Request for Qualifications

for the selection of Providers to provide:

Chore Services
Homemaker Services
Respite Services

for the period of:

July 1, 2024 through June 30, 2027

Area Agency on Aging *Serving Eastern Idaho*

Assistance. Advocacy. Answers on Aging. Area VI Agency on Aging

a division of:
Eastern Idaho Community Action Partnership (EICAP)
935 E Lincoln Rd
Idaho Falls, ID 83401
(208) 522-5391

Completed Qualifications must be physically in the possession of the Area Agency on Aging *Serving Eastern Idaho. As this will be an open RFQ during the period of July 2024- June 2027*

Chore, Homemaker and Respite Services
Request for Qualification Application 2024-2027

Qualification Submission Information – Provider Capability

Legal Name of Provider:
Business Name: (if different from above):
Contact Person: Title:

Physical Address:
Mailing Address (if different):
City: County:
State: Zip:

Telephone number: Fax:
Email of business:

IRS Employer ID #:

Legal status of Provider: ☐ Private Non-Profit ☐ Public Non-Profit
☐ For-Profit ☐ Other, describe:

- If you are a Non-Profit Provider –
  A. Attach copies of the Provider's Article of Incorporation, Bylaws, and 501(c)(3) exempt status. (**Label Attachment #1**)
  B. Did the Provider receive $300,000 or more of Federal funding in the past 12 months?
     ☐ No ☐ Yes – please attach the most recent audit. (**Label Attachment #2**)

- If you are a For-Profit Provider –
  A. What type of For-Profit Provider is your organization?
     ☐ Incorporated ☐ Sole Proprietorship ☐ LLC
     ☐ Partnership ☐ Other:

Business Types: (Check all that apply **and attach documentation**):
(**Label Attachment #3**)

☐ Small business Owned
☐ Woman-Owned, 51% or more owned by 1 or more women
☐ Veteran-Owned, 51% or more owned by a Veteran
☐ Disabled Veteran-Owned, 51% or more owned by a Disabled Veteran
☐ Javits-Wagner-O'Day (JWOD)
☐ Historically Black College & University Minority Institution
☐ Hubzone Small Business Concern, Historically Underutilized Business Zones as Certified with SBA

☐ Disadvantaged, 51% or more owned by one or more socially or economically disadvantaged Individuals, including Black Americans, Hispanic Americans, Native Americans, Asian-Pacific Americans

Which document is attached to this Qualification which demonstrates the Provider's financial soundness? Please choose only one. (**Label Attachment #4**)
☐ Audit Report, within the past 12 months
☐ Credit Report
☐ Better Business Bureau report
☐ Income Tax Statements

What governing body will be responsible for the oversight of the program? Describe this group's size, membership and role. Attach a current list of member's names, addresses, telephone numbers, office positions, year elected, and terms of office. (**Label Attachment #5**)

Attach copies of the Provider's current insurance policies. (**Label Attachment #6**)

What is the mission of the Provider?

Provider chooses to provide the following services:
☐ Chore (yardwork/snow removal, heavy/deep cleaning)
☐ Homemaker (light housecleaning)
☐ United Way Homemaker (for individuals under 60 who qualify)
☐ Respite (providing relief, activities depend on caregivers needs)

Provider submits the Qualification to provide Services in the following area. Choosing the County means, you can cover the entire county:

☐ **Bonneville County**
- ☐ Ammon
- ☐ Idaho Falls
- ☐ Iona
- ☐ Irwin
- ☐ Swan Valley
- ☐ Ucon

☐ **Butte County**
- ☐ Arco
- ☐ Butte City
- ☐ Moore

☐ **Clark County**
- ☐ Dubois
- ☐ Spencer

☐ **Custer County**
- ☐ Challis
- ☐ Clayton
- ☐ Lost River
- ☐ Mackay
- ☐ Stanley

☐ **Fremont County**
- ☐ Ashton
- ☐ Drummond
- ☐ Island Park
- ☐ Newland
- ☐ St Anthony
- ☐ Teton
- ☐ Warm River

☐ **Jefferson County**
- ☐ Hamer
- ☐ Lewisville
- ☐ Menan
- ☐ Mud Lake
- ☐ Rigby
- ☐ Ririe

☐ **Lemhi County**
- ☐ Leadore
- ☐ Salmon

☐ **Madison County**
- ☐ Rexburg
- ☐ Sugar City

☐ **Teton County**
- ☐ Driggs
- ☐ Tetonia
- ☐ Victor

If Provider chooses a specific locale to serve, will the Service have service boundaries?

