RFP Information Packet

Thank you for considering submitting a request for proposal to the Union County Human Services. Please read through this packet – it contains information and documentation that is needed to submit an RFP to Union County Human Services.

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Instructions for Completion of Application

Applicants are responsible for examining all conditions of participation and relevant service specifications and requirements in this invitation to bid prior to submitting a bid.

Proposals should, at minimum, include the following items:

☐ Organization Information Form

Please use this form to identify the applicant, to provide contact information, and pertinent information about the person(s) authorized to complete this application, the contact person that has been designated to work directly with Union County Human Services staff in receiving referrals, and the person designated to handle billing.

In addition, you must confirm that you agree to comply with the attached Conditions of Participation and any or all Service Specifications that apply to your application. All individuals involved in the administration of, and provision of services must be both aware of and in compliance with these specifications.

☐ Service Quotation or Rate Sheet

This document provides each applicant the opportunity to state what services it will provide and the cost per unit. For the services that you wish to provide, indicate the unit cost and the geographic area that you will serve. **Provide a unit cost for 2024**.

The period covered by this application and resulting purchase of service agreement shall begin from the date of award through December 31, 2024.

☐ Statement of Organizational Purpose

Please provide a description of your organization, its history and mission.

☐ Disclosure of Ownership

List the names of all individuals and organizations having direct or indirect ownership interests or controlling interest separately or in combination amounting to an ownership interest of 5% or more in the disclosing entity.

☐ Certificate of Good Standing

If the applicant is a corporation or a limited liability company, please submit a copy of your agency's current Certificate of Good Standing issued by the Secretary of the State of Ohio with the application.

☐ Workers' Compensation Certificate

Please provide a copy of your agency's current Ohio Bureau of Workers' Compensation Certificate of Premium Payment with the application.

☐ **Documentation of Insurance Coverage**

Please provide evidence of liability coverage with the application.

Prior to provision of services, the successful vendor must provide both a certificate of insurance naming Union County as an additional insured as the insurance relates to the work done, service provided, and/or product delivered, and policy endorsements for the services or products provided and the County's additional insured status.

For the additional insured coverage, please also submit either the additional insured endorsement to your policy or the relevant provision from your base policy addressing additional insured coverage.

☐ **Non-Discrimination and Equal Employment Opportunity Affidavit**

All applicants are required to complete and sign the attached non-discrimination and equal employment opportunity document.

Additional information will be required if contract is awarded and must be provided before contract drafting:

- Completed W-9
- Certificate of Insurance showing Union County and Union County Human Services as policy holders (if not previously provided)
- Endorsement to the base insurance policy showing Union County and Union County Human Services as additional insured policy holders (if not previously provided)
- Copies of valid drivers' licenses for each driver and applicant
- Copy of certified driving record from the Ohio Bureau of Motor Vehicles for each driver and applicant
- Criminal background check for each employee and applicant

Organization Information Form

Organization

Company Name: _____

Address: _____

Phone: _____ Email: _____

Federal Tax ID: _____ Type: ☐Individual/Sole Proprietor ☐ Corporation
☐Limited Liability Corporation (LLC)
☐Partnership

Contract Signatory

Name: _____

Address: _____

Phone: _____ Email: _____

Service Coordinator

Name: _____

Address: _____

Phone: _____ Email: _____

Fiscal/Billing Contact

Name: _____

Address: _____

Phone: _____ Email: _____

I understand and agree to the Conditions of Participation contained in the Purchase of Service Application. I am authorized to commit the above organization to comply with these conditions. Further, I have read, understood, agreed to, and am authorized to commit the above organization to provide the service(s) set forth in the Service Specifications of those services for which we are submitting a proposal.

Signature: _____

Printed Name: _____

Title: _____ Date: _____

Non-Discrimination and Equal Opportunity Employment Unsworn Statement

(Made on penalty of perjury)

I _____
Name Title

of _____
Organization Name

made the forgoing proposal; that such does not and shall not discriminate against any employee or applicant for employment because of race, disability, religion, color, sex, or national origin. If awarded the contract under this proposal, the successful Vendor shall take affirmative action to ensure that employees are treated, during employment, without regard to their race, disability, religion, color, sex, or national origin. If successful under the forgoing proposal, Vendor shall post non-discrimination notices in conspicuous places available to employees and applicants for employment setting forth the provisions of this affidavit. Further, Vendor does not and shall not discriminate on the basis of race, color, religion (creed), sex, age (except as permitted by law), national origin (ancestry), disability, marital status, military status, genetic information, gender identity, sexual orientation, low-income status, or limited English proficiency in providing its services.

