**Attachment 1**

**NO PROPOSAL REPLY FORM**

Contract No. HSS-15-012 Contract Title: ALCOHOL AND OTHER DRUG PREVENTION SERVICES FOR ADULTS

To assist us in obtaining good competition on our Request for Proposals, we ask that each firm that has received a proposal, but does not wish to bid, state their reason(s) below and return in a clearly marked envelope displaying the contract number. This information will not preclude receipt of future invitations unless you request removal from the Vendor's List by so indicating below, or do not return this form or bona fide proposal.

Unfortunately, we must offer a "No Proposal" at this time because:

|  |  |  |  |
| --- | --- | --- | --- |
|  | 1. |  | We do not wish to participate in the proposal process. |
|  |  |  |  |
|  | 2. |  | We do not wish to bid under the terms and conditions of the Request for Proposal document. Our objections are: |
|  |  |  |  |
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|  |  |  |  |
|  | 3. |  | We do not feel we can be competitive. |
|  |  |  |  |
|  | 4. |  | We cannot submit a Proposal because of the marketing or franchising policies of the manufacturing company. |
|  |  |  |  |
|  | 5. |  | We do not wish to sell to the State. Our objections are: |
|  |  |  |  |
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|  |  |  |  |
|  | 6. |  | We do not sell the items/services on which Proposals are requested. |
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|  | 7. |  | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| FIRM NAME |  | SIGNATURE |

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| --- | --- | --- |
|  |  | We wish to remain on the Vendor's List **for these goods or services**. |
|  |  |  |
|  |  | We wish to be deleted from the Vendor's List **for these goods or services**. |

 **Attachment 2**

**CONTRACT NO.: HSS-15-012**

**CONTRACT TITLE: ALCOHOL AND OTHER DRUG PREVENTION SERVICES FOR ADULTS**

**DEADLINE TO RESPOND: July 15, 2015 at 11:00 AM (Local Time)**

**NON-COLLUSION STATEMENT**

This is to certify that the undersigned Vendor has neither directly nor indirectly, entered into any agreement, participated in any collusion or otherwise taken any action in restraint of free competitive bidding in connection with this proposal**, and further certifies that it is not a sub-contractor to another Vendor who also submitted a proposal as a primary Vendor in response to this solicitation** submitted this date to the State of Delaware, DIVISION OF SUBSTANCE ABUSE & MENTAL HEALTH

It is agreed by the undersigned Vendor that the signed delivery of this bid represents, subject to any express exceptions set forth at Attachment 3, the Vendor’s acceptance of the terms and conditions of this solicitation including all specifications and special provisions.

**NOTE:** Signature of the authorized representative **MUST** be of an individual who legally may enter his/her organization into a formal contract with the State of Delaware, DIVISION OF SUBSTANCE ABUSE & MENTAL HEALTH.

 COMPANY NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Check one)

|  |  |
| --- | --- |
|  | Corporation |
|  | Partnership |
|  | Individual |

NAME OF AUTHORIZED REPRESENTATIVE

 (Please type or print)

SIGNATURE TITLE

COMPANY ADDRESS

PHONE NUMBER FAX NUMBER

EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 STATE OF DELAWARE

FEDERAL E.I. NUMBER LICENSE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  COMPANY CLASSIFICATIONS: CERT. NO.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Certification type(s) | Circle all that apply |
| Minority Business Enterprise (MBE) | Yes No |
| Woman Business Enterprise (WBE) | Yes No |
| Disadvantaged Business Enterprise (DBE) | Yes No |
| Veteran Owned Business Enterprise (VOBE) | Yes No |
| Service Disabled Veteran Owned Business Enterprise (SDVOBE) | Yes No |

[The above table is for informational and statistical use only.]

PURCHASE ORDERS SHOULD BE SENT TO:

 (COMPANY NAME)

ADDRESS

CONTACT

PHONE NUMBER FAX NUMBER

EMAIL ADDRESS

**AFFIRMATION:** Within the past five years, has your firm, any affiliate, any predecessor company or entity, owner,

Director, officer, partner or proprietor been the subject of a Federal, State, Local government suspension or debarment?

YES NO if yes, please explain

**THIS PAGE SHALL HAVE ORIGINAL SIGNATURE, BE NOTARIZED AND BE RETURNED WITH YOUR PROPOSAL**

SWORN TO AND SUBSCRIBED BEFORE ME this \_\_\_\_\_\_\_\_ day of , 20 \_\_\_\_\_\_\_\_\_\_

Notary Public My commission expires

City of County of State of

**Attachment 3**

Contract No. HSS-15-012

Contract Title: ALCOHOL AND OTHER DRUG PREVENTION SERVICES FOR ADULTS

EXCEPTION FORM

Proposals must include all exceptions to the specifications, terms or conditions contained in this RFP. If the vendor is submitting the proposal without exceptions, please state so below.

🞏 By checking this box, the Vendor acknowledges that they take no exceptions to the specifications, terms or conditions found in this RFP.

|  |  |  |
| --- | --- | --- |
| **Paragraph # and page #** | **Exceptions to Specifications, terms or conditions** | **Proposed Alternative** |
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**Note: use additional pages as necessary.**

**Attachment 4**

Contract No. HSS-15-012

Contract Title: ALCOHOL AND OTHER DRUG PREVENTION SERVICES FOR ADULTS

CONFIDENTIAL INFORMATION FORM

🞏 By checking this box, the Vendor acknowledges that they are not providing any information they declare to be confidential or proprietary for the purpose of production under 29 Del. C. ch. 100, Delaware Freedom of Information Act.

|  |
| --- |
| **Confidentiality and Proprietary Information** |
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**Note: use additional pages as necessary.**

**Attachment 5**

Contract No. HSS-15-012

Contract Title: ALCOHOL AND OTHER DRUG PREVENTION SERVICES FOR ADULTS

BUSINESS REFERENCES

List a minimum of three business references, including the following information:

* Business Name and Mailing address
* Contact Name and phone number
* Number of years doing business with
* Type of work performed

Please do not list any State Employee as a business reference. If you have held a State contract within the last 5 years, please provide a separate list of the contract(s).

|  |  |  |
| --- | --- | --- |
| 1.  | **Contact Name & Title:**  |  |
|  | **Business Name:**  |  |
|  | **Address:**  |  |
|  |  |  |
|  | **Email:**  |  |
|  | **Phone # / Fax #:**  |  |
|  | **Current Vendor (YES or NO):**  |  |  |
|  | **Years Associated & Type of Work Performed:**  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| 2.  | **Contact Name & Title:**  |  |
|  | **Business Name:**  |  |
|  | **Address:**  |  |
|  |  |  |
|  | **Email:**  |  |
|  | **Phone # / Fax #:**  |  |
|  | **Current Vendor (YES or NO):**  |  |  |
|  | **Years Associated & Type of Work Performed:**  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| 3.  | **Contact Name & Title:**  |  |
|  | **Business Name:**  |  |
|  | **Address:**  |  |
|  |  |  |
|  | **Email:**  |  |
|  | **Phone # / Fax #:**  |  |
|  | **Current Vendor (YES or NO):**  |  |  |
|  | **Years Associated & Type of Work Performed:**  |  |

**Attachment 6**

SUBCONTRACTOR INFORMATION FORM

|  |
| --- |
| **PART I – STATEMENT BY PROPOSING VENDOR** |
| 1. CONTRACT NO.HSS-15-012 | 2. Proposing Contractor: | 3. Mailing Address |
| 4. SUBCONTRACTOR |  |
| a. NAME | 4c. Company OSD Classification:Certification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| b. Mailing Address: | 4d. Men Business Enterprise [ ]  Yes [ ]  No4e. Minority Business Enterprise [ ]  Yes [ ]  No4f. Disadvantaged Business Enterprise [ ]  Yes [ ]  No4g. Veteran Owned Business Enterprise [ ]  Yes [ ]  No4h. Service Disabled Veteran Owned Business Enterprise [ ]  Yes [ ]  No |
| 5. DESCRIPTION OF WORK BY SUBCONTRACTOR |
| 6a. NAME OF PERSON SIGNING | 7. BY (*Signature)* | 8. DATE SIGNED |
| 6b. TITLE OF PERSON SIGNING |
|  **PART II – ACKNOWLEDGEMENT BY SUBCONTRACTOR** |
| 9a. NAME OF PERSON SIGNING | 10. BY (*Signature*) | 11. DATE SIGNED |
| 9b. TITLE OF PERSON SIGNING |

 \* Use a separate form for each subcontractor

**Attachment 7**

STATE OF DELAWARE

MONTHLY USAGE REPORT

**SAMPLE REPORT - FOR ILLUSTRATION PURPOSES ONLY**



**Note:** A copy of the Usage Report will be sent by electronic mail to the Awarded Vendor. The report shall be submitted electronically in **EXCEL** and sent as an attachment to dsamhbusinesoperations@state.de.us. It shall contain the six-digit department and organization code for each agency and school district.

