

BIDDERS COMPANY NAME

REQUEST FOR PROPOSAL

#6114

ADMINISTRATION OF RESPITE FUNDS

Prepared by:

Washtenaw County
Purchasing Division
Administration Building
P.O. Box 8645
220 N. Main B-35
Ann Arbor, MI 48107

Anne Strieter, C.P.M.
Senior Buyer





**WASHTENAW COUNTY
FINANCE DEPARTMENT**

Purchasing Division

P.O. Box 8645, 220 N. Main, Ann Arbor, MI 48107-8645
Phone (734) 222-6760, Fax (734) 222-6764

REQUEST FOR PROPOSAL # 6114

November 13, 2003

Washtenaw County Purchasing Division on behalf of the Washtenaw Community Health Organization is seeking proposals for Administration of Respite Funds.

This Request for Applications will be a closed bid.

Sealed Proposals: Contractor will deliver one (1) original and three (3) copies to the following address:

**Washtenaw County
Administration Building
Purchasing Division
220 N. Main St. Room B-35
P.O. Box 8645
Ann Arbor, MI 48107**

by 10:30 am on Monday, November 24, 2003

Proposals received after the above cited time will be considered a late bid and are not acceptable unless waived by the Purchasing Manager.

- Please use the attached self-addressed label or the envelope should be clearly marked "**SEALED RFP # 6114**".
- Please direct purchasing and procedural questions regarding this RFP to Anne Strieter C.P.M. at 734-222-6760 or email strietera@ewashtenaw.org
- Please direct technical questions regarding this RFP to Melissa Austin at (734) 544-3011 or email austinm@ewashtenaw.org

TIMELINE FOR RFP # 6114

Bid to WCHO Board Committee for Review	11-05-2003
Letter notifying potential contractors of bid	11-12-2003
Bid advertised in local newspapers	11-12-2003
Bid available to bidders in Purchasing	11-13-2003
Bid submission deadline	11-24-2003
Bid opening	11-24-2003
Award Recommendations approved by WCHO Board	12-16-2004
Award Notices	12-18-2004
Contracts prepared by	01-01-2004

GENERAL INFORMATION

PURPOSE: WCHO is issuing a Request for Proposal (RFP) for the Administration of Respite Funds. It is the intention of the Washtenaw Community Health Organization Board to provide an array of services to foster stability and continuity for customers with a developmental disability.

POTENTIAL BIDDERS: All interested parties are invited to submit proposals. Each bidder should submit a bid in accordance with the instructions contained herein. A completed application form and requested documentation initiates the evaluation process. Appropriate documentation must be submitted in order to verify each criterion. It is WCHO policy that individual and organizational providers, who contract to provide services, will have met any applicable credentialing or re-credentialing standards.

TERM: This is a closed bid, the contract will be awarded to one Contractor. Funding may continue for a period through September 30, 2006 beginning as close to January 1, 2004 as possible, subject to availability of funds. Continued funding will depend on the Contractor's performance during the prior year provision of services. The initial issuance of this RFP is for Washtenaw County only. It is possible that service could expand to the affiliate counties (Livingston, Lenawee, Monroe) before the end of the contract term. Bidders should indicate their interest and ability to provide service in affiliate counties in the narrative portion of this RFP. **The bidder will incur NO penalty if they choose to serve Washtenaw County only.**

TRANSITION PLANNING: In the event a services contract is awarded to a provider other than the current service provider, a transition plan shall be negotiated between WCHO and the current provider. This plan shall take into account the following factors: minimal disruption of continuity of service for consumers, the timeframe in which the new service provider plans to assume contractual obligations, procurement of any required license and/or certification by the new Service Provider and, to the extent possible, minimal disruption to the current provider's operations

FORMAT FOR SUBMISSIONS: All bids should be typed, double spaced and submitted utilizing the following format: DO NOT BIND OR PLACE THE PROPOSAL IN A HARD COVER

CONDITIONS AND TIME FRAMES: Please note any special conditions or consideration you are requesting. Indicate timeframes you would require for program implementation if your bid is accepted.

TABULATION OF BIDS: All bids will be tabulated by Washtenaw County General Services. A copy of the tabulation, together with all bidding documents, shall become record and available for inspection and copying. Reasonable fees may be charged to groups or individuals requesting copies, if the requests are large.

