B23 DHH RFP OFFLINE TEMPLATE

**Connecticut Office of Early Childhood  
 Birth to Three System  
 Deaf / Hard of Hearing Support Provider**

**Request for Proposals Number OEC-B23-2019  
 Legislative Authority IDEA Part C  
 Connecticut General Statutes Sections 17a-248, 17b-3, 38a-490a**

DHH-1.2 **Required Minimum Qualifications for a Deaf / Hard of Hearing (DHH) Support Provider**To qualify for a contract award, a proposer must document that they have at least one audiologist as an employee who is licensed in Connecticut and who meets the following minimum qualification: Please select one option below.

* Five hundred and fifty (550) direct post-graduate contact hours within a two-year period during the past five years with children under age four.
* There currently is not an audiologist available with the experience required above.

DHH-2.1 **Assurances** Upload one combined PDF of the curriculum vita or resumes for all audiologists who would be working with families in Birth to Three System and documentation of 550 direct post-graduate contact hours within a two-year period during the past five years with children under age four. [NOT contact hours with children under age 5 over the past 5 years.]

Name the file "ProgramName-Audiologists.pdf"  where ProgramName is the name of the program being proposed.

DHH-2.2 Freedom of Information Act  
 All of the information contained in the application submitted in response to this RFP is subject to the provisions of the Freedom of Information Act (FOIA), C.G.S. Sections 1-200 et seq.  The FOIA declares that except as provided by federal law or state statute, records maintained or kept on file by any public agency, as defined in the statute, are public records and every person has the right to inspect and receive a copy of such records.

* I affirm that the person certifying this application understands that this is subject to the provisions of the Freedom of Information Act.

DHH-2.3 The link~~s~~ below has ~~have~~ been coded to open in a new tab but with browser differences it might not, your information will be saved if it doesn't. You'll either need to click Back if that option is available or Paste the URL that was emailed to you into the address bar again. The submission tool will open where you left off. You can also copy and paste each URL below into a new tab in your browser. MS Word versions of the forms below are available at <https://portal.ct.gov/OPM/Fin%20PSA/Forms/Ethics%20Forms>.

~~DHH-2.4 Form 5. Consulting Agreement Affidavit~~ [~~https://portal.ct.gov/-/media/OPM/OPMForm5ConsultingAgreementAffidavit32814pdf.pdf?la=en~~](https://portal.ct.gov/-/media/OPM/OPMForm5ConsultingAgreementAffidavit32814pdf.pdf?la=en) ~~This affidavit accompanies a bid or proposal for the purchase of goods or services with a value of $50,000 or more in a calendar or fiscal year.  Form 5 is normally submitted by the contractor to the awarding State agency with the bid or proposal, however, for a sole source or no bid contract, it is submitted at the time of contract execution.~~ ~~You must download either the PDF or MS Word file and save it on your computer to retain what is entered. Complete the form and save it as a PDF renaming the file as "ProgramName-Form5.pdf" where ProgramName is the name of the program being proposed.  Then upload it here.~~

~~DHH-2.5 Form 6. Affirmation of Receipt of State Ethics Laws Summary~~ [~~https://portal.ct.gov/-/media/OPM/Finance/psa/OPMEthicsForm6Final91511PDFpdf.pdf?la=en~~](https://portal.ct.gov/-/media/OPM/Finance/psa/OPMEthicsForm6Final91511PDFpdf.pdf?la=en) ~~This affirmation accompanies a large State construction contract or a large State procurement contract with a cost of more than $500,000.  Form 6 is normally submitted by the contractor to the awarding State agency with the bid or proposal.  However, for a sole source or no bid contract, Form 6 is submitted at the time of contract execution. When applicable, Form 6 is also used by a subcontractor or consultant of the contractor.  The subcontractor or consultant submits the form to the contractor, who then submits it to the awarding State agency.   
   
You must download either the PDF or MS Word file and save it on your computer to retain what is entered. Complete the form and save it as a PDF renaming the file as "ProgramName-Form6.pdf" where ProgramName is the name of the program being proposed.  Then upload it here.~~

DHH-2.6 Form 7. Iran Certification  
 <https://portal.ct.gov/-/media/OPM/OPMForm7IranCertification32814pdf.pdf?la=en>      
   
 Effective October 1, 2013, this form must be submitted for any large state contract, as defined in section 4-250 of the Connecticut General Statutes.  This form must always be submitted with the bid or proposal, or if there was no bid process, with the resulting contract, regardless of where the principal place of business is located.  Entities whose principal place of business is located outside of the United States are required to complete the entire form, including the certification portion of the form.  United States subsidiaries of foreign corporations are exempt from having to complete the certification portion of the form.  Those entities whose principal place of business is located inside of the United States must also fill out the form, but do not have to complete the certification portion of the form.   
  
You must download either the PDF or MS Word file and save it on your computer to retain what is entered. Complete the form and save it as a PDF renaming the file as "ProgramName-Form7.pdf" where ProgramName is the name of the program being proposed.  Then upload it here. If you currently have a contract with the state of Connecticut you may upload a copy of a current renewal form.

DHH-2.7 Are you an enrolled provider in good standing in Medicaid and any other state or federal program in which you participate?

* Yes
* No

DHH-2.8 Has any state or federal agency taken any action against you or any of your principals or related parties regarding your participation in Medicaid or any other state or federal program?

