ATTACHMENT 1

REVISED EXHIBIT 1
PROPOSER'S ORGANIZATION QUESTIONNAIRE/AFFIDAVIT

MENTAL HEALTH SERVICES IN SPA 6 FOR RWP CLIENTS RFP

APPENDIX D, REQUIRED FORMS

REVISED EXHIBIT 1

PROPOSER'S ORGANIZATION QUESTIONNAIRE/AFFIDAVIT

Please complete, date and sign this form and place it in your proposal's Section A.1. The person signing the form must be authorized to sign on behalf of the Proposer and to bind the applicant in a Contract.

1. If your firm is a corporation or limited liability company (LLC), state its legal name (as found in your Articles of Incorporation) and State of incorporation:

   _____ _____ _____
   Name State Year Inc.

2. If your firm is a limited partnership or a sole proprietorship, state the name of the proprietor or managing partner:

   _____

3. If your firm is doing business under one or more DBA's, please list all DBA's and the County(s) of registration:

Name	County of Registration	Year became DBA
_____	_____	_____
_____	_____	_____

4. Is your firm wholly or majority owned by, or a subsidiary of, another firm? ____ If yes,

   Name of parent firm: _____

   State of incorporation or registration of parent firm:_____

5. Please list any other names your firm has done business as within the last five (5) years.

Name	Year of Name Change
_____	_____
_____	_____

6. Indicate if your firm is involved in any pending acquisition/merger, including the associated company name. If not applicable, so indicate below.

   _____

   _____

Proposer acknowledges and certifies that it meets and will comply with the Minimum Mandatory Qualifications as stated in Paragraph 3.0, of this Request for Proposal, as listed below. **All requirements must be met on the day that proposals are due.**

Check the appropriate boxes:

3.1 Experience

☐ Yes ☐ No 3.1.1 Proposer must have a minimum of three (3) years of experience in the last five (5) years providing mental health services (psychology and/or psychiatry) for a minimum of 50 unique clients served, per year of experience;

And

☐ Yes ☐ No 3.1.2 Proposer must have a minimum of one (1) year of experience in the last three (3) years providing mental health services to persons living with HIV/AIDS (PLWHA).

3.2 Licensed Mental Health Practitioners

☐ Yes ☐ No 3.2.1 Proposer must have a **minimum** of one (1) licensed mental health clinician (e.g. Clinical Psychologist, Clinical Social Worker, Marriage and Family Therapist, Mental Health Counselor, etc.) who is on staff and responsible for overseeing proposed mental health services funded by DHSP;

And

☐ Yes ☐ No 3.2.2 Proposer must have a **minimum** of one (1) licensed Psychiatrist on staff who is responsible for the furnishing or ordering of any drugs or devices, as necessary.

3.3 Medi-Cal Certification and National Provider Identification

☐ Yes ☐ No Proposer must provide evidence of the following: 1) Proposer's current Medi-Cal Certification; and 2) Proposer's National Provider Identification (NPI) number. (*Note:* A copy of Proposer's Medi-Cal Certification should be attached and NPI number should be noted in Proposer's completed REVISED Appendix L, Proposer's Minimum Mandatory Qualifications Form).

3.4 Service Delivery Site

☐ Yes ☐ No Proposer must have a service delivery site located within SPA 6 as described in RFP sub-paragraph 1.2.2, Location of Services(s). *(**Note:** No consideration will be given to proposals for services outside of SPA 6.)*

Proposer further acknowledges that if any false, misleading, incomplete, or deceptively unresponsive statements in connection with this proposal are made, the proposal may be rejected. The evaluation and determination in this area shall be at the Director's sole judgment and his/her judgment shall be final.

Proposer's Name:

_____

Address:

_____

_____

E-mail address:_____ Telephone number:_____

Fax number: _____

On behalf of _____ (Proposer's name), I _____ (Name of Proposer's authorized representative), certify that the information contained in this Proposer's Organization Questionnaire/Affidavit is true and correct to the best of my information and belief.

_____	_____
Signature	Internal Revenue Service Employer Identification Number
_____	_____
Title	California Business License Number
_____	_____
Date	County WebVen Number