**Attachment 8**

**SAMPLE REPORT - FOR ILLUSTRATION PURPOSES ONLY**

|  |
| --- |
| **State of Delaware** |
| **Subcontracting (2nd tier) Quarterly Report** |
| **Prime Name:**  |   |   | **Report Start Date:**  |   |   |   |   |   |
| **Contract Name/Number** |   |   | **Report End Date:**  |   |   |   |   |   |
| **Contact Name:**  |   |   | **Today's Date:**  |   |   |   |   |   |
| **Contact Phone:**  |   |   | \*Minimum Required  | Requested detail |   |   |   |   |   |
| **Vendor Name\*** | **Vendor TaxID\***  | **Contract Name/ Number\*** | **Vendor Contact Name\*** | **Vendor Contact Phone\*** | **Report Start Date\*** | **Report End Date\*** | **Amount Paid to Subcontractor\*** | **Work Performed by Subcontractor UNSPSC** | **M/WBE Certifying Agency** | **Veteran** **/Service Disabled Veteran Certifying Agency**  | **2nd tier Supplier Name** | **2nd tier Supplier Address** | **2nd tier Supplier Phone Number** | **2nd tier Supplier email** | **Description of Work Performed**  | **2nd tier Supplier Tax Id** |
|   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
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**Note:** A copy of the Subcontracting Quarterly Report will be sent by electronic mail to the Awarded Vendor.

Completed reports shall be saved in an Excel format, and submitted to the following email address: vendorusage@state.de.us

**Attachment 9**

Contract No. HSS-15-012

Contract Title: ALCOHOL AND OTHER DRUG PREVENTION SERVICES FOR ADULTS

EMPLOYING DELAWAREANS REPORT

As required by House Bill # 410 (Bond Bill) of the 146th General Assembly and under Section 30, No bid for any public works or professional services contract shall be responsive unless the prospective bidder discloses its reasonable, good-faith determination of:

1. Number of employees reasonable anticipated to be employed on the project: \_\_\_\_\_\_\_\_\_\_\_
2. Number and percentage of such employees who are bona fide legal residents of Delaware: \_\_\_\_\_\_

Percentage of such employees who are bona fide legal residents of Delaware: \_\_\_\_­\_

1. Total number of employees of the bidder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Total percentage of employees who are bona fide resident of Delaware: \_\_\_\_\_\_\_\_\_\_

If subcontractors are to be used:

1. Number of employees who are residents of Delaware: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Percentage of employees who are residents of Delaware: \_\_\_\_\_\_\_\_\_\_\_

“Bona fide legal resident of this State” shall mean any resident who has established residence of at least 90 days in the State.

**Attachment 10**

# State of Delaware

# Office of Supplier Diversity

**Certification Application**

The most recent application can be downloaded from the following site:

<http://gss.omb.delaware.gov/osd/certify.shtml>

Submission of a completed Office of Supplier Diversity (OSD) application is optional and does not influence the outcome of any award decision.

The minimum criteria for certification require the entity must be at least 51% owned and actively managed by a person or persons who are eligible: minorities, Men, veterans, and/or service disabled veterans. Any one or all of these categories may apply to a 51% owner.



**Complete application and mail, email or fax to:**

Office of Supplier Diversity (OSD)

100 Enterprise Place, Suite 4

Dover, DE 19904-8202

Telephone: (302) 857-4554 Fax: (302) 677-7086

 Email: osd@state.de.us

Web site: <http://gss.omb.delaware.gov/osd/index.shtml>

**APPENDIX C:**

***BIDDERS SIGNATURE FORM*** 

**DELAWARE HEALTH AND SOCIAL SERVICES**

**REQUEST FOR PROPOSAL**

**BIDDERS SIGNATURE FORM**

NAME OF BIDDER:

SIGNATURE OF AUTHORIZED PERSON:

TYPE IN NAME OF AUTHORIZED PERSON:

TITLE OF AUTHORIZED PERSON:

STREET NAME AND NUMBER:

CITY, STATE, & ZIP CODE:

CONTACT PERSON:

TELEPHONE NUMBER:

FAX NUMBER:

DATE:

BIDDER’S FEDERAL EMPLOYERS IDENTIFICATION NUMBER:

**THE FOLLOWING MUST BE COMPLETED BY THE VENDOR:**

AS CONSIDERATION FOR THE AWARD AND EXECUTION BY THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES OF THIS CONTRACT, THE (COMPANY NAME)

