



## St. Johns County Board of County Commissioners

Purchasing Division

September 9, 2014

### ADDENDUM #3

**To: Prospective Bidders**  
**From: St. Johns County Purchasing Department**  
**Subject: RFP #14-90 HHS Funding Availability**

This Addendum #3 is issued for clarification on the above titled project, and is hereby incorporated into the subject RFP documents. Each proposer will ascertain before submitting a proposal that he/she has received all Addenda. **Please return the signed Addendum with your proposal.**

1. **Financial Review:** What if an agency that applies is not required to have an "Audited Financial Statement"? How would they be rated fairly in this category?

Currently the County contracts state the following: "For contracts where the total compensation, disbursement, grant, or reimbursable expense (or any combination thereof) **does not exceed** three hundred thousand dollars (\$300,000), then an original, bound audit is not required, **unless the County** determines that an independent audit is warranted (based on other things, the use of such funds), and provides the **PROVIDER** with a written explanation detailing the reason and/or rationale supporting the **COUNTY'S** determination that such an independent audit is warranted."

The pre-qualification asked agencies to provide the following: Have an independent financial audit of the prior fiscal year. The management letter and management's response should also be provided if issued. The unmodified opinion of the Independent Audit firm's current peer review should also be provided. However, if the agency's total annual budget does not exceed \$300,000, an uncertified financial statement may be acceptable. But the County reserves the right to request a certified audit. The financial review should be able to be conducted from the information provided. For agencies with a total annual budget that does not exceed \$300,000, and the agency has submitted uncertified financial documents, the evaluator should give 1.5 points in Section A2 of the Review of Audited Financial Statements. 1.5 is considered a neutral number. Please see attachments.

2. There is no place for the agency name on the review sheets. How will they be identified? A space has been added for the agency name on the evaluation forms. Please see attachments.
3. **Program Quality Review:** Previous Outcome Report, item #63: What if an agency is not currently funded? What should they submit? This was addressed on Addendum #2 item #9: In Appendix II, page 34, Section E, question 63 – we are instructed to attach the most recent **Semi-Annual Report** a Program Document 3. Under Program Document 3, it states to attach the most recent **Quarterly Outcome Report**. Please clarify. The answer to Item #9 on Addendum #2 was "Please submit the agencies most recent semi-annual reports." Outcome reports were not required quarterly. Therefore, the question for the evaluators has been changed to read "Semi-Annual Report / Quarterly Outcome Report." Please see attachments.

4. Evidenced Based Practice Model to be implemented? Example given that in St Johns County in the area of homeless, there is no best practice models being used. There is a best practice model for the homeless, "Housing First" but it is not being used locally. In the past transitional housing has been HUD approved. Is there best practice model in the four key areas: homeless and housing, Community Healthcare, Supportive Services for Employment Opportunities and Aging? Requested research be done and clarification sent out. This was addressed on Addendum #1 item #13: Item 52, we refer to supportive service agencies that use EBP, however, we are required to use HUD/HEARTH performance outcome model. Should we fill in item 52 with Performance Outcome practices? An evidence-based practice (EBP) is commonly accepted as the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of a client. Such practice is generally deemed evidence based only if research has proven significant positive outcomes in two or more controlled studies. The EBP proposed as part of the response to this RFP should meet those commonly accepted principles. The intent of this RFP is to move agencies in the path of using EBP models. If the agency chooses to not use an EBP they should not receive the points. Conversely the agencies that do choose to use an EBP should receive points for moving in that direction.
  
5. **Scoring Tally Methodology:** A question arose regarding how to keep the bias out. The Council would like to see the high score and the low score thrown out or have all the proposals reviewed for consistency. Would like research on this and address in addendum. After consulting with the County Attorney's Office, it has been decided that Purchasing will not throw out the high and low outlier scores. The current Purchasing Evaluation process is to use enough evaluators so the scores will moderate any abnormally high or low scores through the averaging of the total scores. Purchasing will review scores. If unusual scores are found during the Evaluation Meeting, they will be addressed and discussed. The scores may or may not be revised accordingly.

