

**Request for Proposal (RFP)**  
**For an Enhanced Behavioral Day Program**  
**San Diego Regional Center**  
**Community Placement Plan**  
**For Fiscal Year 2024-20245**

The San Diego Regional Center (SDRC) is requesting proposals for the development of Enhanced Behavioral Day Program (EBDP). The program will support those with mild to severe behavioral challenges typically providing services during 9am to 3pm. The program will support persons that have the desire to access the community, pursue secondary education, volunteer or work in the community but require substantial supervision and vocational training. SDRC is seeking culturally competent and bi-lingual Adult Services providers to expand the provision of Innovative Adult Day Services to our underserved communities within SDRC catchment area.

Start-up amount is \$150,000.00, that can only be used for non-recurring costs associated with initially establishing services, which may include administrative components, licensing, location furnishings and supplies, personnel recruitment and training expenses, general equipment and other costs as described per contract. Start-up funds are not available to cover 100% of the development costs.

**Development Time**

The program should be ready to provide services no later than August 31, 2025.

**Demographics**

The delivery of services should be in a community-based setting that meets Home and Community Based Services Final Rule. SDRC is encouraging day programs to increase access and utilization of services for individuals who receive limited to no services. SDRC is seeking culturally competent and bi-lingual Adult Services providers who offer services preferably in the North County with a ratio of 1:3 to expand the provision of Innovative Adult Day Services to our underserved communities within SDRC catchment area.

**Transportation**

Respondents must be prepared to provide transportation services plans, for persons served by the program staff and/or utilize public transportation service options during program service hours. All services and supports provided must take place in integrated and inclusive community-based settings.

**Service Description**

SDRC has identified the need to create an Enhanced Behavioral Support site-based program to service consumers with mild to severe behavioral challenges. The program aims to provide access to the community, pursue secondary education, volunteer training or work in the community but require substantial supervision and vocational training.

**Justification**

Enhanced Behavioral Day Program (EBDP) will offer behavioral supported day programming options to individuals living in the community or in a residential setting. The program will support those with mild to severe behavioral challenges typically providing services during 9am to 3pm. SDRC is seeking culturally competent and bi-lingual Adult Services providers to expand the provision of Innovative Adult Day Services to our underserved communities within SDRC catchment area.

Enhanced Behavioral Day Program will offer the opportunity for adults with developmental disabilities to choose day services to meet their individualized needs, have the opportunity to further develop or maintain employment, volunteer activities, direct their services, pursue post-secondary education, and increase their ability to lead integrated and inclusive lives.

### **Applicant Qualifications**

The following qualifications will be sought in a potential provider and will be assessed by evaluating an applicant's proposal, and responses to interview questions, if applicable.

- Applicants have a proven history of financial responsibility, stability and soundness.
- Applicants must provide site base services in a 1:3 ratio.
- Applicants must offer services preferably in the North County area.
- Applicants must preferably be a site-based program with community options.
- Applicants have a proven history of demonstrating the ability to provide direct supervision or services/supports to persons with developmental disabilities.
- Applicants have proven credentials, licenses, training and/or skills.
- Applicants have a proven history of positive working relationships with the community and applicant agencies.
- Applicants must be in good standing with the regional center and licensing agencies, if applicable.
- Applicant has the administrative capacity to complete the project and/or implement the service in a timely manner.
- Applicants must agree to the Rate Reform requirements, including being a part of the Service Provider Directory and the Rates set by [DDS Directives and Updates posted to the DDS website.](#)

### **Potential Providers MUST have prior experience including**

Meet Title 17 and Regional Center Requirements

### **Submit a Program Design that includes the following:**

- Mission, Vision, and Value Statement
- Goals of Services.
- Description of clients served
- Assessment and Planning
- Anticipated client outcomes
- Geographic area served
- Equity and Diversity

- Organizational chart
- Development Team
- Job descriptions
- Schedule of operation hours
- Training Plan
- Annual program evaluation plan
- Incident and grievance policy
- Mandated reporter and Special Incident Report (SIR) protocol

