



**DISTRICT OF COLUMBIA DEPARTMENT OF MENTAL HEALTH
 CONTRACTS AND PROCUREMENT ADMINISTRATION
 64 NEW YORK AVENUE, NE 4TH FLOOR, WASHINGTON, DC 20002
 PHONE: (202) 671-3174 * FAX: (202) 671-3395**

March 10, 2009

**REQUEST FOR PROPOSALS AMENDMENT NUMBER ONE (1)
RM-09-RFP-BY4-064-DJC for MULTICULTURAL SERVICES AND SUPPORT**

TO ALL PROSPECTIVE BIDDERS:

The original RFP Submission Due Date of Monday, March 16, 2009 has been extended until Friday, March 20, 2009 at 2:00 P.M.

This Amendment is in two parts.

PART I Questions and Answers generated at the pre-proposal conference by Bidders.

PART II Amends certain sections of the Request for Proposals (RFP).

PART I

Question Number	RFP Section	Question
1.	B.2.1	Do 50 people per month mean 50 people ongoing at any given time or 50 people in a month? If a person only comes one time they will count as one of the 50? Are there a minimum number of patients we would be required to see every month?
DMH RESPONSE: The successful Contractor shall serve up to 50 MHRS Consumers consisting of Children and/or Adults who speak English as a second language and/or who are first or second generation immigrants to the United States needing a Multicultural approach to treatment at any given time. There is no minimum number of consumers that are required to being served monthly. In addition, one Consumer can be served multiple times in any given month.		
Question Number	RFP Section	Question
2.	C.3.3.2 & C.4	Is there a particular payment structure that they will use (i.e. different reimbursement amounts for psychiatrist, therapist, and community support?
DMH RESPONSE: The payment for these services is based on a rate per consumer per month for any Multicultural Services provided to a Consumer. This rate does not vary based on the direct service providers' position title.		

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Question Number	RFP Section	Question
3.	C.6.7	In what format should the budget be submitted? Is there a specific budget format to be utilized or will one be provided?
DMH RESPONSE: A Budget Template is attached to this Amendment.		
Question Number	RFP Section	Question
4.	C.5	What is the credential requirement of the staff providing these services? Are there guidelines about how providers must be credentialed?
DMH RESPONSE: DMH seeks proposals from Vendors who are Certified Provider of MHRS services, to provide Multicultural Services and Supports to Adults and Children and Youth, who speak English as a second language and/or who have specific needs related to their status as a first or second generation immigrants to the United States.		
Question Number	RFP Section	Question
5.	N/A	What is the referral process by which consumers will be identified to receive these services?
DMH RESPONSE: The successful Vendor who is awarded a Contract as a result of this RFP shall establish a process to identify Consumers who need Multicultural Services and Supports.		
Question Number	RFP Section	Question
6.	C.2	Is there a diagnostic criteria for consumers to receive these services? Can multicultural services be the only service a consumer is receiving from the awarded Contractor's Agency?
DMH RESPONSE: The successful Vendor awarded a Contract as a result of this RFP shall provide Multicultural Services and Supports for Adults and Children and Youth enrolled in and receiving Mental Health Services from a MHRS certified provider. Therefore, Consumers for Multicultural Services are also Consumers of the public mental health system, who need cultural and linguistic services, along with support that are not otherwise covered or reimbursable by Medicaid. Multicultural Services cannot be the only service a Consumer is receiving from the awarded contractor's agency.		
Question Number	RFP Section	Question
7.	C.6.5 & C.6.6	What is the evaluation measures mentioned in Section C.6.6?
DMH RESPONSE: Please Refer to Section C – Evaluation On an Annual Basis the Vendor's performance shall be evaluated according to the following out- come		

categories.

- Facilitation of linkages to essential social services
- Provision of translation services for non-English speaking consumers
- Provision of culturally-specific services for consumers
- Education (literacy classes, GED preparation, college, vocational courses, etc.)
- Linkage and follow-up with somatic medical care
- Success in meeting needs identified by Consumer
- Linkages with families when appropriate
- Client and family satisfaction
- Linkage and follow-up with substance abuse treatment
- Timely and accurate submission of required data and reports
- Maximizing Medicaid reimbursement

The actual definitions and performance measures shall be appended to the Contract resulting from this RFP after discussions with the Vendor. Evaluation methodology shall include data review, medical record review and interviews with Consumers and their families. The results of the evaluation shall be reported in an aggregate score which shall be used to improve quality and determine contract compliance.

Question Number	RFP Section	Question
8.	C.3.4.2	Can we bill MHRS services provided to undocumented consumers that cannot otherwise be reimbursed through Medicaid since the consumers are not covered by Medicaid FFS or MCO?

DMH RESPONSE:

Providers can be bill for MHRS services provided to undocumented consumers through their local dollar allocation. This Contract is for non-MHRS reimbursable services. The Enrolled Consumer Per Month Rate shall be used to fund any service or support that is not reimbursable by Medicaid including costs of administration, training and the development of new services for the target population.

Question Number	RFP Section	Question
9.	N/A	Can Medicaid Fee for Service rate structure be used as a guide for the pay schedule for the services in this contract?

DMH RESPONSE:

The DC Department of Mental Health cannot advise a potential contractor of the pricing structure that they should utilize to develop their Price Proposal submission. The decision on pricing structure to be utilized within ones Price Proposal is solely a business decision on the part of the Vendor.

Question Number	RFP Section	Question
10.	C.2	Is this a fee for service or rate by individuals served?

DMH RESPONSE:

The agreed upon Enrolled Consumer Per Month Rate shall be billed for each month a Consumer is enrolled and provided Multicultural Services.

Question Number	RFP Section	Question
11.	N/A	Would any “group therapy” be included in the reimbursable treatment plans?
DMH RESPONSE: Group Therapy is a service that is reimbursable by the current MHRS structure and therefore would not be covered by this Contract.		
Question Number	RFP Section	Question
12.	C.6.6	What exactly are the reporting requirements?
DMH RESPONSE: The Vendor shall be required to submit by the tenth of each month a written report in hard and soft copy that includes all Consumers receiving Multicultural Services and Supports, along with the number of encounters to provide translation, culturally specific services with linkage and support services per Consumer per Month. On a quarterly and annual basis, the Vendor shall report on performance according to the above evaluation measures. DMH may require that the Vendor produce additional reporting on a schedule to be negotiated with the Vendor.		
Question Number	RFP Section	Question
13.	B.2.1	Is the \$1,000.00 minimum per patient, per month?
DMH RESPONSE: The District shall order services or pay at least the minimum dollar value of \$1,000.00 per each Contract Period.		

END OF PART 1

PART II

The above referenced RFP is hereby amended as follows:

- B.4 SCHEDULE B PRICING SHEET has been deleted in its entirety and replaced with the following:**

B.5 SCHEDULE B PRICING SHEET

NAME OF CONTRACTOR: SOLICITATION # RM-09-RFP-BY4-064-DJC					
CLIN	SUPPLIES/SERVICES BASE YEAR	QUANTITY (Enrolled Consumers) 50 (Maximum)	UNIT (Months)	UNIT PRICE Per Month	TOTAL AMOUNT
0001	Multicultural Services and Supports in accordance with the Scope of Work herein. These services include: Facilitating linkages to essential social services.	_____	12	\$ _____	\$ _____
0002	Culturally relevant recreational and social activities.	_____	12	\$ _____	\$ _____
0003	Culturally specific treatment and intervention services	_____	12	\$ _____	\$ _____
0004	Culturally relevant educational and vocational activities	_____	12	\$ _____	\$ _____
0005	Transportation for non-Medicaid services	_____	12	\$ _____	\$ _____
0006	Non-traditional and non-federally funded supports for housing, food and clothing	_____	12	\$ _____	\$ _____
0007	Translation and interpretation services	_____	12	\$ _____	\$ _____
0008	Assistance with Medicaid, Food Stamp, and TANF applications	_____	12	\$ _____	\$ _____
0009	Non-Medicaid reimbursable Case Management activities	_____	12	\$ _____	\$ _____
0010	Providing direct assistance and support to consumers for the purpose of ensuring that they receive culturally and linguistically relevant care from non-mental health providers	_____	12	\$ _____	\$ _____
PRINT NAME OF CONTRACTOR _____					
PRINT NAME OF AUTHORIZED REPRESENTATIVE _____					
SIGNATURE OF AUTHORIZED REPRESENTATIVE _____					
DATE _____					

