# Form 1: Agency Application Cover Sheet
# Mental Health Treatment Services
# Youth Continuum of Care

**Instructions:** Complete **one (1) Form 1** for your organization, regardless of how many programs or service categories you are applying for.

Form 1 collects organizational information, authorized contacts, certifications, and contracting information that applies to your entire agency. Form 2 collects information related to programs and services you are applying to provide.

If your organization is applying for more than one program or service category, complete **a separate Form 2 – Program Application Sheet for each individual program or service** you are applying for.

Please note that submitting an application does not guarantee a contract with the County.

**Agency Legal Name**: _____

**Primary Email:** _____ **Phone**: _____

**Business Address/City/Zip**: _____

**Agency Website:** _____

## 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 Moderate Intensity (Non-FSP)
    - ☐ 1.2. Outpatient High Intensity
        - ☐ 1.2.1. Outpatient High Intensity (FSP Level Support)

- ☐ 1.2.2. Therapeutic Behavioral Services (TBS)
- ☐ 1.2.3. Intensive Care Coordination (ICC)
- ☐ 1.2.4. In-Home Behavioral Supports
- ☐ 1.2.5. Child & Family Team (CFT) Facilitation

☐ 1.3. Supported Housing Program Level (field or embedded)

2. Evidence-Based Intensive Outpatient Services
   - ☐ 2.1. High Fidelity Wrap Around
   - ☐ 2.2. Functional Family Therapy (FFT)
   - ☐ 2.3 Multi-Systemic Therapy (MST)
   - ☐ 2.4 Parent-Child Interaction Therapy (PCIT)
3. Day Treatment Services
   - ☐ 3.1. Day Treatment Rehabilitative Program Level
   - ☐ 3.2. Day Treatment Intensive Program Level
4. Foster Care and Residential Services
   - ☐ 4.1. Therapeutic Foster Care (TFC)
5. Early Intervention Services
   - ☐ 5.1. Coordinated Specialty Care (CSC) For First Episode Psychosis (FEP)
   - ☐ 5.2. 0-5 Screening, Assessment and Referral Services
6. Specialty Programs
   - ☐ 6.1. Transcranial Magnetic Stimulation (TMS) Programs
   - ☐ 6.2. Eating Disorder Treatment – Intensive Outpatient Level (EDO-IOP)
   - ☐ 6.3. Eating Disorder Treatment – Partial Hospitalization Program Level (EDO PHP)
   - ☐ 6.4. Eating Disorder Treatment – Residential Level (EDO RES)

# 3 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 Youth 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.

# 4 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: _____

# 5 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.
4. _____ Be aware that, if selected for contract award, the agency will be required to participate in and complete the County of Sonoma Department of Health Services Pre-Award Risk Assessment (PARA) process, including submission of required documentation and participation in any identified corrective action or follow up activities prior to contract execution.

# 6 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:* _____

# 7 SUBMISSION INSTRUCTIONS

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

1. Completed Form 1 – Agency Application Cover Sheet
2. Completed Form 2 – Program Application Sheet for each program or service category being applied for
3. Copies of Certification/Licensure for any indicated services, as applicable
4. Signed Attestation Regarding County Contract, including edits, if any (Form 3)
5. Signed Acceptance of County Insurance Requirements (Form 4)

**Submit all materials to:**

Subject: MH Youth Treatment RFA – [Provider Name]

Email: DHS-Procurement@sonomacounty.gov