### **Applicant Eligibility and Ineligibility**

- Eligibility  
Proposals can be submitted by service provider entities that are authorized to conduct business with the SDRC. Site based day program vendors who follow a 1:3 ratio, preferably servicing the North County area.
- Ineligibility  
Conflict-of-Interest, any individual or entity that has a conflict of interest as established in DDS Regulations, Title 17, Sections 54314 and 54500. Board members of San Diego county Developmental Services Inc. and employees of SDRC are prohibited from submitting proposals.

### **Selection Procedures**

Any proposal may be rejected if it is incomplete or deviates from the specifications in this RFP. SDRC reserves the right to reject any or all proposals and to cancel the RFP process at its discretion. Each proposal will be evaluated by a RFP Selection Committee which is an interdisciplinary team of at least 3 members, who will score each proposal individually before coming together as a team to thoroughly review and discuss each proposal.

### **Proposal will be reviewed and evaluated for:**

- Completeness and responsiveness of the proposal
- Sound and detailed explanation of the use of start-up funds
- Relevant experience and qualifications of the applicant
- Reasonableness of timelines
- Demonstrated financial responsibility, stability and soundness of the applicant.

### **Additional Requirements**

- Proof of Liability Insurance, the selected applicant will be required to maintain general liability.

### **Reservation of Rights**

SDRC reserves the right to request or negotiate changes in a proposal, to accept all or part of a proposal, or to reject any or all proposals. SDRC may, at its sole and absolute discretion, select no provider for these services if, in its determination, no applicant is sufficiently responsive to the need. SDRC reserves the right to withdraw this Request for Proposal (RFP) and/or any item within the RFP at any time without notice. SDRC reserves the

right to disqualify any proposal which does not adhere to the RFP guidelines. This RFP is being offered at the discretion of SDRC. It does not commit SDRC to award any grant.

**Cost for Proposal Submission**

Applicants responding to the RFP shall bear all costs associated with the development and submission of a proposal.

**Deadline Submission & Submission Instructions**

Please send all proposals **by e-mail only** to:

**Brian Uribe, Resource Development  
Manager [rfp@sdrc.org](mailto:rfp@sdrc.org)**

Copies of the proposal must be received at the above e-mail address **no later than 4:00 PM Tuesday December 31<sup>st</sup>, 2024** . Proposals received after this deadline will not be considered. You will receive an email reply confirming receipt of your proposal. **If you do not receive email confirmation, your proposal was not received by SDRC.** Please follow up by phone with Brian Uribe (858) 496-4331 if you **do not** receive confirmation.

# APPLICANT/AGENCY INFORMATION

Applicant/Agency Name \_\_\_\_\_ CPP Project # \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

☐ Non-Profit Corporation      ☐ For-Profit Corporation  
☐ Educational Institution  
☐ Local Government Agency      ☐ Individual  
☐ Other(\_\_\_\_\_)

Contact Person's Name and Job Title: \_\_\_\_\_ Phone \_\_\_\_\_

E-Mail: \_\_\_\_\_

A. List up to four current or previous services implemented by the applicant/agency that provide evidence of experience related to your proposal. Include the service name, the dates that services started (and ended if not currently being provided), and a one sentence description of the type/purpose of the indicated service:

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_

B. List two references that can be contacted in regards to applicant's experience, qualifications and ability to implement this proposal:

1. \_\_\_\_\_  
 Name and Title \_\_\_\_\_ Agency Affiliation \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_
2. \_\_\_\_\_  
 Name and Title \_\_\_\_\_ Agency Affiliation \_\_\_\_\_  
 Address \_\_\_\_\_ Phone \_\_\_\_\_

Application submitted by \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_

## **APPLICANT/VENDOR DISCLOSURE STATEMENT**

### **GENERAL INSTRUCTIONS**

Every applicant or vendor must complete and submit a current Applicant/Vendor Disclosure Statement, DS 1891 (disclosure statement) as part of a complete application packet for vendorization or upon request of the vendoring regional center. The following instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. See 42 CFR 455.101 for additional definitions.