**The due date of September 11, 2014 @ 4:00 p.m. remains the same.**

**Sincerely,  
Bridget Mein  
Contracts Coordinator**

**Acknowledgment**

\_\_\_\_\_  
Signature and Date

\_\_\_\_\_  
Printed Name/Title

\_\_\_\_\_  
Printed Company Name

**End of Addendum #3**

Agency Name \_\_\_\_\_

**A. FATAL FLAW CHECKLIST**

1. The rater must review each Proposal for inclusion of the items listed below. **A "No" response will be given when the policy or document is applicable but not attached.** In the event of a "No" response to any of the following by the raters, the Proposal shall be rejected.
2. In the event the Proposal is rejected, the Rater shall have the Reviewer confirm that the Proposal fails to comply with one or more required item listed below, acknowledge that all procedures were properly followed as identified herein and shall initial next to each "No" response.
3. If the Rater checked "No", and the Reviewer concurs, the Reviewer must indicate in the space provided below, the number(s) of the item(s) in the Fatal Flaw list that resulted in the Fatal Flaw and initial next to the "No" response directly on the list.
4. In the event the Proposal is rejected, then it shall not be forwarded for Financial, or Quality Review, or any additional review based on the Funding, Program, or Service Category.

	Required Item	Yes	No
1	The Proposal was received by the due date and time.		
2	The Original Proposal contains an original signature in ink other than black, under Part I, Section C, Certification of Accuracy and Compliance.		
3	Pre-Qualification: Did the Agency submit a Prequalification package?		
4	Agency responded "Yes" to Item No. 36a, and "No" to Item No. 36b: the agency does not owe any money to the County or is current with payments.		

REQUIRED ATTACHMENTS AND DOCUMENTS CHECKLIST				
	Item	Yes	No	N/A
1	<b>Attachment "A":</b> Agency Verification Form, as provided in Appendix I, is included with original signatures in ink other than black.			
3	<b>Attachment "B":</b> Public Entity Crimes Affidavit, as provided in Appendix I, is included with a notarized original signature affixed.			
4	<b>Attachment "C":</b> Drug Free Workplace Certification is submitted; original signatures required.			
6	<b>Attachment "D":</b> Non-Discrimination Policy Certification is submitted; original signatures required.			
9	<b>Attachment "E":</b> List of Board of Directors of the agency is submitted. Not applicable to Public Entities.			
10	<b>Attachment "F":</b> Organizational Chart is submitted.			
13	<b>Attachment "G":</b> Scrutinized Companies Certification is submitted.			
14	<b>Program Document 1 (ALL):</b> The agency's resume/job descriptions of all staff designated for project. <i>Question No. 60.</i>			
15	<b>Program Document 2:</b> If one or more Outcomes will be measured with a Standardized Measurement Tool(s), attach a copy of the tool(s). <i>Question No. 62.</i>			
16	<b>Program Document 3:</b> Outcome Report. The most recent Quarterly Outcome Report is attached only if agency is seeking renewal, expansion or enhancement of program funded by the HHS in the previous fiscal year. <i>Question No. 63.</i>			
17	<b>Program Document 4:</b> Any Interagency Agreement(s) the agency has in place to provide the proposed service(s). <i>Question No. 65.</i>			
18	<b>Program Document 5:</b> A copy of the certificate from the State of Florida, Department of Children and Families certifying that the agency is licensed to provide the level(s) of substance abuse services proposed is attached.			

Agency passed the Fatal Flaws Review? \_\_\_\_ Yes \_\_\_\_ No

**Fatal Flaw Rater**

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Fatal Flaw Reviewer**

Name (Print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Agency Name** \_\_\_\_\_

**PART IV: ADMINISTRATIVE FATAL FLAW (if applicable)** - If, at any point during the funding process, the HHS becomes aware that the agency's responses to questions about litigation, regulatory action, corrective action, or funds owed are not true, then the Department may at its discretion consider this to be a Fatal Flaw and remove the Proposal from consideration for funds.