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B.6 SCHEDULE B PRICING SHEET

NAME OF CONTRACTOR: SOLICITATION # RM-09-RFP-BY4-064-DJC					
CLIN	SUPPLIES/SERVICES OPTION YEAR ONE	QUANTITY (Enrolled Consumers) 50 (Maximum)	UNIT (Months)	UNIT PRICE Per Month	TOTAL AMOUNT
0001	Multicultural Services and Supports in accordance with the Scope of Work herein. These services include: Facilitating linkages to essential social services.	_____	12	\$ _____	\$ _____
0002	Culturally relevant recreational and social activities.	_____	12	\$ _____	\$ _____
0003	Culturally specific treatment and intervention services	_____	12	\$ _____	\$ _____
0004	Culturally relevant educational and vocational activities	_____	12	\$ _____	\$ _____
0005	Transportation for non-Medicaid services	_____	12	\$ _____	\$ _____
0006	Non-traditional and non-federally funded supports for housing, food and clothing	_____	12	\$ _____	\$ _____
0007	Translation and interpretation services	_____	12	\$ _____	\$ _____
0008	Assistance with Medicaid, Food Stamp, and TANF applications	_____	12	\$ _____	\$ _____
0009	Non-Medicaid reimbursable Case Management activities	_____	12	\$ _____	\$ _____
0010	Providing direct assistance and support to consumers for the purpose of ensuring that they receive culturally and linguistically relevant care from non-mental health providers	_____	12	\$ _____	\$ _____
	PRINT NAME OF CONTRACTOR _____				
	PRINT NAME OF AUTHORIZED REPRESENTATIVE _____				
	SIGNATURE OF AUTHORIZED REPRESENTATIVE _____				
	DATE _____				

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B.7 SCHEDULE B PRICING SHEET

NAME OF CONTRACTOR:
SOLICITATION # RM-09-RFP-BY4-064-DJC

CLIN	SUPPLIES/SERVICES OPTION YEAR TWO	QUANTITY (Enrolled Consumers) 50 (Maximum)	UNIT (Months)	UNIT PRICE Per Month	TOTAL AMOUNT
0001	Multicultural Services and Supports in accordance with the Scope of Work herein. These services include: Facilitating linkages to essential social services.	_____	12	\$ _____	\$ _____
0002	Culturally relevant recreational and social activities.	_____	12	\$ _____	\$ _____
0003	Culturally specific treatment and intervention services	_____	12	\$ _____	\$ _____
0004	Culturally relevant educational and vocational activities	_____	12	\$ _____	\$ _____
0005	Transportation for non-Medicaid services	_____	12	\$ _____	\$ _____
0006	Non-traditional and non-federally funded supports for housing, food and clothing	_____	12	\$ _____	\$ _____
0007	Translation and interpretation services	_____	12	\$ _____	\$ _____
0008	Assistance with Medicaid, Food Stamp, and TANF applications	_____	12	\$ _____	\$ _____
0009	Non-Medicaid reimbursable Case Management activities	_____	12	\$ _____	\$ _____
0010	Providing direct assistance and support to consumers for the purpose of ensuring that they receive culturally and linguistically relevant care from non-mental health providers	_____	12	\$ _____	\$ _____
	PRINT NAME OF CONTRACTOR _____				
	PRINT NAME OF AUTHORIZED REPRESENTATIVE _____				
	SIGNATURE OF AUTHORIZED REPRESENTATIVE _____				
	DATE _____				

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B.8 SCHEDULE B PRICING SHEET

NAME OF CONTRACTOR: SOLICITATION # RM-09-RFP-BY4-064-DJC					
CLIN	SUPPLIES/SERVICES OPTION YEAR THREE	QUANTITY (Enrolled Consumers) 50 (Maximum)	UNIT (Months)	UNIT PRICE Per Month	TOTAL AMOUNT
0001	Multicultural Services and Supports in accordance with the Scope of Work herein. These services include: Facilitating linkages to essential social services.	_____	12	\$ _____	\$ _____
0002	Culturally relevant recreational and social activities.	_____	12	\$ _____	\$ _____
0003	Culturally specific treatment and intervention services	_____	12	\$ _____	\$ _____
0004	Culturally relevant educational and vocational activities	_____	12	\$ _____	\$ _____
0005	Transportation for non-Medicaid services	_____	12	\$ _____	\$ _____
0006	Non-traditional and non-federally funded supports for housing, food and clothing	_____	12	\$ _____	\$ _____
0007	Translation and interpretation services	_____	12	\$ _____	\$ _____
0008	Assistance with Medicaid, Food Stamp, and TANF applications	_____	12	\$ _____	\$ _____
0009	Non-Medicaid reimbursable Case Management activities	_____	12	\$ _____	\$ _____
0010	Providing direct assistance and support to consumers for the purpose of ensuring that they receive culturally and linguistically relevant care from non-mental health providers	_____	12	\$ _____	\$ _____
	_____		12	\$ _____	\$ _____
	PRINT NAME OF CONTRACTOR _____				
	PRINT NAME OF AUTHORIZED REPRESENTATIVE _____				
	SIGNATURE OF AUTHORIZED REPRESENTATIVE _____				
	DATE _____				

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B.9 SCHEDULE B PRICING SHEET

NAME OF CONTRACTOR: SOLICITATION # RM-09-RFP-BY4-064-DJC					
CLIN	SUPPLIES/SERVICES	QUANTITY (Enrolled Consumers)	UNIT (Months)	UNIT PRICE Per Month	TOTAL AMOUNT
	OPTION YEAR FOUR	50 (Maximum)			
	Multicultural Services and Supports in accordance with the Scope of Work herein.				
	These services include:				
0001	Facilitating linkages to essential social services.	_____	12	\$ _____	\$ _____
0002	Culturally relevant recreational and social activities.	_____	12	\$ _____	\$ _____
0003	Culturally specific treatment and intervention services	_____	12	\$ _____	\$ _____
0004	Culturally relevant educational and vocational activities	_____	12	\$ _____	\$ _____
0005	Transportation for non-Medicaid services	_____	12	\$ _____	\$ _____
0006	Non-traditional and non-federally funded supports for housing, food and clothing	_____	12	\$ _____	\$ _____
0007	Translation and interpretation services	_____	12	\$ _____	\$ _____
0008	Assistance with Medicaid, Food Stamp, and TANF applications	_____	12	\$ _____	\$ _____
0009	Non-Medicaid reimbursable Case Management activities	_____	12	\$ _____	\$ _____
0010	Providing direct assistance and support to consumers for the purpose of ensuring that they receive culturally and linguistically relevant care from non-mental health providers	_____	12	\$ _____	\$ _____
	PRINT NAME OF CONTRACTOR				

	PRINT NAME OF AUTHORIZED REPRESENTATIVE				

	SIGNATURE OF AUTHORIZED REPRESENTATIVE				

	DATE				

C.3 SCOPE OF WORK

C.3.1 Delivery of Service under “The successful Vendor who is awarded this Contract shall:”

Delete in its entirety

“Bill in eCura the Enrolled Consumer Per Month Rate for each day in which the enrolled consumer received Multicultural Services and Supports”.

