

**MENTAL HEALTH SERVICES ACT
STATEMENT OF QUALIFICATIONS SHORT FORM**

Proposer Name: _____ Date: _____

If you currently have a mental health contract with the Department of Mental Health (DMH), you are eligible to file this Statement of Qualifications (SOQ) shortened form in response to DMH's Mental Health Services Act (MHSA) Request For Statement of Qualifications (RFSQ) No. DMH111505B1.

1. Please check the appropriate box if you are currently a DMH provider as a:

<input type="checkbox"/>	a. Legal Entity/Mental Health Services provider	Contract No: _____
<input type="checkbox"/>	b. Legal Entity/Institution for Mental Disease (IMD)	Contract No. _____
<input type="checkbox"/>	c. FFS individual or group provider	Contract No. _____
<input type="checkbox"/>	d. Consultant - please describe: _____	Contract No. _____
<input type="checkbox"/>	e. Other - please describe _____	Contract No. _____

2. Please check appropriate box pertaining to a Settlement Agreement with DMH.

<input type="checkbox"/>	No, I do not have a current Settlement Agreement with DMH.
<input type="checkbox"/>	Yes, I do have a current Settlement Agreement with DMH and I am aware that there is a moratorium on expansion and/or implementation of any new programs during the Settlement Agreement's repayment period and that any exemption from this penalty requires justification that this restriction will negatively impact planned program services.

3. Please check all categories of service where you have experience demonstrating that you meet the requirements under one or more of the following service categories as detailed in RFSQ Section 1.3.1. For categories 1, 2, 3, 4 and 4a, include a program narrative that does not exceed two (2) pages/per service category. For category 20a, include a summary of an evaluation your agency completed of the impact a community-based partnership had on the community as a whole or on specific individuals within the community:

<input type="checkbox"/>	1. Full Service Partnerships (FSP)
<input type="checkbox"/>	a. FSP Enhanced Specialized Foster Care Mental Health Services
<input type="checkbox"/>	2. IMD Step-down
<input type="checkbox"/>	3. Respite Care (In-home)
<input type="checkbox"/>	4. Housing Related Supportive Services
<input type="checkbox"/>	a. Housing Trust Fund Program
	(Categories of Service 1, 2, 3, 4 and 4a require program narratives)
<input type="checkbox"/>	5. Peer support, peer counseling, and peer mentoring services
<input type="checkbox"/>	6. Counseling, assessment, and other traditional mental health services (clinic and/or field-based)
<input type="checkbox"/>	7. Alternative crisis services
<input type="checkbox"/>	8. Bridging and support services
<input type="checkbox"/>	9. Workforce training and development
<input type="checkbox"/>	10. Drop-In Center (Transitional Age Youth (TAY) only)
<input type="checkbox"/>	11. Housing – Emergency Vouchers and Project-based Subsidiaries (TAY only)
<input type="checkbox"/>	12. Integrated Services for Co-Occurring MH & Substance Abuse Disorders (COD) (Children only)
<input type="checkbox"/>	13. Probation Camp Services (TAY only)
<input type="checkbox"/>	14. Wellness Centers/Client Run Centers
<input type="checkbox"/>	15. Professional Development and Consultation Program for Integrated Services for COD and HIV/AIDS
<input type="checkbox"/>	16. Older Adult Certificate Training Program
<input type="checkbox"/>	17. Workforce Education and Training Plan (WET)
<input type="checkbox"/>	a. Regional Partnership
<input type="checkbox"/>	18. Prevention and Early Intervention Plan (PEI)
<input type="checkbox"/>	19. Under-Represented Ethnic Populations (UREP)
<input type="checkbox"/>	20. Innovations (INN)
<input type="checkbox"/>	a. INN Evaluation Component (include a summary of an evaluation your agency completed of the impact a community-based partnership had on the community as a whole or on specific individuals within the community)
	(Categories 5 through 20 do not require program narratives)

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4. Please check all target age groups with whom you have recent experience. You will be considered only for target groups checked.
- | | | | |
|--------------------------|----------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | 1. Children (0 to15) | <input type="checkbox"/> | 3. Adults (25-59) |
| <input type="checkbox"/> | 2. TAY (16-25) | <input type="checkbox"/> | 4. Older Adults (60 Years +) |
5. Please check all Service Areas where you provide services and those Service Areas where you do not currently provide services but have an interest in providing services. You will be considered only for service areas checked.
- | | | | |
|--------------------------|-------------------|--------------------------|-------------------|
| <input type="checkbox"/> | 1. Service Area 1 | <input type="checkbox"/> | 6. Service Area 6 |
| <input type="checkbox"/> | 2. Service Area 2 | <input type="checkbox"/> | 7. Service Area 7 |
| <input type="checkbox"/> | 3. Service Area 3 | <input type="checkbox"/> | 8. Service Area 8 |
| <input type="checkbox"/> | 4. Service Area 4 | <input type="checkbox"/> | 9. Countywide |
| <input type="checkbox"/> | 5. Service Area 5 | | |
6. Proof of Insurance is attached to this SOQ - check appropriate boxes
- a. Original certificate of insurance
 - b. 30-day notice of cancellation
 - c. Certificate of insurance with LA County as additional insured
 - d. AM Best Insurer Financial Rating not less than A
- 6A. General Liability - check appropriate boxes
- a. General aggregate \$2 mil coverage
 - b. Products/Completed Operation aggregate \$1 mil coverage
 - c. Personal and Advertising Injury \$1 mil coverage
 - d. Each occurrence \$1 mil coverage
- 6B. Auto
- a. Proof of insurance on ISO policy form CA 00 01 with a limit of liability of \$1 million for each accident
- 6C. Workers' Compensation - check appropriate boxes
- a. Each accident \$1 mil coverage/accident
 - b. Disease – policy limit \$1 mil coverage
 - c. Disease – each employee \$1 mil coverage
 - d. Letter stating no employees (if applicable)
 - e. Letter stating compliance with workers' compensation law for another state (if applicable)
- 6D. Professional Liability - check appropriate boxes
- Liability from any error, omission, negligent or wrongful act of the Contractor, its officers or employees with limits of not less that \$1 million per occurrence and \$3 million aggregate
- 6E. Property Coverage
- Such insurance shall be endorsed naming the County of Los Angeles as loss payee, provides deductibles of no greater than 5% of the property value, and shall be for the full replacement value of County-owned or leased property
7. Statement of Financial Viability
- Yes, I am a financial viable company/organization, as defined in the RFSQ, that can continue in business through the term and can finance all costs of this contract for a period of sixty days at any time during the contract period.
8. Proposer is registered on the County's WebVen accessed at http://doingbusiness.lacounty.gov/main_db.htm or at <http://camisvr.co.la.ca.us/webven/>.
- Yes, my WebVen Registration No. is: _____

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Please check if you understand and agree that submission of this SOQ and the signed signature page of the Master Agreement/Amendment constitutes acknowledgement and acceptance of, and a willingness to comply with, all terms and conditions of Appendix H-A – Master Agreement/Amendment.

Please sign and attach to this Shortened SOQ service category narrative(s), Settlement Agreement justification (if applicable), and all required forms listed under the RFSQ's Appendix A, Exhibits 1 through 12.

On behalf of _____,
(Proposer's Name)

I _____ certify that all statements
(Name of Proposer's Authorized Official)

made in this SOQ submitted by my organization are true and complete to the best of my knowledge and belief. I understand that any false statement(s) of material facts or omissions may subject me to disqualification.

Proposer Name:

Authorized Official's Printed Name and Title:

Authorized Official's Signature:

Date: