciplinary action.

1. Information received, stored, generated or collected in the BCCU system will not be disseminated orally or in written form unless specifically authorized at the direction of DVR.
2. No records leave the Contractors secure location.
3. Computers:
 - a. Computer monitors will be placed in a manner as not to inadvertently reveal confidential information to any employee not involved with processing background checks who are walking past any station, or visiting an employee that does process background checks. If a visitor comes into an employee's workstation, the employee must shut down, turn off the monitor, minimize the screen or leave the workstation with the visitor after taking appropriate measures to secure the information on the monitor;
 - b. Any screen with confidential information is to be closed out or minimized every time an employee moves away or leaves their workstation; and
 - c. All computers will be appropriately turned off or password protected and the monitor screen minimized to ensure security of the computer and the information when an employee leaves their workstation for break, lunch, or prior to leaving the building.
4. Documents:

The following instructions will be in place at all times for correspondence, background authorization forms, RAP sheets, court papers, and any other document related to DVR background checks:

 - a. No documents will be placed on a desk, shelf, or paper stand in a way which reveals information to any employee not involved with processing background checks;
 - b. All documents will be turned face down each time an employee moves away or leaves their workstation for any reason;
 - c. All documents will be placed in a secure, locked drawer prior to leaving the building;
 - d. All locked compartments will be identified to the direct supervisor and keys will be available to the direct supervisor at all times; and
 - e. All documents containing personal or identification information will be placed in "hot trash" barrels to be shred. Items placed in these barrels will be shredded for privacy protection. No documents containing personal or identification information will be placed in a trash can or recycling barrel. If a "hot trash" barrel is not available, all documents are to be shredded immediately.

Statutes dealing with prohibition and penalties for unauthorized release of information from the unit:

RCW 43.43.810 – Obtaining information for false pretenses – Unauthorized use of information -- Falsifying records – Penalty.

Any person who willfully requests, obtains or seeks to obtain criminal offender record information under false pretenses, or who willfully communicates or seeks to communicate criminal offender record information to any agency or person except in accordance with chapter 152, laws of 1972 ex. session, or any member, officer, employee or agent of the section, the council or any participating agency who willfully falsifies criminal offender record information, or any records relating thereto, shall for each such offense be guilty of a misdemeanor.

RCW 10.97.120 – Criminal penalties – Civil action not affected.

Violation of the provisions of this chapter shall constitute a misdemeanor, and any person whether as principal, agent, officer, or director for himself or for another person, or for any firm or corporation, public or private, or any municipality who or which shall violate any of the provisions of this chapter shall be guilty of a misdemeanor for each single violation. Any criminal prosecution shall not affect the right of any person to bring a civil action as authorized by this chapter or otherwise authorized by law.

I have read, understand, and agree to the above confidentiality requirements as an employee of _____ .

Employee Printed Name: _____ Dated: _____

Employee Signature: _____

Supervisor Signature: _____ Dated: _____

To be filed in Background Check Designee's personnel file cc: Employee; DVR Contracts Unit Page 1 of 1



Division of Vocational Rehabilitation
 IL Contract Information
Solicitation #0115-0102
Exhibit L

1. Contractor Information Please PRINT clearly in all boxes, except for signature box.

CONTRACTOR NAME AS REGISTERED WITH THE IRS	CONTRACTOR DBA (IF ANY) FOR THIS CONTRACT
--	---

NAME OF PERSON HAVING SIGNING AUTHORITY TO LEGALLY BIND THE ORGANIZATION TO A DSHS CONTRACT

SIGNING AUTHORITY PERSON'S PHONE NUMBER () - Extension:	SIGNING AUTHORITY PERSON'S EMAIL ADDRESS
---	--

PHYSICAL ADDRESS FOR EACH OF YOUR OFFICES THAT YOU WILL PROVIDE SERVICES FROM. *(Please use separate sheet of paper if more than one)*

STREET: _____, CITY: _____ STATE: _____ ZIP: _____ + _____

2. Contracting Information

A. Is bus transportation available to the location you will serve DVR Clients? Yes No

B. Is your organization currently or has your organization been the subject of any investigation or *finding(s)* due to a DSHS or other state agency investigation regarding the performance of a criminal act, abridgement of human rights or improper billing practices? Yes No

C. Is this the first contract for IL services for your organization? Yes No

D. Years of experience your organization has providing the type of services purchased through this contract? _____ years

E. Have you received any audit findings in the past two (2) years? Yes No

F. Do you have other state agency or other government contracts? Yes No

G. Do you have contract(s) or receive funds for the provision of similar services as purchased through this contract? Yes No

H. Do you have any unresolved invoicing or service issues with any current contracts? Yes No

I. What percentage of staff turnover have you had in the past 12 months? _____%

3. Counties Served by CRP Contractor

Please check only those counties your organization will serve.