**Overall Authority:** *Code of Federal Regulations (CFR), Title 42, Part 455; California Code of Regulations, Title 17, Section 54311. Welfare and Institutions Code, Section 4648.12.*

#### **Important:**

- **IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.**
- **Parents and consumers of Vouchers, Participant-Directed Services, or Purchase Reimbursements:** Complete Part 1 on page 2 and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date.
- Failure to disclose complete and accurate information will result in a denial of enrollment and/or may be cause for termination of vendorization.
- Read **ALL** instructions when completing the disclosure statement.
- Type or print clearly in ink.
- If applicant or vendor must make corrections, please line through, date, and initial in ink. Do not use correction fluid.
- Answer all questions as of the current date.
- If additional space is needed, attach a sheet referencing the part and question being completed.
- Return this completed statement with the complete application package to the regional center to which you are applying.

### **Part 1: Identifying Information**

- A. Specify name of the applicant or vendor, agency, facility or organization, vendor number and service code, business address, and telephone number of applicant or vendor submitting the vendor application.
- B. Specify in what capacity the applicant or vendor is doing business. For example: The name of the corporation under which they are doing business. This name must match the license name, if applicable.
- C. List the National Provider Identifier, of the applicant or vendor, if any.
- D. List the Social Security Number, Date of Birth, and/or the Federal Employer Identification Number (EIN) of the applicant or vendor, if any. Enter Vendor's nine-digit EIN assigned by the IRS in the following format: XX-XXXXXXX.
  - An EIN is used to identify the accounts of employers and certain others who have no employees.
  - For more information about an EIN, please check <http://www.irs.gov> for "Employer Identification Numbers" or "EIN". Whenever this Disclosure Statement requests an EIN about an individual or entity, it has the same meaning.
- E. Check the entity type that best describes the structure of your organization.

### **Part 2: Ownership and Control Interests. Use the following definitions to identify the individuals you should enter in A, B and C of this section. See 42 CFR 455.101 for additional definitions.**

- "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in the applicant or vendor. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or vendor;
- "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, agency or business entity;
- "Ownership Interest" means the possession of equity in the capital, the stock, or the profits of the applicant or vendor.
- "Person with an Ownership or Control Interest" means a person or corporation that:
  - A) Has an ownership interest totaling 5 percent or more in an applicant or vendor;
  - B) Has an indirect ownership interest equal to 5 percent or more of an applicant or vendor;
  - C) Has a combination of direct or indirect ownership interests equal to 5 percent or more in an applicant or vendor;
  - D) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or vendor if that interest equals at least 5 percent of the value of the property or assets of the applicant or vendor;
  - E) Is an officer or director of an applicant or vendor that is organized as a corporation; or
  - F) Is a partner in an applicant or vendor that is organized as a partnership.
- "Significant Business Transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of an applicant or vendor's total operating expenses.

- “Subcontractor” means an individual, agency, or organization to which an applicant or vendor has contracted or delegated some of the management functions or responsibilities of providing services.
- “Wholly Owned Supplier” means a supplier whose total ownership interest is held by an applicant or vendor or by a person, persons, or other entity with an ownership or control interest in an applicant or vendor.

**Part 3: Excluded Individuals or Entities. (See page 3. Must be disclosed if applicable.)**

“Excluded Individuals or Entities” means those individuals and entities that have been placed on either the U.S. Department of Health and Human Services Office of Inspectors’ General (OIG) List of Excluded Individuals/Entities or the Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible Provider List of persons, or individuals and entities that have been convicted of a criminal offense related to involvement in any program under Medicare, Medicaid or the Title XX services program, or those individuals and entities that meet the criteria included in Title 17, Section 54311(a)(6).