C.6.4 Enter/Update Case Information into DMH Case Management Database

Delete in its entirety

“The Vendor shall be expected to complete fields in the eCura database including, but not limited to enrollment and authorization information. In addition, other information may be collected in databases, spreadsheets, or other electronic format”.

G.1 INVOICE PAYMENT

Delete this statement only in its entirety “If they bill through Ecura we don’t need an invoice section and need to describe claims submission.”

SECTION M - EVALUATION FACTORS has been deleted in its entirety and replaced with the following:

SECTION M - EVALUATION FACTORS

M.1 EVALUATION FOR AWARD

The Contract shall be awarded to the responsive/responsible Prospective Contractor whose offer is most advantageous to the District, based upon the Evaluation Criteria specified below. Thus, while the points in the Evaluation Criteria indicate their relative importance, the total scores shall not necessarily be determinative of the award. Rather, the total scores shall guide the District in making an intelligent award decision based upon the Evaluation Criteria.

M.2 TECHNICAL RATING SCALE

The Technical Rating Scale is as follows:

<u>Numeric Rating</u>	<u>Adjective</u>	<u>Description</u>
1	Unacceptable	Fails to meet minimum requirements; major deficiencies which are not correctable.
2	Poor	Marginally meets minimum requirements; major deficiencies which shall be correctable.
3	Acceptable	Meets requirements; only minor deficiencies which are correctable.
4	Good	Meets requirements; no deficiencies.
5	Excellent	Exceeds most, if not all requirements; no deficiencies.

For example, if a sub-factor has a point evaluation of 0 to 6 points, and (using the Technical Rating Scale) the District evaluates as “good” the part of the proposal applicable to the sub-factor, the score for the sub-factor is 4.8 (4/5 of 6). The sub-factor scores shall be added together to determine the score for the factor level.

M.3 TECHNICAL CRITERIA

Business Capability (90 POINTS)

- | | POINTS |
|--|---------------|
| A. Vendor demonstrates expert experience and past performance delivering Multicultural Services and Supports to culturally and linguistically diverse adults and children and youth populations in the District of Columbia. | 25 |
| B. Vendor demonstrates detailed program plan outlining what Multicultural Services and Supports will be delivered to a culturally and linguistically diverse population. | 25 |
| C. Vendor demonstrates detailed program plan outlining how consumers will be identified for Multicultural Services and Supports, | 25 |

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and the service delivery strategy to be used to deliver those services and supports.

- D.** Vendor demonstrates plan to collect and analyze information to report program activities and program effectiveness in meeting required performance measures. 15

M.4 PRICE CRITERIA (10 POINTS)

M.4.1 Cost Proposal Criteria

- Submission of budget and the narrative and justifications, existing resources, and other in-kind supports.
- Specify training expenses, startup and implementation, administrative costs, salaries and benefits.
- Narrative justification for each line item in the proposed budget, as well as descriptions for existing resources and supports.

M.4.2 The Price Evaluation shall be objective. The Prospective Contractor with the lowest cost/price proposal shall receive the maximum price points. All other proposals shall receive a proportionately lower total score. The following formula shall be used to determine each Contractor's evaluated cost/price score:

$$\frac{\text{Lowest cost/price proposal} \times \text{weight}}{\text{Cost/price of proposal being evaluated}} = \text{evaluated cost/price score}$$

M.5 PREFERENCE (0-12 POINTS)

M.6 TOTAL

M.7 CLAUSES APPLICABLE TO ALL OPEN MARKET SOLICITATION

M.7.1 A. Preference for Local Business, Disadvantaged Businesses, Resident Business Ownerships or Businesses Operation in an Enterprise Zone.

1. General Preferences

Under the provisions of D.C. Law 13.169, "Equal Opportunity for Local, Small or Disadvantaged Business Enterprises Amendment Act of 2000" (the "Act", as used in this section), the District shall apply preferences in evaluating offers from businesses that are local, disadvantaged, resident business ownership or located in an enterprise zone of the District of Columbia.

For evaluation purposes, the allowable preferences under the Act for this procurement are as follows:

1. Four percent reduction in the bid price or the addition of four points on a 100 point scale for a local business enterprise (LBE) certified by the Local Business Opportunity Commission (LBOC);
2. Three percent reduction in the bid price or the addition of three points on a 100 point scale for a disadvantaged business enterprise (DBE) certified by the LBOC;
3. Three percent reduction in the bid price or the addition of three points on a 100 point scale for a resident business ownership (RBO), as defined in Section 2 (a)(8A) of the Act, and certified by the LBOC; and
4. Two percent reduction in the bid price or the addition of two points on a 100 point scale for a business located in an enterprise zone, as defined in Section 2(5) of D.C. Law 12.268 and in 27 DCMR 899, 39 DCR 9087.9088 (December 4, 1992).

Any prime Contractor that is a LBE certified by the LLBOC shall receive a four percent (4%) reduction in bid price for a bid submitted by the LBE in response to an Invitation for Bid (IFB) or the addition of four points on a 100 point scale added to the overall score for bids submitted by the LBE in response to a Request for Proposals (RFP).

Any prime Contractor that is a DBE certified by the LBOC shall receive a three percent (3%) reduction in the bid price for a bid submitted by the DBE in response to an IFB or the addition of three points on a 100 point scale added to the overall score for proposals submitted by the RBO in response to a RFP.

Any prime Contractor that is a business enterprise located in an enterprise zone shall receive a two percent (2%) reduction in bid price for a bid submitted by such business enterprise in response to an IFB or the addition of two points on a 100 point scale added to the overall score for proposals submitted by such businesses in response to a RFP.

B. Preferences for Sub-Contracting in Open Market Solicitations with no LBE, DBE, RBO Sub-Contracting Set Aside

The preferences for sub-Contracting in open market solicitations where there is no LBE, DBE or RBO Sub-Contracting set aside are as follows:

1. If the prime Contractor is not a certified LBE, certified DBE, certified RBO or a business located in the enterprise in an enterprise zone, the District shall award the above stated preferences by reducing the bid price or by increasing the points proportionally based on the total dollar value of the bid or proposal that is designated by the prime Contractor for sub-Contracting with a certified LBE, DBE, ROBO or business located in an enterprise zone.

- 2 If the prime Contractor is a joint venture that is not certified LBE, certified DBE or certified RBO joint venture, or if the prime Contractor is a joint venture that includes a business in the enterprise zone but such business located in an enterprise zone does not own and control at least fifty-one percent (51%) of the joint venture, the District shall award the above stated preferences by reducing the bid price or by increasing the points proportionately in the proposal based on the total dollar value of the bid or proposal that is designated by the prime Contractor for a certified LBE, DBE, RBO or business located in an enterprise zone, for participation in the joint venture.

For Example:

If a non-certified prime Contractor sub-contracts with a certified local business enterprise for a percentage of the work to be performed on an RFP, the calculation of the percentage points to be added during evaluation would be according to the following formula:

Amount of Sub-Contract

$$\frac{\text{Amount of Sub-Contract}}{\text{Amount of Contract}} \times 4 (*) = \text{Points Awarded for Evaluating LSDBE Sub-Contracting}$$

(*)Note: Equivalent of four (4) points on a 100 point scale

The maximum total preference under the Act of this procurement is twelve percent (12%) for bids submitted in response to an IFB or the equivalent of twelve (12) points on a 100 point scale for proposals submitted in response to a RFP. Any prime Contractor receiving the full bid price reduction or point addition to its overall score for a particular preference shall not receive any additional bid price reduction or points for further participation on a sub-contracting level for that particular preference. However, the prime Contractor shall receive a further proportional bid price reduction or point addition on a different preference for participation on a sub contracting level for that different preference. For example, if a LBE prime Contractor receives the four percent bid price reduction or the equivalent of four points on a 100 point scale, the LBE prime Contractor does not receive a further price reduction or additional points if such Contractor proposes sub-contracting with a DBE, the LBE prime Contractor receives a further proportional bid price reduction or point addition for the DBE participation on the sub-Contracting level.