_____
Affidavit (Printed or Typed Name)

_____
Signature

_____
Date

_____
Company Name

_____
Address

_____
Witness (Printed or Typed Name)

_____
Signature

_____
Date

Union County Transportation Conditions of Participation

Condition 1 – Agency Structure

The Provider is a business or service agency with a history of operating and providing transportation services to individuals for at least one year before the point of application. A Provider, if a corporation or limited liability company, is in good standing with the Ohio Secretary of State. A Provider operating under a fictitious or trade name shall be property registered with the Ohio Secretary of State.

1. The Provider shall demonstrate a year business history supported by business records and/or professional references that will demonstrate the Provider's ability to perform the duties of the contract and provide high-quality services. The Provider shall provide business documents and/or statements, ensuring criteria are met as listed below.

    - The provider must meet a minimum of one of the following criteria:

        1. Provider is a current Union County Human Services (UCHS) transportation provider. Any present or former UCHS provider agency or agency owner who has had UCHS clients removed from their care or service due to poor performance or non-compliance issues will be examined during the bid evaluation process.

            -OR-

        2. Provider agency must demonstrate a business history of providing transportation services to individuals for at least 1 year prior to point of application to UCHS, which is defined as the date of opening of this invitation to bid. The following documentation is required with bid submission:

            a. **One year business history:** Applicant must furnish proof of supporting documentation as evidence of Provider's one year transportation service provision. Evidence of paid service provision to consumers for a minimum of one year; written confirmation of the banking relationship during the year prior to application.

            b. **One year of Business Insurance:** Applicant is also required to submit supporting documentation of current business insurance coverage. (See Condition 3 below).

    - The provider shall disclose all parties having ownership/interest in or control of the agency.

    - The Provider shall have a written statement defining the purpose of their business or service agency.

    - The Provider shall have written policies. If the provider has a governing board, the provider shall have written bylaws; and if the provider is incorporated, the provider shall have written articles of incorporation.

    - The Provider's direct service staff shall be eligible for employment under Ohio Revised Code (O.R.C.) §5123.081(B) and Provider shall comply with O.R.C. §5123.081(C), as amended or replaced, as a condition of providing service.

    - The Provider shall have a written table of organization that clearly identifies lines of administrative, advisory, contractual, and supervisory authority and responsibility to the direct care level.

- The Provider is operating the business in compliance with applicable Federal, State and Local laws, regulations, and orders, including Public Health Orders.

- The Provider shall comply with all applicable federal and state privacy laws, including the Health Insurance Portability and Accountability Act regulations (HIPAA).

- The Provider shall comply with current anti-discrimination laws in service delivery to consumers.

Condition 2 – Physical Facility

The Provider has a fixed, permanent location from which to conduct business.

- The Provider shall have a computer with software to document and track services, a printer, a telephone, fax machine, and the capacity, whether by staff or by an answering device, service or other means, to take telephone calls between 9:00 a.m. and 4:00 p.m., Monday through Friday.

- Provider shall supply the UCHS with an alternate telephone number to be used for administrative purposes only, in the event of an emergency and the provider cannot be reached at the primary agency telephone number.

- The Provider shall utilize a secure, locked storage space for all UCHS client records.

Condition 3 – Administrative Policies

The Provider has written procedures supporting the operation of the business and its services.

- The Provider shall have a system to document services delivered and billed that complies with the UCHS program requirements.

- The Provider shall submit evidence of business insurance coverage as required below. Throughout the term of the contract, the Provider shall obtain and maintain a comprehensive insurance program affording, at minimum, the items indicated below:

    1. **Comprehensive General Liability:** $1,000,000 annual combined single limit per occurrence with $2,000,000.00 annual aggregate

    2. **Automobile Liability Insurance:** $1,000,000 annual combined single limit per occurrence with $2,000,000.00 annual aggregate, including transportation for hire coverage

- The Provider shall have Certificates of Insurance providing that during the term of the contract the Provider shall be insured at all locations where it undertakes business operations for the types of insurance and limits of liability as indicated above. These certificates of insurance must be provided prior to contract drafting.

    1. All such Vendor's insurance policies shall be primary and non-contributory.

2. All policies must show the full name of the organization or individual and must match what is registered with the State.

3. These policies shall contain the following special provisions: The company agrees that thirty (30) days prior to the cancellation or reduction of the insurance afforded by this policy with respect to the contract involved, written notice shall be delivered to: Union County Human Services, PO Box 389, Marysville, OH 43040.

4. In addition to a Certificate of Insurance, Vendor shall provide additional insured endorsements to the underlying policy for the additional insured coverage, listing Union County and Union County Human Services as additional insured policy holders.

