Government of the District of Columbia

HUMAN CARE AGREEMENT CONTRACTOR QUALIFICATIONS RECORD

STATUTORY AND REGULATORY AUTHORITY

The Procurement Practices Human Care Agreement Amendment Act of 2000 (D.C. Law 13-155) authorizes the District of Columbia Chief Procurement Officer, or his or her designee, to award human care agreements for the procurement of social, health, human, and education services directly to individuals in the District. The Human Care Agreement Contractor Qualifications Record (CQR) is an application package that will facilitate the process of pre-qualifying contractors for a human care agreement with the District of Columbia in accordance with D.C. Law 13-155 and Chapter 19, 27 DCMR, the regulations.

GENERAL INSTRUCTIONS

1. *Please read and complete each section of the Human Care Agreement Contractor Qualifications Record form. All information must be completed in the spaces provided, or marked "N/A."*

2. *An original signature must be provided in those sections where a signature is required. Copies or a stamped signature **is not** acceptable.*

3. *Included in the package that will be provided to you will be a copy of the "Standard Contract Provisions For Use With District of Columbia Government Supply and Services Contracts", dated November 2004. Please read this document carefully before you complete the Contractor's Qualifications Record. The "Standard Contract Provisions For Use With District of Columbia Government Supply and Services Contracts," dated March 2007, will be incorporated by reference into each Human Care Agreement that is entered into between a contractor that will provide human care services and the District of Columbia.*

4. *Also included in the package that will be provided to you will be forms required by the Department of Small and Local Business Development. You must complete those forms and return them with your package to make it complete and for you to be considered for a Human Care Agreement. The forms are for:*

   a. *Compliance with Section 5 of Mayor's Order 85-85, "Equal Opportunity Obligations in Contracts" and*
   b. *Compliance with Equal Opportunity for Local, Small and Disadvantaged Business Enterprises Amendment Act of 1998, as amended (D.C. Laws 12-268 and 13-169).*

5. *You may use Section VIII, the "Remarks Section", on page 6, to provide additional information or to expand on information that is provided in response to the request for information.*

6. *Please include and attach all information, documentation, and data as instructed and required.*

7. *In those instances where check boxes are provided, please check only the box or boxes which apply.*

CHECKLIST

☐	Did you include your Taxpayer Identification Number?	☐	Did you attach a copy of your most recent Financial Statement?
☐	Did you attach the information required In Section III, Disclosure Information, on page 2?	☐	Did you attach a copy of all licenses and certifications, including any specialty certifications?
☐	Did you list all personnel critical to the performance of your Organization in Section VI	☐	Are you providing a facility? Then, did you attach a copy of the Certificate of Occupancy for each facility?
☐	Did you attach a Certificate of Incorporation, if applicable?	☐	Did you attach a Certificate of Good Standing, if applicable?
☐	Did you attach a copy of your LSDBE certification, if applicable?	☐	Did you attach or include your salary history, if applicable?

FREQUENTLY ASKED QUESTIONS

Q	Can I fax my application for processing?	**A**	No. Contractor Qualifications Records must contain original, not copied signatures.
Q	Is this form available electronically?	**A**	Yes, the Contractor Qualifications Record (CQR) is available on the Office of Contracting and Procurement web site, www.ocp@dc.gov.
Q	Who or what is an Individual?	**A**	The term "individual" means a human person who may be licensed, certified, or otherwise authorized or qualified to perform or provide specific human care services. The individual may be solo practitioner or a part of a group.
Q	Who or what is an Organization?	**A**	The term "organization" means an entity, other than an individual, that is licensed, certified, or otherwise authorized, or qualified, to provide or perform human care services in the normal course of business. The license, certification, or other recognition is granted to the organization entity. Individual owners, managers, or employees of the organization may also be certified, licensed, or otherwise recognized as individual providers in their own right. Examples may include a corporation, joint venture, clinic, hospital, or partnership.

