Print Form

ITEM #1

DATE:_____

Mr. Corey Hoze, Director
Milwaukee County Department of Health and Human Services
1220 West Vliet Street, Suite 301R
Milwaukee, WI 53205

Dear Mr. Hoze:

I am familiar with the *"Year 2009 Professional Service Agreement Program Guidelines and Technical Requirements"* set forth by the Milwaukee County Department of Health and Human Services and am submitting the attached proposal that, to the best of my knowledge, is a true and complete representation of the requested materials.

Sincerely,

Authorized Signature _____

Title_____

Name of Agency _____

YEAR 2009 APPLICATION SUMMARY SHEET

Item 2

Agency_____Agency Director_____

Name of parent company and/or affiliated enterprises if agency is a subsidiary and/or affiliate of another business entity _____

Address_____

(Street) (City) (State) (Zip)

Contact Person _____

Telephone# _____Email _____

Agency Fiscal Period_____Federal ID Number_____

(Mo/Day/Year-Mo/Day/Year)

Please complete the following information for each 2009 program proposed in your application. Program name, and if applicable, a program number must be assigned to each program. This application must include programs from only one division. In order to apply for programs from more than one division, a separate, complete application must be submitted for each division.

Division: BHD☐ DCSD ☐ DSD☐ ESD☐ Housing☐

(REFER TO TABLE OF CONTENTS IN PROGRAM REQUIREMENTS FOR PROGRAM NUMBER & NAME)

A. Program Number:_____**Program Name:**_____

Continuation☐ Expansion☐ New☐

2008 Funding: _____ 2009 Request:_____

Site(s):

(1) _____ (3) _____

(2) _____ (4) _____

B. Program Number:_____**Program Name:**_____

Continuation☐ Expansion☐ New☐

2008 Funding: _____ 2009 Request: _____

Site(s):

(1) _____ (3) _____

(2) _____ (4) _____

C. Program Number:_____**Program Name:**_____

Continuation☐ Expansion☐ New☐

2008 Funding: _____ 2009 Request: _____

Site(s):

(1) _____ (3) _____

(2) _____ (4) _____

THIS SHEET MUST BE ATTACHED TO THE TOP OF THE APPLICATION PACKAGE.. PLEASE DUPLICATE AS NEEDED.

APPLICATION CONTENTS – I. INITIAL SUBMISSION

This content summary sheet must be attached immediately after the cover letter.

Technical Requirements Item #	Item Description	Application: Check Each Item Included	Application: Page # of Application
INTRODUCTION			
1	Cover Letter	☐	
2	Application Summary Sheet	☐	
SECTION 1 – PROGRAM DESCRIPTIONS/SCOPE OF WORK – DCSD & ESD			
SECTION 2 – AGENCY APPLICATION – To be completed for ALL proposals: DCSD, ESD, MSD			
	Application Contents	☐	
3	Authorization To File	☐	
8	Mission Statement	☐	
10	Licenses and Certificates	☐	
11	Indemnity, Data And Information, and HIPAA Compliance Statement	☐	
13	Disclosure	☐	
14	Conflict Of Interest & Prohibited Practices Certification	☐	
15	Equal Employment Opportunity Certificate	☐	
16	Equal Opportunity Policy	☐	
17	Certification Statement Regarding Debarment And Suspension	☐	
18	Additional Disclosures	☐	
19	Certification Regarding Compliance With Background Checks – Children & Youth	☐	
20	Certification Regarding Compliance With Background Checks - Caregiver	☐	
SECTION 3 – PROGRAM APPLICATION – DCSD, ESD			
26	Agency Employee Hours and Salaries (Forms 2 and 2A)	☐	
27	Employee Demographics Summary	☐	
28	Employee Hours-Related Organization Disclosure (Form 2C)	☐	
30	Program Organizational Chart	☐	
31a	Program Logic Model	☐	
31b	Program Narrative	☐	

31c	Performance Assessment For Agency	☐	
31d	Performance Assessment For Agency Leadership	☐	
32	Provider Application Site Information	☐	
33	Staffing Pattern	☐	
34	Staffing Requirements	☐	
35	Personnel Roster/Certification of Provider Credentials	☐	
36	Accessibility	☐	
37	Evaluation Plan	☐	
38	Client Characteristics Chart	☐	
39	Program Volume Data (Form 1)	☐	
40	Anticipated Program Expenses (Forms 3 and 3S)	☐	

SECTION 4 – DISADVANTAGED BUSINESS UTILIZATION – DCSD, EDS, MSD

42	DBE Forms	☐	

SECTION 5 – NO SUBMISSIONS REQUIRED

OVERVIEW OF PROPOSAL REVIEW PROCESS, PROPOSAL REVIEW EVALUATION CRITERIA, QUALITY ASSURANCE, REQUIRED REPORTS – DCSD, ESD

Overview Of Proposal Process
Proposal Review Evaluation Criteria
Quality Assurance
SECTION 6 – PROGRAM DESCRIPTIONS/SCOPE OF WORK **PROPOSAL REVIEW CRITERIA – MSD ONLY**

Agency attests that all items and documents checked are complete and included in the application packet.