- The Provider shall have a written procedure which identifies the steps a client shall take to file a liability claim.

- The Provider shall have a written procedure for documenting all client incidents and reporting the incidents to UCHS. The Provider shall maintain evidence of reporting the incident to UCHS via phone, fax, or e-mail. All incidents must be reported to UCHS within 24 hours.

    1. An incident is defined, per OAC 173-3-01, as "an event that is inconsistent with the routine care or routine provision of goods and services to a consumer. An incident may involve a consumer, caregiver (to the extent it impacts a consumer), provider, provider's staff, ODA's staff or other administrative authorities. Examples of an incident are abuse, neglect, abandonment, an accident, or an unusual situation resulting in an injury to a person or damage to the person's property or equipment."

    2. The Provider shall obtain written approval from the client to release client specific information to Union County Human Services and have a written policy regarding confidentiality. Client information received or submitted shall be treated as confidential.

    3. The Provider agrees that the use or disclosure by any party of any information concerning clients for any purpose not directly connected to the delivery of purchased services is prohibited, except upon written consent of the client or their responsible parent or guardian.

    4. The Provider shall retain all records supporting transportation service to UCHS clients for a period of 6 years or until an initiated fiscal audit is completed, whichever is later. Notwithstanding the above, if there are litigation, claims, audits, negotiations, or other actions that involve any of the records cited and that have started before the expiration of the six-year period, then such records must be retained until completion of the actions and resolution of all issues, or the expiration of the six-year period, whichever occurs later.

    5. The Provider shall notify UCHS via phone, fax, or e-mail of any and all client complaints reported to the Provider agency.

    6. The Provider shall immediately notify UCHS in writing, of any changes to corporate structure, Federal Tax ID#, or if the vendor is purchased by, or merges with, another business entity.

    7. In the event a Provider desires to be released from the terms and conditions of the UCHS contract, the provider must submit this request in writing to UCHS. UCHS requires a minimum of ten (10) calendar days in advance of the date of termination.

    8. The Provider shall not engage in behavior that constitutes a conflict of interest in which the provider is in a position to exploit a professional or official capacity in some way for their personal or agency's benefit or interest or may create a lack of objectivity or partiality.

9. Any loss of state and/or federal funding or reimbursement to UCHS shall result in the immediate termination of this agreement on the date that state and/or federal funding or reimbursement is no longer available, or later, as otherwise stipulated by UCHS. UCHS shall notify the Provider in writing as to the date that state and/or federal funding or reimbursement is no longer available to UCHS.

Condition 4 — Personnel Policies

The Provider has written personnel policies that support lawful personnel practices.

- The Provider shall have written job descriptions or statements of job responsibilities that include qualifications for each position involved in the direct delivery of UCHS services.

- The Provider shall maintain a personnel file on every staff member (including volunteers and contract workers), who provides direct service to UCSS clients. This file shall include:

    1. A resume or application for employment that includes a description of work history

    2. Written documentation of employee applicant's signed consent for verification of previous employment, training, and experience

    3. Written documentation of Provider confirmation/verification of employee's previous employment, experience, and training

    4. Written verification of licensure/certification and a valid driver's license, if applicable.

    5. A copy of the performance appraisals signed and dated by the employee and staff member conducting the appraisal

    6. A copy of the UCHS Provider Staff Code of Ethics signed and dated by the employee

- The Provider has written procedures that require it to conduct background checks on all applicants as well as procedures that do not permit hiring an applicant who has been convicted of a disqualifying offense, as defined in ORC § 3701.881 and Ohio Administrative Code (O.A.C.) § 173-9-01 or other actions that pose a risk to the clients, unless there is documentation to validate the hiring consistent with the foregoing statutory references. The Provider shall maintain a documentation log to support completion of Bureau of Criminal Identification and Investigation (BCII) checks on all service workers and supervisory personnel.

- The Provider agrees that any driver who provides services under the agreement shall have a valid operator’s license not under any suspension or other court or administrative restriction.

Condition 5 — Service Delivery

The Provider must deliver services in compliance with service specification(s) and in accordance with the plan designed and authorized by UCHS. UCSS does not guarantee a volume of service for providers. All referrals and authorizations are sent through the transportation request form via email or fax.

- The Provider shall deliver services in compliance with service specification(s) and in accordance with the services as authorized by UCHS.

- The Provider, its employees, approved subcontractors, or agents, shall deliver services in compliance with any Public Health Order, public health regulation, and consistent with Responsible Restart Ohio protocols, Sector Specific Operating Requirements of the State of Ohio or Union County, and Guidelines from the United States Centers for Disease Control and Prevention.

