Appendix A

## Proposal Submission Template

Out of School Youth Programs

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:[ ]  Non Profit[ ]  Governmental[ ]  Private for Profit |

1. Total Number of Enrollments:
2. Average Program Hours per Enrollment:
3. Number of Cycles of Training if applicable:

Complete the following (add more rows as needed):

|  |  |  |
| --- | --- | --- |
| Cycle # | Start/End Date | Cost |
|  |  |  |
|  |  |  |

If awarded a contract, are you willing to offer fewer cycles than proposed? Y/N

 Minimum number of cycles you would be willing to implement:

1. Total Amount Requested: $
2. Requested funds for this program are % of organization's total budget.
3. Amount of Training Expense to be paid by the Participant: $

 Description of services/supplies to be paid by Trainee if any:

1. **Demonstrated Ability** *All responses are limited to one page per question unless otherwise noted*.
2. Describe your organization’s ability to operate high quality training 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. If the proposed program is new, please describe other training program’s past performance if applicable or the organization’s past performance and ability to operate high quality training programs.
3. Describe your organization’s ability to manage grant funded programs.
4. Describe your organization’s ability to provide services to vulnerable populations or populations with barriers to education and employment.
5. **Participants** *All responses are limited to one page per question unless otherwise noted*.
6. Describe your criteria for participant selection. Include how you will outreach, recruit, and assess each participant’s needs and skill level. Be sure to include the assessment(s) or partnerships in place to assess participants.
7. Please provide a description of conditions, behaviors, and barriers of typical participants as well as demographic information on this participant group.
8. Include in your description how your program will alleviate common barriers (e.g. transportation, financial planning, substance abuse, etc.) to training completion, employment, and employment retention.
9. **Program Design** *All responses are limited to one page per question unless otherwise noted*.
10. Provide a comprehensive outcome statement that describes what a participant will have achieved after successfully completing the proposed program. This should include all credential(s) received, job title, and expected wages. *This should be no more than 100 words*.
11. Outline the critical occupational and skills needs the proposed training will address. How were these needs identified? Include how the proposed program meets the current and projected needs of the local employers and how the proposed program benefit the needs of the community, state, and/or other stakeholder.
12. Describe the program schedule and intensity that includes all program components. It should be clear when enrollments are to occur, when each component begins and ends, programs hours of operation, training schedule, and training hours planned for each component. Include how you will ensure youth program personnel are available beyond nontraditional hours of operation to provide needed support and services when applicable.

Attach the proposed curriculum, if applicable.

1. In a narrative fashion, describe how a specific participant will flow through the elements of your program (from recruitment to 12 months follow up services).
2. Describe how your program provides access to each of the Mandated Program Elements (listed in section (II)(C) of the RFP. Programs are not required to directly provide all of the program elements but are required to ensure youth have access to everyprogram element in order to provide a comprehensive program. Your answer should address each of the 14 elements and clearly identify which mandated elements will be directly provided and which will be provided by partners, by purchasing (e.g. Occupational Skills Training), or other linkages. *Five page limit*:
3. Describe how your program will address work readiness/soft skills that are in demand. This include appropriate work behaviors and other sought after skills such as problem solving, teamwork, oral and written communication, organization skill, and competency on Microsoft Office products.
4. Describe (include resources dedicated to do so) your plan to develop, place and support retention in participant outcomes. Include how you will prepare and educate youth on the variety of post-secondary options and how you will build and maintain relationships with local employers to increase job opportunities and placements.
5. Describe what you believe your proposed program’s advantages are as compared to similar programs.
6. **Staff, Linkages and Partners** *All responses are limited to one page per question unless otherwise noted.*
7. 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.
8. Please complete the chart below to show your linkages within the community, key people/organizations, and other partnerships that enhance your program’s services and quality. At a minimum this should include all Linkage Team members. Add more rows as needed.

|  |  |  |  |
| --- | --- | --- | --- |
| **Organization Type**(i.e. Employer, Human Service Provider, or Other Partner) | **Name of Organization** | **On Linkage Team? (Y/N)** | **Role/Commitment** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. **Bonus Criteria**-*All responses are limited to one page per question unless otherwise noted.*

The Bonus Points may be allotted in three areas. They are not required, only desired. Proposers may seek points in all, some, or none of these areas. If you are seeking Bonus Points for this proposal, please address the applicable questions.

1. **Promise Communities**-Describe how your program will target Promise Communities. In addition, please identify which Promise Community(ies) are proposed to be targeted by placing a “Y” in the Proposed column.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Zipcode** | **Proposed**  | **Zipcode** | **Proposed**  | **Zipcode** | **Proposed**  | **Zipcode** | **Proposed**  |
| **19801** |  | **19720** |  | **19943** |  | **19947** |  |
| **19802** |  | **19901** |  | **19952** |  | **19966** |  |
| **19805** |  | **19904** |  | **19933** |  |  |  |
| **19701** |  | **19977** |  | **19956** |  |  |  |
| **19702** |  | **19934** |  | **19973** |  |  |  |

1. **Pathways-**Describe how your program will replicate at least one Pathway (as defined in the Appendix E). Describe how the program focuses on strategies that support students completing the Pathway being proposed.

If you are proposing for the allowed planning period, please provide a timeline with milestones, as well as a description of how your budget supports this planning period. (Up to 8 month planning period allowed)

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. **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: Milestones

Attachment 7: Program Budget

**Attachment 1**

**RFP NO.: LAB 18 001-OUTSCHTRNG**

**RFP TITLE: Out of School Youth Program**

**DEADLINE TO RESPOND: March 29, 2018 at 1:00 PM (Local Time)**

**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. **LAB 18 001-OUTSCHTRNG**

RFP Title: Out of School Youth Program

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** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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

**Attachment 3**

RFP No. **LAB 18 001-OUTSCHTRNG**

RFP Title: Out of School Youth Program

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.

|  |
| --- |
| **Confidentiality and Proprietary Information** |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

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

**Attachment 4**

RFP No. **LAB 18 001-OUTSCHTRNG**

RFP Title: Out of School Youth Program

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

**Attachment 6**

Milestones

Performance Milestone participant numbers (e.g. Credential, Day 1-90) should be projected to meet the Real-Time performance measures found in section (II)(F) of this RFP. This should be established by multiplying the performance measure per milestone by the projected number of Exits.

|  |  |  |  |
| --- | --- | --- | --- |
|  | Milestones | Total Participants Year 1 | Total Participants Year 2 |
|  | Recruitment |  |  |
|  | New Enrollments |  |  |
|  | *(List Training Components. Use as many lines as needed to identify the services provided)* |  |  |
|  | Successfully Completed Program |  |  |
|  | Attained Credential |  |  |
|  | Exits (enter follow up phase) |  |  |
|  | Day 1 Outcome  |  |  |
|  | Day 30 Outcome  |  |  |
|  | Day 60 Outcome |  |  |
|  | Day 90 Outcome  |  |  |

|  |  |
| --- | --- |
|  | **TOTAL** |
| 1. Staff Salaries
 |  |
| 1. Staff Fringe Benefits
 |  |
| 1. Staff Salary and Fringe for Work Experience (of lined 1 & 2 and not included in total)
 |  |
| 1. Staff Salary and Fringe Total (Do not include Line 3 amount in the 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)
 |  |
| Heat/AC |  |  |  |
| Phone |  |  |  |
| Electric |  |  |  |
| 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
 |  |
| 1. Training Materials

BooksSoftwareVideosOther (specify) |  |
|  |
|  |
|  |
|  |
| 1. Printing/Advertising
 |  |
| 1. Travel

StudentStaff |  |
|  |
|  |
| 1. Staff Training
 |  |
| 1. Participant Payments (Wages. OJT Payments, etc...)
 |  |
| 1. Participant Fringes
 |  |
| 1. Insurance:
 |  |
| 1. Professional Services: (Specify)
 |  |
| 1. Overhead/Indirect for Parent Organization:
 |  |
| 1. Profit:
 |  |
| 1. Other: (Specify)
 |  |
| 1. **TOTAL**
 |  |

**EMPLOYEE LISTING**

**SALARY AND FRINGE EXPENSES**

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

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

**LIST EVERY EMPLOYEE BY TITLE**

**(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 |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

***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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

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