Government of the District of Columbia

HUMAN CARE AGREEMENT CONTRACTOR QUALIFICATIONS RECORD

1. DATE OF FILING / /	2. FILING TYPE: ☐ NEW ☐ UPDATE ☐ CORRECTION ☐ REMOVAL	FOR OCP USE ONLY: *DATE RECEIVED BY OCP:*

SECTION I – GENERAL INFORMATION

1. NAME OF INDIVIDUAL/ ORGANIZATION

a. Name:

b. Title:

c. Physical Street Address:

d. City, State & Zip Code:

e. Office Phone: f. Office Facsimile No:

g. E-Mail:

2. TYPE OF ORGANIZATION *(Please check the appropriate box.)*

☐ INDIVIDUAL ☐ JOINT VENTURE

☐ CORPORATION ☐ GENERAL PARTNERSHIP

☐ SOLE PROPRIETORSHIP ☐ LIMITED PARTNERSHIP

3. STATE OF INCORPORATION *(Please check the appropriate box.)*

☐ DISTRICT OF COLUMBIA ☐ COMMONWEALTH OF VIRGINIA

☐ STATE OF MARYLAND ☐ STATE OF DELAWARE

☐ OTHER: _____

Date Of: _____

3. IS ORGANIZATION?

☐ FOR PROFIT ☐ NON-PROFIT

5. SOCIAL SEC. / TAXPAYER ID NO:

6. DUNN & Bradstreet No:

7. ARE YOU OR THE ORGANIZATION CERTIFIED IN D.C. AS?

☐ Small ☐ Local ☐ Disadvantaged ☐ Resident-Owned

☐ Enterprise Zone ☐ Longtime Resident

SECTION II – FINANCIAL RESPONSIBILITY INFORMATION

(Please Provide and Attach a Copy of Your Most Recent Financial Statement.)

1. **Name and Address of Accountant:**	2. Name and Address of Financial Institution:
3. Name and Title of Contact Person:	**4. Name and Title of Contact Person:**
5. Telephone No.: / **6. Fax No.:**	**7. Telephone No.:** / 8. Fax No.:
9. Date Of Attached Financial Statement (Must be Within Last 12 Months):	*10. Do You/Organization Owe Any Outstanding District /Federal Taxes:* District Taxes: ☐ NO ☐ YES - Federal Taxes: ☐ NO ☐ YES

11. MEDICAID – MEDICARE INFORMATION:

a. Are You / Organization a Certified Medicaid Provider? ☐ YES ☐ NO Medicaid Number: _____ Date: _____

b. Are You / Organization a Certified Medicare Provider? ☐ YES ☐ NO Medicare Number: _____ Date: _____

SECTION III – DISCLOSURE INFORMATION

(If yes to any questions below, please explain fully in REMARKS SECTION, or attach a separate statement.)

1. Have you or the Organization ever been debarred, suspended or sanctioned from any state or federal program?
☐ YES ☐ NO

2. Is your license, or any in the organization currently suspended or restricted in any way?
☐ YES ☐ NO

3. Have you or the principals of the Organization ever been, indicted, convicted of or pled guilty to a crime (excluding minor traffic citation), or been imprisoned for a crime in the past 10 years.:
☐ YES ☐ NO

4. Are there any judgments, or pending civil lawsuits, or investigations against you or the Organization, or its principals?:
☐ YES ☐ NO

5. Have you or the Organization ever had any outstanding criminal fines, restitution orders, or overpayments identified in the District or any state?:
☐ YES ☐ NO

6. Are you, or is anyone in your organization, related by blood or marriage to any individual employed by the District government?:
☐ YES ☐ NO

SECTION IV – ORGANIZATION HISTORY, BACKGROUND AND EXPERIENCE

1. List All Contracts With the District Government Within the Past Five (5) Years:

	Agency	Description of Service	Amount	Dates	Contract Number
A				to	
B				to	
C				to	
D				to	
E				to	

(Please Use and Attach a Separate Sheet for Additional Items.)

2. List All Contracts With Other Governments or Private Institutions Within the Past Five (5) Years:

	Agency	Description of Service	Amount	Dates	Contract Number
A				to	
B				to	
C				to	
D				to	
E				to	

(Please Use and Attach a Separate Sheet for Additional Items.)