ADMISSION AND DISCHARGE: The Washtenaw Community Health Organization will identify potential customers for funded programs. WCHO encourages a focus on adapting services to meet the needs of individuals. Non-acceptance of customers meeting the identified criteria for participation in the Program may result in financial penalties and/or cancellation of the contract.

ADMINISTRATIVE CONTROL SYSTEM: Any agency contracting with WCHO is required to have an internal accounting and administrative control system in place which (1) protects against waste, fraud and inefficiency; (2) ensures accuracy and reliability in accounting and operating data; and (3) assures compliance with agency policies. This system should include: a) clear lines of responsibility; b) subdivision of duties; and c) a clear separation of accounting functions from custody or access to assets.

CRITERIA FOR JUDGING PROPOSALS

The Washtenaw Community Health Organization reserves the right to reject all bids, to waive or not waive informalities or irregularities in bids or bidding procedures, and to accept any bid determined through the review process to represent the best interest of WCHO and its customers. Bids will not be awarded solely on the basis of cost and selected proposals may not be the lowest bids.

Bids will be reviewed and scored in the following areas:

Administration of Respite Funds

Overall Completeness of Bid	No points (bid not accepted if incomplete)
Consumer Input/Communication	15 points
Human Resources	5 points
Previous Experience	10 points
Program Capacity/Finance	30 points
Outcome Measures	20 points
History of Bidder	20 points
Total Possible:	100 points

SITE REVIEW

A site visit or Contract Monitoring Evaluation tool may be used for current providers and new bidders. The results of the review from either of these evaluation tools will be scored and included into the History of the Bidder portion of scoring.

POTENTIAL BIDDER INTERVIEWS

Interviews may be scheduled after the initial scoring of the bid is complete. Bidders meeting the minimum required points may be interviewed. All interviews will be standardized and scored.

DESCRIPTION OF SERVICES

General Overview

PURPOSE OF PROGRAM:

- **Respite:** To offer voucher based respite services that provide the family the maximum control over the type and frequency of services used. This may include but is not limited to personal assistance staffing in or out of home, enhanced child or day care, camp or day camp. To offer an annual voucher that provides the family with funds to purchase respite services of their choice. To act as a fiscal intermediary for the respite program to provide payroll and voucher payment services.

POPULATION TO BE SERVED: Persons with a developmental disability who are enrolled consumers of WCHO.

PROGRAM OUTCOMES: Service design must recognize that many consumers, families and Supports Coordinators may initially be unfamiliar with budgeting, employer responsibilities and financial reports. All required elements must be designed and implemented in a way that is understandable and usable by consumers, families and non-financial staff.

Administration of Respite Funds shall include the following:

1) Financial administration for consumers/families who wish to directly hire and supervise their own respite workers funded through WCHO.

The Respite Program Administrator shall act as an agent of the consumer by performing the financial duties of an employer including:

- Assisting consumers with all required registration such as obtaining a federal identification number
- Issuance of wage payments based on an agreed upon budget and verification by the consumer that services have been performed
- Issuance of Social Security Payments
- Issuance of benefit payments
- Other applicable wage deductions
- Tax withholding and payments to the taxing authority
- Issuance of W-2 forms and tax statements
- Provide information and consultation regarding worker's compensation, including maintaining a list of insurance companies, assisting Supports Coordinators and consumers with application process, issuing payment to the insurance company, maintaining verification of coverage on file
- Provide information and consultation to consumers and Supports Coordinators regarding verification of citizenship or resident alien status of employees, including providing consumers with needed forms
- Provide information regarding mechanisms and fees for completing employee driving record checks and employee background checks, issuance of payments for such checks
- Maintain an employer file on behalf of each consumer, unless otherwise agreed in writing for an individual consumer. Assure that all required employee paperwork, including an employer/employee agreement is on file before issuing paychecks to any individual on behalf of the consumer
- Develop and maintain a handbook for consumers as employers, develop and provide a checklist and folder to consumers containing all required forms and information for the employment process

RFP# 6114 Administration of Respite Services

- Provide training and consultation to individuals and groups on financial requirements of employers

