Attachment B

HARBOR REGIONAL CENTER
APPLICANT INFORMATION

Applicant/Agency Name: ____

Address: ____

Applying for: ____

☐ Non-Profit Corporation ☐ For-Profit Corporation ☐ Partnership

☐ Other (please specify) ____

Contact Person's Name and Job Title:____

Work Phone/Cell Phone:____

Email Address:____

NAME OF PARENT CORPORATION (IF APPLICABLE)
*(must identify, if any, excluded individuadditional sheet)

Provide current or previous services implemented by the applicant/agency that provide evidence of experience related to your proposal. Include the service name, the dates that services started (and ended if not currently being provided), and a one sentence description of the type/purpose of the indicated service:

Attachment B

HARBOR REGIONAL CENTER
APPLICANT INFORMATION

List three references, including job title and agency affiliation that can be contacted in regards to the applicant's experience, qualifications and ability to implement this proposal:

1.____

2.____

3.____

____

AUTHOR OF PROPOSAL

Knowingly and willfully failing to fully and accurately disclose the information requested may result in rejection of proposal.

By signing, you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform the Regional Center, in writing, within 30 days of any changes or if additional information becomes available.

____

SIGNATURE OF PERSON AUTHORIZED TO BIND ORGANIZATION

____

DATE

Attachment C

HARBOR REGIONAL CENTER
STATEMENT OF OBLIGATION

(Please attach additional pages if needed)

1. The applicant is presently providing services to individuals with developmental disabilities:
   ☐ Yes ☐ No
   If **YES**, please indicate name, location, type, and capacity of services:

2. The applicant is presently providing to individuals other than those with intellectual and developmental disabilities:
   ☐ Yes ☐ No
   If **YES**, please indicate name, location, type, and capacity of services:

3. Is the applicant currently receiving grant money/funding from any other sources to develop services for individuals with intellectual and developmental disabilities?
   ☐ Yes ☐ No
   If **YES**, indicate funding source and scope of grant project.

4. The applicant is planning to expand existing services (through a Letter of Intent and with or without grant funds) from a source other than Harbor Regional Center during Fiscal Year 2023-2024:
   ☐ Yes ☐ No
   If **YES**, please explain in detail.

5. Describe other professional/business obligations. Include name, location, type, and capacity of service/obligation. Do not include services you expect to provide if awarded this grant.

6. Has the applicant or any member of the applicant's organization received a citation from a regional center or state licensing agency <u>within the last two (2) years?</u>
   ☐ Yes ☐ No
   If **YES**, please explain in detail.

7. Has the applicant or a member of the applicant's organization or staff <u>ever received</u> a citation from any agency for abuse?
   ☐ Yes ☐ No
   If **YES**, please explain in detail.

Attachment D

HARBOR REGIONAL CENTER
FINANCIAL INFORMATION

Applicant/Agency Name: ____

Project: ____

Line of Credit Available? □ Yes □ No Amount: ____________________

Please provide the most recent audited financial statement (preferred) or a current financial statement that includes all of the information listed below:

FINANCIAL STATUS AS OF: ____________________, 20________

ASSETS:

Cash on hand and in commercial and savings account	
Notes and Receivables	
Inventory, Equipment, Furniture and Furnishings	
Real Estate (Market Value)	
Other Assets	

FIXED ASSETS:

Buildings and/or Structures	
Real Estate Holdings	
Long Term Investments	
TOTAL ASSETS AND FIXED ASSETS	

LIABILITIES:

Accounts and Notes Payable (Balance Due)	
Salaries and Wages Payable	
Real Estate Loans or Mortgages (Balance Due)	
Payroll and Real Estate Taxes Payable	
Potential Judgements and Liens	
TOTAL LIABILITIES	

NET ASSETS	

Reference who may be contacted regarding applicant's/agency's qualifications and experience in financial management:

Name/Title: ____

Agency/Company: ____

Address: ____

Phone: ____________________ Cell Phone: ____________________

Budget/Financial Information Submitted by:

Name______________________________ Date____________________

Attachment E

HARBOR REGIONAL CENTER
PROPOSED BUDGET FOR START-UP COSTS

ITEM	PROJECTED COST
Rehab of site to meet HRC Specifications, city building codes and ADA requirements (for non-HDO projects)	
Site Lease	
Office Supplies	
Specialized Household/Program Equipment	
Communication Systems	
Travel Expenses (for cross training or those that are outside of the HRC catchment area referred to program)	
Staff Recruitment Costs (e.g., advertising, finger printing, certifications, etc.)	
Staff Training	
Consultant Fees	
Licensing Fees	
Program/Household Supplies	
Furniture	
Kitchen Equipment/Appliances	
Food (for start-up only – not ongoing)	
Utilities (trash, gas, water, electricity, telephone)	
Insurance meeting HRC requirements (vehicle, liability worker's comp, etc.)	
Program Supplies/Recreational & Adaptive Equipment	
Vehicle Lease	
Vehicle Maintenance (gasoline, service, repairs, etc.)	
Fire and Safety Costs (sprinklers, alarms, etc.)	
Other General Expenses (please specify)	
Administrative Overhead (up to 15% of direct costs)	
Applicant's proposed contribution	
TOTAL PROJECTED START-UP COSTS	

In addition to the projected cost for each item, be sure to include a detailed breakdown/description of how each line item was constructed. The RFP amount should not cover the entire cost of project. P**lease include the financial investment you will bring to this project.**

Attachment F

HARBOR REGIONAL CENTER
SAMPLE MONTHLY BUDGET FOR ONGOING COSTS

The budget must demonstrate the financial aspects of the proposal.
The projected costs cannot exceed 15% administrative overhead.

ITEM	PROJECTED COST
Staff Wages (DSP, Clinical staff, etc.)	
Staff Benefits (specify details)	
Administrator Salary	
Office Equipment	
Communication Systems	
Program Consultants (RN, Respiratory, Therapist, PT, SLP, etc.)	
Travel Expenses (for cross training or for meeting individuals that live out of HRC catchment area)	
Staff Recruitment Costs (e.g., advertising, finger printing, sign-on)	
Monthly Lease Amount	
Licensing Fees	
Furniture	
Program Equipment	
Utilities (trash, gas, water, electricity, telephone)	
Insurance meeting HRC's requirements (vehicle, fire, household, worker's comp, liability to include abuse /molestation, etc.)	
Program Supplies/Recreational & Adaptive Equipment	
Vehicle Lease	
Vehicle Maintenance (gasoline, repairs, regular checks, etc.)	
Facility Maintenance	
Ongoing Training Expenses	
Payroll/Bookkeeping	
Other General Expenses (Specify)	
TOTAL PROJECTED MONTHLY ONGOING COSTS	
PROPOSED REIMBURSEMENT RATE Per Day or	
PROPOSED REIMBURSEMENT RATE Per Hour (4 hour day)	

In addition to the projected cost for each item, be sure to include a detailed breakdown/description of how each line item was constructed. (If necessary, adjust outline to your program needs, but address requested line item.)

State of California–Health and Human Services Agency	Department of Developmental Services
DS 1891 (7/2011)

APPLICANT/VENDOR DISCLOSURE STATEMENT

GENERAL INSTRUCTIONS

Every applicant or vendor must complete and submit a current Applicant/Vendor Disclosure Statement, DS 1891 (disclosure statement) as part of a complete application packet for vendorization or upon request of the vendoring regional center. The following instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. See 42 CFR 455.101 for additional definitions.

Overall Authority: Code of Federal Regulations (CFR), Title 42, Part 455; California Code of Regulations, Title 17, Section 54311. Welfare and Institutions Code, Section 4648.12.

Important:

- **IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.**
- ***Parents and consumers of Vouchers, Participant-Directed Services, or Purchase Reimbursements:*** Complete Part 1 on page 2 and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date.
- Failure to disclose complete and accurate information will result in a denial of enrollment and/or may be cause for termination of vendorization.
- Read ***ALL*** instructions when completing the disclosure statement.
- Type or print clearly in ink.
- If applicant or vendor must make corrections, please line through, date, and initial in ink. Do not use correction fluid.
- Answer all questions as of the current date.
- If additional space is needed, attach a sheet referencing the part and question being completed.
- Return this completed statement with the complete application package to the regional center to which you are applying.

Part 1: Identifying Information

A. Specify name of the applicant or vendor, agency, facility or organization, vendor number and service code, business address, and telephone number of applicant or vendor submitting the vendor application.
B. Specify in what capacity the applicant or vendor is doing business. For example: The name of the corporation under which they are doing business. This name must match the license name, if applicable.
C. List the National Provider Identifier, of the applicant or vendor, if any.
D. List the Social Security Number, Date of Birth, and/or the Federal Employer Identification Number (EIN) of the applicant or vendor, if any. Enter Vendor's nine-digit EIN assigned by the IRS in the following format: XX-XXXXXXX.