C. Preference for Open Market Solicitations with LBE, DBE or RBO Sub-Contracting Set Aside

If the solicitation is an open market solicitation with LBE, DBE or RBO sub-contracting set-aside, the prime Contractor shall receive the LBE, DBE, or RBO preferences only if it is a certified LBE, DBE or RBO. There shall be no preference awarded for sub-contracting by the prime Contractor with a LBE, DBE or RBO, even if the prime Contractor proposes LBE, DBE or RBO sub-contracting above the sub-contracting levels required by the solicitation. However, the prime Contractor shall be entitled to the full preference for business located in an enterprise zone if it is a business located in an enterprise zone or proportional preference if the prime Contractor sub-

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contracts with a business located in an enterprise zone. The maximum total preference under the Act for this procurement is twelve percent (12%) for bids submitted in response to an IFB or the equivalent of twelve (12) points on a 100 point scale for proposals submitted in response to a RFP.

D. Preferences for Certified Joint Ventures Including Local or Disadvantaged Businesses or Resident Business Ownerships.

When an LBOC-certified joint venture includes a local business enterprise (LBE), disadvantaged business enterprise (DBE) or a resident business ownership (RBO), and the LBE, DBE or RBO owns and controls at least fifty-one percent (51%) of the venture, the joint venture shall receive the preference as if it were a certified LBE, DBE, or RBO.

E. Preference for joint Ventures Including Businesses located in an Enterprise Zone.

When a joint venture includes a business located in an enterprise zone, and such business located in an enterprise zone owns and controls at least fifty-one percent (51%) of the venture, the joint venture shall receive the preferences as if it were a business located in an enterprise zone.

1. Contractor Submission for Preferences

Any Contractor seeking to receive preferences on this solicitation shall submit at the time of, and as part of its bid or proposal the following documentation as applicable to the preference being sought:

(a) Evidence of Contractor's, sub-contractor, or joint venture partner's certification or self certification as a LBE, DBE or RBO to include:

(1) A copy of all relevant letters of certification for the Local Business Opportunity Commission (LBOC); or

(2) A copy of the sworn notarized Self-Certification Form prescribed by the LBOC, along with an acknowledgement letter issued by the Director of the LBOC. Businesses with principal offices located outside of the District of Columbia shall first be certified as LBE's before qualifying for self-certification.

2. Evidence that Contractor or any sub-contractor is located in an enterprise zone.

In order for a Contractor to receive allowable preferences under this solicitation, the Contractor shall include the relevant information as described in subparagraphs (a) and (b) of this clause as part of its proposal.

Refer to J.2.1 for the Self-Certification Package. In order to receive any preferences under this solicitation, any Contractor seeking self-certification shall complete and submit the forms to:

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Office of Local Business Development
Attn: LSDBE Certification Program
441 Fourth Street, NW, Suite 970N
Washington, DC 20001

All Contractors are encouraged to contact the Local, Small and Disadvantaged Business Enterprises Certification Program at (202) 727-3900 if additional information is required on certification procedures and requirements.

Penalties for Misrepresentation – Any material misrepresentation on the sworn notarized self-certification form could result in termination of the Contract, Contractor’s liability for civil and criminal action in accordance with the Act, D.C. Law 12.268, and other District laws, including debarment.

Local, Small, and Disadvantaged Business Enterprise Sub-Contracting

When a prime Contractor is certified by the Office of Local Business Development as a local, small or disadvantaged business or a resident business ownership, the prime Contractor shall perform at least fifty percent (50%) of the Contracting effort, excluding the cost of materials, goods and supplies with its own organization resources, and if it sub-contracts fifty percent (50%) of the sub-contracting effort, excluding the cost of materials, goods and supplies shall be with certified local, small or disadvantaged business enterprises and resident business ownerships, unless a waiver is granted by the Contracting Officer, with prior approval and consent of the Director of the LBOC under the provisions of 27 DCMR 805, 39 DCR 5578.5580 (July 24, 1992). By submitting a signed bid or proposal, the prime Contractor certifies that it shall comply with the requirements of paragraph (a) of this clause.

***** END OF SECTION M *****

END OF PART II

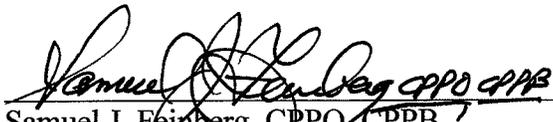
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ALL OTHER TERMS AND CONDITIONS OF THE REQUEST FOR PROPOSALS REMAIN UNCHANGED.

Only one copy of this amendment is being sent to prospective Offerors. Offerors shall sign below and attach a signed copy of this amendment to each proposal to be submitted to the place specified for receipt of proposals. Proposals shall be mailed or delivered in accordance with the instructions provided in the original RFP. In the event your proposal has been previously deposited with the Department of Mental Health, Contracts and Procurement Administration (DMH/CPA), submit this signed Amendment in a sealed envelope, identified on the outside by the RFP number and submission date. This signed Amendment must be received by the DMH/CPA no later than the date and time for closing.

Failure to acknowledge receipt of Amendment One (1) for Solicitation Number RM-09-RFP-BY4-064-DJC may be cause for rejection of any proposal submitted in response to the subject RFP.

Signed:



Samuel J. Feinberg, CPPO, CPPB
Director, Contracts and Procurement
Agency Chief Contracting Officer

Amendment Number One (1) is hereby acknowledged and is considered a part of the proposal for Solicitation Number RM-09-RFP-BY4-DJC.

Signature of Authorized Representative

Date

Title of Authorized Representative

Print or Type Name of Offeror

**DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH
BUDGET PACKAGE
(CERTIFIED COST AND PRICING DATA)**

BUDGET PACKAGE COVER MEMO

PROVIDER: _____

MAILING ADDRESS: _____

CONTACT NAME: _____

SERVICE: _____

ORIGINAL **REVISION**

CONTRACT NO: _____

CONTRACT ADMENDMENT/REVISION (NUMBER _____)

PERIOD FROM _____ TO _____

DATE DELIVERED/MAILED TO DMH: ____/____/____

APPROVED BY AUTHORIZED PROVIDER OFFICIAL:

Name

Title

Signature

NOTE: ALL INFORMATION MUST BE SUBMITTED TO THE CONTRACTS AND PROCUREMENT ADMINISTRATION, c/o Director of Contracts and Procurement , 64 New York Avenue, NE 4th Floor, Washington, DC 20002. Any information submitted to any other location or person shall not be considered.

RECEIVED IN DMH/CONTRACTS AND PROCUREMENT ADMINISTRATION:

DATE: ____/____/____

RECEIVED BY: _____
Name and Title

**BUDGET PACKAGE COMPLETE
(ALL SCHEDULES COMPLETED, INCLUDING ALL REQUIRED ATTACHMENTS AND BUDGET NARRATIVE)**

ADEQUATE NUMBER OF COPIES SUBMITTED (ONE (1) ORIGINAL AND THREE (3) COPIES)

**GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH**

BUDGET PACKAGE INSTRUCTIONS

The following schedules comprise the Department of Mental Health (DMH) budget package:

BUDGET PACKAGE COVER MEMO

BUDGET SUMMARY FORM

SCHEDULE 1: SALARY AND WAGE JUSTIFICATION

SCHEDULE 2: FRINGE BENEFIT JUSTIFICATION

SCHEDULE 3: CONSULTANTS / EXPERTS JUSTIFICATION

SCHEDULE 4: OCCUPANCY COST JUSTIFICATION

SCHEDULE 5: TRAVEL AND TRANSPORTATION COST JUSTIFICATION

SCHEDULE 6: SUPPLIES AND MINOR EQUIPMENT COST JUSTIFICATION

SCHEDULE 7: CAPITAL EQUIPMENT AND OUTLAYS COST JUSTIFICATION

SCHEDULE 8: CLIENT EXPENSE COST JUSTIFICATION

SCHEDULE 9: COMMUNICATIONS COST JUSTIFICATION

SCHEDULE 10: OTHER DIRECT COST JUSTIFICATION

SCHEDULE 11: INDIRECT / OVERHEAD COST JUSTIFICATION

The budget package serves as part of the certified cost and pricing data required by the Government of the District of Columbia, Department of Mental Health (District, DMH or the Agency). The provider is required to complete all sections of the budget package according to these instructions and any other instructions provided by the District. All schedules must be completed and the appropriate documentation attached, as stated in these instructions. Failure to attach required documentation shall result in the rejection of the provider's Offer. Attach additional sheets if necessary.