The agency has failed to disclose the following:

This will be removed from funding consideration.: Yes\_\_\_\_\_ No\_\_\_\_\_

Department Director Name  
(or designee): \_\_\_\_\_

Date: \_\_\_\_\_

**PART V: SCORING** (to be completed by HHS Staff)

PART I: Organizational Capability Review: Max Score: 18 **Agency's Score** \_\_\_\_\_ **(A)**

PART II: Financial Review: Max Score= 36, Min Score= 18 Pass; Fail. **Financial Statements +**  
Budget Form Max Score=18 Min Score= 9 Pass; Fail. **Budget Forms Score** \_\_\_\_\_ **(B)**

Part III: Program Quality Review: Max Score=135 Min Score=68 Pass; Fail. **PQ Score** \_\_\_\_\_ **(C)**

**PART VI: Administrative Fatal Flaw** Y\_\_\_\_\_ N\_\_\_\_\_

TOTAL Max Score=207  
TOTAL Min Score= 95

**TOTAL: Agency's Total Score (Rounded to the nearest whole number)** **(A+B+C)** \_\_\_\_\_ **(D)**

Staff Reviewer Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Reviewer's signature indicates the scoring is clear and the addition has been checked for the accuracy of the agency's total score.

**The Evaluation Committee, or respective advisory board, shall review the proposal for the final determination as to whether to recommend for funding, in whole or in part, the agency to the SJC Board of County Commissioners. If the agency is not recommended for funding, a letter indicating the decision not to fund shall be sent to the representative designated as the "contact person" on the cover page (page 1) of the proposal.**

**Agency Name** \_\_\_\_\_

**Financial Review:** All proposals devoid of fatal flaws will receive a Financial Review that includes a review of the organization's audited financial statements, if applicable, and review of the budget forms submitted in the proposal.

**A. REVIEW of AUDITED FINANCIAL STATEMENTS** - Calculate and enter the figures from the agency's Audited Financial Statements in to the Financial Review Worksheet. Enter each percent from the Worksheet into the appropriate Component cell below. Assign a Component Point value of 1, 2, or 3 for each based on the percent.

Item Number	Item Section A-1	Component	Component Points				Item Points	Notes
			0	1	2	3		
PreQual	<b>Audited Financial Statements</b>	Current Assets as a percent of Current Liabilities = _____% <b>Risk Assessment</b> = ____ (100% or higher = 0 pts, 86%-99%= 4 points, 85% or less = 8 points)	49.9% or <	50% to 109.9%	110 to 150.9%	151% or >		Not Applicable to Public Entities
		Cash/Market Securities/Receivables as a % of Current Liabilities = _____% <b>Risk Assessment</b> = ____ (86% or higher = 0 points, 76%-85%= 4 points, 75% or less = 8 points)	4.9% or <	5% to 9.9%	10% to 15.9%	16% or >		
		Total Liabilities as a percent of Total Assets = _____% <b>Risk Assessment</b> = ____ (85% or less = 0 points, 86%-99%= 4 points, 100% or higher= 8 points)	20% or >	19% to 11%	10% to 1%	0% or <		
		Contingent Liabilities as a percent of Net Assets = _____% <b>Risk Assessment</b> = ____ (None = 0 points, 1%-9%= 4 points, 10% or higher = 8 points)	20% or >	19.9% to 11%	10.9% to 1%	.9% or <		
		Administrative Expenses as a percent of Total Expenses = _____% <b>Risk Assessment</b> = ____ (30% or less = 0 points, 31%-35%= 4 points, 36% or higher= 8 points)	30.1% or >	20.1%-30%	15.1%-20%	0%-15%		
		Total Grant Funds as a percent of Total Revenue = _____% <b>Risk Assessment</b> = ____ (59% or less = 0 points, 60%-80%= 4 points, 81% or higher= 8 points)	75% or >	74.9% - 50.9%	50% - 25.1%	25% or <		
		Risk Value Assessment – Add up values from six boxes above. Place a check in the component point box that contains the point total. <i>For example:</i> if subtotal of Risk points was 15, the component point box "19-10" would be checked and assigned 2 points	48-30	29-20	19-10	9-0		
	Section A-2	For agencies with a total annual budget that does not exceed \$300,000, and the agency has submitted uncertified financial documents, the evaluator should give 1.5 points in Section A2 of the Review of Audited Financial Statements. 1.5 is considered a neutral number.	<b>DISAGREE= 0 points</b>	<b>NON AUDITED STATEMENT = 1.5 points</b>	<b>AGREE = 3 points</b>	<b>Item Points</b>	<b>Notes</b>	
PreQual	<b>Audited Financial Statements</b>	The Organization received an Unqualified opinion.						
		There is no "Going Concern" comment.						
		The Notes to the Financial Statements are complete and explanatory.						
		There are no significant "Related Party" transactions that materially affect the AFS.						
		There are no material weaknesses.						
<b>Maximum AFS points = 36</b>						<b>Total AFS points =</b>	Passed _____	
<b>Minimum required AFS points = 18</b>							Failed _____	
							NA _____	