3. If You Are Applying As An INDIVIDUAL, Please List Your Employment Or Work History for past five (5) years:

	Name of Employer	Address	Duties	Name of Supervisor	Dates of Employment	Telephone
A					to	
B					to	
C					to	
D					to	
E					to	
F					to	

(Please Use and Attach a Separate Sheet for Salary History and Additional Items.)

4. List At Least Five (5) References Familiar With Service Delivery:

	Name	Tittle/Position	Affiliation	Telephone	Fax	E-Mail
A						
B						
C						
D						
E						

(Please Use and Attach a Separate Sheet for Additional Items.)

4. ARE YOU A UNIITED STATES CITIZEN?

☐ YES ☐ NO

5. ARE YOU A PERMANENT RESIDENT? ***(Please Attach Documentation To Support))***

☐ YES ☐ NO

6. IF YOU ARE NOT A CITIZEN, CAN YOU PROVIDE AND SUBMIT VERIFICATION OF YOUR LEGAL RIGHT TO WORK IN THE UNITED STATES? *(Please Attach Documentation To Support.)*

☐ YES ☐ NO

SECTION V – EDUCATION, CREDENTIALS AND LICENSURE

1. Please List All Colleges (Undergraduate and Graduate) and Professional Institutions Attended:

	Chief Study Subject Area	Name of College, University or Professional School	Address and Zip Code	Dates Attended	Date And Type Degree Awarded
A				To	
B				To	
C				To	
D				To	
E				To	

(Please Use and Attach a Separate Sheet for Additional Items.)

2. Please List All Professional Certifications and Licenses (Copies Must Be Attached):

	License/Certification	Agency/Entity	State	Number	Effective Dates	Date Issued
A					to	
B					to	
C					to	
D					to	
E					to	

(Please Use and Attach a Separate Sheet for Additional Items.)

3. Please List All Speciality, Certifications and Licenses (Copies Must Be Attached):

	Specialty License/Certification	Agency /Entity	State	Number	Effective Dates	Date Issued
A					to	
B					to	
C					to	
D					to	

(Please Use and Attach a Separate Sheet for Additional Items.)

4. HAVE YOU OR ANY MEMBER OF THE ORGANIZATION EVER HAD ANY LICENSE, CERTIFICATION OR CREDENTIAL REVOKED OR SUSPENDED? ☐ YES ☐ NO

(*If yes, please explain in REMARKS SECTION, or attach a detailed explanation, including dates, type of license, certification, credential and all circumstances surrounding the event(s).)*

(Please Use and Attach a Separate Sheet for Additional Items.)

5. Please list any hospital affiliations or privileges below:

	Name of Individuals(s)	Name of Hospital	Address	Type Privilege/Affiliation	Telephone	Fax No.
A						
B						
C						
D						

(Please Use and Attach a Separate Sheet for Additional Items.)

6. HAVE YOU OR ANY MEMBER OF THE ORGANIZATION EVER HAD ANY HOSPITAL PRIVILEGES REVOKED, FOR ANY REASON? ☐ YES ☐ NO

(*If yes, please explain in REMARKS SECTION, or attach a detailed explanation, including dates, type of license, certification, credential and all circumstances surrounding the event(s).)*

SECTION VI – SERVICE DATA AND INFORMATION

1. GENERAL SERVICE CATEGORIES: Pleas Check Each Of The General Service Categories For Which You Or The Organization Are Applying.