Authorized Signature: _____ Date: _____

Printed Name:_____ Title:_____

Agency: _____

YEAR 2009 AUTHORIZATION TO FILE RESOLUTION *Item 3*
(Applicable for Non-Profit and For-Profit Corporations Only)

This is to certify that at the _____ (Date) meeting of the Board of

Directors of_____(Agency Name), the

following resolution was introduced by _____(Board Member's Name),

and seconded by: _____ (Board Member's Name), and unanimously approved by

the Board:

BE IT RESOLVED, that the Board of Directors of _____ _____ (Agency

Name) hereby authorizes the filing of an application for the Year 2009 Milwaukee

County Department of Health and Human Services (DHHS) funding.

In connection therewith,

_____ (Name and Title)

and_____ (Optional Name(s) and Title) is (are) authorized to negotiate with Milwaukee County DHHS staff.

In accordance with the Bylaws (Article _____, Section _____) of_____ _____(Agency Name),

_____ (Name and Title)

and _____ (Optional Name(s) and Title) is (are)

authorized to sign the Year 2009 Purchase of Service Contract(s).

Name: _____ _____
(Signature of the Secretary of

the Board of Directors) Date: _____

Printed Name: _____

YEAR 2009 MISSION STATEMENT

ITEM # 8

Agency_____

Name of parent company and/or affiliated enterprises if agency is a subsidiary and/or affiliate of another business entity _____

Submit your agency's Mission Statement:

YEAR 2009 INDEMNITY, DATA & INFORMATION SYSTEMS COMPLIANCE, HIPAA

Indemnity/Insurance

Contractor agrees to the fullest extend permitted by law, to indemnify, defend and hold harmless, the County and its agents, officers and employees, from and against all loss or expense including costs and attorney's fees by reason of liability for damages including suits at law or in equity, caused by any wrongful, intentional, or negligent act or omission of the Contractor, or its (their) agents which may arise out of or are connected with the activities covered by this agreement.

Contractor shall indemnify and save County harmless from any award of damages and costs against County for any action based on U.S. patent or copyright infringement regarding computer programs involved in the performance of the tasks and services covered by this agreement.

Provision for Data and Information Systems Compliance

Contractor shall utilize computer applications in compliance with County standards in maintaining program data related to the contract, or bear full responsibility for the cost of converting program data into formats useable by County applications.

Health Insurance Portability and Accountability Act

The contractor agrees to comply with the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the extent those regulations apply to the services the contractor provides or purchases with funds provided under this contract.

Authorized signature_____ Date _____

Agency_____

YEAR 2009 DISCLOSURE

Item 13

Milwaukee County Employee

Submit a list of any Milwaukee County employee, or former County employee to whom your agency paid a wage, salary, or independent contractor fee during the preceding three-year period. Include payments made during 2006, 2007, 2008 to any person who was at the time of payment, also employed by Milwaukee County.

Employee	2006 Wages	2007 Wages	2008 Wages

Related Party Relationships

Submit a full disclosure of the relationship, including the extent of interest and amount of estimated income anticipated from each source, for each individual if any board member, stockholder, owner, officer, or member of the immediate family of any board member, stockholder, owner or officer, holds interest in firms from which materials or services are purchased by the agency, its subsidiaries, or affiliates. "Immediate family" means an individual's spouse or an individual's relative by marriage, lineal descent, or adoption who receives, directly or indirectly, more than one-half of his/her support directly from the individual or from whom the individual receives, directly or indirectly, more than one-half of his/her support.

Name	Relationship	% or Estimated Income

Submit a full disclosure of the relationship, including the extent of interest and amount of estimated income anticipated from each source, for each individual if any board member, stockholder, officer, owner, employee or member of any of the aforementioned immediate family serve on the Board of Directors of subsidiaries and/or affiliates of the agency or any other firm from which materials or services are purchased by the agency.

Name	Relationship	% or Estimated Income

____ **No employment relationship with Milwaukee County employees and no related party relationship, as defined above, exists.**

___The agency does not rent from or contract with any person who has ownership or employment interest in the agency; serves on the Board of Directors; or is a member of the immediate family of an owner, officer, employee, or board member. **If such a relationship exists, submit a copy of lease agreements, certified appraisals, and contract agreements, etc.**

Authorized Signature: _____ Date: _____

Printed Name: _____Title:_____

Agency: _____

YEAR 2009 CONFLICTS OF INTEREST AND PROHIBITED PRACTICES *ITEM #14*

Interest in Contract

No officer, employee or agent of the County who exercises any functions or responsibilities with carrying out any services or requirements to which this contract pertains has any personal interest, direct or indirect, in this contract.

