Appendix E

## Proposal Submission Template

America’s Promise Grant

IT Training and Workforce Intermediary

1. **General Proposal Information**

 Name and Address of Applicant Organization

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

 (NAME)

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

 (STREET)

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

 (CITY, STATE) (ZIP CODE)

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

 (CONTACT PERSON)

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

 (TELEPHONE NUMBER)

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

 (E-MAIL ADDRESS)

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

 (Website URL)

**DUNS #:**

 **EIN ID #:**

|  |  |
| --- | --- |
| County (ies) this program will serve?[ ]  New Castle County[ ]  Kent County[ ]  Sussex County[ ]  Statewide | Organization Type 1:[ ]  Non Profit[ ]  Governmental[ ]  Private for Profit |
|  |  |

1. Total Amount Requested: $
2. Requested funds for this program are % of organization's total budget.
3. The anticipated non-governmental contribution to this program is $\_\_\_\_\_\_
4. **Demonstrated Ability** *All responses are limited to one page per question unless otherwise noted*.
5. Describe your organization’s ability to operate high quality intermediary services or programs that have resulted in high employment rates or similar outcomes as described in the Performance Measures outlined in the Scope of Services of the RFP. This should include past achieved performance.
6. Describe your organizations ability to manage grant funded programs.
7. **Participants** *All responses are limited to one page per question unless otherwise noted*.
8. Describe your criteria for participant selection. Include how you will outreach, recruit, and assess each participant’s IT training and employment needs and skill level. Be sure to include the assessment(s) or partnerships in place to assess participants.
9. Describe how you will match trained participants with employment opportunities in IT.
10. **Program Design** *All responses are limited to one page unless otherwise noted*.
11. Describe how your proposed program will provide each of the following required service design elements *(one page per element is allotted)*:
	1. Recruitment for Delaware Tech IT certificate training programs
	2. Assessment of Recruited Jobseekers
	3. Placement into Delaware Tech IT training
	4. Case management (*Include in your description how your program will alleviate common barriers to training completion, employment, and employment retention).*
	5. Work Readiness *(Include in your description how planned activities were designed to meet employer needs)*
	6. Work Based Learning Activity
	7. Placement in Employment and Follow-Up (*include in your description your plan to develop and place participants in employment opportunities within the IT field. Describe how you will build and maintain relationships with local employers to increase job opportunities and placements)*
12. In a narrative fashion, describe how two different participants will flow through the elements of your program (from recruitment to 90 day employment retention).
13. Describe your proposed Application Process (see Appendix B of the RFP for guidance).
14. Describe what you believe your proposed program’s advantages are as compared to similar programs.
15. **Staff, Linkages and Partners** *All responses are limited to one page per question unless otherwise noted.*
16. Provide Staff Qualifications for any position for which funding is requested in whole or in part. If staff are not currently employed with your organization, please provide the minimum qualifications you will use to recruit for the position and timeline to hire (e.g. 10, 15 or 30 days after awarded).
17. Please complete the chart below to show your linkages within the community, key people/organizations, and other partnerships that enhance your programs services and quality. Please include employers and human service providers for support services. Add more rows as needed.

|  |  |  |
| --- | --- | --- |
| **Organization Type**(i.e. Employer, Human Service Provider, or Other Partner) | **Name of Organization** | **Role/Commitment** |
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1. **Bonus Points**

***To be completed only if requesting Bonus Points.***

1. Leveraged Resources- Describe how the proposed program is leveraging resources through braiding funds, direct financial or in-kind contributions by other programs, employers, investors, stakeholder, etc. Be sure to explain the source of funds and how they will be used to support the program and achieve programmatic goals. In addition complete the following:
* Cash Contribution Amount:
* In-Kind Amount:
* Other:
1. Targeting Disadvantaged Populations-Describe how the program will target and recruit disadvantaged populations such as low-income, promise communities, underrepresented in the targeted IT occupations, dislocated workers and other communities with training and employment barriers to help them pursue or advance in middle-to-high-skilled employment in IT occupations.
2. **Certificate of Information and Authorization-*Must be completed for your proposal to be considered***

By submitting this proposal, I hereby certify that to the best of my knowledge all information contained in this proposal is accurate and complete, that this is a valid proposal and that I am legally authorized to submit and to represent this organization.

**Signature (live):**

**Name:**

**Title:**

**Organization:**

1. **Attachments-***Required except unless noted*

Attachment 1: Non-Collusion Statement

Attachment 2: Exceptions

Attachment 3: Confidentiality and Proprietary Information

Attachment 4: Business References

Attachment 5: Subcontractor Information Form (only if applicable)

Attachment 6: Program Budget

**Attachment 1**

**RFP NO.:**

**RFP TITLE:**

**DEADLINE TO RESPOND:**

**NON-COLLUSION STATEMENT**

This is to certify that the undersigned Provider 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 Provider who also submitted a proposal as a primary Provider in response to this solicitation** submitted this date to the State of Delaware, Workforce Development Board.

