**Appendix B**

**RFP#** LAB 20 001-OneStopOP

**Date:** November 2, 2020

**Subject:** Submission Template, Non-collusion, Exceptions, Confidential Information, Business References, Subcontractor Information

Appendix B

**One Stop Operator**

**Agency Information and Proposal Form**

**RFP # LAB 20 001 – OneStopOP**

(Please type responses within this document)

1. **Agency Information**

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

Name of Agency/Organization

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

Street Address

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

City State Zip Code

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Website URL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DUNS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EIN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization Type:  Non-Profit  Governmental  Private for Profit

2. **Primary Contact** **Information**

Primary Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Contact Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Contact e-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. **Program Information**

Program(s) proposed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total amount requested: $\_\_\_\_\_\_\_\_\_\_\_\_\_

Requested funds are \_\_\_\_\_% of organization’s total budget

4. **Program Design**

* 1. Describe your experience in facilitating meetings. Include some examples of the desired results and how they were obtained.
  2. Describe your experience in working across multiple organizations, programs, or a variety of entities.
  3. Describe how you plan to accomplish the tasks and goals outlined in this RFP.
  4. Describe the skills you think are critical to accomplishing the tasks and goals outlined in this RFP. Demonstrate how you possess these skills through examples of your experience.
  5. Describe a time when you were able to identify the following:
     1. Best Practice
     2. Opportunity
     3. Problem
     4. What did it result in and describe the step you took to get there.
  6. Describe your knowledge of human service and/or workforce programs in Delaware.
  7. Please enter a proposed schedule of activities that will take place and an estimated date they will occur. All dates should be within the performance period. You may add or delete rows as needed.

|  |  |  |
| --- | --- | --- |
|  | Activity | Estimated Date  Achieved |
| 1 |  |  |
| 2 |  |  |
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| 7 |  |  |

* 1. Budget Summary

|  |  |  |  |
| --- | --- | --- | --- |
| LINE ITEM | | | TOTAL |
| Staff Salaries | | |  |
| Staff Fringe Benefits | | |  |
| SUBTOTAL | | |  |
| Rent (inc. cost per sq. ft./hr. rates) | | |  |
| Utilities (List as a % of Annual Expense) | | |  |
| Heat/AC |  |  |  |
| Phone |  |  |  |
| Electric |  |  |  |
| Other |  |  |  |
| Consumable Office Supplies | | |  |
| Postage | | |  |
| Printing/Advertising | | |  |
| Travel | | |  |
| Professional Services: (List) | | |  |
| Overhead/Indirect for Parent Organization: | | |  |
| Other: (Please specify) | | |  |
| Other: (Please specify) | | |  |
| GRAND TOTAL | | |  |

**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 1**

**RFP NO.:** LAB 20 001-OneStopOP

**RFP TITLE:**One Stop Operator – Workforce System Meeting Facilitation and Coordination

**DEADLINE TO RESPOND:** December 4, 2020 @ 1:00 PM

**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

**Attachment 2**

**RFP NO.:** LAB 20 001-OneStopOP

**RFP TITLE:** One Stop Operator – Workforce System Meeting Facilitation and Coordination

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.:** LAB 20 001-OneStopOP

**RFP TITLE:** One Stop Operator – Workforce System Meeting Facilitation and Coordination

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.:** LAB 20 001-OneStopOP

**RFP TITLE:** One Stop Operator – Workforce System Meeting Facilitation and Coordination

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**

LAB 20 001-OneStopOP

**SUBCONTRACTOR INFORMATION FORM**

By checking this box, the Provider acknowledges that they do not intend to employ subcontractors in performance of the services found in this RFP.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PART I – STATEMENT BY PROPOSING PROVIDER** | | | | |
| 1. RFP NO.  **LAB 20 001-OneStopOP** | | 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  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**