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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: | |