Application
Mental Health Treatment Services
Adult Continuum of Care

Only one application is required per agency, even if applying for multiple areas/programs. Please note that submitting an application does not guarantee a contract with the County.

Agency Legal Name: _____

Agency Website: _____ **Phone**: _____

Mailing Address/City/Zip: _____

Location of Services Address/City/Zip: _____

1 ORGANIZATIONAL CATEGORY

- ☐ Private Not-for-Profit
- ☐ Private For-Profit
- ☐ Public Non-Profit
- ☐ B-Corporation
- ☐ Other: _____

2 SERVICE CATEGORIES

Using the checkboxes below, please identify which service categories you are applying to provide. Details of services found in Attachment A: Service Categories & Program Information:

1. Outpatient Services
    - ☐ 1.1. Outpatient High-Moderate Intensity (Non-FSP)
    - ☐ 1.2. Outpatient High Intensity (FSP Level Support)
    - ☐ 1.3. ACT Level
    - ☐ 1.4. Supported Housing Program Level (field or embedded)
2. Day Treatment Services
    - ☐ 2.1. Day Treatment Rehabilitative Program Level
    - ☐ 2.2. Day Treatment Intensive Program Level
3. Residential Services
    - ☐ 3.1. Transitional Residential Program Level
4. High-Intensity Wraparound: Embedded Services Level
    - ☐ 4.1. High-Intensity Program Embedded within Long-Term Care

5. Specialty Programs

- ☐ 5.1. TMS (Transcranial Magnetic Stimulation) Programs
- ☐ 5.2. Eating Disorder Treatment – Intensive Outpatient Level (EDO IOP)
- ☐ 5.3. Eating Disorder Treatment – Partial Hospitalization Program Level (EDO PHP)
- ☐ 5.4. Eating Disorder Treatment – Residential Level (EDO Res)
- ☐ 5.5. Supported Employment: Individual Placement and Support (IPS)

3 PROGRAM DESCRIPTION

Please briefly describe your program(s). You may attach program brochures or other information material as applicable.

Is your program currently part of the Adult Mental Health Treatment Continuum of Care?
☐ Yes ☐ No

What does your program add to the continuum to improve the network of providers?

What is your current/proposed program capacity? (e.g., number of beds, target monthly census)

Does your program serve any unique populations? (e.g., gender, age, dual-diagnosis, trauma, conservatees)

Does your program provide field-based services? ☐ Yes ☐ No

What region(s) does your program serve? (check all that apply)

☐ Central County ☐ South County

☐ North County ☐ West County

☐ East County ☐ Out of County

4 SERVICE PROVISION DETAILS

For any Service Categories selected above, please fill details below.

Service Category	Evidence Based Practices or Specialties	Population Served	Hours of Operation	Frequency and Duration of Services	Address of Facility
e.g. *3.1 Transitional Residential Program Level*	***e.g.*** *DBT, CBT, Dual-diagnosis, eating disorders, trauma*	***e.g.*** *Men, Women, TAY Ages 18-24, veterans, etc.*	***e.g.*** *24 Hours, M-F 8AM – 5PM*	***e.g.*** *Daily 3-5 hours, monthly case management, weekly therapy*	***e.g.*** *2227 Capricorn Way, Santa Rosa, CA 95407*

5 LICENSING & CERTIFICATION INFORMATION

As indicated in Attachment A: Service Categories & Program Information, all programs will require site certification before commencing services. If your program is already a provider in the Adult Mental Health Continuum, please attach copies of appropriate certifications for the services you have indicated in this application. Additionally, if your program requires licensing through the California Department of Social Services (CDSS), please attach licensing information.

6 CONTRACTING INFORMATION

Authorized Signer

Name of Person Authorized to sign contracts: _____

Title: _____ Phone: _____

Email: _____

Program Contact

Name of Agency Programmatic Lead: _____

Title: _____ Phone: _____

Email: _____

Contracting/Administration Contact

Name of Agency Contracting Lead: _____

Title: _____ Phone: _____

Email: _____

Fiscal Contact

Name of Agency Fiscal Lead: _____

Title: _____ Phone: _____

Email: _____

Privacy Officer

Name Agency Privacy Officer: _____

Title: _____ Phone: _____

Email: _____

7 CONDITIONS FOR CONTRACTING WITH THE COUNTY OF SONOMA

In order to contract with the County, an individual or agency must meet the following criteria and agree to the criteria by initialing each criteria below.

1. _____ Be legally capable and willing to contract with the County based on Sample Contract.
2. _____ Be able to comply with and provide current insurance documents as described.
3. _____ Be willing to attend monthly provider meetings and maintain routine communication with Department Program Contact.

8 ATTESTATION

To the best of my knowledge and belief, all information in this proposal is true and correct. The Respondent and/or Cosigner will comply with all of the requirements of the application process and the subsequent contract with the County.

Signature: _____ *Date:* _____

Printed Name: _____

9 SUBMISSION INSTRUCTIONS

Please check to make sure the below are included with your Application:

1. Signed Application (all pages of this document)
2. Copies of Certification/Licensure for any indicated services, as applicable
3. Supplemental Questions (Form 2)
4. Signed Attestation Regarding County Contract, including edits, if any (Form 3)
5. Signed Acceptance of County Insurance Requirements (Form 4)

Send all materials to:

Subject: MH Adult Treatment RFA – [Provider Name]

Email: DHS-Procurement@sonomacounty.gov