**Title 17, California Code of Regulations, Section 54311(a)(6)  
(Criteria for Excluded Individuals or Entities)**

The name, title and address of any person(s) who, as applicant or vendor, or who has ownership or control interest in the applicant or vendor, or is an agent, director, members of the board of directors, officer, or managing employee of the applicant or vendor, has within the previous ten years:

- (A) Been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of an elder or dependent adult or child, or in any connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse; or
- (B) Been found liable any civil proceeding for fraud or abuse involving any government program; or
- (C) Entered into a settlement in lieu of conviction involving fraud or abuse in any government program.

**PLEASE FILL OUT**

**Part 1. Applicant/Vendor Information**

A. Name of applicant or vendor, entity, agency, facility, or organization as reported to IRS:

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Vendor Number and Service Code:

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Business Address:

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Telephone number (with area code):

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B. Name registered with California Secretary of State, if any:

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C. National Provider Identifier (NPI), if any:

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D. Social Security Number (SSN), Date of Birth (DOB), and/or Federal Employer Identification Number (EIN), if any:

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E. Check the entity type that best describes the structure of the applicant or vendor individual, business entity, agency, facility or organization: Check **only one** box:

- ☐ **Parent or Consumer for Vouchers, Participant-Directed Services, or Purchase Reimbursements** (Complete Part 1 above and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date).
- ☐ **Sole Proprietor (Unincorporated)**
- ☐ **General Partnership**      ☐ **Limited Partnership**      ☐ **Limited Liability Partnership**
- ☐ **Limited Liability Company:**      **State of formation:** \_\_\_\_\_
- ☐ **Governmental**
- ☐ **Corporation:**      **Corporate number:** \_\_\_\_\_ **State incorporated:** \_\_\_\_\_
- ☐ **Nonprofit – Check One:**      ☐ **Unincorporated Association**      ☐ **Religious/Charitable**  
                                                 ☐ **Corporation**      ☐ **Other (specify):** \_\_\_\_\_

**Part 2. Ownership, indirect ownership, and managing employee interests (If not applicable, please indicate.)**

**A.** List the name(s), title(s), address(es), SSNs, and DOBs of individuals for organizations having direct or indirect ownership interests, and/or managing employees in the applicant/vendor (see instructions for definitions). Also list all members of a group practice. Attach additional pages as necessary to list all officers, owners, management and ownership individuals and entities.

| Name | Title | Address | SSN | DOB |
|------|-------|---------|-----|-----|
|      |       |         |     |     |
|      |       |         |     |     |
|      |       |         |     |     |

**B.** List those persons named in 'A' above or 'Part 4. A' below, that are related to each other as spouse, parent, child, or sibling.

| Name | Relationship | Address |
|------|--------------|---------|
|      |              |         |
|      |              |         |
|      |              |         |

**C.** List the name, address, vendor number and service code, SSN, NPI and/or EIN of any other applicant or vendor in which a person with an ownership or controlling interest in the applicant or vendor also has an ownership or control interest of at least 5 percent or more. For example: Are any owners of the applicant or vendor also owners of Medicare or Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.)

| Name | Address | Vendor Number and Service Code | SSN, NPI and/or EIN |
|------|---------|--------------------------------|---------------------|
|      |         |                                |                     |
|      |         |                                |                     |
|      |         |                                |                     |
|      |         |                                |                     |
|      |         |                                |                     |

**Part 3. Excluded Individuals or Entities (If not applicable, please indicate.)**

List the name, title, and address of any person, as applicant or vendor, or entity with an ownership or control interest, any agent, director, officer, or managing employee of the applicant or vendor who is an excluded individual or entity, as defined on page 2.

| Name | Title | Address |
|------|-------|---------|
|      |       |         |
|      |       |         |
|      |       |         |

**Part 4. Subcontractor (If not applicable, please indicate.)**

**A.** List the name, title, address, SSN, NPI and/or EIN of each person or entity with an ownership or control interest in any subcontractor in which the applicant or vendor has direct or indirect ownership of 5 percent or more. State percentage.