HEREBY GRANTS, CONVEYS, SELLS, ASSIGNS, AND TRANSFERS TO THE STATE OF DELAWARE ALL OF ITS RIGHTS, TITLE AND INTEREST IN AND TO ALL KNOWN OR UNKNOWN CAUSES OF ACTION IT PRESENTLY HAS OR MAY NOW HEREAFTER ACQUIRE UNDER THE ANTITRUST LAWS OF THE UNITED STATES AND THE STATE OF DELAWARE, RELATING THE PARTICULAR GOODS OR SERVICES PURCHASED OR ACQUIRED BY THE DELAWARE HEALTH AND SOCIAL SERVICES DEPARTMENT, PURSUANT TO THIS CONTRACT.

**APPENDIX D:**

***CERTIFICATION SHEET***



**DELAWARE HEALTH AND SOCIAL SERVICES**

**REQUEST FOR PROPOSAL**

**CERTIFICATION SHEET**

As the official representative for the proposer, I certify on behalf of the agency that:

a. They are a regular dealer in the services being procured.

b. They have the ability to fulfill all requirements specified for development within this RFP.

c. They have independently determined their prices.

d. They are accurately representing their type of business and affiliations.

1. They will secure a Delaware Business License.
2. They have acknowledged that no contingency fees have been paid to obtain award of this contract.
3. The Prices in this offer have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other contractor or with any competitor;
4. Unless otherwise required by Law, the prices which have been quoted in this offer have not been knowingly disclosed by the contractor and prior to the award in the case of a negotiated procurement, directly or indirectly to any other contractor or to any competitor; and
5. No attempt has been made or will be made by the contractor in part to other persons or firm to submit or not to submit an offer for the purpose of restricting competition.
6. They have not employed or retained any company or person (other than a full-time bona fide employee working solely for the contractor) to solicit or secure this contract, and they have not paid or agreed to pay any company or person (other than a full-time bona fide employee working solely for the contractor) any fee, commission percentage or brokerage fee contingent upon or resulting from the award of this contract.
7. They (check one) operate \_\_\_an individual; \_\_\_\_\_a Partnership \_\_\_\_a non-profit (501 C-3) organization; \_\_\_\_\_a not-for-profit organization; or \_\_\_\_\_for profit corporation, incorporated under the laws of the State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
8. The referenced offerer has neither directly or indirectly entered into any agreement, participated in any collusion or otherwise taken any action in restraint of free competitive bidding in connection with this bid submitted this date to Delaware Health and Social Services.
9. The referenced bidder agrees that the signed delivery of this bid represents the bidder’s acceptance of the terms and conditions of this invitation to bid including all Specifications and special provisions.
10. They (check one): \_\_\_\_\_\_\_are; \_\_\_\_\_\_are not owned or controlled by a parent company. If owned or controlled by a parent company, enter name and address of parent company:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Violations and Penalties:**

Each contract entered into by an agency for professional services shall contain a prohibition against contingency fees as follows:

1. The firm offering professional services swears that it has not employed or retained any company or person working primarily for the firm offering professional services, to solicit or secure this agreement by improperly influencing the agency or any of its employees in the professional service procurement process.
2. The firm offering the professional services has not paid or agreed to pay any person, company, corporation, individual or firm other than a bona fide employee working primarily for the firm offering professional services, any fee, commission, percentage, gift, or any other consideration contingent upon or resulting from the award or making of this agreement; and
3. For the violation of this provision, the agency shall have the right to terminate the agreement without liability and at its discretion, to deduct from the contract price, or otherwise recover the full amount of such fee, commission, percentage, gift or consideration.

The following conditions are understood and agreed to:

a. No charges, other than those specified in the cost proposal, are to be levied upon the State as a result of a contract.

b. The State will have exclusive ownership of all products of this contract unless mutually agreed to in writing at the time a binding contract is executed.

Date Signature & Title of Official Representative

 Type Name of Official Representative

**APPENDIX E**

*STATEMENTS OF COMPLIANCE FORM*



**DELAWARE HEALTH AND SOCIAL SERVICES**

**REQUEST FOR PROPOSAL**

**STATEMENTS OF COMPLIANCE FORM**

As the official representative for the contractor, I certify on behalf of the agency that (Company Name) will comply with all Federal and Delaware laws and regulations pertaining to equal employment opportunity and affirmative action. In addition, compliance will be assured in regard to Federal and Delaware laws and regulations relating to confidentiality and individual and family privacy in the collection and reporting of data.

Authorized Signature:

Title:

Date: