

**HUMAN CARE AGREEMENT CONTRACTOR QUALIFICATIONS RECORD****STATUTORY AND REGULATORY AUTHORITY**

D.C. Official Code § 2-354.06 authorizes the District of Columbia Chief Procurement Officer, or his or her designee, to award human care agreements for the procurement of social, health, human, and education services directly to individuals in the District. The Human Care Agreement Contractor Qualifications Record (CQR) is an application package that will facilitate the process of pre-qualifying providers for a human care agreement with the District of Columbia in accordance with District law and regulations (27 DCMR Chapter 19).

**GENERAL INSTRUCTIONS**

1. Please read and complete each section of the Human Care Agreement Contractor Qualifications Record form. All information must be completed in the spaces provided, or marked "N/A." Include and attach all information and documentation as required.
2. Incorporated by reference in each Human Care Agreement between a provider and the District of Columbia will be the "Standard Contract Provisions for Use with District of Columbia Government Supplies and Services Contracts" ("SCP"). The full text of these provisions is available at <https://ocp.dc.gov>, under **Quick Links**, click on **"Required Solicitation Documents"**.
3. You will be required to complete the Bidder/Offeror Certifications Form and return it with your package. This form is available at <https://ocp.dc.gov>, under **Quick Links**, click on **"Required Solicitation Documents"**.
4. You may use Section VIII, the "Remarks Section", on page 6, to provide additional information or to expand on information that is provided in response to the request for information.
5. In those instances where check boxes are provided, please check only the box or boxes which apply.

**CHECKLIST**

	Did you include your Taxpayer Identification Number?		Did you attach a copy of your most recent Financial Statement?
	Did you attach your completed Bidder-Offeror Certification?		Did you attach a copy of all licenses and certifications, including any specialty certifications?
	Did you list all personnel critical to the performance of your Organization in Section VI?		Did you attach a copy of the Certificate of Occupancy for each facility, if applicable?
	Did you attach a Certificate of Incorporation, if applicable?		Did you attach a Certificate of Good Standing?

**FREQUENTLY ASKED QUESTIONS**

<b>Q</b>	How do I submit my application for processing?	<b>A</b>	Applications must be submitted electronically using the District's E-Sourcing system
<b>Q</b>	Is this form available electronically?	<b>A</b>	Yes, the Contractor Qualifications Record (CQR) is available on the Office of Contracting and Procurement website, <a href="https://OCP.dc.gov">https://OCP.dc.gov</a> , Quick Links, Required Solicitation Documents.
<b>Q</b>	Who or what is an Individual?	<b>A</b>	The term "individual" means a human person who may be licensed, certified, or otherwise authorized or qualified to perform or provide specific human care services.
<b>Q</b>	Who or what is an Organization?	<b>A</b>	The term "organization" means an entity, other than an individual, that is licensed, certified, or otherwise authorized, or qualified, to provide or perform human care services in the normal course of business. The license, certification, or other recognition is granted to the organization entity. Individual owners, managers, or employees of the organization may also be certified, licensed, or otherwise recognized as individual providers in their own right. Examples may include a corporation, joint venture, clinic, hospital, or partnership.

**HUMAN CARE AGREEMENT CONTRACTOR QUALIFICATIONS RECORD**

1. Date of Filing / /		2. Filing Type: <input type="checkbox"/> New <input type="checkbox"/> Renewal	
<b>SECTION I – GENERAL INFORMATION</b>			
1. NAME OF INDIVIDUAL/ ORGANIZATION		2. Name of Principal Addressee 3. Title of Principal Addressee	
4. Physical Street Address Including City, State and Zip Code			
5. Office Phone:		6. E-Mail Address	
7. Organization Web Address			
8. Social Security No. for an Individual Applicant /Taxpayer ID No. for an Organization			
9. ARE YOU OR THE ORGANIZATION CERTIFIED BY DISTRICT OF COLUMBIA DEPARTMENT OF SMALL AND LOCAL BUSINESS DEVELOPMENT AS A CERTIFIED BUSINESS ENTERPRISE? Yes <input type="checkbox"/> No <input type="checkbox"/>			
<b>SECTION II – FINANCIAL RESPONSIBILITY INFORMATION</b> Please Provide and Attach a Copy of Your Most Recent Financial Statement (Must be Dated Within Last 12 Months)			
1. Name and Address of Accountant:		2. Name and Address of Financial Institution:	
3. Telephone No:	4. Fax No:	5. Telephone No:	6. Fax No:
<b>SECTION III - MEDICAID– MEDICARE or OTHER LICENSURE INFORMATION</b>			
1. Are You/Organization a Certified Medicaid Provider? <input type="checkbox"/> YES <input type="checkbox"/> NO Medicaid Number: _____ Date: _____			
2. Are You/Organization a Certified Medicare Provider? <input type="checkbox"/> YES <input type="checkbox"/> NO Medicare Number: _____ Date: _____			
3. DC Medicaid Waiver Letter Of Approved Services Must Be Attached if Required to Determine Qualification			
4. Are You/Organization Certified by the Department of Behavioral Health as a Community Based Service Provider? <input type="checkbox"/> YES <input type="checkbox"/> NO			
5. Are You/Organization Certified by Another District Agency as a Service Provider? <input type="checkbox"/> YES <input type="checkbox"/> NO			
6. Certification of Licensure with Another District Agency Must Be Attached if Required to Determine Qualification			