☐ Yes ☐ No

Explain Boundaries:

Qualification Application

Assurances and Required Activities. By submitting this Qualification, Provider commits to perform the following listed assurances and activities and will provide written documentation thereof if awarded a contract:

1. The Provider will ensure access to the Services program will be equally available to all eligible consumers.
   ☐ Yes ☐ No

2. The Provider has read, understands in full, and will follow the AAA's Services Scope of Work – as outlined in the Guide to Request for Qualifications.
   ☐ Yes ☐ No

3. The Provider will provide Outreach to locate persons in the community who are not participating in available senior programs or receiving senior services for which they qualify. Provider will identify their service needs; provide information about aging programs and services available; and assist them in accessing services they need or want to participate in.
   ☐ Yes ☐ No

4. The Provider will ensure the geographically difficult areas of the locale are served.
   ☐ Yes ☐ No

5. The Provider will accommodate for cultural differences and take them into account when delivering services.
   ☐ Yes ☐ No

6. The Provider will make accommodations to work with persons who have various types of disabilities, including but not limited to, vision and hearing impairments.
   ☐ Yes ☐ No

7. The Provider will make accommodations to work with persons who speak a language other than English.
   ☐ Yes ☐ No

8. The Provider will maintain confidentiality of client information.
   ☐ Yes ☐ No

9. The Provider will annually assess client satisfaction.
   ☐ Yes ☐ No

10. The Provider has procedures for handling injuries to clients, staff, and volunteers.
☐ Yes ☐ No

11. The Provider is an equal opportunity employer and has an affirmative action policy, if applicable.
☐ Yes ☐ No

12. The Provider will electronically report accurate fiscal and program data, on time, as required in the General Terms and Conditions of the AAA Contract, or as requested.
☐ Yes ☐ No

**** THE FOLLOWING SECTIONS WILL EXPAND BASED ON EXPLANATIONS. PLEASE TYPE IN THE BOXES BELOW THE QUESTION. HANDWRITTEN EXPLANATIONS WILL NOT BE ACCEPTABLE.**

Qualification Narrative provision and Past Performance.

14. Has the Provider been a previous direct Provider with the AAA?
☐ Yes ☐ No

15. Attach job descriptions, by title, for **all** personnel, paid and volunteer, including administrative personnel who will support the Service(s) program. (**Label Attachment #7**)

16. Does the Provider ☐ Own **or** ☐ Lease any facilities needed to deliver the proposed service? (**Label Attachment #8 – Leased Facilities only**)

17. Describe in detail the Service(s) that the Provider has provided to individuals aged 60 years and older (seniors) and others within the last 12 months. If none, describe the Service(s) that the Provider is planning to provide.

18. Describe in detail what strengths uniquely qualify the Provider to provide Service(s)?

Cost Effectiveness, Budget, and Line Items.

19. Describe in detail any activities and/or methods the Provider employs that are designed to increase community involvement, participation, donations, and other support for AAA-funded services.

20. If the Provider utilizes volunteers, describe in detail such utilization. How are they recruited; how and where are the volunteers placed; what duties are completed; are stipends paid, etc.

Partnership, Collaboration and Fund Leveraging. A component of the AAA programs is networking and coordination with other appropriate agencies, organizations, businesses, etc.

21. Describe the Provider's networking and coordinating strategies for the following:
    a. Home Health Agencies
    b. Hospital and Physicians
    c. Local Government
    d. Long Term Care Facilities
    e. Senior Housing Complexes
    f. Other Senior Service Providers
    g. Businesses
    h. Other

22. If applicable, describe any partnerships the Provider has or anticipates to ensure that services are delivered. Include partnering organizations' names, funding sources, partners' cash contributions, in-kind, etc.

