PROPOSAL APPLICATION PACKET

Wyoming County Department of Mental Health

REQUEST FOR PROPOSALS
TO
OPERATE a PART 822 OUTPATIENT CHEMICAL DEPENDENCE TREATMENT PROGRAM and RELATED SERVICES

ISSUED Feb 8, 2010

APPLICATION DUE DATE Mar 22, 2010

APPLICATION CHECKLIST

The Checklist below indicates the items required to be submitted in response to this Request for Proposals. Please complete this Checklist marking the items included in your submission with an "X" and submit the Checklist along with the completed application.

Applicant Organization Name:____

______Application Cover Sheet

____ Narrative Part I Agency/Organization Narrative

- **____ Attachment A: List of agency Board of Directors**
- **____ Attachment B: Board resolution authorizing submission of proposal**
- **____ Attachment C: Program Listing Form (State certified/licensed programs, government and other grants)**
- **____ Attachment D: Table of organization**
- **____ Attachment E: Copies of all OASAS treatment services Program Scorecards**
- **____ Attachment F: Copies of two (2) most recent audited CFRs**
- **____ Attachment G: Copies of most recent audited Financial Statement and Federal 990 form for tax-exempt organizations**

______Narrative Part II: Program Narrative

- **____ Attachment H: Implementation Time Line Form**
- **____ Attachment I: Site Information/Capital Request Form**
- **_____ Attachment J: List of contracts with Local Governmental Unit and any other informal written agreements**

Budget Part III

______Budget Form: Wyoming County-supplied excel spreadsheet

______Budget Justification Narrative

APPLICATION COVER SHEET

AGENCY IDENTIFYING AND CONTACT INFORMATION

Please complete all information on this form and include an original signature in your submission.

Name of Organization:____

Address: ____

____

Contact Person Name: ____

Contact Person Title: ____

Contact Person Telephone #:____

Contact Person E-mail Address: ____

Signature of Person Authorized to Submit This Proposal:

____

Name:__________________________________

Title:__________________________________

Date:__________________________________

Attachment C

PROGRAM LISTING FORM

Please complete the table below listing all programs that your agency operates that currently hold a license or certification from ANY New York State Department or Office.

Program Type	NYS Office Certifying	Operating Certificate #	Expiration Date	Duration of Certification
Example: Outpatient	*OMH*	*OC XXXX*	*12/31/09*	*3 years*

Briefly list federal and other grants and dates of expiration:

Attachment H

IMPLEMENTATION TIME LINE FORM

Please complete the Implementation Time Line Form. Identify the key actions or tasks that are necessary to accomplish or transition the operation of the service to your organization. For completion date, show the month in which the action or task is to be completed starting from notification of your project's selection, portrayed as "month 1", "month 2", etc. Be as specific as possible to demonstrate your understanding of the steps involved in developing the service. Add additional rows if necessary.

Implementation Time Line

Key Action/Task	Completion Month

Attachment I: Site Information/Capital Request Form

Corporate Headquarters			Date:
Provider Name (full legal name):			
Street/P.O. Box:	City:	State:	Zip:
Contact Person:		Title:	
Telephone:	E-mail:		
Project Site			
Street/P.O. Box:	City:	State:	Zip:
Service(s) to be Provided at Site:			
1. Project Purpose: (Check all that apply) a) Site Renovation/rehabilitation ____ b) Purchase of Facility ____			
2. Estimated Project Cost: Purchase Cost: ____________ Renovation/rehab. Cost (attach any cost detail available): _____________			
3. Briefly Describe the physical plant and your rationale for selecting this site for the program(s) proposed:			

4. Indicate approximate square footage of space:

5. Briefly describe the proposed scope of work in the project:

6. Site Acquisition:

a) Has a probable site been identified? ____Yes ____No

b) How do you expect to acquire the site? ____Lease ____Purchase ____Other (attach explanation)

c) Have you obtained an option on the site? ____Yes ____No

d) Has an appraisal or fair market rental study of the proposed site been completed? ____*Yes ____No

* This information may be requested at a future time.

9. Has a feasibility study has been completed for the project? ____*Yes ____No

* This information may be requested at a future time.

10. Planned project financing:

a) Provider funds: $

b) Commercial loans/debt: $

c) Grants (other than OASAS): $

d) OASAS: $

11. Has this financing plan been adopted by the governing authority? ____Yes ____ No

<u>Provider Official</u>

Name:

Title: Date:

New York State Office of Alcoholism and Substance Abuse Services,SCHEDC2009 (Modified WCDMH)

Wyoming County Outpatient Chemical Dependency Treatment Program
Request for Proposals
Budget Worksheet - 2010 Annual Budget

BUDGET INFORMATION: Based upon the available funding as previously indicated within this RFP, please enter the following information to outline your agencies ability to provide services. Annualize all amounts.

UNITS OF SERVICE: (Please refer to the CFR manual for Unit of Service definition)

Annual number of units of service:		Total FTE Direct Care Staff:	0
Annual number of individuals served:		Staff to Client Ratio:	:

Gross cost/U:	
Net cost/UOS:	

Staffing: Please complete each position using CFR position/title descriptions/codes

Staffing position title	Position Code	Annual Salary	Prog Admin or Direct Care	Ann. Hrs. Worked	Standard Work Week	Credential /QHP?
		$ -				

<u>**Expenses:**</u>

Personal Services (from above):	$ -
Fringe Benefits:	$ -
OTPS: Itemize any costs over $5,000:	
Utilities	$ -
Treatment Supplies	$ -
Travel/training	$ -
Office supplies	$ -

FB Ratio to PS:	

	$ -	
	$ -	
	$ -	
All Other <$,5000 each	$ -	
Total OTPS:	$ -	
Property:	$ -	
Equip.: Itemize any costs >$3,000	$ -	
Computer equipment	$ -	
Telephone system	$ -	
Furnishings	$ -	
	$ -	
Total Equipment:	$ -	
Agency Admin & Overhead:	$ -	A&OH Percentage:
Total Expense:	$ -	See Program Financing section of RFP for OASAS approved expense level.

<u>Budgeted Revenue:</u>

Patient fees/Self Pay	$ -	Please attach planned sliding fee scale
Third Party Revenues (specify:)	$ -	
	$ -	
	$ -	
	$ -	
Other 3rd party (cumulative):	$ -	
Total Third Party	$ -	
Medicaid	$ -	
Medicare	$ -	
Other (specify):	$ -	
	$ -	
	$ -	
Total Other:	$ -	
Total Revenue:	$ -	See Program Financing section of RFP for OASAS approved revenue level.
Net Deficit	$ -	
Net Deficit Funding	$ 300,104.00	Total State Aid & Local Share
Non-Funded	$ -	