- UCHS shall determine eligibility for all clients requesting transportation services.

- The Provider shall have a written procedure for verifying service delivery when a client signature cannot be obtained.

Condition 6 — Compliance

The Provider shall comply with all contract requirements, Conditions of Participation, relevant Service Specifications, monitoring, and reporting requirements established by Union County Human Services.

- The Provider shall allow representatives of UCHS access to the Provider facility and full access to policies, procedures, records, and other documents related to provision of service to UCHS clients and shall cooperate with said representatives in periodic reviews.

- The Provider shall maintain compliance with all contract requirements, Conditions of Participation (COP), and relevant Service Specifications (SS) during the term of this contract. Failure to maintain compliance may result in the following actions:

    1. A Provider who is found to be non-compliant with a COP or SS may:

        a) Be required to submit a Plan of Correction

        b) Subject to contract termination, depending on the severity

- A Provider who is found to have repeated non-compliance issues with the COP or SS, or when non-compliance poses a health and/or safety risk to the UCHS client, may:

        a) Be required to submit a Plan of Correction

        b) Subject to contract termination, depending on the severity

- A Provider who is found to have repeated non-compliance issues with the COP and SS, has repeatedly failed to show their ability to meet the terms and conditions of the contract, or is found to have serious noncompliance issues which pose a health and/or safety risk to the UCHS client may have the contract terminated.

- The Provider shall immediately notify Union County Human Services in writing of any of the following changes:

    1. Changes in policy related to service delivery

    2. Changes in name, corporate structure, or service provision

    3. Office relocations, changes in phone numbers

4. Changes in Managerial staff

Condition 7 - Billing

The Provider shall submit billings to Union County Human Services monthly. The Provider's request for payment is due no later than the 15th of the subsequent month following the date of service.

- The Provider shall bill monthly for only those units authorized by UCHS and delivered by the Provider.
- The Provider shall bill for actual units of service delivered rounded off to the nearest 1/10th mile. Worker's time spent for travel, breaks, meal breaks, or administrative activities shall not be billed to UCHS.
- UCSS has the right to refuse payment to the Provider when requests for payment are not received within sixty days of the date of service delivery.
- The compensation paid to a Provider and its representatives shall be the sole and exclusive consideration for the goods and/or services provided under that contract. No additional fee, cost, or donation of any sort shall be charged to or solicited from any eligible UCHS client.
- The Provider shall not solicit donations from clients whose services are provided under UCHS.
- UCHS reserves the right to adjust invoices for mathematical errors, incorrect rates, or non-covered services. Any changes to the submitted invoice will be communicated to the Provider.
- The Provider shall maintain written documentation of all units of service delivered. UCHS has the right to refuse payment, or require re-payment to the UCHS, for any units of service billed to the UCHS when the Provider agency does not have written documentation to support the provision of service.
- Medicaid-eligible trips will not be paid without complete location names and addresses, as required by Medicaid.
- UCHS normally makes payments within 30 days from the day the complete and accurate invoice is received. All submitted invoices must include the documentation listed in the transportation service specifications.

Service Specifications – Transportation

INVOICING

Invoices should be sent to Union County Human Services (UCHS) within thirty days of the end of each month for the preceding month.

The invoices must include the names of the client's name, the number of units (rounded to 1/10 mile), and the amount claimed based on the negotiated unit rate. Proper documentation is required to be sent with the invoice and may include approval forms, spreadsheets, log sheets, or other approved documents.
Invoices may be emailed, faxed, or mailed to UCHS:

EMAIL: UNION_ACCT_RECV@JFS.OHIO.GOV

FAX: (937) 644-8700

UNION COUNTY HUMAN SERVICES
PO BOX 389
MARYSVILLE, OHIO 43040
ATTN: FISCAL

Auditing

All invoices submitted will be reviewed by the fiscal unit for accuracy, completeness, and the necessary documentation prior to payment.

UCHS reserves the right to adjust invoices for mathematical errors, incorrect rates, or non-covered services.
The reported expenditures are subject to audit by the appropriate local, state, and federal officials after each payment is made.

PAYMENT

Payment terms are Net 30 and begin with the receipt of an **accurate and complete invoice.**

REQUIRED INFORMATION FOR ALL TRIPS

To be considered accurate and complete for payment processing, all invoices must include:

1. Name of person served
2. Trip Date
3. Specific name of location (i.e. Dr. Smith – not just "foot doctor")
4. Specific street address
5. Client's signature that trip was taken
6. Number of units (miles)
7. Rate
8. Total invoice amount (rate x units)
9. Explanation and/or documentation for any additional fees or services:
    a. Wait time charges must indicate wait start time and wait end time
    b. Charges due to time of trip or short scheduling should be documented with date/time and reason
    c. Charges related to off-hours, or non-business days must be indicated
    d. Charges due to distances must be indicated

Medicaid-eligible trips will not be paid without complete location names and addresses, as required by Medicaid.