**SECTION IV- ORGANIZATION HISTORY, BACKGROUND AND EXPERIENCE****1. List All Contracts With the District government Within the Past Five (5) Years:**

	Agency	Description of Service	Amount	Dates	Contract Number
A				to	
B				to	
C				to	
D				to	
E				to	

*(Please Use and Attach a Separate Sheet for Additional Items.)***2. List All Contracts With Other Governments or Private Institutions Within the Past Five (5) Years:**

	Agency	Description of Service	Amount	Dates	Contract Number
A				to	
B				to	
C				to	
D				to	
E				to	

*(Please Use and Attach a Separate Sheet for Additional Items.)***3. If Applying as An INDIVIDUAL, Please List Your Employment Or Work History for past five (5) years:**

	Name of Employer	Address	Duties	Name of Supervisor	Dates of Employment	Telephone
A					to	
B					to	
C					to	
D					to	
E					to	
F					to	

*(Please Use and Attach a Separate Sheet for Salary History and Additional Items.)***4. List At Least Five (5) References Familiar With Service Delivery:**

	Name	Title/Position	Affiliation	Telephone	Fax	E-Mail
A						
B						
C						
D						
E						

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**SECTION V-- EDUCATION, CREDENTIALS AND LICENSURE****1. If Applying as an INDIVIDUAL, Please List All Colleges (Undergraduate and Graduate) and Professional Institutions Attended:**

Chief Study Subject Area	Name of College, University or Professional School	Address and Zip Code	Dates Attended	Date And Type Degree Awarded
A			To	
B			To	
C			To	
D			To	
E			To	

*(Please Use and Attach a Separate Sheet for Additional Items.)***2. If Applying as an INDIVIDUAL, Please List All Professional Certifications and Licenses (Copies Must Be Attached):**

License/Certification	Agency/Entity	State	Number	Effective Dates	Date Issued
A				to	
B				to	
C				to	
D				to	
E				to	

*(Please Use and Attach a Separate Sheet for Additional Items.)***3. If Applying as an INDIVIDUAL, Please List All Specialty Certifications and Licenses (Copies Must Be Attached) Organizations, Please refer to Section III if Applicable:**

Specialty License/Certification	Agency/Entity	State	Number	Effective Dates	Date Issued
A				to	
B				to	
C				to	
D				to	

*(Please Use and Attach a Separate Sheet for Additional Items.)***4. HAVE YOU OR ANY MEMBER OF THE ORGANIZATION EVER HAD ANY LICENSE, CERTIFICATION OR CREDENTIAL REVOKED OR SUSPENDED? ☐ YES ☐ NO***(If yes, please explain in REMARKS SECTION, or attach a detailed explanation, including dates, type of license, certification, credential and all circumstances surrounding the event(s).)**(Please Use and Attach a Separate Sheet for Additional Items.)***5. Please list any hospital affiliations or privileges below:**

Name of Individuals(s)	Name of Hospital	Address	Type Privilege/Affiliation	Telephone	Fax No.
A					
B					
C					
D					

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**SECTION VI – SERVICE DATA AND INFORMATION**

**1. GENERAL SERVICE CATEGORIES:** please check each of the general service categories for which you or the organization are applying.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Education (EDS)         | <input type="checkbox"/> Human Services (HUM)   | <input type="checkbox"/> Social Services (SOC)        |
| <input type="checkbox"/> Special Education (SED) | <input type="checkbox"/> Behavioral Health (BH) | <input type="checkbox"/> Youth/Juvenile Justice (JUV) |
| <input type="checkbox"/> Health (HTH)            | <input type="checkbox"/> Psychology (PSY)       |   |

