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| **Qualification Requirements. I certify that:**  | **Confirmed by DHS**  |
| 1 | [ ]  Yes[ ]  N/A | My facility is qualified to claim nonprofit status. **[Check “N/A” if not a nonprofit organization.]**  | [ ]  Yes [ ]  No |
| 2 | [ ]  Yes | My facility has a past record of sound business integrity and a history of being responsive to past contractual obligations.  | [ ]  Yes [ ]  No |
| 3 | [ ]  Yes | My facility is financially stable and solvent and has adequate cash reserves to meet all financial obligations while awaiting reimbursement from the State. | [ ]  Yes [ ]  No |
| 4 | [ ]  Yes | My facility will fulfill all responsibilities and deliverables outlined in the RFA Exhibit A: Scope of Work. | [ ]  Yes [ ]  No |
| 5 | [ ]  Yes | My facility has read and is willing to comply with all terms, conditions and contract exhibits addressed in the RFA. | [ ]  Yes [ ]  No |
| 6 | [ ]  Yes | My facility will contain its indirect costs at a percentage rate not to exceed twenty-two percent (22%) of personnel costs including benefits. | [ ]  Yes [ ]  No |
| 7 | [ ]  Yes | My facility is a CCS approved Regional NICU and will maintain approval status for the duration of the Contract. | [ ]  Yes [ ]  No |
| 8 | [ ]  Yes | My facility is a California Perinatal Quality Care Collaborative (CPQCC) partner and shall maintain that partnership for the duration of the Contract. | [ ]  Yes [ ]  No |
| 9 | [ ]  Yes | My facility will report data and participate in the program evaluation activities, as specified by the CMS Branch. | [ ]  Yes [ ]  No |
| 10 | [ ]  Yes | My facility assures that the HRIF Coordinator for this project will be a CCS paneled provider and licensed as a Registered Nurse, Medical Social Worker, Occupational Therapist, Physical Therapist, or a Psychologist. | [ ]  Yes [ ]  No |
| 11 | [ ]  Yes | My facility assures that the HRIF Coordinator for this project will have at least two (2) years experience in a Regional or Community NICU; one (1) year of which must be in an HRIF program, or as a discharge planner for an NICU and/or in a community-based Medically Vulnerable Infant Program. This experience may have been at a comparable out-of-state facility. | [ ]  Yes [ ]  No |
| 12 | [ ]  Yes | My facility assures that the HRIF Coordinator will be paid through the contract and shall not use the HRIF fee-for-service billing codes to reimburse any services the HRIF Coordinator provides under this Contract. (For a list of these billing codes, see Exhibit L: CCS Program Service Code Grouping 06 – HRIF Program.) | [ ]  Yes [ ]  No |

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| 13 | **My facility has submitted the Attachments to the RFA in the following order:** |  |
| A | [ ]  Yes | Attachment 1: Application Cover Page  | [ ]  Yes [ ]  No |
| B | [ ]  Yes | Attachment 2: Certification of Agreement Checklist | [ ]  Yes [ ]  No |
| C | [ ]  Yes | Attachment 3: Payee Data Record (STD 208)  | [ ]  Yes [ ]  No |
| D | [ ]  Yes | Attachment 4: Budget Detail Worksheets (Attachments B1, B2, and B3)  | [ ]  Yes [ ]  No |
| E | [ ]  Yes | Attachment 5: List of CCS Approved NICUs for which the Applicant Provides HRIF Services | [ ]  Yes [ ]  No |
| F | [ ]  Yes | Attachment 6: HRIF Coordinator’s Curriculum Vitae/Resume | [ ]  Yes [ ]  No |
| G | [ ]  Yes | Attachment 7: Contractor Certification Clauses | [ ]  Yes [ ]  No |
| H | [ ]  Yes | Attachment 8: Contract Information Form | [ ]  Yes [ ]  No |
| **Certification by Applicant’s Authorized Agent:** |
| Name of Firm (Printed): |
| By: ***(Authorized Signature)***: |
| Printed Name and Title of Person Signing: |
| Email Address of Person Signing: | Telephone Number of Person Signing: |
| Date Executed: | Executed in the County of: |