- ☐ Education (EDS)
- ☐ Special Education (SED)
- ☐ Health (HTH)
- ☐ Human Services (HUM)
- ☐ Mental Health (MEN)
- ☐ Psychology (PSY)
- ☐ Social Services (SOC)
- ☐ Youth/Juvenile Justice (JUV)
- ☐ _____

2. POPULATIONS: Pleas Check All That Apply For Populations.

- ☐ Children & Youth (CYG)
- ☐ Children & Youth-Detained (CYD)
- ☐ Children & Youth-Committed (CYC)
- ☐ Children & Youth-Supervision (CYS)
- ☐ Special Education (SED)
- ☐ Adults (ADT)
- ☐ Adult Forensic-Psychiatric (AFP)
- ☐ Adult Forensic-Correctional (FC)
- ☐ Physically Disabled (DIS)
- ☐ Mentally Retarded (MRD)
- ☐ Developmentally Disabled (DVD)
- ☐ Geriatric (GER)
- ☐ Pregnant Women (PGW)
- ☐ Hearing Impaired (HIM)
- ☐ Blind/Visually Impaired (BLD)
- ☐ Homeless (HLS)
- ☐ Multicultural (MLT)
- ☐ HIV/AIDS (HIV)
- ☐ Dually Diagnosed (DUD)
- ☐ _____

3. SETTING CODES: Please Check The Settings Where You Or The Organization Can Or Will Provide Service.
(If You Or The Organization Has A Facility, Then A Certificate of Occupancy Must Be Included and Attached.)

- ☐ Addiction Treatment Facility (ADF)
- ☐ Ambulatory Care/Surg Center (AMB)
- ☐ Child Development Center (CDC)
- ☐ Comm Day Program (CDP)
- ☐ Comm Health Center (CHC)
- ☐ Comm Residential Facility (CRF)
- ☐ Crisis Center (CRC)
- ☐ Foster Care Home (FCH)
- ☐ Detention Facility–Youth (DFY)
- ☐ Detention Facility –Adult (DFA)
- ☐ Dialysis Center (DIA)
- ☐ Group Home –Youth (YGH)
- ☐ Group Home-MR (MGH)
- ☐ Homeless Shelter (HOS)
- ☐ In the Field (FLD)
- ☐ Inpatient-Pychiatric (INP)
- ☐ Inpatient-Medical (INM)
- ☐ Intermed Care Center-MR (IMR)
- ☐ Laboratory (LAB)
- ☐ Nursing Care Facility (NCF)
- ☐ Outpatient Clinic (OTC)
- ☐ Private Home (PRH)
- ☐ Provider's Office or Facility (POF)
- ☐ School (SCH)
- ☐ _____

4. SPECIFIC SERVICE CATEGORIES: Please Check the Specific Service Categories That Apply To You or The Organization in which you are qualified, including licenses, or certified, to provide services:

- ☐ Addiction Treatment Services (ADT)
- ☐ Allergy (ALG)
- ☐ Addiction Treatment Services (ADT)
- ☐ Assessment/Diagnosis (ASS)
- ☐ Audiology (AUD)
- ☐ Assessment Diagnosis (ASD)
- ☐ Birthing Services (BIR)
- ☐ Case Management-Family Services (CMF)
- ☐ Case Management-Medical (CMM)
- ☐ Case Management-Social (CMS)
- ☐ Child Care Services (DAY)
- ☐ Chore Services (CHR)
- ☐ Consulting (CON)
- ☐ Counseling Services (CSL)
- ☐ Crisis Intervention Services (CRI)
- ☐ Day Treatment Services (Habilitation) (DTR)
- ☐ Dental Services (DEN)
- ☐ Dialysis Services (DIA)
- ☐ Early Childhood Intervention (ECI)
- ☐ EPSDT Screening (EPS)
- ☐ Family Services (FAM)
- ☐ Homemaker Services (HOM)
- ☐ Dental Hygienist (DHY)
- ☐ Laboratory Screening Services (LAB)
- ☐ Mental Health (MEN)
- ☐ Midwiifery (MID)
- ☐ Music Therapy (MTH)
- ☐ Neurology (NEU)
- ☐ Nutrition and Dietary (NUT)
- ☐ Occupational Therapy (OTH)
- ☐ Optometry (OPT)
- ☐ Pediatric (PED)
- ☐ Personal Care Services (PCS)
- ☐ Physical Therapy (PTH)
- ☐ Podiatry (POD)
- ☐ Pre-Natal Services (PNA)
- ☐ Psychological Services (PSC)
- ☐ Pyschiatric (PSY)
- ☐ Recreation Therapy (RTH)
- ☐ Respiratory Care Services (RES)
- ☐ Respite Care (RSC)
- ☐ Supported Employment Services (SES)
- ☐ Social Worker Services (SWS)
- ☐ Speech Therapy (STH)
- ☐ Transportation Services (TRS)
- ☐ Visiting Nurse (home) (VIS)
- ☐ Vocational Rehabilitation (VOC)
- ☐ _____