| Name | Title | Address | Percentage | SSN, NPI and/or EIN |
|------|-------|---------|------------|---------------------|
|      |       |         |            |                     |
|      |       |         |            |                     |
|      |       |         |            |                     |

**B.** List the name, title, address, SSN, NPI and/or EIN of each subcontractor or wholly owned supplier in which the applicant or vendor has had any significant business transactions within 5 years of the application or request.

| Name | Title | Address | SSN, NPI, and/or EIN |
|------|-------|---------|----------------------|
|      |       |         |                      |
|      |       |         |                      |
|      |       |         |                      |

**APPLICANT/VENDOR SIGNATURE**

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become vendored, or if the service provider already is vendored, a termination of its vendorization.

By signing this disclosure statement, you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform the vendoring Regional Center, in writing, within 30 days of any changes or if additional information becomes available.

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**Name of Applicant/Vendor or Authorized Representative**

**Title**

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**Signature**

**Date**

**Recordkeeping and Access to Records**

Subject to the provisions of Title 17, California Code of Regulations, Section 54311 and Code of Federal Regulations, Title 42, Part 455.105, an applicant or vendored provider agrees to provide access for the review of any and all ownership disclosure information and/or documentation upon written request by the vendoring regional center, the Department of Developmental Services, the State Medicaid Agency, Department of Health Care Services, any State survey team, the Secretary of the United States Department of Health and Human Services, or any duly authorized representatives of the above named entities.

**Privacy Statement**

All information requested on the application and the disclosure statement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department of Developmental Services pursuant to 26 USC 6041. This information is required by the authority of Welfare and Institutions Code, Section 4648.12 and Title 17, California Code of Regulations, Section 54311. The consequences of not supplying the mandatory information requested are denial of vendorization as a regional center vendor or termination of vendorization. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, or licensing programs in other states.

## BUDGET AND FINANCIAL INFORMATION

Applicant/Agency Name \_\_\_\_\_ CPP Project # \_\_\_\_\_

FINANCIAL STATUS AS OF \_\_\_\_\_, 20\_\_\_\_

Line of Credit Available?      0      Yes      LI      No      Amount \_\_\_\_\_

## ASSETS

Cash on hand and in commercial and savings accounts \_\_\_\_\_

Notes and Receivables \_\_\_\_\_

Inventory, Equipment, Furniture and Furnishings \_\_\_\_\_

Real Estate (Market Value) \_\_\_\_\_

Other Assets: \_\_\_\_\_

TOTAL ASSETS ..... \_\_\_\_\_

## LIABILITIES

Accounts and Notes Payable (Balance Due) \_\_\_\_\_

Salaries and Wages Payable \_\_\_\_\_

Real Estate Loans or Mortgages (Balance Due) \_\_\_\_\_

Payroll and Real Estate Taxes Payable \_\_\_\_\_

Other Liabilities: \_\_\_\_\_

TOTAL LIABILITIES ..... \_\_\_\_\_

Reference who may be contacted regarding applicant's/agency's qualifications and experience in financial management:

Name/Title \_\_\_\_\_ Agency/Company \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Budget/Financial Information Submitted by \_\_\_\_\_  
Name Date

## BUDGET FOR PROJECT START-UP

## PERSONNEL SERVICES (Staff and Consultants)

| Job Title                                       | Number<br>(or %)<br>FTE | FTE Monthly<br>Salary with<br>Fringe Benefit | Number<br>of<br>Months | TOTAL |
|-------------------------------------------------|-------------------------|----------------------------------------------|------------------------|-------|
| 2 .                                             |                         |                                              |                        |       |
| 3 .                                             |                         |                                              |                        |       |
| 4 .                                             |                         |                                              |                        |       |
| 5 .                                             |                         |                                              |                        |       |
| Employee Fringe Benefits ( _____ % of Salaries) |                         |                                              |                        |       |
| START-UP                                        |                         |                                              |                        |       |
| PERSONNEL SERVICES                              |                         |                                              |                        |       |
| SUBTOTAL                                        |                         |                                              |                        |       |

