**Cover Letter**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date  Licensee Name  Company Name (if applicable)  Address  City, State, Zip  Email Address  Phone Number  Dear County of San Mateo:  I am pleased to submit the enclosed application to be a provider of Attendant Care Services for Aging & Adult Services for the County of San Mateo. I have read and agreed to all the term and conditions outlined in the Application Information Document along with all the attachments and enclosures referenced.  I meet the minimum qualifications outlined in the Application Information Document. I certify and can provide evidence if requested that I have the appropriate training, license, and certification required to perform the services that I am proposing to provide to the County. I am staffed with the ability to respond to service requests if given 24 hour notice and also in emergency situations with less than 24 hours’ notice. I have the capacity to service all geographic areas throughout San Mateo County including the coast-side, if requested.  The following are authorized officer(s) or employee(s) to represent, submit, and commit this proposal under the terms of the proposal:   |  |  |  | | --- | --- | --- | | **Name** | **Title** | **Authorized Signature** | |  |  |  | |  |  |  |   Please do not hesitate to contact me if you have any questions.  Sincerely,  <Authorized Signature>  Authorized Representative Name |

**TAB 1 Qualifications and Experience:**

|  |
| --- |
| 1. Provide a statement of qualifications for your organization, a statement of the size of firm, a description of services including techniques, approaches and methods provided by your organization, and a statement of the extent of experience/history providing the services requested.   **Proposer’s Response:** |
| 1. How many full time employees (FTEs) do you plan to assign to this project if you are selected?   **Proposer’s Response:** |
| 1. How many people in total are employed by your company? Delineate between employees and consultants.   **Proposer’s Response:**   |  |  |  | | --- | --- | --- | | **# of Employees** | **# of Consultants** | **Total** | |  |  |  | |
| 1. List the professional qualifications for each individual that would be assigned to provide services requested by using the grid below.   **Proposer’s Response:**   |  |  |  |  | | --- | --- | --- | --- | | **Name** | **License #** | **Years of Experience** | **# of clients served** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |

**TAB 2 Philosophy and Service Model:**

This section describes your philosophy and service model for meeting the services required. Relevant considerations include the quality and feasibility of your approach to meeting these needs, the manner in which you plan to provide adequate staffing (including planning for absences and back-up coverage, training, background checks, and staff monitoring, etc.), and equipment or other resources provided by you (if applicable).

|  |
| --- |
| 1. Describe how you will fulfill the needs of the County.   **Proposer’s Response:** |
| 1. Identify how you will meet all other aspects of the scope of work and related requirements stated above. List any items that you cannot provide.   **Proposer’s Response:** |
| 1. Describe your method and frequency of communication with the County regarding the quality of services being contracted for.   **Proposer’s Response:** |

**TAB 3 Customer Service:**

|  |
| --- |
| 1. How will your services meet the needs of County clients and/or the public?   **Proposer’s Response:** |
| 1. In the event of any problem, who is to be contacted within your organization and describe how you will address such problems and the timeframe for addressing them?   **Proposer’s Response:** |
| 1. Please describe your most challenging professional client experience and how did you overcome the challenge.   **Proposer’s Response:** |
| 1. Describe a situation where you were able to provide services in less than four hours response timeframe and the outcome of that service.   **Proposer’s Response:** |
| 1. Please let us know which areas and cities in San Mateo County that you will not be able to provide service.   **Proposer’s Response:** |
| 1. How do you address your staff no shows that may occur when you provide services to the County?   **Proposer’s Response:** |
| 1. What experience and training do your staff have with providing services for behaviorally challenging clients (i.e. mental health and/or dementia)?   **Proposer’s Response:** |

**TAB 4 Claims, Licensure, Non-Discrimination, and Health Insurance Portability and Accountability Act (HIPAA) Violations Against Your Organization:**

|  |
| --- |
| 1. List any current licensure, HIPAA, non-discrimination claims against you/your organization and those having occurred in the past five years, especially any resulting in claims or legal judgments against you.   **Proposer’s Response:** |

**TAB 5 Quality/Program Evaluation:**

Each program may have specific quality/evaluation issues, below are some examples:

|  |
| --- |
| 1. How do you ensure that you are continuously providing the best level of service for the County of San Mateo if awarded a contract?   **Proposer’s Response:** |
| 1. How do you ensure that each client receiving services under your care are having their health care needs met as best as possible?   **Proposer’s Response:** |
| 1. Describe licensing, professional development, and training that you will undergo and how that will contribute to your work if awarded a contract.   **Proposer’s Response:** |

**TAB 6 References:**

1. List at least three business and client references for which you have recently provided similar services. Include contact names, titles, phone numbers and e-mail addresses for all references provided.

**Proposer’s Response:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Title** | **E-Mail** | **Phone #** | **Relation** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. Provide at least three references from peers in your industry for whom can attest to your experience, reputation, knowledge, and verify the content of your application. Include names, titles, e-mail addresses and phone numbers for these individuals.

**Proposer’s Response:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Title** | **E-Mail** | **Phone #** | **Relation** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**TAB 7 Statement of Compliance with County Contractual Requirements:**

|  |
| --- |
| A sample of the County’s standard contract (including Exhibits A and B) is attached to this RFP. Each proposal must include a statement of the proposer’s commitment and ability to comply with each of the terms of the County’s standard contract, including but not limited to the following:   1. The County non-discrimination policy 2. The County equal employment opportunity requirements 3. County requirements regarding employee benefits 4. The County jury service pay ordinance 5. The hold harmless provision 6. County insurance requirements 7. The County Living Wage Ordinance 8. All other provisions of the standard contract   In addition, the proposer should include a statement that it will agree to have any disputes regarding the contract venued in San Mateo County or Northern District of California.  **Proposer’s Response:** |
| The proposal must state any objections to any terms in the County’s contract template and provide an explanation for the inability to comply with the required term(s). If no objections are stated, the County will assume the proposer is prepared to sign the County standard contract template as provided.  **Proposer’s Response:** |

**TAB 8 Services and Cost:** The County is seeking the following services. If you are willing, able, and appropriately licensed to provide these services, please indicate the rates under the rate column. Please only complete for the services that you are seeking to provide. Please refer to Enclosure 3 Attachment 1: Description of Services for details on each service listed.

|  |  |  |
| --- | --- | --- |
| **Service** | **Unit** | **Rates** |
|
|
| **Caregiver Services** | | |
| Caregiver Visit (max 1.5 hours) | Per Visit |  |
| Minimum 2 Hours | Per Hour |  |
| Minimum 4 Hours for a couple | Per Hour |  |
|  |  |  |
| **Health Care Professional Services** | | |
| RN (including initial assessments) | Visit |  |
| LVN | Visit |  |
| OT | Visit |  |
| PT | Visit |  |
| ST | Visit |  |
| Case Management-RN (MSSP Only) | Visit |  |
|  |  |  |
| **In-Home Respite & Protective Supervision** | | |
| In-home respite & protective supervision | Per Hour |  |
| Professional Care Assistance | Per Hour |  |
|  |  |  |
| **In-Home Care/Sleep Over Night** | | |
| In-home care/sleep overnight 12 hours (night) | Visit |  |
| **24 Hour Live-In-Care** | | |
| Primary Care (Basic Care) | Day |  |
| Secondary Care (Medium Level Care) | Day |  |
| Tertiary Care (Heavy Care) | Day |  |
| Transportation-(2 hours or less) | Visit |  |
| Transportation-(> 2 hours) | Hour |  |