

BIDDERS COMPANY NAME

REQUEST FOR PROPOSAL

#6300

ADVOCACY SERVICES

Prepared by:

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

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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 # 6300

October 24, 2006

Washtenaw County Purchasing Division on behalf of Washtenaw County Health Organization is issuing a Request for Proposal for Advocacy Services for a three-year period, ending 9/30/09. It is the intention of the Board to provide an array of services including self-determination, self-advocacy, and consumer and family resources.

Proposals will not be accepted after the deadline date and time below.

Sealed Proposals: Please submit one (1) original and two (2) copies to the following address:

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

By 3:00 p.m. on Friday, November 17, 2006

- Please clearly mark the envelop "**SEALED RFP #6300**".
- Please direct any technical questions regarding this RFP to WCHO Provider Relations Unit at (734) 544-3000 or wchopru@washtenaw.org
- Please direct procedural questions regarding this RFP to Anne Strieter at (734) 222-6760 or strietera@washtenaw.org.

Thank You

INITIAL TIMELINE FOR RFP #6300

Bid to WCHO for Review	10-17-2006
Letter notifying potential contractors of bid	10-20-2006
Bid advertised in local newspapers	10-23-2006 & 10-26-2006
Bid available to bidders in Purchasing	10-23-2006
Bid submission deadline by 3:00PM	11-17-2006
Bid opening at 3:00 PM	11-17-2006
Bidder Site Reviews/Interviews begin	11-20-2006- 11-24-2006
Award Recommendations approved by WCHO Board	12-06-2006
Award Notices	12-08-2006
Contracts prepared by	12-11-2006

A COMPLETED BID WILL INCLUDE:

1. **A Coversheet**
2. **A checklist**
3. **A General application**
Including copies of Current License, Certification, Registration and Accreditation
4. **A general Narrative Application**
5. **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)
6. **Any and all compliance audits (program specific)**
7. **Board Minutes from the last six (6) months**
8. **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. The **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.

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

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include the **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 COMMUNITY HEALTH ORGANIZATION** Director.

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GENERAL INFORMATION

PURPOSE: Washtenaw Community Health Organization is issuing a Request for Proposal for Advocacy services. It is the intention of the Washtenaw Community Health Organization Services Board to provide an array of services including self-determination, self-advocacy and consumer & family resources. Bidder must demonstrate the ability to provide information regarding resources, services, entitlements and assistance with access to needed services.

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 WASHTENAW COMMUNITY HEALTH ORGANIZATION policy that individual and facility providers, who contract to provide services, will have met any applicable credentialing or recredentialing standards.

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 Washtenaw Community Health Organization 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 the WASHTENAW COMMUNITY HEALTH ORGANIZATION. 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: Washtenaw Community Health Organization will identify potential customers for funded programs. WASHTENAW COMMUNITY HEALTH ORGANIZATION encourages a focus on adapting services to meet the needs of individuals. Non-acceptance of customers meeting

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the identified criteria for participation may result in financial penalties and/or cancellation of the contract. Should waiting lists for services develop, providers must provide COMMUNITY SUPPORTS AND TREATMENT SERVICES with a process for prioritization of customers with the Mental Health Code.

ADMINISTRATIVE CONTROL SYSTEM: Any agency contracting with Washtenaw Community Health Organization 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

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 Washtenaw Community Health Organization and its customers. Bids will not be awarded solely on the basis of cost and selected proposals may not be the lowest bids.

All bids will be evaluated by a committee of Washtenaw Community Health Organization staff and/or Board members or consumers of Washtenaw Community Health Organization services utilizing the following criteria:

The ability, capacity and skill of the bidder to perform the contract and to provide the services required including a willingness to accept customers.

The compatibility of the contractor's service philosophy with proposed services and with the mission and direction of Washtenaw Community Health Organization.

The previous experience of the bidder in providing services similar to those proposed or in meeting the needs of the target population.

The character, integrity, reputation of the bidder, as evidenced by letters of support.

The quality, creativity and soundness of the bidders proposal for the particular program proposed.

The mechanisms for primary and secondary consumer input and mechanisms for quality management/improvement.

The number and scope of any conditions attached to the bid.

Whether the bidder is currently in default to the WASHTENAW COMMUNITY HEALTH ORGANIZATION for any Recipient Rights, Grievance & Appeal or Financial Stability of the Organization.

Collaboration with other direct programs and contractual agencies of the Washtenaw Community Health Organization system that improve continuity of service for consumers. Linkages/coordination with Client Services Management/supports coordination activities is included in this category.

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Bids will be reviewed and scored in the following areas:

General

Overall Completeness of Bid	5 points
Consumer Family Input	20 points
Program Capacity/Structure/Philosophy	20 points
Finance	20 points
Quality of Service	20 points
History of the Bidder	15 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.