2) Direct payment to vendors on behalf of the consumer for WCHO funded services which are funded through a pre-authorized individual budget. The Respite Program Administrator shall pay invoices or bills in accordance with the individual's budget as follows:

- Pay all accurate, signed invoices or requests for disbursement within 14 days or less of receipt. Issue emergency checks within 1 working day of request.
- Disburse participant funds from appropriate budget categories
- Ensure that disbursements do not exceed total authorized budget
- Notify Supports Coordinator or WCHO Administrative staff if request will result in total budget being exceeded or if expense will exceed allotted line item by more than 10% for time period in question
- Notify the consumer and the consumer's Support Coordinator if an invoice is unable to be paid due to:
 - Lack of signature
 - Lack of employment agreement on file
 - Other discrepancies

3) Provide administration of Respite funds for persons with developmental disability.

- Maintain a roster of enrolled families and maintain an ongoing accounting of their utilization of pre-authorized funds on a quarterly basis.
- Process payments and maintain records of emergency approvals for increased or one time allotment of respite funds.
- Provide consumers/families with monthly statements for SDI and Children's Waiver and quarterly statements for Respite/Family Friend participants reflecting their utilization and remaining funds
- Initiate contact with families who are underutilizing their quarterly allotment to determine if they wish to request funds to be carried over.
- Maintain close coordination with WCHO Service Coordinator.
- Maintain and publish a resource list for families illustrating creative and effective uses of respite funds.
- Monitor ability-to-pay status of consumers and collect appropriate amounts from consumers/families to ensure correct billing of WCHO

MINIMUM STANDARDS of service provided:

- Proposals should describe mechanisms that would be employed to provide this service and propose a fee structure.
- A rationale should be provided for the fee structure, with sample projected costs.
- Agency should demonstrate the ability to handle payments for both on-going staffing costs and individually approved and reimbursed expenses such as transportation and costs of community participation.
- Agency must be willing to process documentation in any format required for Home and Community Based Waiver or other form of third party reimbursement.
- Agency may be expected to participate in finance committee work groups and training related to the Michigan Self-Determination Project.

BUDGET: Budget will be based upon consumer's selection of voucher model as a form of services. No guarantee can be made regarding the amount of business. The Respite budget varies, as Respite funds are linked to individual consumers' Supported Living Budget, and the program currently serves approximately 200 consumers. The allowable administrative rate will not to exceed 10%. **Please include an attachment detailing administrative costs and how these costs were determined (i.e. per client,**

per transaction, etc.) The WCHO reserves the right to set the final budget for these services and does not guarantee that amounts submitted in the bid will be the contracted amounts.

A COMPLETED BID WILL INCLUDE:

1. **A coversheet**
2. **A general application**
Including copies of Current License, Certification, Registration and Accreditation
3. **A general narrative application**
4. **Proof of agency's financial stability:**
Last 2 fiscal year Independent Audit Reports (including notes, complete balance sheet, statement of Activity, statement of cash flow, schedule of revenue and expenses by program)
5. **Any and all compliance audits (program specific)**
6. **Board Minutes from the last six (6) months**
7. **Insurance – Minimum Requirements**

Worker's Compensation Insurance with Michigan statutory limits and Employers Liability Insurance with minimum limit of 100,000 each accident for any employee.

Comprehensive / Commercial General Liability Insurance with a combined single limit of 1,000,000 each occurrence for bodily injury and property damage. **Washtenaw Community Health Organization** shall be added as **"additional insured"** on general liability policy with respect to the services provided under the contract.

Automobile Liability Insurance covering all owned, hired and non-owned vehicles with Personal Protection Insurance and Property Protection Insurance to comply with the provisions of the Michigan No Fault Insurance Law, including residual liability insurance with a minimum combined single limit of 1,000,000 each accident for bodily injury and property damage. Policy shall include **Washtenaw Community Health Organization** as additional insured with respect to automobile liability.

Professional Liability Insurance for claims or damages arising out of an error, omission, of negligent act in the performance of professional services with a minimum limit of \$1,000,000 per occurrence. Policy shall include **Washtenaw Community Health Organization** as additional insured with respect to professional liability.

Insurance policies must be issued by companies licensed to do business in Michigan or approved to do business in Michigan and such companies must be well rated and acceptable to the Washtenaw County Administrator.