In the event that AFS are waived as a Fatal Flaw, then the review of AFS above shall also be waived as to the applicable Service Category.

Audited Financial Statement Reviewer Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Reviewer Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Agency Name** \_\_\_\_\_

**B. REVIEW of BUDGET FORMS** - Unless otherwise specified, points should be assigned for each component of the response according to the following scale: omitted = 0; partially met = 1 point; fully met = 2 points; exceptionally met = 3 points.

Item Number	Item	Component	Component Points				Item Points	Notes
			0	1	2	3		
66	<b>Budget Summary</b> requires aggregate dollar amounts in each expense category for which funds are being requested.	Column 1: Requested funding amounts are clear, accurately calculated, total is within advertised available.						
		Column 2: Other Funding is contributing to the project. Maximum 1 point.						
		Administrative Cost in Column 1 is no more than 15% of Personnel plus Non Personnel Subtotals.	> 15%	15 - 10%	9 - 1%	0%		
67	<b>Budget Narratives</b> Provide a description of each line item in the Requested Funding column, and (if applicable) the Other Funding column on the Budget Summary form.	Requested Funds Narrative justifications are clear and complete.						
		Requested Funds Narrative includes no disallowed expenses.						
68		Requested Funds Narrative costs are correctly calculated and equal Total Expenses on Budget Summary						
		Other Funds Narrative identifies Source of the funds, and equals Total Expenses for Other Funding (Item 66, column 2). Maximum 2 points.						
<b>Maximum Budget Forms points = 18</b>			<b>Minimum points required = 9</b>			<b>Total Budget Form points:</b>		

The Organization **PASSED** \_\_\_\_\_ **FAILED** \_\_\_\_\_ the Audited Financial Statement threshold; or N/A \_\_\_\_\_ is a Unit of Government.

The Proposal **PASSED** \_\_\_\_\_ **FAILED** \_\_\_\_\_ the Budget Forms threshold.

**If either the agency or proposal failed the Financial Review, then the proposal shall not be forwarded for Quality Review and the proposal shall be rejected.**

Budget Proposal Rater  
Name: (Print) \_\_\_\_\_

Staff Reviewer  
Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Agency Name \_\_\_\_\_

**PART I: ORGANIZATIONAL REVIEW** (to be completed by the Organizational Capability Rater)

**C. ORGANIZATIONAL CAPABILITY REVIEW FOR ALL SERVICE CATEGORIES – 1. Unless otherwise specified, points should be assigned for each component of the response according to the following scale: omitted = 0; partially met = 1 point; fully met = 2 points; exceptionally met = 3 points.**