* Yes
* No

DHH-2.9 Enter the name of the proposed DHH Support Provider program in the space below:

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DHH-2.10 **DHH SUPPORT PROVIDER PRIMARY CONTACT PERSON**

* Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DHH-2.11 **DHH SUPPORT PROVIDER FISCAL AGENT**

* Fiscal Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Agency Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Agency Contact Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Agency Contact Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Current DUNS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* FEIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DHH-2.12 Upload a complete listing of all personnel who will be working as part of the DHH Support Provider program including audiologists, teachers, and support staff.  This list must include: Name, Discipline / Role,  FTE,  whether the person is an employee or sub-contractor, number of years of experience with children under age 4, special training or certifications, fluent use of non-English languages.  In the FTE header include the number that was used in the denominator for a full-time work week. Name the file "ProgramName-PersonnelList.pdf" where ProgramName is the name of the program being proposed.

**Family Centered**

DHH-2.14 Describe how your agency assures that families are connected to other families. (Maximum 2000 characters with spaces.)

DHH-2.15 Describe how your program provides culturally effective supports to families. (Maximum 2000 characters with spaces.)

DHH-2.16 Describe the basic principles of intervention that your agency follows for families with infants and toddlers who are deaf or hard of hearing. (Maximum 3000 characters with spaces.)

DHH-2.17 Upload examples of any handouts created by your agency that you do or would share with families about the supports you provide. Name the file "ProgramName-Handouts.pdf" where ProgramName is the name of the program being proposed.

**Leadership**

DHH-2.19 Describe your agency’s experience with working with other providers to assure that supports for families with infants and toddlers who are DHH are comprehensive.  (Maximum 3000 characters with spaces.)

DHH-2.20 Upload one PDF of letters of reference from other agencies. Name the file "ProgramName-References.pdf"  where ProgramName is the name of the program being proposed.

DHH-2.21 Describe your agency’s experience with a state’s Early Hearing Detection and Intervention (EHDI) program. (Maximum 1000 characters with spaces.)

DHH-2.22 Describe the Quality Assurance systems that your program has in place to assure compliance as well as respectful, quality, positive results for families in Early Intervention. (Maximum 3000 characters with spaces.)

**Evidence-based**

DHH-2.24 Describe how your agency assures that it follows the recommendations in the most recent JCIH standards. (Maximum 4000 characters with spaces.)

DHH-2.25 Describe equipment currently in use at your agency that is appropriate for infants and toddlers. (Maximum 3000 characters with spaces.)

DHH-2.26 Describe your agency’s experience with purchasing, fitting, monitoring the function of, and repairing appropriate hearing technology for infants and toddlers. (Maximum 2000 characters with spaces.)

DHH-2.27 Describe the practices that your agency uses to implement successful and secure Remote Early Intervention / Tele-health / Tele-practice. (Maximum 2000 characters with spaces.)

**Transition**

DHH-2.29 Is this proposal on behalf of a Local School District?

* Yes
* No

DHH-2.30 Upload one PDF that demonstrates evidence of past or current collaboration with the Local Education Agencies (LEAs) where you would like to support families in Connecticut's Birth to Three System. Combine multiple files into one PDF.Name the one file "ProgramName-LEAPartners.pdf"  where ProgramName is the name of the program being proposed.

DHH-2.31 Describe activities/practices that help prepare families and their children for transitioning from Birth to Three to Early Childhood Special Education. (Maximum 2000 characters with spaces.)

**Fiscal and IT**

DHH-2.33 Upload one PDF of audited financial statements for each of the last two fiscal years. If audited financial statements for each of the last two fiscal years are not available, scan and upload comparable statements along with an explanation of the submission of documents other than audited financial statements.  Name the one file "ProgramName-Financials.pdf" where ProgramName is the name of the program being proposed.

DHH-2.34 Is your agency financially able support purchasing hearing technology prior to receiving reimbursement from the OEC or Medicaid/Commercial payers?

* Yes
* No

DHH-2.35 Does your agency have mechanisms for reimbursing parent for the cost of travel related expenses to come to your office when necessary?

* Yes
* No

DHH-2.36 Describe how your program collects and enters accurate and timely data. (Maximum 2000 characters including spaces.)

DHH-2.37 Download this file, ProgramName-Towns.xlsx, enter the number of families (assuming 1 child per family) you would like to supporton any given day in each town where you would like to receive referrals, save, rename and upload it here.  NOTE: Rename the file so that "ProgramName" is the name of the program being proposed.

DHH-2.38 If selected, are you willing and able to accept referrals and support families in the following towns:  Salisbury, Sharon, North Canaan, Canaan and/or Cornwall (not ~~Cromwell)~~ without additional distance payments?

* Yes - all of the towns listed
* Yes - at least one of the towns listed
* No

DHH-2.39 If selected, are you willing and able to accept referrals and support families in the following towns:  Thompson, Putnam, Woodstock, Pomfret and/or Killingly without additional distance payments?

* Yes - all of the towns listed
* Yes - at least one of the towns listed
* No

DHH-2.40 If selected, are you willing and able to accept referrals and support families in the following towns:  Greenwich, Stamford, Darien, New Canaan and/or Norwalk without additional distance payments?

* Yes - all of the towns listed
* Yes - at least one of the towns listed
* No