5. LICENSURE AND CERTIFICATION CATEGORIES: Please Check All of the Licensure and Certification categories that Apply to You or the Organization in which you are qualified, And Are Licensed Or Certified To Provide Services:

- ☐ Acupuncture Therapist (ACC)
- ☐ Advanced Practice Registered Nurse (ARN)
- ☐ Architect (ARC)
- ☐ Audiologist (AUD)
- ☐ Certificate of Occupancy (COO)
- ☐ Child Development (CHD)
- ☐ Dental Hygienist (DHY)
- ☐ Dentist (DEN)
- ☐ Chiropractor (CHP)
- ☐ Foster Care Provider (FOS)
- ☐ Funeral Directors (FUN)
- ☐ Gynecology (GYN)
- ☐ Massage Therapy (MAS)
- ☐ Naturopathy (NAT)
- ☐ Nurse-Anesthetist (RNA)
- ☐ Nurse-Midwife (RNM)
- ☐ Nurse Practitioner (RNP)
- ☐ Nutritionist & Dietician (NUT)
- ☐ Obstetrician (OBS)
- ☐ Occupational Therapist (OTH)
- ☐ Optometrist (OPT)
- ☐ Opthomology (OPG)
- ☐ Pharmacist (PHM)
- ☐ Physical Therapist (PTH)
- ☐ Physician (DOC)
- ☐ Physician Assistant (PAS)
- ☐ Podiatrist (POD)
- ☐ Practical Nursing (LPN)
- ☐ Professional Counseling (PRO)
- ☐ Psychologist (PSC)
- ☐ Pyschiatrist (PSY)
- ☐ Registered Nurse (RNN)
- ☐ Respiratory Care (RES)
- ☐ Social Worker-Clinical (SWC)
- ☐ Social Worker (SWS)
- ☐ _____

6. LANGUAGE SKILLS: Please Check All that Apply for Your Or The Organization's Language Skills:

- ☐ English (ENG)
- ☐ Spanish (SPN)
- ☐ International/Universal Sign (SGN)
- ☐ Italian (ITL)
- ☐ French (FRN)
- ☐ Haitian Creole (CRE)
- ☐ Vietnamese (VTN)
- ☐ Korean (KOR)
- ☐ Chinese–Cantonese (CCA)
- ☐ Chinese-Mandarin (CMA)
- ☐ Ethiopian (Amharic) (AMH)
- ☐ _____

SECTION VII – PERSONNEL CRITICAL TO ORGANIZATION PERFORMANCE

1. Please list All of the Personnel In your Organization Who Are Critical To organization Performance. Please List Officers, Clinical Directors, Medical Directors, Service Supervisors, and Sub-Contractors Essential to the Performance of Services in this Qualifications Record and Attach Resumes Coded to this Section. Attach Any Copies of Licenses, Certifications, or Credentials Where Applicable.:

	Name	*Title/Position*	*Affiliation*	*Telephone*	*Fax*	*E-Mail*
A						
B						
C						
D						

.

SECTION VIII – REMARKS SECTION

1. *Please use this section to respond to or to continue to response to any previous question, or request for information. In addition, please feel free to use this section to provide additional information vital to determining your or the organizations qualifications to enter into a Human Care Service Agreement with the District of Columbia*

SECTION IX – CERTIFICATIONS AND INCORPORATIONS BY REFERENCE

1. DRUG-FREE WORKPLACE CERTIFICATION: *Please provide Certification That You Or The Organization Does Or Will Operate In A Drug-Free Manner.*

I/We, _____ of _____

Hereby give, affirm and provide certification that I/We have received and have read the requirements on having and maintaining a Drug-Free Workplace in the District of Columbia, agree to be bound by those requirements and the remedies stated in the requirements, and further certify that I/We realize that making a false, fictitious, or fraudulent certification may render the maker subject to prosecution under Title 18, United States Code, Section 1001.