Transportation Approval Process

Clients may contact a transportation provider directly for transportation. The client is responsible for providing the required documentation to UCHS or the transportation vendor to obtain transportation.

Transportation providers are required to confirm the client is eligible for transportation with a UCHS Case Manager. Transportation providers must have the client sign a release (included in this packet), which allows UCHS to release eligibility information to vendors for transportation.

A transportation request form should be submitted to UCHS for all requested trips (included in this packet). The form must be completed and sent to the UCHS case manager for approval or denial of trip(s). In some circumstances, a blanket approval may be granted on a month-to-month basis.

COMPLIANCE

Per OAC 5101:9-2(b) All programs, services, and benefits that are administered, supervised, authorized and/or participated in by a county agency shall be operated in accordance with the nondiscrimination requirements of the Title VI of the Civil Rights Act of 1964, as amended; section 504 of the Rehabilitation Act of 1973, as amended; the Age Discrimination Act of 1975; the Multiethnic Placement Act of 1994, as amended by the Interethnic Adoption Provisions of 1996; the American with Disability Act Amendment of 2008; Title IX of the Education Amendments of 1972, and the Workforce Innovation and Opportunity Act (WIOA) of 2014.

The county agency is responsible for ensuring compliance with this rule by all county agency contractors.

Transportation Request form

To be completed by the transportation provider:

Transportation Provider: _____

Requesting to provide NET transportation for: _____

Client's Address: _____

Client's Phone Number: _____

Transportation will be provided on the following date(s): _____

Client's Date of Birth: _____ Last four of Client's Social Security Number: _____

List of location(s) where client will be transported.

Trip Date	Name of Location* (be specific)	Address*	Round Trip Y / N	Covered by Medicaid Y / N	Client's Signature (Required)

At the end of each trip, the client must sign to state that they were transported to the location, that it was a Medicaid covered trip, and if the transportation was provided round trip.

***Please note: Medicaid-eligible invoices will not be paid without complete location names and addresses.**

To be completed by UCDHS:

Client is Approved _____ Date(s) approved for: _____

Client is Denied _____ Reason of denial: _____

Completed by: _____

Title: _____ Date: _____

Authorization for Release of Information

Ohio Department of Job and Family Services

APPLICANT/RECIPIENT AUTHORIZATION FOR RELEASE OF INFORMATION

Office Use Only	
Applicant/Recipient Name	**Case Number**
Name of CDJFS Representative/Unique Identifier/Date	
Marcie Parker	

I, _____, hereby authorize _____ to disclose
(Name of Individual) **(Name of covered entity, such as CDJFS, employer, etc.)**

the information listed below to Union County Human Services for the purpose of determining
(Who will receive the information?)

eligibility for cash assistance, medical assistance and/or food stamp benefits; or for the following reason(s): permission to verify information electronically, verbally, and in writing if client is eligible for NET transportation.

Information to be released: UCDJFS will verify if the above-named client is Medicaid elgible for NET Transportation wtih the above-named vendor.

By signing below, I understand that:

This authorization shall expire on until revoked by client or until revoked by me in writing, whichever comes first.
(Date or completion of "event"- reason the signed authorization is needed)

I have the right to revoke or cancel this authorization at any time by providing notice in writing to the following address:
Union County Human Services, 940 London Ave. Suite 1800 Marysville, OH 43040

The revoking or canceling of this authorization does not affect the use or disclosure of information that occurred prior to the date that authorization was canceled.

Any information used or disclosed as per this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected by federal or state law.

This authorization is **NOT** for the release or use of protected health information (PHI) – please use the appropriate medical release authorization form.

I am aware of my responsibilities to report completely and fully all facts that bear upon my eligibility for all cash assistance, medical assistance and/or food stamp benefits. I realize if the requested information reveals I have improperly reported my situation, the information may be given to the prosecuting attorney for possible civil action or criminal prosecution.

Completion of this form is voluntary, but necessary to determine eligibility for cash assistance, medical assistance and/or food stamp benefits.

Signature of Applicant/Recipient or Authorized Representative	Date	Representative's Legal Authority to Applicant/Recipient (Such as parent, guardian, power of attorney, auth rep, etc.)

Please reply in the space below, sign and date.

Signature/Title of Person Supplying Information **Telephone Number** **Date**

JFS 07341 (04/2004)