Interest of Other Public Officials

No member or the governing body of a locality, County or State and no other public official of such locality, County or State who exercises any functions or responsibilities in the review or approval of the carrying out of this contract has any personal interest, direct or indirect, in this contract.

Contractor covenants s/he presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of services under this contract. Any conflict of interest on the part of the Contractor will be disclosed to the County. In the event Contractor has a conflict of interest that does not permit Contractor to perform the services under the contract with respect to any client or recipient, Contractor will notify the County and will provide the County with all records and reports relating to same.

Prohibited Practices

Contractor attests that it is familiar with Milwaukee County's Code of Ethics, Chapter 9 of Milwaukee County Code of General Ordinances, which states in part, "No person may offer to give any County officer or employee or his immediate family, or no County officer or employee or his immediate family may solicit or receive anything of value pursuant to an understanding that such officer's or employee's vote, official action, or judgment would be influenced thereby."

Said chapter further states, "No person(s) with a person financial interest in the approval or denial of a contract being considered by a County department or with an agency funded and regulated by a County department, may make a campaign contribution to any candidate for an elected County office that has final authority during its consideration. Contract considerations shall begin when a contract is submitted directly to a County department or to an agency until the contract has reached its final disposition, including adoption, county executive action, proceedings on veto (if necessary) or departmental approval."

Where Agency intends to meet its obligations under this or any part of this Request For Proposal through a subcontract with another entity, Agency shall first obtain the written permission of County; and further, Agency shall ensure it requires of its subcontractors the same obligations incurred by Agency under this Request For Proposal.

Authorized Signature _____ Date _____

Agency _____

YEAR 2009EQUAL EMPLOYMENT OPPORTUNITY CERTIFICATE *Item 15*

FOR MILWAUKEE COUNTY CONTRACTS

In accordance with Section 56.17 of the Milwaukee County General Ordinances and Title 41 of the Code of Federal Regulations, Chapter 60, SELLER or SUCCESSFUL BIDDER or CONTRACTOR or LESSEE or (Other-specify),(Hence forth referred to as VENDOR) certifies to Milwaukee County as to the following and agrees that the terms of this certificate are hereby incorporated by reference into any contract awarded.

Non-Discrimination

VENDOR certifies that it will not discriminate against any employee or applicant for employment because of race, color, national origin, sex, age or handicap which includes but is not limited to the following: employment, upgrading, demotion or transfer, recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training including apprenticeship.

VENDOR will post in conspicuous places, available to its employees, notices to be provided by the County setting forth the provision of the non-discriminatory clause.

A violation of this provision shall be sufficient cause for the County to terminate the contract without liability for the uncompleted portion or for any materials or services purchased or paid for by the contractor for use in completing the contract.

Affirmative Action Program

VENDOR certifies that it will strive to implement the principles of equal employment opportunity through an effective affirmative action program, which shall have as its objective to increase the utilization of women, minorities, and handicapped persons and other protected groups, at all levels of employment in all divisions of the seller's work force, where these groups may have been previously under-utilized and under-represented.

VENDOR also agrees that in the event of any dispute as to compliance with the aforestated requirements, it shall be his responsibility to show that he has met all such requirements.

Non-Segregated Facilities

VENDOR certifies that it does not and will not maintain or provide for its employees any segregated facilities at any of its establishments, and that it does not permit its employees to perform their services at any location under its control, where segregated facilities are maintained.

Subcontractors

VENDOR certifies that it has obtained or will obtain certifications regarding non-discrimination, affirmative action program and nonsegregated facilities from proposed subcontractors that are directly related to any contracts with Milwaukee County, if any, prior to the award of any subcontracts, and that it will retain such certifications in its files.

Reporting Requirement

Where applicable, VENDOR certifies that it will comply with all reporting requirements and procedures established in Title 41 Code of Federal Regulations, Chapter 60.

Affirmative Action Plan

VENDOR certifies that, if it has 50 or more employees, it will develop and/or update and submit (within 120 days of contract award) an Affirmative Action Plan to: -Mr. Paul Grant, Audit Compliance Manager, Milwaukee County Department of Audit, 2711 West Wells Street, Milwaukee, WI 53208 [Telephone No.: (414) 278-4246].

VENDOR certifies that, if it has 50 or more employees, it has filed or will develop and submit (within 120 days of contract award) for each of its establishments a written affirmative action plan. Current Affirmative Action plans, if required, must be filed with any of the following: The Office of Federal Contract Compliance Programs or the State of Wisconsin, or the Milwaukee County Department of Audit, 2711 West Wells Street, Milwaukee, WI 53208 [Telephone No.: (414) 278-4246].

If a current plan has been filed., indicate where filed _____ and the year covered_____.

VENDOR will also require its lower-tier subcontractors who have 50 or more employees to establish similar written affirmative action plans.

Employees

VENDOR certifies that it has (No. of Employees) _____employees in the Standard Metropolitan Statistical Area (Counties of Milwaukee, Waukesha, Ozaukee and Washington, Wisconsin) and (No. of Employees) _____employees in total.