- An EIN is used to identify the accounts of employers and certain others who have no employees.
- For more information about an EIN, please check http://www.irs.gov for "Employer Identification Numbers" or "EIN". Whenever this Disclosure Statement requests an EIN about an individual or entity, it has the same meaning.

E. Check the entity type that best describes the structure of your organization.

Part 2: Ownership and Control Interests. Use the following definitions to identify the individuals you should enter in A, B and C of this section. See 42 CFR 455.101 for additional definitions.

- "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in the applicant or vendor. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or vendor;
- "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, agency or business entity;
- "Ownership Interest" means the possession of equity in the capital, the stock, or the profits of the applicant or vendor.
- "Person with an Ownership or Control Interest" means a person or corporation that:
  A) Has an ownership interest totaling 5 percent or more in an applicant or vendor;
  B) Has an indirect ownership interest equal to 5 percent or more of an applicant or vendor;
  C) Has a combination of direct or indirect ownership interests equal to 5 percent or more in an applicant or vendor;
  D) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or vendor if that interest equals at least 5 percent of the value of the property or assets of the applicant or vendor;
  E) Is an officer or director of an applicant or vendor that is organized as a corporation; or
  F) Is a partner in an applicant or vendor that is organized as a partnership.
- "Significant Business Transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of an applicant or vendor's total operating expenses.

- "Subcontractor" means an individual, agency, or organization to which an applicant or vendor has contracted or delegated some of the management functions or responsibilities of providing services.
- "Wholly Owned Supplier" means a supplier whose total ownership interest is held by an applicant or vendor or by a person, persons, or other entity with an ownership or control interest in an applicant or vendor.

Part 3: Excluded Individuals or Entities. *(See page 3. Must be disclosed if applicable.)*

"Excluded Individuals or Entities" means those individuals and entities that have been placed on either the U.S. Department of Health and Human Services Office of Inspectors' General (OIG) List of Excluded Individuals/Entities or the Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible Provider List of persons, or individuals and entities that have been convicted of a criminal offense related to involvement in any program under Medicare, Medicaid or the Title XX services program, or those individuals and entities that meet the criteria included in Title 17, Section 54311(a)(6).

Title 17, California Code of Regulations, Section 54311(a)(6)
(Criteria for Excluded Individuals or Entities)

The name, title and address of any person(s) who, as applicant or vendor, or who has ownership or control interest in the applicant or vendor, or is an agent, director, members of the board of directors, officer, or managing employee of the applicant or vendor, has within the previous ten years:
(A) Been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of an elder or dependent adult or child, or in any connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse; or
(B) Been found liable any civil proceeding for fraud or abuse involving any government program; or
(C) Entered into a settlement in lieu of conviction involving fraud or abuse in any government program.

PLEASE FILL OUT

Part 1. Applicant/Vendor Information

A. Name of applicant or vendor, entity, agency, facility, or organization as reported to IRS:

___

Vendor Number and Service Code:

___

Business Address:

___

Telephone number (with area code):

___

B. Name registered with California Secretary of State, if any:

___

C. National Provider Identifier (NPI), if any:

___

D. Social Security Number (SSN), Date of Birth (DOB), and/or Federal Employer Identification Number (EIN), if any:

___

E. Check the entity type that best describes the structure of the applicant or vendor individual, business entity, agency, facility or organization: Check **only one** box:

□ **Parent or Consumer *for Vouchers, Participant-Directed Services, or Purchase Reimbursements*** (Complete Part 1 above and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date).
□ **Sole Proprietor (Unincorporated)**
□ **General Partnership** □ **Limited Partnership** □ **Limited Liability Partnership**
□ **Limited Liability Company: State of formation:** __________
□ **Governmental**
□ **Corporation: Corporate number:** __________ **State incorporated:** __________
□ **Nonprofit – Check One:** □ **Unincorporated Association** □ **Religious/Charitable**
□ **Corporation** □ **Other (specify):** ___________

Part 2. Ownership, indirect ownership, and managing employee interests (If not applicable, please indicate.)

A. List the name(s), title(s), address(es), SSNs, and DOBs of individuals for organizations having direct or indirect ownership interests, and/or managing employees in the applicant/vendor (see instructions for definitions). Also list all members of a group practice. Attach additional pages as necessary to list all officers, owners, management and ownership individuals and entities.