This budget package should be completed after the offering organization has developed a complete and detailed budget for operating the service(s) being proposed. These DMH forms and instructions are not expected to substitute for the organization's own budgeting process.

GENERAL INSTRUCTIONS

In completing the DMH budget package, the following order of completion should be followed:

Schedule 1 through 11 should be completed in order, followed by the Budget Summary Form. The Budget Package Cover Memo should be completed last.

On each page, numbers need to be totaled both down columns and across rows. If additional copies of any schedule page are needed, number each page as "PAGE _____ OF _____ PAGES" on the header (e.g. Page 1 of 3). Total the amounts on each page of the schedule and enter the total amount for all of the pages of the schedule on the first page of the schedule only.

In completing the budget, vendors are to distinguish the costs associated with each facility that the vendor proposes to use to provide services. The budget schedules give space for three facilities. (If only one facility is involved, complete only Column (2)). Vendors who are proposing to use more than three facilities should make additional copies of the schedule pages.

All cost estimates must be fully documented. See the schedule specific instructions for the documentation, which is required, for any given budget item.

Note that in general, "minor" is defined as costing less than \$2,500.00; "major" as anything over \$2,500.00.

Use whole dollar amounts, rounding amounts of 50 cents or more up to the next whole dollar and amounts of 49 cents or less down to the next whole dollar.

Each part of the DMH budget package contains certain identifying "header" information which should be completed as follows:

Provider – enter the name of the organization offering to provide the service. If different levels of a single organization are involved (e.g., a separately (not necessarily though) named site within a larger organization), enter the name of the organization with ultimate financial responsibility for delivering the service.

Original/Revision – enter an "X" in the appropriate box to show whether this package is the original budget (the one first submitted to DMH for the period covered) or a revision. If a revision, enter the sequential number of the revision (e.g. the first revision is Number 1, etc.).

RFP/Contract No. – enter the Request for Proposal number corresponding to the RFP under which the vendor is proposing to provide service. Enter the Contract number if this budget is for a renewal, amendment or extension to a contract in force. **If the District has not provided a contract number or RFP number, please leave this field blank.**

For Period – enter the beginning and end dates to be covered by the proposed budget.

Provider must also submit a Budget Narrative that explains in narrative form each proposed item in the attached budget, to the extent that such explanation or itemization is not already included in an attachment to a particular budget schedule. The Budget Narrative is an essential part of the provider's budget submission.

The specific instructions for each schedule are on the following pages. Please read all instructions carefully. Failure to include all information required by each schedule, including all attachments, shall result in the rejection of the Offer.

SCHEDULE 1: SALARY AND WAGE JUSTIFICATION

This Schedule shows the salaries or wages to be paid to each of the organization's employees for the provision of services under this contract. It is completed by filling out eight columns with the following information regarding the organization's payroll:

Column (1): Position Title: Enter the title of each position to be used in carrying out this service.

Column (2): Name: Enter the name of the person who will fill each position. If an individual has not yet been hired, enter "TBF" for "To be Filled," and enter the date on which the position is to be filled. Attach the job announcement and a commitment letter stating offeror's intent to hire contingent upon award of contract.

Column (3): Salary or Hourly: If the position is a salaried position, place an "S" in this column. (Note: a position is salaried if a paycheck is issued without regard to hours worked. Individuals in salaried positions are usually paid a level amount each period, earn annual and sick leave, and are paid for holidays). If this position is an hourly position or a volunteer position, place an "H" in this column. (Note: a position is hourly if the pay depends strictly on the number of hours worked. Hourly positions are usually paid a different amount each pay period. Unlike Consultants or Experts, however, the organization pays certain fringe benefits for hourly employees, such as Social Security (FICA)). Volunteers are to be considered hourly employees for purposes of calculating the in-kind value of contributed services.

Column (4): Base Salary/Hourly Wages: The entry in this column will be different, depending on whether a the position is on a salary or hourly wage basis.

For salaried positions, enter the base salary corresponding to the period covered by this budget. (Note: include in base salary the amounts paid for vacation, holidays, and other leave. Bonuses, personal use of organizational assets, auto allowances, and other cash-value fringe benefits should be included in salary). Include any anticipated salary increase for each position by pro-rating the increase salary over the period after the increase is anticipated to be given. If a position is "To Be Filled," enter the salary corresponding to the part of the period the position will be paid.

Column (5): % of Time or # of Hours on This Service: For salaried positions, enter the percentage of overall time the individual will spend on this service. **(Note: if a salaried person spends normal "9-to-5" working hours on this service and then devotes additional hours to other business of the organization, the entry cannot be 100 percent).**

For hourly positions, enter the total number of hours the individual will spend on this service. (Note: if an hourly employee is expected to work some these hours in an "overtime" or other premium-pay circumstance, modify the number of hours accordingly and attach documentation. For example, if an hourly employee is expected to work 40 hours of overtime at "time-and-a-half" during the period covered by this budget, enter these hours as 60 hours – 1.5 X 40 – in addition to regular hours worked. Volunteers do not qualify for premium-pay calculations).

Column (6): Total Salary/Wage Cost: Multiply the entry in Column (4) by the entry in Column (5) to determine the total amount of salaries and wages (cash and in-kind) attributable to providing this service for the period covered by this budget.

Column (7): Other Business Activity: If the position is charged to any other business activity for the District of Columbia (contract, grant et al.) other than the contract for which this budget is being submitted, enter "Y" and attach documentation to show the amount charged to all other business activity. If the position is charged to no other business activity, enter "N."

SCHEDULE 2: FRINGE BENEFIT JUSTIFICATION

This Schedule shows the amount that will be paid by the organization on behalf of employees carrying out the work of this contract for each of the following four categories of fringe benefits (provided such benefits are granted under approved plans and are distributed equitably):

Social Security (FICA) - the amount paid by the employer (separate from the amount withheld from an employee's salary or wages). Contributions are made at a rate fixed by Federal law. Currently, the rate is 7.65 percent – 6.2 percent for OASDI on the first \$61,200 and 1.45 percent for Medicare with no ceiling or wage base. When rate is expected to change for another calendar year, make separate calculations for the part of each period to be covered by this contract.

Health/Hospitalization Insurance- the amount paid by the employer for health, hospitalization, dental, accidental, disability, or life insurance (in addition to any amount withheld from an employee's salary or wages). A **CERTIFICATE OF INSURANCE** is required to document hospitalization, life insurance and/or long-term disability.

Worker's Compensation- the amount paid by the employer for mandatory worker's compensation insurance under Federal and District or State law. The rate of employer contribution is experience-rated. Attach a **CERTIFICATE OF INSURANCE** showing the schedule of benefits for worker's compensation.

Unemployment Insurance- the amount paid by the employer for mandatory unemployment insurance under Federal and District or State law. The rate of employer contribution is experience-rated. Attach **THE CONTRIBUTION RATE NOTICE** for unemployment insurance.