<input type="checkbox"/> STATEWIDE	<input type="checkbox"/> Ferry	<input type="checkbox"/> Klickitat	<input type="checkbox"/> Skamania
<input type="checkbox"/> Adams	<input type="checkbox"/> Franklin	<input type="checkbox"/> Lewis	<input type="checkbox"/> Snohomish
<input type="checkbox"/> Asotin	<input type="checkbox"/> Garfield	<input type="checkbox"/> Lincoln	<input type="checkbox"/> Spokane
<input type="checkbox"/> Benton	<input type="checkbox"/> Grant	<input type="checkbox"/> Mason	<input type="checkbox"/> Stevens
<input type="checkbox"/> Chelan	<input type="checkbox"/> Grays Harbor	<input type="checkbox"/> Okanogan	<input type="checkbox"/> Thurston
<input type="checkbox"/> Clallam	<input type="checkbox"/> Island	<input type="checkbox"/> Pacific	<input type="checkbox"/> Wahkiakum
<input type="checkbox"/> Clark	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Pend Oreille	<input type="checkbox"/> Walla Walla
<input type="checkbox"/> Columbia	<input type="checkbox"/> King	<input type="checkbox"/> Pierce	<input type="checkbox"/> Whatcom
<input type="checkbox"/> Cowlitz	<input type="checkbox"/> Kitsap	<input type="checkbox"/> San Juan	<input type="checkbox"/> Whitman
<input type="checkbox"/> Douglas	<input type="checkbox"/> Kittitas	<input type="checkbox"/> Skagit	<input type="checkbox"/> Yakima

4. I certify, under penalty of perjury as provided by the laws of the State of Washington, that all of the foregoing statements are true and correct, and that I will notify DSHS of any changes in any statement.

CONTRACTOR SIGNATURE	DATE
PRINTED NAME	TITLE

APPLICANT'S CHECKLIST
Solicitation #0115-0102
Exhibit M

Administrative Requirements

- Letter of Submittal
- Bidder Certification and Assurance form completed and signed (Exhibit A)
- Contractor Intake forms (s) (Exhibit B)
 - Washington State Master Business License (Sample - Exhibit C)
 - 501(c)(3) IRS letter designating your status as a nonprofit (if applicable)
 - List of partners, members, directors, officers, and board members, including title, phone number, and e-mail. (not applicable to sole proprietors).
- OFM Statewide Payee Registration and W-9 forms (Exhibit E)
- Statewide Vendor Status form (Exhibit F)
- Certificate of Insurance (Sample – Exhibit G)
- Code of Ethics and Standards of Practice Form (Exhibit O)
- 3 References