Compliance

VENDOR certifies that it is not currently in receipt of any outstanding letters of deficiencies, show cause, probable cause, or other notification of noncompliance with EEO regulations.

Executed this_____day of_____, 20____by: Firm Name_____

By _____Address _____

(Signature)

Title_____City/State/Zip _____

YEAR 2009 EQUAL OPPORTUNITY POLICY *ITEM # 16*

_____ is in compliance with the equal opportunity policy and standards of the Wisconsin Department of Health and Family Services and all applicable Federal and State rules and regulations regarding nondiscrimination in employment and service delivery.

EMPLOYMENT - AFFIRMATIVE ACTION & CIVIL RIGHTS

It is the official policy of _____ that no otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subjected to discrimination in employment in any manner on the basis of age, race, religion, color, sex, national origin or ancestry, handicap, physical condition, developmental disability, arrest or conviction record, sexual orientation, military/veteran status or military participation. We pledge that we shall comply with Affirmative Action and Civil Rights standards to ensure that applicants are employed and that employees are treated during their employment without regard to the above named characteristics. Such action shall include but not be limited to the following: employment, upgrading, demotion, transfer, recruitment, or recruitment advertising, layoff or termination, rates of pay or other forms of compensation and selection for training including apprenticeship.

_____ has a written Affirmative Action Plan which includes a process by which discrimination complaints may be heard and resolved.

SERVICE DELIVERY - CIVIL RIGHTS

It is the official policy of _____ that no otherwise qualified applicant for services or service recipient shall be excluded from participation, be denied benefits or otherwise be subjected to discrimination in any manner on the basis of age, race, religion, color, sex, national origin or ancestry, handicap, physical condition, developmental disability, arrest or conviction record, sexual orientation, military/veteran status or military participation. We pledge that we shall comply with civil rights laws to ensure equal opportunity for access to service delivery and treatment without regard to the above named characteristics. _____ has a written Civil Rights Action Plan which includes a process by which discrimination complaints may be heard and resolved.

All officials and employees of _____ are informed of this statement of policy. Decisions regarding employment and service delivery shall be made to further the principles of affirmative action and civil rights.

To ensure compliance with all applicable Federal and State rules and regulations regarding Equal Opportunity and nondiscrimination in employment and service delivery, _____ _____ has been designated as our Equal Opportunity Coordinator. Any perceived discrimination issues regarding employment or service delivery shall be discussed with Ms./Mr. _____. Ms./Mr. _____ may be reached during week days at _____.

A copy of the Affirmative Action Plan and/or the Civil Rights Action Plan including the process by which discrimination complaints may be heard and resolved is available upon request.

_____

(Director or Chief Officer) (Title) (Date)

This Policy Statement shall be posted in a conspicuous location.

MILWAUKEE COUNTY DEPARTMENT OF HEALTH AND HUMAN SERVICES

Certification Regarding Debarment and Suspension

CERTIFICATION STATEMENT

DEBARMENT AND SUSPENSION

The contractor certifies to the best of its knowledge and belief, that it and its principals: (1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency; (2) have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property; (3) are not presently indicted for or otherwise criminally charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in (2) of this certification; and, (4) have not within a three-year period preceding this contract had one or more public transactions (Federal, State or local) terminated for cause or default.

Authorized Signature _____ Date _____

Agency _____

ADDITIONAL DISCLOSURES

Item 18

1. Has your company or any representative, owner, partner or officer ever failed to perform work awarded or had a contract terminated for failure to perform or for providing unsatisfactory service?

   ☐ Yes ☐ No If yes, on a separate page please provide a detailed explanation.

2. Within the past five (5) years, has your company or any representative, owner, partner or officer (collectively "your company) ever been a party to any court or administrative proceedings where the violation of any local, state or federal statute, ordinance rule or regulation by your Company was alleged?

   ☐ Yes ☐ No If yes, on a separate page, please provide a detailed explanation outlining the following:

   - Date of citation or violation
   - Description of violation
   - Parties involved
   - Current status of citation

3. Within the past 5 years has your organization had any reported findings on an annual independent audit?

   ☐ Yes ☐ No If yes, on a separate page please provide a detailed explanation.

4. Within the past 5 years, has your organization been required to submit a corrective action plan by virtue of review or audit by independent auditor, or any governmental agency or purchaser of services?

   ☐ Yes ☐ No If yes, on a separate page please provide a detailed explanation including if the corrective action has been accepted by the purchasing agency and completely implemented? If not, please explain remaining action required by purchasing agency.

5. Have you, any principals, owners, partners, shareholders, directors, members or officers of your business entity ever been convicted of, or pleaded guilty, or no contest to, a felony, serious or gross misdemeanor, or any crime or municipal violation, involving dishonesty, assault, sexual misconduct or abuse, or abuse of controlled substances or alcohol, or are charges pending against you or any of the above persons for any such crimes by information, indictment or otherwise?