Other Benefits- any other employer-paid benefits. **Attach** justification for any additional fringe benefits offered to employees. (Bonuses, personal use of organizational assets, auto allowances, and other cash value fringe benefits should be included in salary. Do not include vacation or other leave in this category – leave is included in salary).

Columns (2) – (4): Employer Payments on Behalf of Employees to work on this Contract/RFP- for each type of employee (salaried, full-time employees in Column (2); salaried, part-time employees in column (3); and hourly employees in column (4)) who will be involved in providing this service, calculate the amount that the organization expects to pay for fringe benefits. Enter the total amount of fringe benefits payable for each category of employees in the space provided. Total the benefits for each category of employees and enter on the line labeled "TOTAL BENEFITS."

Column (5): Total Employer Payments for this Benefit- **Add** together the entries on each line of Columns (2) through (4) and enter the total on the appropriate line of Column (5). Total all benefits and enter on the line labeled "TOTAL BENEFITS."

Note: It is currently the policy of the Department of Mental Health to cap the fringe rate paid under its contract at a maximum of 23.4 percent. Any proposed fringe rate that exceeds 23.4 percent shall not be considered.

SCHEDULE 3: CONSULTANTS / EXPERTS JUSTIFICATION

This schedule shows the amount to be paid by the organization to consultants, specialists, experts and other contract employees who will be paid no fringe benefits. It is completed by filling out the following six columns:

Column (1): Position Title- enter the title of each position to be filled by a consultant or expert (e.g. Consulting Pediatrician, Social Worker, etc.).

Column (2): Name- enter the name of the person who will fill each position. **Attach** a copy of the signed consultant agreement. If an individual has not yet been hired, enter "TBF" for "To be Filled," and enter the date on which the position is to be filled. **Attach** a job announcement and a commitment letter stating offeror 's intent to hire contingent upon award of contract.

Column (3): Base Wage/Hour- enter the basic rate at which the consultant or expert will be paid for each hour worked. If the payment basis is other than hourly (e.g. daily or monthly), convert to an hourly rate and attach justification for other than hourly payment.

Column (4): No. of Hours for Period- enter the number of hours each consultant or expert will work during the period specified for delivering this service.

Column (5): Total Cost- multiply the entry in column (3) by the entry in column (4) to determine the total amount of compensation for consultants and experts covered by this budget.

Column (6): Other Business Activity: If the consultant/expert is charged to any other business activity for the District of Columbia (contract, grant et al.) other than the contract for which this budget is being submitted, enter "Y" and attach documentation to show the amount charged to all other business activity. If the consultant/expert is charged to no other business activity, enter "N."

SCHEDULE 4: OCCUPANCY COST JUSTIFICATION

This schedule shows the amount to be paid by the organization for occupying space necessary to carry out the planned service.

The schedule is completed by filling out four columns with summary information on the amounts budgeted for the following categories of occupancy cost:

Rent- rental or lease payment for space used in delivering the service. Attach a copy of the lease or rental agreement. Attach justification of lease costs in excess of \$8.00 per square foot. (Note: If space is donated, include the fair market value of the in-kind contribution to the value of the service. If space is owned, enter mortgage or depreciation amounts and attach documentation).

Gas/Electric/Oil/ Water- utilities necessary to carry out the service. Attach separate documentation for each component of utility cost.

Trash- separately contracted trash and solid-waste removal. If no special contract arrangements are necessary (i.e. municipal removal) enter "N/A."

Maintenance- separately contracted janitorial and maintenance services. If no special arrangements are necessary (i.e. provided by employees), enter "N/A."

Insurance- separately paid fire, liability or accident insurance associated with specific space. If no special arrangements are necessary (i.e., provided under a master policy for all sites), enter "N/A."

Pest Control- separately contracted pest control and/or extermination services. If no special arrangements are necessary (i.e., provided by employees) enter "N/A."

Repairs-separate repair costs incurred.

Other- all other costs related to occupying space for the purpose of delivering the identified service. Attach explanation and documentation.

SCHEDULE 5: TRAVEL AND TRANSPORTATION JUSTIFICATION

This Schedule record the amount to be paid by the organization for travel and transportation necessary to carry out the planned service.

The Schedule is completed by filling out three columns with summary information on the amounts budgeted for the following categories of travel and transportation cost:

Vehicle Lease- rental or lease payments for autos, vans, or trucks used in delivering the service. (Note: If vehicles are donated, include the fair market value of the in-kind contribution to the value of the service). Attach a description of the vehicle and copy of the lease.

Vehicle Depreciation- “accounting-type” charges to account for the future replacement cost of a vehicle already owned. (Note that no vehicle purchased outright with Government funds may be depreciated).

Gasoline/Oil/Supplies- “consumable” supplies necessary to operate vehicles in order to provide travel and transportation in support of the service. Attach separate documentation of each element of cost for each vehicle.

Tires/Batteries- “major” items of expense relative to operating vehicles for travel and transportation to support the planned service. (In general, maintenance and repairs for vehicles not owned or leased by the organization are not allowable).

Maintenance and Repairs- routine maintenance and required repairs of vehicles used in providing travel and transportation to support the planned service. (In general, maintenance and repairs for vehicles not owned or leased by the organization are not allowable).

Insurance- collision, liability and other insurance related to providing travel and transportation to support the planned service.

Registration- vehicle registration and licensing related to providing travel and transportation to support the planned service.

Mileage/Fares- mileage reimbursements and taxi/subway/bus fares related to providing travel and transportation to support the planned service.

Other- all other costs related to providing travel and transportation to support the planned service. Attach explanation and documentation.

SCHEDULE 6: SUPPLIES AND MINOR EQUIPMENT COST JUSTIFICATION

This schedule shows the amount to be paid by the organization for various supplies and minor equipment necessary to carry out the planned service.

Using one column for each proposed facility, record the amounts budgeted for the following categories of supplies/equipment cost:

Office Supplies- paper, pencils and other consumable supplies used in delivering the service.
(Note: If most office supplies are used in a central/administrative office, identify one of the “Facility” columns as this office and enter all budgeted amounts under that column).

Household Supplies- cleaning, cooking, and other consumable supplies used in operating a household as part of delivering the service.

Household Furnishings- small items of furniture, utensils, and other minor furnishing items used in operating a household as part of delivering the service.

Other Supplies- All other supplies required for the purpose of delivering the identified service. Attach explanation and documentation.

Other Equipment- all other equipment costs for the purpose of delivering the identified service. Attach explanation and documentation.

SCHEDULE 7: CAPITAL EQUIPMENT AND OUTLAYS COST **JUSTIFICATION**

This Schedule shows the amounts to be paid by the organization for capital equipment and other major outlays to carry out the planned service.

Using one column for each proposed facility, record the amounts budgeted for the following categories of capital equipment cost:

Vehicle Purchase- vehicles purchased for use in delivering the service. This includes cars, trucks and vans. (Note: If most vehicles are assigned to a central/administrative office, identify one of the "Facility" columns as this office and enter all budgeted amounts under that column). Attach a description of the vehicle and documentation of price.

Major Repairs- repairs to a facility other than minor "maintenance" expenses included in Schedule 4 (Occupancy Cost Justification). Attach documentation.

Major Equipment- major equipment purchased for use in delivering the service. Attach a description and documentation.

Other Capital Outlays- all other supplies required for the purpose of delivering the identified service. Attach explanation and documentation.

SCHEDULE 8: CLIENT EXPENSE COST JUSTIFICATION

This Schedule shows the amount to be paid by the organization for client expenses to carry out the planned service.

Using one column for each proposed facility, enter the amounts budgeted for the following categories of client expense costs:

Food- food provided to clients.

Clothing- clothing provided to clients.