Technical Requirements

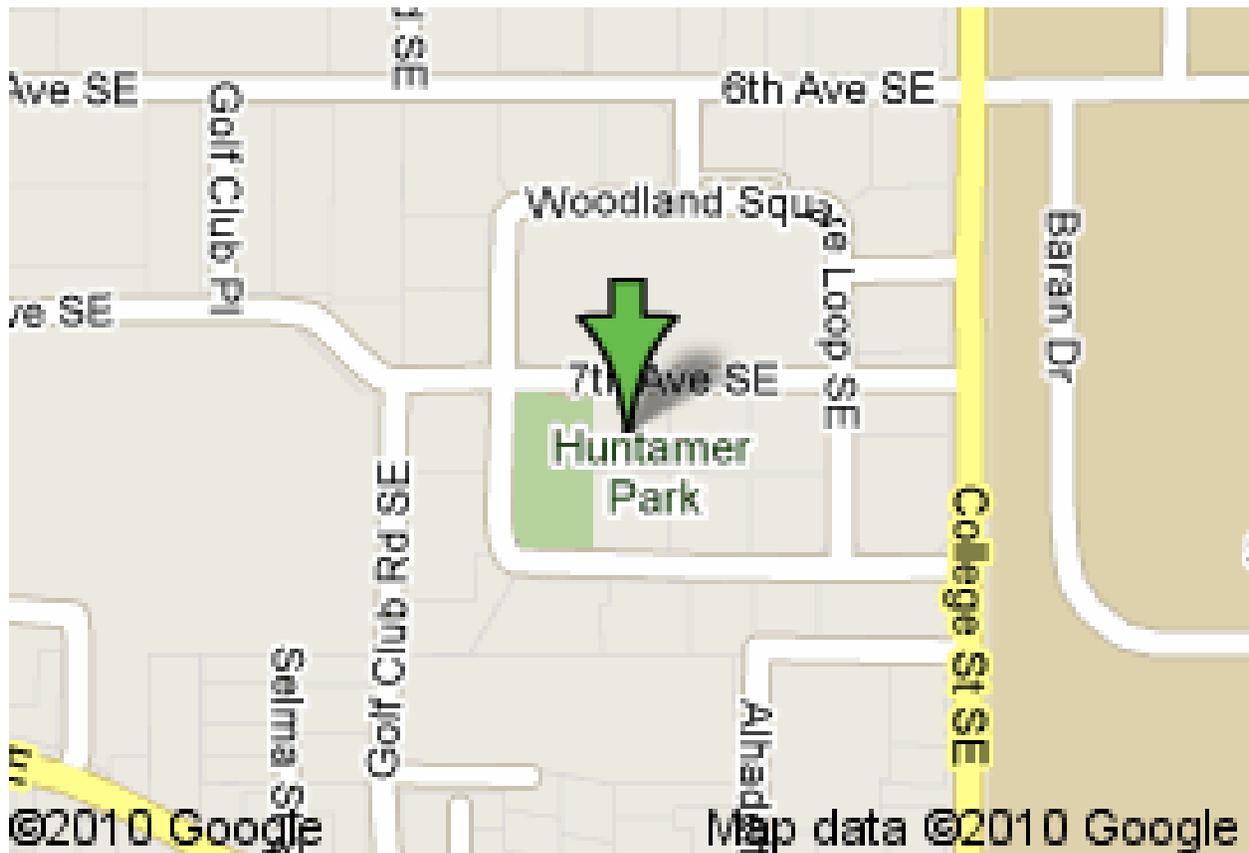
- IL Services and Qualifications Form (Exhibit H)
- Background Authorization Form(s) (Exhibit I)
- Background Check Contractor Designated Contact Form (Exhibit J)
- Background Check Confidentiality Agreement (Exhibit K)

Management, Experience and Qualifications Requirements

- IL Contract Information Form (Exhibit L)
- Fire/Safety Inspection Certificate; **OR**
- Statement verifying that you do not own, lease, or rent a premises where you provide services, but meet clients in public locations.
- Responses to Questions in Management, Experience and Qualifications Section

DSHS/DVR Physical Location Map
Solicitation #0115-0102
Exhibit M

DSHS/DVR Headquarters - Physical location
4565 7th AVE SE
Lacey WA 98503



**Open Enrollment - IL Services
#0115-0102
Exhibit O**

**Code of Ethics and Standards of Practice
Independent Living Services**

Introduction

The following Code of Ethics outlines the guiding principles that should underlie the actions of all individuals and organizations delivering DVR IL Services to DVR clients. The Standards of Practice describe how the Code of Ethics should be applied operationally. These standards will provide a foundation and basis for adjudication should DVR learn of possible ethical violations by a DVR IL Service Contractor.

CODE OF ETHICS

To promote the highest standards of ethical conduct, all staff members of DVR IL Service Contractors shall:

- Hold paramount the well-being of people served professionally;
- Respect and uphold DVR Clients;
- Uphold the principals of informed choice;
- Practice only in area(s) of competency;
- Respect the DVR Clients' privacy and release no information about the DVR Client without his/her expressed, written permission;
- Engage in no conduct that constitutes a conflict of interest or that adversely reflects on his or her professional practice;
- Seek only deserved, honest and reasonable monetary reimbursement for services;
- Issue only objective and truthful statements regarding services; and,
- Comply with the laws and policies that guide professional practice.