It is agreed by the undersigned Provider that the signed delivery of this bid represents, subject to any express exceptions set forth at Attachment 2, the Provider’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, Workforce Development Board.

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

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

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:

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 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 2**

**RFP NO.:**

**RFP TITLE:**

EXCEPTION FORM

Proposals must include all exceptions to the specifications, terms or conditions contained in this RFP. If the provider is submitting the proposal without exceptions, please state so below. The State of Delaware reserves the right to deny any and all exceptions taken to the RFP requirements.

 [ ]  By checking this box, the Provider 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: Provider may use additional pages as necessary, but the format shall be the same as provided above.**

**Attachment 3**

**RFP NO.:**

**RFP TITLE:**

CONFIDENTIAL INFORMATION FORM

[ ]  By checking this box, the Provider 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.

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| **Confidentiality and Proprietary Information** |
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**Note: Provider may use additional pages as necessary, but the format shall be the same as provided above.**

**Attachment 4**

**RFP NO.:**

**RFP TITLE:**

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

**State of Delaware personnel MAY NOT BE USED as references.**

Attachment 5

SUBCONTRACTOR INFORMATION FORM

|  |
| --- |
| **PART I – STATEMENT BY PROPOSING PROVIDER** |
| 1. RFP NO.**LAB 18 001-ADULTTRNG** | 2. Proposing Provider Name: | 3. Mailing Address |
| 4. SUBCONTRACTOR |  |
| a. NAME | 4c. Company OSD Classification:Certification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| b. Mailing Address: | 4d. Women 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**

|  |  |
| --- | --- |
|  | **TOTAL** |
| 1. Staff Salaries
 |  |
| 1. Staff Fringe Benefits
 |  |
| 1. Staff Salary and Fringe Total
 |  |
| 1. Supportive Services To Participants
 |  |
| 1. Rent (inc. cost per sq. ft./hr. rates)
 |  |
| 1. Custodial Services
 |  |
| 1. Utilities (List as a % of Annual Expense)
 |  |
| 1. Heat/AC
 |  |  |  |
| 1. Phone
 |  |  |  |
| 1. Electric
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| 1. Other
 |  |  |  |
| 1. Consumable Office Supplies
 |  |
| 1. Postage
 |  |
| 1. Equipment and Furniture Purchase: (Itemize on Attached Page)
 |  |
| 1. Equipment Rental: (Itemize on Attached Page)
 |  |
| 1. Tuition
 |  |
| 1. Entrance Fees
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| 1. Training Materials
2. Books
3. Software
4. Videos
5. Other (specify)
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| 1. Printing/Advertising
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| 1. Travel
2. Student
3. Staff
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| 1. Staff Training
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| 1. Participant Payments (Wages. OJT Payments, etc...)
 |  |
| 1. Participant Fringes
 |  |
| 1. Insurance:
 |  |
| 1. Professional Services: (List)
 |  |
| 1. Overhead/Indirect for Parent Organization:
 |  |
| 1. Profit:
 |  |
| 1. Other: (Specify)
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| 1. **TOTAL**
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**EMPLOYEE LISTING**

**SALARY AND FRINGE EXPENSES**

AREA OF TRAINING:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR: \_\_\_\_\_\_\_\_\_

ORGANIZATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST EVERY EMPLOYEE BY TITLE**

**ADD ROWS AS NEEDED**

**USE ADDITIONAL PAGES TO LIST EACH EMPLOYEE NUMERICALLY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| POSITION | DATES OF EMPLOYMENT HOURS PER WEEK (if seasonal give # of weeks and hourly rate) (If part-time, indicate hourly rate) |  | SALARY | FRINGE | TOTAL | FUNDED STAFF HOURS |
| Person #1 |  | THIS PROGRAM  |  |  |  |  |
|  |  | OTHER |  |  |  |  |
| Person #2 |  | THIS PROGRAM  |  |  |  |  |
|  |  | OTHER |  |  |  |  |
| Person #3 |  | THIS PROGRAM  |  |  |  |  |
|  |  | OTHER |  |  |  |  |

Organization\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Training \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BUDGET BACK-UP PAGE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| LINENUMBER | ITEM | NUMBER OF EACH | AMOUNT | EXPLANATION/REMARKS |
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***SUPPORTIVE SERVICE TO PARTICIPANTS***

CONTRACTOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TYPE OF TRAINING\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TOTAL AMOUNT OF SUPPORTIVE SERVICES: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENTS MUST NOT RECEIVE CASH. VOUCHERS ARE TO BE USED FOR GOODS AND SERVICES) CONTRACTORS MUST MAINTAIN A CUMULATIVE LOG TO DOCUMENT CLIENTS RECEIVED SUPPORTIVE SERVICE(S). AT A MINIMUM THIS LOG MUST INCLUDE CLIENT NAME, STAFF AND CLIENT SIGNATURE, AMOUNT OF SUPPORTIVE SERVICES GIVEN, AND VENDOR.

Furthermore, contractors will only be reimbursed for direct benefits they have given to client.

TYPE OF PAYMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXPLANATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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