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|  | **EXHIBIT A** **Letter of Submittal** |
| RFP 2021-2JRE |

This portion of the RFP will not be scored. Please answer each question/requirement directly on this sheet. If you do not have an answer or information to one or more question(s), enter NA or “none,” please do not leave any section blank.

Bidders who do not meet minimum eligibility and qualifications shall be deemed non-responsive and will not receive further consideration. Please attach any licenses, certifications, or other documents that provide proof of eligibility and qualifications. If you do not have documents to attach, please explain how you do and/or will meet requirements under each section.

1. **BIDDER ELIGIBILITY**
2. The Bidder is currently licensed by the Department of Health (DOH) to provide the services in the RFP. Include current license number and expiration date:
3. Must have an established, or be able to obtain, a National Provider Identifier (NPI). If the Bidder already has a number, please provide all NPI numbers:
4. If the Bidder is a current Network Provider, they must be in good standing with Thurston Mason Behavioral Health Administrative Services Organization (TMBH-ASO) and the Department of Health (DOH). Please list any current corrective actions or licensing probations:
5. **MINIMUM QUALIFICATIONS**
6. No agency history of being found guilty of patient abuse or neglect by any state regulatory entity or accreditation entity within the past five (5) years.
7. No history of having certification and/or licensed revoked by any state regulatory entity within the past five (5) years.

**The Bidder attests that they meet the eligibility and minimum qualifications and that the funding awarded for the contract will not supplant any other existing mental health, substance use, inpatient, or residential programming operated by the Bidder.**

Signature Date

1. **ADMINISTRATIVE REQUIREMENTS**

|  |  |
| --- | --- |
| Business Name: |       |
| Primary Address: |       |
| Phone: |       | Fax: |       |
| Email: |       | Website: |       |
| RFP Contact: |       | Phone: |       |
| DUNS# (if known):  |       | TAX ID: |       |

Please list the appropriate contact person for each of the categories below (if there is no one in a certain position, please leave blank):

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Phone** | **Email** |
| Executive Director/CEO/President: |       |       |       |
| Financial Manager/CFO: |       |       |       |
| Medical Director: |       |       |       |
| Clinical Director: |       |       |       |
| Management Information (Data): |       |       |       |
| Contracts Manager: |       |       |       |
| Quality Management: |       |       |       |
| Complaints/Grievances: |       |       |       |
| Compliance Officer: |       |       |       |
| ADA Compliance: |       |       |       |

Please provide three (3) references. By listing these references, you agree that TMBH-ASO has the right to contact these references and inquire about services delivered and overall performance.

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| **(1) Name** | **Title** | **Address** |
|       |       |       |
| **Phone** | **Email** | **Relationship (Provider, Associate, Etc.)** |
|       |       |       |
| **(2) Name** | **Title** | **Address** |
|       |       |       |
| **Phone** | **Email** | **Relationship (Provider, Associate, Etc.)** |
|       |       |       |
| **(3) Name** | **Title** | **Address** |
|       |       |       |
| **Phone** | **Email** | **Relationship (Provider, Associate, Etc.)** |
|       |       |       |

1. **LICENSING REVIEWS**

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| **Question** | **Yes** | **No** |
| 1. Agency solicits primary source verification for all licensed, certified, or registered staff, including contracted staff (MHP’s, CDP’s, Specialists, Med staff, etc.)?
 | [ ]  | [ ]  |
| 1. \*Within the past five years:
 |  |  |
| * Has the Agency received disciplinary action by the Department of Health (DOH)?
 | [ ]  | [ ]  |
| * Has the Agency been subject to State or DOH licensing investigations or actions?
 | [ ]  | [ ]  |
| * Has the Agency been named as a party in Malpractice suits which are pending, gone to trial and /or resulted in payment made to plaintiff?
 | [ ]  | [ ]  |
| * Has the Agency had a debarment or suspension by Medicare and/or Medicaid?
 | [ ]  | [ ]  |
| * Have any staff (including subcontractors) had a debarment or suspension by Medicare and/or Medicaid?
 | [ ]  | [ ]  |
| 1. Does the Agency conduct criminal background checks as a routine condition of pre-employment?
 | [ ]  | [ ]  |
| 1. Does the Agency conduct criminal background checks post-employment? If yes, how often:
 | [ ]  | [ ]  |
| 1. Does the Agency search the List of Excluded Individuals/Entities (LEIE) as a routine condition of pre-employment?
 | [ ]  | [ ]  |
| 1. Does the Agency search the List of Excluded Individuals/Entities (LEIE) post-employment? If yes, how often:
 | [ ]  | [ ]  |

**\*If answered “yes” to any question under two (2), please explain:**

1. **DEBARMENT CERTIFICATION**
2. The prospective Bidder certifies to the best of its knowledge and belief that it and its principals:
3. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;
4. 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;
5. Are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification;
6. Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default; and
7. Does not employ any person nor contracts with any person or agency excluded from participation in federal health care programs under either 42 U.S.C. 1320a-7 (§§1128 or 1128A Social Security Act) or debarred or suspended.

I understand that a false statement on this certification may be grounds for rejection of this proposal or termination of any award. In addition, under 18 USC Sec. 1001, a false statement may result in a fine of up to $10,000 or imprisonment for up to 5 years, or both.

**AUTHORIZED PROPOSAL SIGNATURE**

**Note: The signature of an authorized representative is required to complete this Form. Stamped signatures are not acceptable.**

Name (please print) Title

Signature Date