STANDARDS OF PRACTICE

In the following areas, all staff members of DVR IL Service Contractors shall:

Respect for DVR Clients

- Hold the Client's well-being paramount and consider each Client individually;
- No discriminate in the provision of services or products on the basis of disability, race, national origin, religion, cred, gender, age, veteran status, marital status, or sexual orientation; and,
- Only recommend, support, or implement services that do not expose the DVR Client (or others) to unreasonable risk, exploitation, and/or personal injury. Inform the customer as fully as possible to all risk.

Informed Choice

- When recommending services, fully involve the DVR Client and inform him or her of all reasonable options available, including costs. These recommendations shall not be limited to anyone's perceptions about the availability of resources;
- Fully inform the DVR Client of his or her advocate about all aspects of any final recommendations and make only reasonable statements about expected outcomes;
- Consider the current and future needs of the DVR Client when developing recommendations and fully inform the Client of those perceived needs; and,
- Fully and accurately disclose to the DVR Client the qualifications of all staff members who will service them directly.

Professionalism and Competency

- Comply with all licensing, credentialing and/or accreditation requirements recognized in their field of service;
- Provide services only within the scope of their competency, taking into account their education, experience, and training and recognizing the limits of their own skills and knowledge in any professional area;
- Take on only those professional commitments and agreements that they can fulfill, and carry out those obligations in a timely manner;
- Stay current in aspects of their professional practice through ongoing education. Topics should include accessibility, funding, legal issues, recommended rehabilitation practices, clinical practice, and emerging service or technologies;
- No provide professional services, nor allow any representative to provide services, while under the influence of drugs or alcohol or while substance abuse or a health condition influences their judgment;
- Not engage in conduct that reflects adversely on their profession or calls into question their fitness to serve DVR Clients; and,
- Avoid an action, intentional or accidental, professional or personal, that would exploit the dependence and trust of the DVR Client.

Service Delivery

- When the DVR Client's best interest requires it, collaborate or "team up" with providers from other professional disciplines to deliver services. DVR IL Service Contractors shall present only complete and factual information about other providers;
- Within the scope of their competency, use every resource reasonably available to meet the DVR Client's needs. This may require referring the Client to other practitioners or sources for services or supplies; and,
- Maintain procedures to measure the effectiveness and efficiency of their operations and to enhance service quality.

Conflict of Interest

- Maintain only those **professional** relationships that do not create a real or perceived conflict of interest. DVR IL Service Contractors shall inform the DVR Client or their advocates of any employment relationships, professional affiliations, or fiduciary interests that may be perceived as a conflict of interest. DVR IL Service Contractors must decline to provide services when any such affiliation or interest is likely to influence their professional judgment; and,

- Make every effort to avoid **personal** relationships that could influence their professional judgment or be perceived as a conflict of interest.

Sound Business Practices

- Not engage in fraud, waste, or abuse when charging for services;
- Be truthful and accurate in all public statements about the services and products they provide;
- Stay within the scope of services agreed upon by DVR Clients and DVR;
- Maintain sound business practices and financial records by using General Accepted Accounting Principles (GAAP); and,
- Maintain adequate records of evaluations, assessments, services, recommendations, reports, or products provided and preserve the confidentiality of those records, unless disclose is required by law, or the protection of the DVR Client or the public.

Signature

Printed Name and Title

Organization Name

Date

Telephone Number

Email Address



DIVISION OF VOCATIONAL REHABILITATION
INDEPENDENT LIVING SERVICES CONTRACT
Contractor Employee(s) to Provide IL Services and Service(s) Approved

ORGANIZATION'S LEGAL NAME:

DBA (if any):

USE ADDITIONAL COPIES OF THIS FORM, IF NEEDED, TO LIST CURRENT OR NEW EMPLOYEES AND THE SERVICES THEY ARE APPROVED OR REQUEST TO PROVIDE.

List existing Employees currently approved by DVR to provide IL Services and what services they are approved to provide. Employees approved through the current contract do **not** need to resubmit current resume and educational transcripts.

First Name	Last Name	IL Evaluations	IL Skills Training	IL Work-Related Systems Access
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List *NEW* Employees to be reviewed and approved to provide IL Services and mark the services you request them to provide. Please include: 1) a current resume; and 2) official educational transcripts for each new employee to be reviewed.

		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I certify under penalty of perjury as provided by the laws of the State of Washington, that all of the foregoing statements are true and correct, that I commit to the proposed service fee(s) throughout the life of this contract and that I will notify DSHS of any changes in statement.

Signature of Person Completing Form:

Phone:

Printed Name and Title:

Email:

Date: / /