Funding Qualification and Profile

Client Choice: Each client is assessed and authorized to receive specified service. Each client is provided with a list of AAA's authorized providers and designates the provider of their choice. A client may, at any time at their sole discretion, terminate the services of a provider and designate another authorized provider.

Unit of Service: A service unit equals one hour, or fraction thereof, in service to the client. Transportation to and from the client's home may **not** be included as part of the service unit.

Rate: The AAA's reimbursement rate is $17.00 per hour for Chore, Homemaker, and Respite Services.

Reimbursement: The AAA reimburses not more than once per month in amounts not to exceed those authorized by the AAA Service Enrollment Plan. The Service Plan indicates the amount the AAA will reimburse and the amount the client is to be billed. **NOTE: The AAA reserves the right to deny any claim in excess of the hours authorized by the AAA. It is the Provider's responsibility to monitor the scheduling of services in accordance with the authorized amounts.**

Fees**:** A client's payment is determined by the AAA during the initial screening process to ensure the client consents to the fee, if required. Clients whose self-declared income exceeds one hundred percent (100%) of poverty (as established annually by the United States Department of Health and Human Services) are required to pay a fee for service. All fees are based on the type of funding and if applicable, sliding fee scale, that is provided annually by the Idaho Commission on Aging.

The Provider is solely responsible for collecting the client's portion of the fee for service. The Provider must invoice the client in a timely manner and the client is not responsible for payment of fees for services if invoiced by the Provider more than ninety days after the month in which services were rendered.

A Provider must establish a standardized system for billing and collecting fees. The fee for service must be deducted from the Provider's cost per unit and the AAA will pay the difference. The Provider must maintain accounting records of all fees and of all monies expended from these sources.

Clients whose annual income falls below poverty shall be given the opportunity to make voluntary donations. All donations must be submitted to the Area Agency.

Chore, Homemaker and Respite Services
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Qualification Submission Letter

In submitting this Qualification, Provider certifies and acknowledges that:

1. The RFQ and all attached documents have been read and understood and all information provided is true, complete, and accurate to the best of Provider's knowledge. Should an investigation at any time disclose any misrepresentation or falsification information provided by Provider to the Area Agency on Aging Serving Eastern Idaho (AAA) hereunder, this Qualification may be rejected, and contracts entered into may be terminated.

2. Enclosed, at a minimum, is **all** information requested in this RFQ.

3. One single-sided original and one single-sided copy is being submitted in a sealed envelope as instructed within this RFQ.

4. Any RFQ amendments received in regard to the Provider's original RFQ are signed and submitted with this Qualification.

5. Provider certifies that the assurances contained in this Qualification have been met by the Provider.

6. Provider certifies that the submission of this Qualification did not involve collusion or other anti-competitive practices.

7. Provider certifies as to non-Debarment.

8. Provider agrees to comply with all applicable Idaho Commission on Aging and Area Agency on Aging Serving Eastern Idaho service specifications, contract terms, manuals, policies and directives, and all applicable federal, state and local laws.

9. Provider agrees to provide services to eligible individuals regardless of the source of funding.

10. Provider certifies, upon award of contract, to maintain liability insurance as specified in the General Terms and Conditions of the AAA's Contract.

11. The person signing on behalf of the Provider is legally authorized to submit this Qualification and to make this certification.

_____ _____

Signature of Provider Official **Date**

_____

Title of Provider Official

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Qualification Submittal Checklist

- ☐ Qualification Submission Information
  - ☐ Attachment 1 – Non-Profit – Article of Incorporation, Bylaws, and 501(c)(3) status –(if applicable)
  - ☐ Attachment 2 – Audit – (if applicable)
  - ☐ Attachment 3 – Proof of Business Type
  - ☐ Attachment 4 – Financial Soundness
  - ☐ Attachment 5 – Governing Body – Membership Information
  - ☐ Attachment 6 – Insurance Coverage
- ☐ Funding Qualification and Profile
- ☐ Qualification Application
  - ☐ Attachment 7 – Job Descriptions.
  - ☐ Attachment 8 – Leased Facilities
- ☐ Qualification Submittal Letter
- ☐ Qualification Submittal Checklist

- ☐ Debarment Certification