Name (Please Print)	*Title*	*Signature*	*Date*

(May be signed on behalf of individual or organization.)

2. **STANDARD CONTRACT PROVISIONS FOR USE WITH DISTRICT OF COLUMBIA SUPPLY AND SERVICES CONTRACTS:** ***Please provide Certification That You Or The Organization Agree To Be Bound By the Standard Contract Provisions of the District of Columbia.***

I/We, _____ of _____

Hereby give, affirm and provide certification that I/we have received and have read the Standard Contract Provisions For Use With District of Columbia Government and Supply Contracts ("Standard Contract Provisions"), dated November 2004, and agree to be bound by all of the provisions, including The requirements of the Occupational Safety and Health Act of 1970 (as amended), the Service Contract Act of 1965 (41 U.S.C. 351-358), the Buy America Act (41 U.S.C.), and the Non-Discrimination provisions. Further, I/We agree and understand that the Standard Contract Provisions shall be Incorporated by reference into any contract or agreement that shall be signed between Me, or My Organization, and the District of Columbia.

Name (Please Print)	*Title*	*Signature*	*Date*

3. **INFORMATION CONSENT:** ***Please Provide Certification That You Or The Organization Provide Consent To The District To Obtain Additional Information As Needed.***

I/We, _____ of _____

Hereby give, provide and express my consent for representatives of the Office of Contracting and Procurement, Government of the District of Columbia, to obtain any information from any professional organization, business entity, individual, government agency, or academic institution concerning the Professional license status or certification referenced in this document. This material shall be held, maintained and updated by the Office of Contracting and Procurement. I further understand that the Office of Contracting and Procurement will use this information solely for internal purposes pertaining to the evaluation of the qualifications of individuals and organizations to provide human care services, as appropriate, in the District of Columbia.

Name (Please Print)	*Title*	*Signature*	*Date*

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE CHIEF FINANCIAL OFFICER
OFFICE OF TAX AND REVENUE

TAX CERTIFICATION AFFIDAVIT

THIS AFFIDAVIT IS TO BE COMPLETED ONLY BY THOSE WHO ARE REGISTERED TO CONDUCT BUSINESS IN THE DISTRICT OF COLUMBIA.

Date: _____

Name of Organization/Entity: _____

Address: _____

Business Telephone No.: _____

Principal Officer:

Name: _____ Title:_____

Soc. Sec. No.:_____

Federal Identification No.: _____

Contract No.: _____

Unemployment Insurance Account No.:_____

I hereby certify that:

1. I have complied with the applicable tax filing and licensing requirements of the District of Columbia.
2. The following information is true and correct concerning tax compliance for the following taxes for the past five (5) years:

		Current	Not Current	Not Applicable
District:	Sales and Use	( )	( )	( )
	Employer Withholding	( )	( )	( )
	Ball Park Fee	( )	( )	( )
	Corporation Franchise	( )	( )	( )
	Unincorporated Franchise	( )	( )	( )
	Personal Property	( )	( )	( )
	Real Property	( )	( )	( )
	Individual Income	( )	( )	( )

The Office of Tax and Revenue is hereby authorized to verify the above information with the appropriate government authorities. The penalty for making false statements is a fine not to exceed $5,000.00, imprisonment for not more than 180 days, or both, as prescribed by D.C. Official Code § 47-4106.

This affidavit must be notarized and becomes void if not submitted within 90 days of the date notarized.

_____ _____

Signature of Authorizing Agent Title

_____
Print Name

Notary: DISTRICT OF COLUMBIA, ss:

Subscribed and sworn before me this _____ day of _____Month and Year

Notary Public: _____

My Commission Expires:_____