## OPERATING EXPENSES

|                                            | Monthly<br>Amount | Number<br>of<br>Months | TOTAL |
|--------------------------------------------|-------------------|------------------------|-------|
| Office and/or Facility Lease               |                   |                        |       |
| Insurance                                  |                   |                        |       |
| Utilities                                  |                   |                        |       |
| Travel                                     |                   |                        |       |
| Purchased Equipment and<br>Supplies (list) |                   |                        |       |
| 2 .                                        |                   |                        |       |
| 3 .                                        |                   |                        |       |
| 4 .                                        |                   |                        |       |
| 5 .                                        |                   |                        |       |
| Other-                                     |                   |                        |       |
| Administrative Overhead                    |                   |                        |       |
| START-UP                                   |                   |                        |       |
| OPERATING EXPENSES                         |                   |                        |       |
| SUB-TOTAL                                  |                   |                        |       |

TOTAL START-UP  
BUDGET

Submitted by

Name

Date

# COMMUNITY PLACEMENT PLAN REQUEST FOR PROPOSAL

Appendix E

## PROPOSAL REVIEW/SELECTION CRITERIA

*(The minimum requirement will be 70% of the total possible points)*

Project Number \_\_\_\_\_ Applicant /Agency \_\_\_\_\_

|                                                                                                                                                                                | Maximum Score | Initial Proposal Score | Final Score |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|------------------------|-------------|
| <b>A. Agency Description</b>                                                                                                                                                   |               |                        |             |
| 1. The applicant/agency has prior relevant experience and credentials in the developmental disabilities and/or mental health field.                                            | 10            |                        |             |
| 2. The applicant/agency's philosophy is positive, consumer oriented and appropriate to the goals of the proposed project.                                                      | 5             |                        |             |
| 3. The applicant/agency's history indicates the capability of developing, managing, and operating the proposed project in San Diego County.                                    | 10            |                        |             |
| <b>B. Project Description</b>                                                                                                                                                  |               |                        |             |
| 1. The expected service outcomes are clear and consistent with the goals of the proposed project.                                                                              | 5             |                        |             |
| 2. The proposed use of personnel (direct care staff and consultants), including the selection, management and training of staff should ensure quality outcomes in the project. | 15            |                        |             |
| 3. The plan for providing services, including the description of the needs of the consumers who will be served, is consistent with the goals of the project.                   | 5             |                        |             |
| <b>C. Work Plan/Timelines</b>                                                                                                                                                  |               |                        |             |
| 1. The work plan indicates a thorough knowledge of the processes and procedures needed to complete the project.                                                                | 10            |                        |             |
| 2. The timeline for project development is realistic and meets deadlines.                                                                                                      | 10            |                        |             |
| <b>D. Budget/Finances</b>                                                                                                                                                      |               |                        |             |
| 1. The applicant/agency's financial statement reflects sound fiscal practices. Assets are sufficient to undertake the proposed project.                                        | 5             |                        |             |
| 2. The start-up budget is reasonable and demonstrates a good appraisal of actual costs involved in completing the project.                                                     | 5             |                        |             |
| 3. The estimate for on-going service rate is cost-effective and consistent with funding for similar programs.                                                                  | 5             |                        |             |
| <b>E. Proposal Responsiveness</b>                                                                                                                                              |               |                        |             |
| 1. The overall proposal indicates an ability to follow directions and is an appropriate response to the RFP                                                                    | 10            |                        |             |
| 2. The proposal provides evidence of innovative practices in providing services.                                                                                               | 5             |                        |             |
| <b>TOTAL</b>                                                                                                                                                                   | <b>100</b>    |                        |             |

Proposal review completed by: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_