**COVER SHEET
WASHTENAW COMMUNITY HEALTH ORGANIZATION
REQUEST FOR PROPOSAL
GENERAL AGENCY INFORMATION**

**FOR WASHTENAW COMMUNITY HEALTH ORGANIZATION USE ONLY
DO NOT WRITE IN SHADED AREA**

RFP # 6114 ADMINISTRATION OF RESPITE FUNDS	Date Issued: November 2003	Total application Score:
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SUBMITTING AGENCY PLEASE FILL IN THE INFORMATION BELOW.

A. Name of Proposing Agency

B. Address

C. Services agency is bidding on: Administration of Respite Funds

D. Contact person for potential interviews, title & phone

Name

Title

()

Phone

E. Organization, name & title of authorized signatories

Name

Title

Name

Title

**WASHTENAW COMMUNITY HEALTH ORGANIZATION
AGENCY APPLICATION**

Identifying Information		
Agency Name: _____		
Federal Tax ID Number _____		
Billing Street Address _____		
City _____	State _____	Zip _____
Billing Phone Number: _____		
Contact Person _____	Emergency Contact Number _____	

Board Composition
Please list the names of your Board Members and the relationship/representation they hold/title

Accreditation/Certification

PLEASE ATTACH AN ADDITIONAL SHEET IF THERE IS INSUFFICIENT AMOUNT OF SPACE.
ATTACH COPIES OF CURRENT LICENSE, CERTIFICATION, REGISTRATION AND ACCREDITATION

Is the agency currently accredited or have licensure? Yes No

Type of Accreditation: _____

Expiration Date: _____

Has the agency ever had its accreditation or licensure revoked, suspended, or limited?

Yes No Not Applicable

Is there action pending to revoke, suspend, or limit the agency's accreditation or licensure?

Yes No Not Applicable

Has the agency's state license/certification ever been revoked, suspended, or limited?

Yes No Not Applicable

Is action pending to revoke, suspend or limit the agency's license/certification?

Yes No Not Applicable

Has the agency had any sanctions imposed by Medicare and/or Medicaid?

Yes No Not Applicable

If yes was answered to any of the above questions, please provide the current status and details on a separate sheet.
Please include the following: description of incident, including correspondence with state licensing boards, and/or a detailed description of any litigation, including settlements, court awards etc.

General Information

Is your office handicap accessible?

Yes No

Please list office hours:

Is your office accessible through public transportation?

Yes No

Is your agency available to respond to scheduled interview appointments with potential consumers within 5 business days of contact from Washtenaw CSTS or local CMHs?

Yes No

If no what is the time frame?

Does the agency have 24 hour on call staff availability?

Yes No

Does your agency utilize any type of “in the field” communication? (i.e. cell phones, pagers, etc.). If yes, provide a list of staff names/positions and relevant contact numbers.

Yes No

Does your agency use other providers to furnish call/back coverage?

Yes No

Please indicate which forms of documentation your agency currently uses:

- Daily written progress notes
- Weekly written progress notes
- Incident reports
- Staff activity logs
- Other _____

Please list the continuing education and training activities in which agency leadership has participated in the last two years or will be participating in the next two years:

Please check the standard reports your computer system can produce:

Membership_____	Eligibility_____	Demographics_____
Access Times_____	Costs_____	Referrals_____
Outcomes_____	Services_____	Progress_____
Grievances_____		

CURRENT MALPRACTICE LIABILITY INSURANCE INFORMATION

Name of Insurer _____ Policy Number _____

Address _____

Expiration Date _____

Amount of Coverage

Individual \$ _____ Minimum Required: Individual _____

Aggregate \$ _____ Aggregate _____

Please attach a copy of the face sheet of current certificate of liability coverage.

Have any malpractice claims been filed against the agency/group within the past ten years or are any currently pending?

Yes No

Have any malpractice allegations involving the agency/group work ever been settled by your carrier prior to the filing of either a claim or a lawsuit?

Yes No

If you answered yes to either question please complete the Malpractice Suit Information Form, explaining each claim or allegation, the circumstances, including relevant dates and how it was disposed.

MALPRACTICE SUIT INFORMATION FORM

CONFIDENTIAL

Submit Individual Sheet for Each Case Settled and/or Pending in the Past Ten Years. Also submit additional sheets if needed. Copy Form as Necessary.