DESCRIPTION OF SERVICES

SELF DETERMINATION, SELF-ADVOCACY, CONSUMER AND FAMILY RESOURCES

Service Areas:

1. General information and referral services to families, children and adults with developmental disabilities. Provision of information regarding resources, services, entitlements and assistance with access to needed services. Service to be available 40 hours per week via telephone with the capacity for face to face assistance when needed. Includes response to individual requests and community education to families, individuals, service professionals and general community audiences.
2. Management of the family support subsidy for approximately 180 families, including outreach, enrollment, and re-enrollment and monitoring of status in accordance with the standards set forth in the Michigan Department of Community Health Medicaid Provider Manual, The Michigan Mental Health Code and administrative rules.
3. Benefit assistance, education and advocacy to persons with developmental disabilities, mental illness.
 - Training and education to COMMUNITY SUPPORTS AND TREATMENT SERVICES staff and primary and secondary consumers regarding benefits and entitlements, including but not limited to SSI, SSD, Medicaid, Medicare, DHS. Provide a minimum of 4 trainings per year for staff of COMMUNITY SUPPORTS AND TREATMENT SERVICES, consumers, families and self advocates and contract agencies regarding benefit entitlement or other agreed upon topics.
 - Provides direct support to persons with a CSM or Supports Coordinator, provides consultation to staff for persons with a CSM or Supports Coordinator.
4. Promotion of the full implementation of Person Centered Planning and Service Delivery:
 - Participate in or facilitate individual Person Centered Planning upon request of consumer or family

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5. Facilitation and Coordination of Self Advocacy by Persons with Developmental Disabilities

- Facilitate or provide staffing support for opportunities for persons with developmental disabilities to develop self advocacy skills
- Facilitate and coordinate opportunities for persons with developmental disabilities to engage in self advocacy as individuals and groups
- Assist adults, families and children in individual self advocacy with service systems and public entities

Budget

Should grant funds from DCH be made available to offset any costs associated with these activities that the contractor shall make good faith effort to secure these funds and that the grant dollars may be used to offset costs here, unless otherwise negotiated. \$174,300 with a local match of \$37,300 is available for all other functions identified in the Description of Services

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

RFP #6300

**Request for Proposal for:
Advocacy Services**

**Date
Issued:
10/23/06**

**Date
Closed:
11/17/09**

**Total Application
Score:**

SUBMITTING AGENCY PLEASE FILL IN THE INFORMATION BELOW.

A. Name of Proposing Agency

B. Address

C. Contact Person for Potential Interviews, Title & Phone

Name *Title*

() _____
Phone

D. 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

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Agency Information: Please answer the following questions:

Is your office handicap accessible?

Yes No

Please list office hours:

Is your office accessible through public transportation?

Yes No

Is your agency able to respond to urgent referrals within 24 hours of contact from the consumer of Community Supports and Treatment? Yes No

Is your agency available to respond to scheduled interview appointments with potential consumers within 48 hours of contact from Community Supports and Treatment?

Yes No

If no what is the time frame?

Does the agency have 24 hour on call staff availability?

Yes No

Please check the standard reports your Organization can produce:

Membership_____	Eligibility_____	Demographics_____
Access Times_____	Costs_____	Referrals_____
Outcomes_____	Services_____	Progress_____
Grievances_____		

Please indicate if your agency has the technological capacity (personal computer and internet access) to use the WCHO electronic record?

Yes No

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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 facility/group within the past ten years or are any currently pending?

Yes No

Have any malpractice allegations involving the facility/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.

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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 Facility/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: _____

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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 WASHTENAW COMMUNITY HEALTH ORGANIZATION 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 WASHTENAW COMMUNITY HEALTH ORGANIZATION concerning this application.

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

Signature Date

Title

Please Print Name

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Release of Information

WASHTENAW COMMUNITY HEALTH ORGANIZATION

_____, have applied to be a Washtenaw Community Health Organization
Agency/Group Name

Service 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 WASHTENAW COMMUNITY HEALTH ORGANIZATION any and all information
relating to my past and current professional

liability insurance claims experience.

Signature Date

Title

AGENCY General Narrative Application

Agency:

Person Completing this Application:

Current Services/Locations:

Service Philosophy – Please tell us about your service philosophy.

Previous Experience (History of the Bidder)

Describe your Agency’s previous experience delivering Advocacy services.

Letters of Support –

Please attach 3 letters of support showing collaboration and consumer involvement.

Consumer/Family Input

Does your agency collect consumer input? Please give examples of who is responsible for collecting and/or handling input, and how changes may result from input.

Program Capacity/Structure

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.

Explain how you will provide service in each of the areas described on pp. 7&8. Which FTEs (described above) will be devoted to which areas of service.

Finance

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?

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, invoicing