   ☐ Yes ☐ No If yes, on a separate page, please provide a detailed explanation.

Authorized Signature: _____ Date: _____

Printed Name: _____Title: _____

Agency: _____

CERTIFICATION STATEMENT *Item 19*

RESOLUTION REGARDING FILE 99-233 REQUIRING BACKGROUND CHECKS FOR AGENCIES SERVING YOUTH

This is to certify that _____
(Name of Agency/Organization)

(1) has received and read the enclosed, "PROVISIONS OF RESOLUTION REQUIRING BACKGROUND CHECKS ON DEPARTMENT OF HUMAN SERVICES CONTRACT AGENCY EMPLOYEES PROVIDING DIRECT CARE AND SERVICES TO MILWAUKEE COUNTY CHILDREN AND YOUTH;"

(2) has a written screening process in place to ensure background checks on criminal and gang activity for current and prospective employees providing direct care and services to children and youth; and,

(3) is in compliance with the provisions of File No. 99-233, the Resolution requiring background checks.

Authorized Signature: _____ Date: _____

Printed Name: _____Title: _____

Agency: _____

CERTIFICATION STATEMENT *Item 20*

RESOLUTION REGARDING CAREGIVER AND CRIMINAL BACKGROUND CHECKS

(Applies to all agencies with employees who meet the definition of "caregiver", per definition below)

Contract agencies and agencies with which the DHHS has reimbursable agreements shall certify, by written statement, that they will comply with the provisions of ss.50.065 and ss.146.40 Wis. Stats. and HFS 12 and HFS 13, Wis. Admin. Code *State of Wisconsin Caregiver Program* (all are online at http://www.legis.state.wi.us/rsb/code.htm). Agencies under contract shall conduct background checks at their own expense.

DEFINITION: EMPLOYEES AS CAREGIVERS (Wisconsin Caregiver Program Manual, http://dhfs.wisconsin.gov/caregiver/pdffiles/Chap2-CaregiverBC.pdf)

A caregiver is a person who meets all of the following:
- is employed by or under contract with an entity;
- has regular, direct contact with the entity's clients or the personal property of the clients; and
- is under the entity's control.

This includes employees who provide direct care and may also include housekeeping, maintenance, dietary and administrative staff, if those persons are under the entity's control and have regular, direct contact with clients served by the entity.

This is to certify that _____
(Name of Agency/Organization)

is in compliance with the provisions of ss.50.065 and ss.146.40 Wis. Stats. and HFS 12 and HFS 13, Wis. Admin. Code *State of Wisconsin Caregiver Program*

Authorized Signature: _____ Date: _____

Printed Name:
_____Title:_____

Agency: _____

FORM 2B - YEAR 2009 EMPLOYEE DEMOGRAPHICS SUMMARY *Item 27*

(will be filled automatically, if linked budget forms are used)

Complete for each program within each disability/target group as listed in Columns (5)-(9) of Form 2. For each program, summarize by position code, as listed in Column 2 of Form 2, the number of full-time equivalent employees in every demographic code combination listed in Column 3, Form 2.

Calculation to determine the number of full-time equivalents (FTE's) assigned to provide the service:

1. Determine the number of hours a full-time employee is required to work per week. This number, usually 40, becomes the denominator. *

2. For each program, Form 2/2A, Columns 5-9, summarize by position code, Form 2/2A, Column 2, and Employee Demographic Code, Form 2/2A, Column 3, the total number of hours worked by position code and employee demographic code. This number becomes the numerator.

3. Divide the total number of hours worked per position code and employee demographic code by the number of hours a full-time employee is required to work to arrive at the number of FTE's (by position code and employee demographic code) working in a program.

Program	Position Code (Column 2, Form 2 Code)	Employee Demographics	Number of FTEs

*If full-time equivalents (FTE's) are not based on 40 hours per week, specify: _____hours/week.

Authorized Signature: _____ Date: _____

Printed Name: _____Title:_____

Agency: _____

FORM 2C - YEAR 2009 EMPLOYEE HOURS - RELATED ORGANIZATION DISCLOSURE *Item 28*

For each employee of your agency who works for more than one related organization which may or may not be under contract to Milwaukee County, the total number of weekly hours scheduled for each affiliated corporate or business enterprise must be accounted for by program/activity.

"Related Organization" is defined as:

Employee Name	Related Organization/ Employer	Program/Activity	Total Weekly Hours

Please check the statement below, sign and date the form if the above condition does not exist.

_____No employee of the agency works for more than one related organization that may or may not be under contract to Milwaukee County.