Name	Title	Address	SSN	DOB

B. List those persons named in **'A'** above or **'Part 4. A'** below, that are related to each other as spouse, parent, child, or sibling.

Name	Relationship	Address

C. List the name, address, vendor number and service code, SSN, NPI and/or EIN of any other applicant or vendor in which a person with an ownership or controlling interest in the applicant or vendor also has an ownership or control interest of at least 5 percent or more. For example: Are any owners of the applicant or vendor also owners of Medicare or Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.)

Name	Address	Vendor Number and Service Code	SSN, NPI and/or EIN

Part 3. Excluded Individuals or Entities (If not applicable, please indicate.)
List the name, title, and address of any person, as applicant or vendor, or entity with an ownership or control interest, any agent, director, officer, or managing employee of the applicant or vendor who is an excluded individual or entity, as defined on page 2.

Name	Title	Address

Part 4. Subcontractor (If not applicable, please indicate.)

A. List the name, title, address, SSN, NPI and/or EIN of each person or entity with an ownership or control interest **in any subcontractor** in which the applicant or vendor has direct or indirect ownership of 5 percent or more. State percentage.

Name	Title	Address	Percentage	SSN, NPI and/or EIN

B. List the name, title, address, SSN, NPI and/or EIN of each **subcontractor or wholly owned supplier** in which the applicant or vendor has had any significant business transactions within 5 years of the application or request.

Name	Title	Address	SSN, NPI, and/or EIN

APPLICANT/VENDOR SIGNATURE

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become vendored, or if the service provider already is vendored, a termination of its vendorization.

By signing this disclosure statement, you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform the vendoring Regional Center, in writing, within 30 days of any changes or if additional information becomes available.

Name of Applicant/Vendor or Authorized Representative	Title
Signature	**Date**

Recordkeeping and Access to Records

Subject to the provisions of Title 17, California Code of Regulations, Section 54311 and Code of Federal Regulations, Title 42, Part 455.105, an applicant or vendored provider agrees to provide access for the review of any and all ownership disclosure information and/or documentation upon written request by the vendoring regional center, the Department of Developmental Services, the State Medicaid Agency, Department of Health Care Services, any State survey team, the Secretary of the United States Department of Health and Human Services, or any duly authorized representatives of the above named entities.

Privacy Statement

All information requested on the application and the disclosure statement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department of Developmental Services pursuant to 26 USC 6041. This information is required by the authority of Welfare and Institutions Code, Section 4648.12 and Title 17, California Code of Regulations, Section 54311. The consequences of not supplying the mandatory information requested are denial of vendorization as a regional center vendor or termination of vendorization. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, or licensing programs in other states.

REQUEST FOR PROPOSALS
CONFLICT OF INTEREST/VENDOR DUPLICATION STATEMENT

Vendor Name: ______________________________

Site Address: ______________________________

Other Location, if any: ______________________________

Phone Number: ______________________________ Email Address: ______________________________

Director and/or Contact Person: ______________________________ Title: ______________________________

Governing Body or Management Organization: ______________________________

According to Section 54314 of California's Title 17 Regulations, the following applicants shall not be eligible for vendorization:

a) Any officer or employee of the State of California;
b) Any individual or entity in which an officer or employee of the State of California has a financial interest, as defined in the Government Code, Section 87103;
c) Employees and board members of any regional center with a conflict of interest pursuant to Title 17, Sections 54500 through 54525;
d) Any individual or entity in which the regional center employee or board member has a relationship that creates a conflict of interest pursuant to Title 17, Sections 54500 through 54525.

1. Have you ever been vendored (i.e., been issued a vendor number) by this or any other Regional Center?
   - ☐ No
   - ☐ Yes, under the name: ______________________________
     Name *Date* *Regional Center*

   Type of service vendored: ______________________________

2. Are you or any members of your immediate family an employee or officer of the following?
   Please check all that apply
   - ☐ State of California: please specify ______________________________
   - ☐ Department of Developmental Services
   - ☐ Regional Center
   - ☐ Regional Center Board of Directors

If you checked any of the above, please list the city of employment, job title, and your relationship:

____

3. Do you feel there would be a conflict of interest in your provision of services to the Regional Center and persons served?
   ☐ Yes ☐ No

____
Applicant's Signature Date