Allowances- cash for personal needs provided to clients. This does not include wages for work performed under an employment agreement between the client and the organization.

Medical- medical costs incurred on behalf of clients. This category should include only costs for treatment and supplies not covered by Medicaid and not available at government clinics or other government facilities.

Dental- dental costs incurred on behalf of clients. This category should include only costs for treatment and supplies not covered by Medicaid and not available at government clinics or other government facilities.

Training- instructional costs incurred on behalf of clients, including tuition, books, equipment, and other expenditures directly related to training required by this contract. If transportation costs are included, provide a detailed documentation statement. This category should not include costs for consultants hired to instruct clients.

Recreational: costs incurred in recreational activities as proposed.

Socio-Cultural: costs incurred in meeting specific socio-cultural needs as proposed.

Other- any other costs incurred on behalf of clients as part of the delivery of this service, which cannot be legitimately included in one of the earlier categories. If other client expense costs are identified, provide a detailed documentation statement.

SCHEDULE 9: COMMUNICATIONS COST JUSTIFICATION

This Schedule shows the amount to be paid by the organization for communications necessary to carry out the planned service.

Using one column for each proposed facility, enter the amounts budgeted for the following categories of communications capital costs:

Telephone- telephone service to be used for delivering the identified service. This includes local and long distance service. (Note: If all telephone service is billed to a central/administrative office, and costs cannot be attributed to separate facilities, identify one of the 'Facility' columns as this office and enter all budgeted amounts under that column).

Postage- charges associated with sending letters and packages as part of the delivery of this service.

Delivery- distributing packages or other goods related to delivery of this service. (In general, delivery is to be avoided when the mail is used).

Copying- duplication expenses associated the delivering the identified service.

Other- any other anticipated costs related to communication, but not covered under one of the above categories. Attach explanation and documentation.

SCHEDULE 10: OTHER DIRECT COST JUSTIFICATION

This Schedule record the amounts to be paid by the organization for any other directly identifiable costs necessary to carry out the planned service not covered on Schedule 1 through 9.

Using one column for each proposed facility, enter the type of expenses and dollar amount. Attach a detailed program and cost justification.

SCHEDULE 11: INDIRECT / OVERHEAD COST JUSTIFICATION

This Schedule shows the amounts to be paid by the organization for indirect, overhead or other administrative (sometimes referred to as Supporting Services) costs related to carrying out the planned service.

Indicate whether you have a previously approved Indirect Costs Rate. The current approval letter must be attached to your schedule. If there is not an approved rate and the administration cost is based on a percentage of direct cost from prior audited figures, attach the audit.

Using one column for each proposed facility, enter the amounts budgeted for the following categories of indirect / overhead cost:

Administration- general organizational administration not associated with carrying out the specific service. This typically includes the salary, fringe benefits and overhead associated with a central administrative office. It includes a variety of activities not identifiable with program functions, but which are indispensable to their conduct and to the organization's corporate existence.

Financial Management- the services of a qualified accountant and / or bookkeeper necessary to carry out the identified service. (Note: If financial management services are included in the "Administration" line, above, leave this line blank).

Audit- the services of a qualified auditing organization to determine that all-accounting principles were followed in managing the finances associated with delivering the identified service. (Note: If audit services are included in the "Administration" or "Financial Management" lines, above, leave this line blank).

Other Indirect / Overhead: any other costs required for delivering the identified service, which can neither be classified in one of the above three indirect/overhead categories, nor in an "Other Direct Cost" category on Schedule 10. Attach explanation and documentation.

THE BUDGET SUMMARY FORM

The Budget Summary Form is to be completed after Schedules 1 through 11 have been completed. It shows the total costs of providing the identified service and identifies the portion of total costs the organization is asking the Department of Mental Health. It is completed by filling out three columns based on the amounts recorded on Schedules 1 through 11.

Transfer the totals from Schedules 1-11 onto the appropriate line in **Column (3): Total Cost** and calculate the subtotal.

If applicable, enter a fee on line 12 of this column and fill in the blank in the parentheses on line 12. Fees can only be charged by for-profit organizations.

Add any fee to the Subtotal and enter the sum in the line entitled "TOTAL BUDGET."

In **Column (2): Other Funds** identify the portion of total costs shown in Schedules 1-11 which are to be covered by other funding sources or are to be donated (in-kind), either through the services of volunteers (in-kind labor) or through other donated goods or services (in-kind rent, donated vehicles, etc.).

Sum these entries and enter the total on the line entitled "SUBTOTAL BEFORE FEE" and "TOTAL BUDGET."

Fee may not be donated, so make no entry on line 12 of Column 2.

Column (1): DMH Funds – Calculate the entries in this column by subtracting the entries in Column 2 from the entries in Column 3.

END

**DEPARTMENT OF MENTAL HEALTH
BUDGET SUMMARY FORM**

PROVIDER NAME _____ SERVICE _____

ORIGINAL () REVISION () (NUMBER _____) RFP/CONTRACT NO. _____

FOR PERIOD FROM _____ TO _____

	(1) DMH FUNDS	(2) OTHER FUNDS	(3) TOTAL COST
1 Salaries			
2 Fringe Benefits			
3 Consulting / Experts			
4 Occupancy			
5 Travel and Transportation			
6 Supplies & Minor Equipment			
7 Capital Equipment & Outlays			
8 Client Costs			
9 Communications			
10 Other Direct Costs			
11 Indirect Cost / Overhead			
SUBTOTAL BEFORE FEE			
12 FEE (% OF SUBTOTAL)			
13 TOTAL BUDGET			

- Attach Schedule 1
 - Attach Schedule 2
 - Attach Schedule 3
 - Attach Schedule 4
 - Attach Schedule 5
 - Attach Schedule 6
 - Attach Schedule 7
 - Attach Schedule 8
 - Attach Schedule 9
 - Attach Schedule 10
 - Attach Schedule 11
- (IF APPLICABLE)

**DEPARTMENT OF MENTAL HEALTH
SCHEDULE 2: FRINGE BENEFIT JUSTIFICATION**

PROVIDER NAME _____ SERVICE _____ PAGE _____ OF _____

FACILITY NAME/ADDRESS _____

ORIGINAL () REVISION () (NUMBER _____) RFP/CONTRACT NO. _____

FOR PERIOD: FROM _____ TO _____

EMPLOYER PAYMENTS ON BEHALF OF EMPLOYEES TO WORK ON THIS CONTRACT

(1) BENEFIT CATEGORY	(2) SALARIED-FULL TIME	(3) SALARIED-PART TIME	(4) HOURLY	(5) TOTAL EMPLOYER PAYMENTS FOR BENEFIT
SOCIAL SECURITY (FICA)				
HEALTH INSURANCE				
UNEMPLOYMENT INSURANCE				
WORKERS COMPENSATION				
OTHER BENEFITS				
TOTAL BENEFITS				

ATTACH JUSTIFICATION FOR ALL BENEFITS

FRINGES AS A PERCENT OF SALARIES & WAGES

**DEPARTMENT OF MENTAL HEALTH
SCHEDULE 4: OCCUPANCY COST JUSTIFICATION**

PROVIDER NAME _____ SERVICE _____ PAGE _____ OF _____

ORIGINAL () REVISION () (NUMBER _____) RFP/CONTRACT NO. _____

FOR THE PERIOD OF: FROM _____ TO _____

(1) EXPENSE CATEGORY	(2) COST FOR FACILITY #1	(3) COST FOR FACILITY #2	(4) COST FOR FACILITY #3	(5) TOTAL OCCUPANCY FOR ALL FACILITIES
RENT				
GAS / ELEC / OIL / WATER				
TRASH				
MAINTENANCE				
INSURANCE				
PEST CONTROL				
REPAIRS				
OTHER				

**USE ADDITIONAL PAGES IF MORE THAN THREE FACILITIES ARE INCLUDED IN ONE BUDGET

**ATTACH COPIES OF AGREEMENT(S) FOR ALL RENTED OR LEASED FACILITIES

TOTAL OF ENTRIES ON THIS PAGE

TOTAL OF ALL SCHEDULE 4 PAGES
(ENTER ON PAGE 1 ONLY)

DEPARTMENT OF MENTAL HEALTH
SCHEDULE 5: TRAVEL AND TRANSPORTATION COST JUSTIFICATION

PROVIDER NAME _____ SERVICE _____ PAGE _____ OF _____

ORIGINAL () REVISION () (NUMBER _____) RFP/CONTRACT NO. _____

FOR THE PERIOD OF: FROM _____ TO _____

(1) EXPENSE CATEGORY	(2) VEHICLE COSTS	(3) NON-VEHICLE COSTS	(4) TOTAL TRAVEL AND TRANSPORTATION COST
VEHICLE LEASES			
VEHICLE DEPRECIATION			
GASOLINE/OIL/SUPPLIES			
TIRES/BATTERIES			
MAINTENANCE/REPAIRS			
INSURANCE			
REGISTRATION			
MILEAGE/FARES			
OTHER			
TOTAL OF ALL ENTRIES ON THIS PAGE			

ATTACH DESCRIPTIONS OF ALL VEHICLES AND COPIES OF FINANCING TOTAL OF ALL SCHEDULE 5 PAGES _____ ARRANGEMENTS. (ENTER ON PAGE 1 ONLY)

ATTACH EXPLANATION OF ANY OTHER TRAVEL OR TRANSPORTATION COSTS, INCLUDING JUSTIFICATION OF ANY OUT-OF-TOWN TRAVEL

DEPARTMENT OF MENTAL HEALTH

SCHEDULE 6: SUPPLIES AND MINOR EQUIPMENT COST JUSTIFICATION

PAGE _____ OF _____

PROVIDER NAME _____ SERVICE _____

ORIGINAL () REVISION () (NUMBER _____) RFP/CONTRACT NO. _____

FOR THE PERIOD OF: FROM _____ TO _____

(1) EXPENSE CATEGORY	(2) COST FOR FACILITY #1	(3) COST FOR FACILITY #2	(4) COST FOR FACILITY #3	(5) TOTAL SUPPLIES
OFFICE SUPPLIES				
HOUSEHOLD SUPPLIES				
HOUSEHOLD FURNISHINGS				
OFFICE EQUIPMENT				
OTHER SUPPLIES				
TOTAL OF ALL ENTRIES ON THIS PAGE				

ATTACH EXPLANATION OF ANY OTHER SUPPLIES OR OTHER EQUIPMENT COSTS, WITH ITEMIZED LISTS

TOTAL OF ALL SCHEDULE 6 PAGES
(ENTER ON PAGE 1 ONLY)

**DEPARTMENT OF MENTAL HEALTH
SCHEDULE 7: CAPITAL EQUIPMENT AND OUTLAYS COST JUSTIFICATION**

PROVIDER NAME _____ SERVICE _____ PAGE _____ OF _____

ORIGINAL () REVISION () (NUMBER _____) RFP/CONTRACT NO. _____

FOR THE PERIOD OF: FROM _____ TO _____

(1) EXPENSE CATEGORY	(2) COST FOR FACILITY #1	(3) COST FOR FACILITY #2	(4) COST FOR FACILITY #3	(5) TOTAL FOR ALL FACILITIES
VEHICLE PURCHASE *				
MAJOR REPAIRS				
MAJOR EQUIPMENT				
OTHER CAPITAL OUTLAYS**				

TOTAL OF ALL ENTRIES ON THIS PAGE _____

USE ADDITIONAL PAGES IF MORE THAN THREE FACILITIES ARE INCLUDED IN ONE BUDGET

* ATTACH ITEMIZED LISTS
** ATTACH EXPLANATION OF ANY OTHER CAPITAL OUTLAYS ANTICIPATED, WITH ITEMIZED LISTS

TOTAL OF ALL SCHEDULE 7 PAGES _____
(ENTER ON PAGE 1 ONLY)

**DEPARTMENT OF MENTAL HEALTH
SCHEDULE 8: CLIENT EXPENSE COST JUSTIFICATION**

PROVIDER NAME _____ SERVICE _____

ORIGINAL () REVISION () (NUMBER _____) RFP/CONTRACT NO. _____

FOR THE PERIOD OF: FROM _____ TO _____

(1) EXPENSE CATEGORY	(2) COST FOR FACILITY #1	(3) COST FOR FACILITY #2	(4) COST FOR FACILITY #3	(5) TOTAL FOR ALL FACILITIES
FOOD				
CLOTHING				
ALLOWANCES/STIPENDS				
MEDICAL				
DENTAL				
TRAINING*				
RECREATION				
SOCIO-CULTURAL				
OTHER**				
TOTAL OF ALL ENTRIES ON THIS PAGE				

USE ADDITIONAL PAGES IF MORE THAN THREE FACILITIES ARE INCLUDED IN ONE BUDGET
 * ATTACH ITEMIZED LISTS
 ** ATTACH EXPLANATION OF ANY OTHER CLIENT COSTS ANTICIPATED

TOTAL OF ALL SCHEDULE 8 PAGES

**DEPARTMENT OF MENTAL HEALTH
SCHEDULE 9: COMMUNICATIONS COST JUSTIFICATION**

PAGE _____ OF _____

PROVIDER NAME _____ SERVICE _____
 ORIGINAL () REVISION () (NUMBER _____) RFP/CONTRACT NO. _____
 FOR THE PERIOD OF: FROM _____ TO _____

(1) EXPENSE CATEGORY	(2) COST FOR FACILITY #1	(3) COST FOR FACILITY #2	(4) COST FOR FACILITY #3	(5) TOTAL FOR ALL FACILITIES
TELEPHONE				
POSTAGE				
DELIVERY				
COPYING				
OTHER				
TOTAL OF ALL ENTRIES ON THIS PAGE				

USE ADDITIONAL PAGES IF MORE THAN THREE FACILITIES ARE INCLUDED IN ONE BUDGET

* ATTACH ITEMIZED LISTS
 ** ATTACH EXPLANATION OF ANY OTHER COMMUNICATIONS COST ANTICIPATED, WITH ITEMIZED LISTS

TOTAL OF ALL SCHEDULE 9 PAGES

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(ENTER ON PAGE 1 ONLY)

**DEPARTMENT OF MENTAL HEALTH
SCHEDULE 11: INDIRECT / OVERHEAD COST JUSTIFICATION**

PROVIDER NAME _____ SERVICE _____ PAGE _____ OF _____

ORIGINAL () REVISION () (NUMBER _____) RFP/CONTRACT NO. _____

FOR THE PERIOD OF: FROM _____ TO _____

(1) EXPENSE CATEGORY	(2) COST FOR FACILITY #1	(3) COST FOR FACILITY #2	(4) COST FOR FACILITY #3	(5) TOTAL FOR OTHER INDIRECT COSTS
ADMINISTRATION				
FINANCIAL MANAGEMENT				
AUDIT				
OTHER INDIRECT/OVERHEAD				
TOTAL OF ALL ENTRIES ON THIS PAGE				

IF A PERCENTAGE IS USED, ATTACH APPROVAL LETTER FOR INDIRECT COSTS RATE OR PRIOR AUDITED FIGURES THAT JUSTIFIES THE PERCENTAGE USED.

ATTACH EXPLANATION OF ANY OTHER INDIRECT OR OVERHEAD EXPENSES, WITH DETAILED COST JUSTIFICATION

TOTAL OF ALL SCHEDULE 11 PAGES
(ENTER ON PAGE 1 ONLY)