Authorized Signature_____ Date _____

Print:_____

Agency _____

PROGRAM LOGIC MODEL

ITEM # 31

example

A	B	C	D	E	F	G	H
Inputs	**Processes/Program Activities**	**Outputs**	**Expected Outcomes**	**Indicators**	**Projected level of achievement**	**For evaluation report**	
						Actual level of achievement	**Description of changes**
Staff *Clients* *Community sites (list major ones)* *Community living curriculum* *Transportation (vans)*	*Staff establish sites for community activities.* *Staff and clients identify community interests.* *Staff arrange/coordinate transportation to/from community activities.* *Staff facilitate community activities.* *Staff conduct pre and post activity workshops to teach and support clients' involvement in community life*	*32 unduplicated clients participated in 500 community living experiences.*	*Outcome 1:Clients increase awareness of community resources.*	*Number and percent of clients who demonstrate an increase in awareness of community resources, as measured by pre and post test scores*	*24 (75%) of clients will achieve the outcome*		
			Outcome 2: Clients increase utilization of public and private services in their community.	*Number and percent of clients who demonstrate an increase in utilization of public and private services in their community*	*24 (75%) of clients will achieve the outcome*		
			Outcome 3: Clients generalize acquired skills to other home and community living situations	*Number and percent of clients who generalize acquired skills to other home and community living situations*	*24 (75%) of clients will achieve the outcome*		

PROGRAM LOGIC MODEL

ITEM #31a

A	B	C	D	E	F	G	H
Inputs	**Processes/Program Activities**	**Outputs**	**Expected Outcomes**	**Indicators**	**Projected level of achievement**	**For evaluation report**	
						Actual level of achievement	**Description of changes**

PERFORMANCE ASSESSMENT FOR NEW APPLICANT AGENCY *Item 31c*

For existing agencies (agencies with some history of operating activity) without current or recent-within last two years-DHHS contracting experience, complete and submit this form. **This document shall be completed by a prior fundor**, and is subject to verification**.**

Performance Assessment for (Agency)_____

_____

From (Funding Source)_____

_____

Please provide the following information relating to Agency's history with Funding Source.

1. Name of Program_____

   _____

2. When and for how long did Funding Source fund this program?_____

   _____

   _____

   _____

3. Program volume: How many people did this program serve?_____

   _____

4. Target Population: What was the primary target population for this program?_____

   _____

   _____

   _____

5. What was the dollar amount provided by Funding Source?_____/year

6. What services were provided through this program?_____

   _____

   _____

   _____

   _____

   _____

   _____

7. Cost reimbursement framework? (Y/N)_____

   _____

   _____

8. If no longer funding this program, why not?_____

   _____

9. What level of program performance was achieved? Please calibrate your ratings according to the following scale:

    0 Does/did not meet expectations
    1 Meets/met very little of what is/was expected
    2 Meets/met fewer than half of expectations
    3 Meets/met more than half of expectations
    4 Meets/met all expectations
    5 Exceeds/exceeded all expectations

Please evaluate the following performance areas circling the number corresponding to the rating scale on previous page:

Appropriate use of budget

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ NA ☐

Comments:

Achievement of established outcomes

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ NA ☐

Comments:

Timely submission of program reports

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ NA ☐

Comments:

PERFORMANCE ASSESSMENT FOR NEW APPLICANT AGENCY *Item 31c page 3*

Accurate submission of program reports

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ NA ☐

Comments:_____

_____

_____

Signed,_____

Name (print)_____

Title _____

PERFORMANCE ASSESSMENT FOR NEW APPLICANT *Item 31d*

ORGANIZATIONAL LEADERSHIP

For new agencies, or for agencies without a contracting history of any kind, complete and submit this form. A separate form should be submitted for the *head of the organization, senior fiscal and program staff*. **This document shall be completed by a prior fundor or by a prior employer**, and is subject to verification**.**

A separate form should be submitted for the *head of the organization and senior fiscal and program staff*. Please have a prior fundor or a prior employer complete the form(s).

Performance assessment for (Individual):_____

From (Agency)_____

Please provide the following information relating to Individual's history with Agency.

1. Individual's title_____

2. When and for how long did Individual work for Agency?_____
   _____

3. Program volume: How many people were served by this program?_____
   _____

   What was Individual's role in program administration?

   _____☐ Direct _____☐ Indirect (supervision) _____☐ Limited or none

4. Target Population: What was the primary target population for this program?_____
   _____
   _____
   _____

5. What was the dollar amount provided by Funding Source?_____/year

   What was Individual's role in fiscal management of the program?

   _____☐ Direct _____☐ Indirect (supervision) _____☐ Limited or none

6. What services were provided through this program?_____
   _____
   _____
   _____

7. If no longer funding this program, why not?_____

_____

_____

_____

Signed _____

Name (print)_____

Title _____

2009 PROVIDER APPLICATION SITE INFORMATION *Item 32*

Providers offering services at more than one location must provide the following information for each site:

Agency Name:	Site Name:
Site Address:	City/State/Zip:
Site Contact Person:	Title:
Phone:	Email:
Fax:	

Describe differences in programs or services available at this site:

Total number of unduplicated consumers you are presently able to serve at any one time: _____

Total number of unduplicated consumers you are currently serving: _____

Please check if your agency provides the following at this site:
☐ Programs for men ☐ Programs for women ☐ Programs for men & women
☐ Services for pregnant women
☐ Services for families with children ☐ Childcare provided
☐ Services for Persons Involved in the Criminal Justice System
☐ Services for the Developmentally/Physically Disabled
☐ Services for persons with co-occurring mental health and substance use disorders

Hours of operation: ☐ for specific program ☐ for all programs at this site
☐ Monday:
☐ Tuesday:
☐ Wednesday:
☐ Thursday:
☐ Friday:
☐ Saturday:
Sunday:
☐ Emergency contact available 24 hours ☐ Emergency number_____

Authorized Signature: _____ Date: _____

Printed Name:_____ Title:_____

Agency: _____

STAFFING PATTERN

Item 33

Describe the staffing pattern and its relationship to the volume of clients or services to be provided. Describe in terms of staff to client ratios, client volume or case load per staff, or how many staff are needed to perform a particular activity. Any program with the potential to require 24-hour coverage must submit a detailed description of how, by staff position, coverage will be provided. Provide a description of your agency's proposed strategy for handling fluctuations in staffing needs. Please cite specific examples. Examples may include, but are not limited to: referral networks, flexible staffing, on-call staff, or "pool" workers, and other strategies to expand or reduce physical or staff capacity due to crisis, variations in client volume, or other staffing emergencies.

Agencies providing services at more than one site must include a description of the staffing pattern for each site, if different. If the staffing pattern is the same for each site, include a statement to that effect.

YEAR 2009 STAFFING REQUIREMENTS *Item 34*

Indicate the number of staff necessary to achieve your proposal objectives, considering only direct staff, as indicated by codes 02 and 04 on Forms 2 and 2A. Executive staff providing direct services to clients should be budgeted as either "Professional Salaries" or "Technical Salaries" on Budget Forms 2 and 2A. Provide a job description plus necessary qualifications for each direct service position (sections A & B) (make additional copies as necessary). ***Complete the attached roster for current staff working in each program for which an application is being submitted.*** If the position is unfilled at the time of application submission, indicate the vacancy and provide updated staffing form within 30 days of when position is filled.

PROGRAM_____2009 PROGRAM No._____

POSITION_____# POSITIONS NEEDED_____

Job Description for this position as required to meet the needs of the program specifications. Include qualifications needed to perform job (including certifications or licenses and experience requirements to perform the job).

Annual tuition reimbursement granted for this position: $_____

Annual turnover for *this position*, as measured by Total number of separations (including voluntary and involuntary) from this position in the twelve months prior to completing this application divided by the Average number of employees in this position for the twelve months prior to completing this application (show calculation): _____/_____=_____

For Behavioral Health Division applications, include copies of staff licenses, certifications and diplomas.

Authorized Signature: _____ Date: _____

Printed Name: _____Title:_____

Agency: _____

CURRENT PERSONNEL ROSTER – DIRECT SERVICE

Employee Name	Position/ Title	Academic Degrees	Licenses / Certificates	# Program related in-service / continuing education hours completed in previous year	Years of experience in related field	Years of exp. with physically disabled clients as a target pop.	Years of exp. with visually impaired clients as a target pop.	Years of exp. with hearing impaired clients as a target pop.	Years of exp. with clients with limited English proficiency	List languages spoken, other than English

Certification Statement Regarding Provider Credentials

The contractor certifies the following: (1) all providers' licenses and certificates as listed above are current and valid; (2) providers are current and up-to-date with all training requirements as required by the State of Wisconsin; (3) the agency has a system in place to verify providers' credentials and completion of required education and training; and (4) the agency maintains all provider credentials on file and agrees to make these documents available for review upon request by Milwaukee County DHHS.

Authorized Signature: _____ Date: _____

Printed Name: _____Title: _____

Agency: _____

Accessibility:

What is your agency's plan to accommodate clients:

- With physical disabilities

- With hearing impairment

- With visual impairment

- Who are non- English speaking or have limited English proficiency

- Who require personal care assistance

List any other services enhancing program access. e.g. agency located near public transportation, etc.

2009 CLIENT CHARACTERISTICS CHART

Agency Name _____

Disability/Target Group _____

Program Name _____

Facility Name & Address _____ **2009 Prgm No.**_____

CY 2009 Estimated

1. Unduplicated Count of Clients to be Served/Year (Form 1, Column 1). If your estimate differs from prior year actual, provide a narrative explanation:

		Number	Percent (%)	Prior year actual
2. Age Group:	**a. 0 - 2**			
	b. 3 - 11			
	c. 12 - 17			
	d. 18 - 20			
	e. 21 - 35			
	f. 36 - 60			
	g. 61 & over			
	TOTAL			

		Number	Percent (%)	Prior year actual
3. Sex:	**a. Female**			
	b. Male			
	TOTAL			

		Number	Percent (%)	Prior year actual
4. Ethnicity:	**a. Asian or Pacific Islander**			
	b. Black			
	c. Hispanic			
	d. American Indian or Alaskan Native			
	e. White			
	TOTAL			

		Number	Percent (%)	Prior year actual
5. Other:	**a. Handicapped individuals**			
	b. Not applicable			
	TOTAL			

Rev 6/07	**Date Submitted:**	

The total in each category must be equal to the number in Form 1, Column 1, Total Number of Cases (Clients) to be Served per Year.

MILWAUKEE COUNTY COMMUNITY BUSINESS DEVELOPMENT PARTNERS (CBDP) OFFICE
CERTIFICATE OF GOOD FAITH EFFORTS

The intent of this certification is to document the good faith efforts implemented by the apparent successful consultant/service provider in soliciting and utilizing DBE firms to meet DBE participation requirements. This certificate will assist Milwaukee County in determining whether the apparent successful consultant/service provider has implemented comprehensive good faith efforts.

Failure to implement "good faith" efforts to the satisfaction of Milwaukee County could result in the rejection of the proposal.

I, _____, do hereby acknowledge that I am the _____ of _____, who has been identified as the apparent successful consultant/service provider on the following Milwaukee County Project:

Project No.	Project Title	Total Contract Amount	DBE Percentage	
			Goal	Pledged

Provide a brief summary on why you believe your firm is unable to meet the DBE participation goals on this project (Attach additional pages if necessary.)

I hereby certify that I have utilized comprehensive "good faith" efforts to solicit and utilize DBE firms to meet the DBE participation requirements of this contract proposal, as demonstrated by my responses to the following questions:

A. <u>Identifying Subcontract Work Items</u>

Consultants/service providers are encouraged to select portions of work to be subcontracted in a manner which will increase the likelihood of meeting DBE goals. In selecting work to be subcontracted, consultant/service provider will consider, where appropriate, breaking down contracts into economically feasible units to facilitate DBE participation.

1. **Which portion(s) or section(s) of the contract proposal, in terms of the nature of work, were selected to be subcontracted to DBE firms (or broken down into economically feasible units to facilitate DBE participation)?**

<u>B. Notifying DBE Firms of Contracting Opportunities</u>

2. In the table below, indicate which firms received written notification of work items to be subcontracted. In the appropriate space, also indicate when firms received subsequent telephone solicitations. Please attach additional

page(s) so that all companies contacted are listed. (Attach photocopies of all written solicitations to DBE firms to this certificate.)

Company Contacted	Date of Written Notification	DBE (Yes/No)	Date of Follow-up Telephone Call

3. Identify publications in which announcements or notifications were placed and published, if any. (Attach copies of proof of each announcement or notification.)

Published Announcement/Publication (please describe)	Date

4. Identify DBE associations or organizations that received written notifications, including dates of all notifications. Provide name of person and date of follow-up call. If no follow-up calls made, explain why not. (Attach copies of letters sent as proof of notification.)

DBE Association/Organization	Date of Notification	Contact Person	Date of Follow-Up Call

5. Were the services of the Milwaukee County's Community Business Development Partners (CBDP) Office used to assist in the recruitment of DBE firms?

Yes _____ ☐ No _____ ☐

Contact was made by: telephone _____ ☐ written correspondence _____ ☐

Date contacted: _____ Person Contacted: _____

C. <u>Providing DBEs With Assistance</u>

6. Explain any efforts undertaken to provide DBE firms with adequate information about project scope of work and requirements of the contract:

7. Describe any efforts undertaken to assist interested DBE firms in obtaining lines of credit or insurance required by Milwaukee County or the contractor:

8. Describe any other efforts initiated to provide special assistance to DBE firms interested in participating in the project.

D. Soliciting Proposal/Quotes From Interested DBE Firms

Contractors must solicit proposal/quotes in good faith with interested DBE firms. Quotes, proposals, and bids from interested DBE firms must not be rejected by contractors without sound justification.

9. Indicate in the table below which DBE firms submitted quotes on the contract proposal. Also, provide a brief explanation of why any of these DBE project quotes were rejected. Please attach additional pages(s) if necessary.

Name/Address/Contact Person of DBE Firm	Work Quoted and Explanation for Rejecting Quotes

10. Other comments you want Milwaukee County to consider:

NOTE: The information requested as set forth above is the minimum information required by Milwaukee County's Community Business Development Partners (CBDP) Office and CBDP may request the Contractor to submit information on certain other actions taken to secure DBE participation in an effort to meet the goals.

AFFIDAVIT

STATE OF WISCONSIN)

) ss

COUNTY OF _____)

The undersigned, having been first duly sworn, says that the information given in the above certificate is true and correct to the best of his/her knowledge and belief.

Signed: _____

Bidder/Authorized Representative

Subscribed and sworn to before me:

This _____ day of _____, 20 _____.

_____

Notary Public

My commission expires _____, 20 ____.