If no claims, please indicate N/A _____

Name of Case _____

Case Number _____ Court _____

Date of Occurrence _____ Date Case Filed _____ Payment Due _____

Allegations which are the basis of the claim: _____

Description of Circumstances in the Case: _____

Description of Agency/Group Participation in the Case: _____

Description of Defense / Expert Witness Reviews in the Case: _____

Disposition of Claim _____

Date of Disposition _____ Amount of Judgment or Settlement _____

Name(s) of the Defendant(s) Named in the Claim or Suite (if any) _____

Disposition of other Defendants _____

Amount of Judgment or Settlement _____

Insurance Company(s) Involved (if any) _____

I hereby certify that the above information is accurate and true and understand the information included in this form will be kept confidential and will only be used for credentialing/recredentialing. I understand that any information submitted on or with this form which is found to be false or intentionally misleading may result in rejection from Washtenaw Community Health Organization as a network provider

Signature of Applicant _____ Date: _____

ATTESTATION-AUTHORIZATION TO DISCLOSE INFORMATION

I hereby certify on behalf of _____, that all information in this application and the copies of state license(s), certificates of insurance, and accreditation are true and accurate. I fully understand that any significant misstatements in or omissions from this application will void this application and any subsequent agreement on the part of WCHO regarding this agency participation in its provider network panel.

I also release from liability all individuals and organization who provide information in good faith and without malice at the request of the WCHO concerning this application.

I understand that the agency participation as a provider for WCHO is dependent upon review of this application and completion of the credentialing process.

Signature

Date

Title

Please Print Name

Release of Information

Washtenaw Community Health Organization

_____, have applied to be a Washtenaw Community Health
Agency/Group Name
Organization Provider. As part of the credentialing process, I must provide WCHO with
information relating to my professional liability insurance coverage and malpractice claims
experience. To facilitate this process, I authorize WCHO to contact _____
Professional Liability Carrier
_____ to obtain any and all information relating to my current professional
liability coverage. I further authorize _____
Professional Liability Carrier
to release to WCHO any and all information relating to my past and current professional
liability insurance claims experience.

Signature

Date

Title

AGENCY Narrative Application-ADMINISTRATION OF RESPITE FUNDS

Agency:

Person Completing this Application:

Current Services/Locations:

Consumer Input/Communication

Please describe one specific way in which consumers are involved in the operations of your agency. Address how this has positively impacted the area of performance improvement, policy development, or the agency's mission.

Please describe how the agency will provide orientation to the families at the initiation of service.

Discuss how the agency will handle ongoing communication with families. Be sure address the agency's tracking mechanism for fund monitoring of individual consumers, and how that information will be communicated.

Human Resources

Please provide a description of staff who would work in this program. Include their job title, any degree or credentialing that would be required, and the function of their position.

Previous Experience or Training

Describe your agency's previous experience providing the services for which you are applying; or, what steps has your agency taken to train and prepare staff to provide the services being bid on?

Program Capacity/Finance

For Respite funding, consumers are assessed fees based on an ability to pay scale. The contractor would be required to collect the fees from the consumer/family, and bill the remaining amount to the WCHO. Is your agency willing and able to do this?

YES

NO

WCHO reimburses for respite at a rate of \$1.25 per 15 minutes, subject to change in availability of funding. What does the agency propose for an administrative to charge to WCHO? (administrative fee should be based on each month an enrolled consumer receives services and may not exceed 10%)

Financial Stability:

Describe your agency's overall financial status. Include information about your assets, level of receivables, liabilities, fund balance and cash flow.

When was your last financial audit completed? What auditor notes or comments were included in your audit? Do you have a plan of correction addressing those areas? What corrective steps have you taken? Attach plan of correction including status.

How often are financial statements produced? What is your process of review? Who reviews and acts upon the financial reports? How often are the financial statements given to your board?

Internal Controls (Checks and Balances:

Describe the internal control system (division of labor) you have in place. Focus on the following areas: cash receipts, check processing, purchasing and invoicing.

Outcome Measures

Using your agency's performance improvement system, please provide an outcome measure for each of the outcomes detailed in the Program Outcomes section that your agency is bidding on. Please indicate if attachments are included.