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|  | *Delaware Health*  *And Social Services*  **Division of Management Services** |

PROCUREMENT

DATE: January 29, 2016

HSS 15 057

**COMPREHENSIVE BEHAVIORAL HEALTH OUTPATIENT TREATMENT SERVICES FOR ADULTS**

FOR

DIVISION SUBSTANCE ABUSE AND MENTAL HEALTH

Date Due: February 18, 2016

11:00AM

ADDENDUM # 3Please Note:

THE ATTACHED SHEETS HEREBY BECOME A PART OF THE ABOVE MENTIONED BID. RFP Forms

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

Kieran Mohammed

*PROCUREMENT ADMINISTRATOR*

**(302)255-9291**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ceasar McClain

(302) 255-9417

STATE OF DELAWARE

**Attachment 1**

**NO PROPOSAL REPLY FORM**

Contract No. HSS-15-057 Contract Title: COMPREHENSIVE BEHAVIORAL HEALTH OUTPATIENT TREATMENT 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-15-057**

**CONTRACT TITLE: COMPREHENSIVE BEHAVIORAL HEALTH OUTPATIENT TREATMENT SERVICES FOR ADULTS**

**DEADLINE TO RESPOND: 2/18/2016 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-15-057

Contract Title: COMPREHENSIVE BEHAVIORAL HEALTH OUTPATIENT TREATMENT 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-15-057

Contract Title: COMPREHENSIVE BEHAVIORAL HEALTH OUTPATIENT TREATMENT 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-15-057

Contract Title: COMPREHENSIVE BEHAVIORAL HEALTH OUTPATIENT TREATMENT 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:** |  | | |
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| 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-15-057 | | 2. Proposing Vendor Name: | | 3. Mailing Address |
| 4. SUBCONTRACTOR | |  | | |
| a. NAME | | 4c. Company OSD Classification:  Certification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| b. Mailing Address: | | 4d. Men Business Enterprise  Yes  No  4e. Minority Business Enterprise  Yes  No  4f. Disadvantaged Business Enterprise  Yes  No  4g. Veteran Owned Business Enterprise  Yes  No  4h. 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](mailto: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**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **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](mailto:vendorusage@state.de.us)

**Attachment 9**

Contract No. HSS-15-057

Contract Title: COMPREHENSIVE BEHAVIORAL HEALTH OUTPATIENT TREATMENT 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.