Item Number	Item	Component	Component Points				Item Points	Notes
			0	1	2	3		
23	<b>Description of the Responding Agency:</b> Including its years of operation, general service mission, and experience in project management.	Years of operation (1 point for each year, up to a maximum of 3 points).						
		Experience administering government funds (1 point for each year, up to a maximum of 3 points).						
		Proposed project/service(s) is clearly compatible with the Agency's mission.						
29	<b>Cultural Competence</b> is evidenced in the Agency's guiding principles, individual culturally appropriate care planning, and staff development.	The Agency's guiding principles and standards clearly address Cultural Competence						
		Cultural Competence is clearly evident in the Agency's individual care planning for clients.						
		The Agency's professional development standards/staff training requirements clearly ensure Cultural Competence in service delivery.						
<b>C. 1. Total Positive Organizational Capability Points</b>								

**2. Possible deductions FOR ALL SERVICE CATEGORIES. Please note that each item may result in a reduction in points to the Organizational Capability Score and Total Quality Point Score.**

Item Number	Item	There will be a five (5)-point deduction for each additional page.					Points	Notes
1st page, App. III Instructions	<b>Page limit Part I:</b> 8 page limit for responses to items 1 to 43 Appendix I.	Number of pages above 8. ___ x 5 = ___					( )	
	<b>Page limit Part II:</b> 25 page limit for responses to items 42 to 68 Appendix II.	Number of pages above 25. ___ x 5 = ___					( )	
33	Litigation or Regulatory Action: Identify whether there has been litigation or regulatory action. If neither has occurred, or where Applicant Agency was successful, put (0).	Check the correct deduction.	0	-3	-6	-9	( )	
		No Litigation or Regulatory Action						
		Involved loss of professional accreditation. Regulatory action or litigation did not or minimally affect service to clients.						
		Involved license suspension as an outcome, fiscal negligence, negligence in mishandling of client affairs, or negligence that effected clients.						
34 and 35	Corrective Action: If the agency has been placed on Corrective Action, describe the action. If no corrective action, put (0).	Check the correct deduction.	0	-3	-6	-9	( )	
		No Corrective Action						
		No significant issues, but some minor ones						
		Significant issues which were resolved.						

		Significant issues which were <u>not</u> resolved.						
		Check the correct deduction.	0	-3	-6	-9		
38	Utilization: Identify whether there has been underutilization of St. Johns County funds in the past 3 years. If none, put (0).	No underutilization occurred. Agency used between 95% and 100% of awarded funds.						
		Underutilization occurred, but between 94.9% and 90% of awarded funds were utilized.						
		Underutilization occurred, and between 89.9% and 85% of awarded funds were utilized.						
		Underutilization occurred. Less than 84.9% of awarded funds were utilized.						

**C. 2. Total Negative Organizational Capability Points**

**C.1. Points minus C.2. Points = Total Organizational Capability Points Maximum Organizational Capability Points Available = 18**

Org. Capability Rater Name: (Print) \_\_\_\_\_  
 Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_

Staff Reviewer Name: \_\_\_\_\_  
 Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_



**Agency Name** \_\_\_\_\_

**PART III: PROGRAM QUALITY REVIEW** - Unless otherwise specified, points should be assigned for each component of the response according to the following scale: omitted = 0; partially met = 1 point; fully met = 2 points; exceptionally met = 3 points.

**Name the Evidence Based Practice Model to be implemented:** \_\_\_\_\_

Item Number	Item	Component	Component Points				Item Points	Notes
			0	1	2	3		
47-51	<b>Target Population:</b> What is the target population to be served, including presenting problems or special conditions of eligibility?	Eligibility, admittance criteria are clearly described.						
		Evidence that sufficient numbers of clients meet these criteria is presented.						
		Referral source(s) are clear.						
		Client racial/ethnic and demographic information is complete.						
		Staff racial/ethnic characteristics are similar to clients served.						
		Number of clients is reasonable.						
52	<b>Evidence Based Practice Model</b>	The description presented suggests a clear understanding of the chosen Evidence Based Practice model.						
		The Proposal intends to implement all components of the Evidence Based Practice Model.						
		The Evidence Based Practice Model is appropriate for the proposed target population.						
		All staff members are trained/certified in the Evidence Based Practice Model.						
		The plan to maintain fidelity to the Evidence Based Practice Model is clear and achievable.						
53	<b>Program Narrative:</b> Identify the purpose of the program and how it will operate.	The program description includes purpose, benefits, services to be delivered, and delivery timelines.						
		Program description clearly reflects any Category/Service specific requirements from the applicable Chapter.						
		Agency capacity indicating staff to client ratio / caseload size is reasonable for the proposed services.						
		Client benefits are clearly identified.						
		Start-up/marketing plans are clearly defined and reasonable.						
54	<b>List of Services:</b> to be provided and the number of clients to receive each.	Services and number of clients are clear.						
		Services are consistent with program intent.						
		All services needed for outcome attainment are included.						
55	<b>Experience:</b> with providing the proposed services to the proposed target population.	Experience providing the proposed services is clearly demonstrated. (1 point for each year, maximum 3 points)						
		Experience serving the proposed target population is clearly demonstrated.(1 point for each year, maximum 3 points)						
		Proven outcomes while providing the proposed services to the proposed target population are clearly demonstrated.						
56	<b>Location:</b> Where will the services be provided?	Service delivery locations are clear and specific.						
		Accessibility to the target population is clearly demonstrated.						
57	<b>Time and Frequency:</b> When will the services be provided? Identify the days of the week, hours of operation and length of client contact.	Hours and days of program operation are clearly defined.						
		Hours and days of program operation sufficiently address client access.						
		The planned frequency and duration of client contact is sufficient to anticipate outcome attainment.						
58	<b>Accreditation:</b> is current and relevant to the proposed program / services.	The agency maintains an accreditation that is current and relevant to the proposed program / services. Maximum 2 points.						
59	<b>Cost Containment:</b> Describe how funds will be monitored and reported	Monitoring of service utilization is clearly described.						
		Plan addresses adjustments made as a result of over or underutilization of services						
		Communications with County Staff regarding use of funds and status is clearly described.						

60 and Program Document 1	<b>Staff:</b> Describe how the program will be staffed. List all positions, qualifications, duties, and % of time devoted to the program.	The proposed staff chart is complete with each position clearly defined.								
		The number of staff is sufficient to address the proposed number of Clients.								
		Staff credentials meet the minimum advertised in the RFP.								
		The resume or job descriptions for Program Manager and direct service staff are attached and include sufficient credentials.								
61	<b>Output Objectives:</b> List the Output Objectives for the proposed program.	The Outputs are clearly stated.								
		The Outputs are consistent with the proposed client numbers and services.								
		The Outputs are sufficient to attain the Outcomes.								
62 and Program Document 2	<b>Proposed Outcomes and Measures:</b> Complete the Outcome Chart for a minimum two (2) outcomes including at least one (1) indicator with clear measures for each.	The Outcome Chart is complete and clear.								
		The Outcomes charted address the minimum required outcomes.								
		The indicators are measurable, using percents, timeframes, and/or other measures								
		Data Sources for each indicator include standardized measurement tool(s).								
		Attainment is likely based on the proposed services.								
63 and Program Document 3	<b>Previous Outcome Report:</b> Programs currently funded through HSD should submit the most recent Outcome Report.	The correct Semi-Annual / Quarterly Outcome Report has been submitted. (maximum 1 point)								
		The Semi-Annual / Quarterly Outcome Report demonstrates attainment of all outcomes.								
64, 65 and Program Document 4	<b>Collaboration:</b> better integrates services or eliminates their duplication.	How the Organization will work with other agencies that service the Client/Family is clearly demonstrated. If the proposed services are dependent on the resources of another organization, an Interagency Agreement, or similar document, is attached.								
<b>Maximum Score = 135</b>			<b>Minimum Average Score required = 68</b>			<b>Total points Questions 47 through 65:</b>				

**The agency PASSED \_\_\_\_\_, FAILED \_\_\_\_\_ the Program Quality threshold; or N/A \_\_\_ applied in a non-Program Quality Category. In the event the proposal does not receive the minimum acceptable score in the Program Quality Review, then the proposal shall be rejected.**

Quality Rater Name: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

Staff Reviewer Name: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Date: \_\_\_\_\_