**2. POPULATIONS:** please check all that apply for populations.

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Children & Youth (CYG)                    | <input type="checkbox"/> Adults (ADT)                                   | <input type="checkbox"/> Residential Habilitation (IDD/RH) | <input type="checkbox"/> Homeless (HLS)                   |
| <input type="checkbox"/> Children & Youth-Detained (CYD)           | <input type="checkbox"/> Adult Forensic-Psychiatric (AFP)               | <input type="checkbox"/> Geriatric (GER)                   | <input type="checkbox"/> Multicultural (MLT)              |
| <input type="checkbox"/> Children & Youth-Committed (CYC)          | <input type="checkbox"/> Adult Forensic-Correctional (FC)               | <input type="checkbox"/> Pregnant Women (PGW)              | <input type="checkbox"/> HIV/AIDS (HIV)                   |
| <input type="checkbox"/> Children & Youth-Supervision (CYS)        | <input type="checkbox"/> Physically Disabled (DIS)                      | <input type="checkbox"/> Hearing Impaired (HIM)            | <input type="checkbox"/> Dually Diagnosed (DUD)           |
| <input type="checkbox"/> Special Education (SED)                   | <input type="checkbox"/> Intellectual or Developmental Disability (IDD) |  | <input type="checkbox"/> Deaf, Deafblind, Hard of Hearing |
| <input type="checkbox"/> Blind/Low Vision/Visually/ Impaired (BLD) |   |  |   |

**3. SETTING CODES:** please check the settings where you or the organization can or will provide service.

*(If You Or The Organization Has A Facility, Then A Certificate of Occupancy Must Be Included and Attached.)*

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Addiction Treatment Facility (ADF) | <input type="checkbox"/> Foster Care Home/Host Home(FCH) | <input type="checkbox"/> Homeless Shelter (HOS)              | <input type="checkbox"/> Nursing Care Facility (NCF)         |
| <input type="checkbox"/> Ambulatory Care/Surg Center (AMB)  | <input type="checkbox"/> Detention Facility–Youth (DFY)  | <input type="checkbox"/> In the Field (FLD)                  | <input type="checkbox"/> Outpatient Clinic (OTC)             |
| <input type="checkbox"/> Child Development Center (CDC)     | <input type="checkbox"/> Detention Facility –Adult (DFA) | <input type="checkbox"/> Inpatient-Psychiatric (INP)         | <input type="checkbox"/> Private Home (PRH)                  |
| <input type="checkbox"/> Comm Day Program (CDP)             | <input type="checkbox"/> Dialysis Center (DIA)           | <input type="checkbox"/> Inpatient-Medical (INM)             | <input type="checkbox"/> Provider's Office or Facility (POF) |
| <input type="checkbox"/> Comm Health Center (CHC)           | <input type="checkbox"/> Group Home –Youth (YGH)         | <input type="checkbox"/> Intermediate Care Facility (ICF/ID) |  |
| <input type="checkbox"/> School (SCH)                       |  |  |  |

**4. SPECIFIC SERVICE CATEGORIES:** please check the specific service categories that apply to you or the organization in which you are qualified, including licenses, or certified, to provide services:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Addiction Treatment Services (ADT)          | <input type="checkbox"/> Dental Services (DEN)               | <input type="checkbox"/> Personal Care Services (PCS)        |
| <input type="checkbox"/> Allergy (ALG)                               | <input type="checkbox"/> Dialysis Services (DIA)             | <input type="checkbox"/> Physical Therapy (PTH)              |
| <input type="checkbox"/> Addiction Treatment Services (ADT)          | <input type="checkbox"/> Early Childhood Intervention (ECI)  | <input type="checkbox"/> Podiatry (POD)                      |
| <input type="checkbox"/> Assessment/Diagnosis (ASS)                  | <input type="checkbox"/> EPSDT Screening (EPS)               | <input type="checkbox"/> Pre-Natal Services (PNA)            |
| <input type="checkbox"/> Audiology (AUD)                             | <input type="checkbox"/> Family Services (FAM)               | <input type="checkbox"/> Psychological Services (PSC)        |
| <input type="checkbox"/> Assessment Diagnosis (ASD)                  | <input type="checkbox"/> Homemaker Services (HOM)            | <input type="checkbox"/> Psychiatric (PSY)                   |
| <input type="checkbox"/> Birthing Services (BIR)                     | <input type="checkbox"/> Dental Hygienist (DHY)              | <input type="checkbox"/> Recreation Therapy (RTH)            |
| <input type="checkbox"/> Case Management-Family Services (CMF)       | <input type="checkbox"/> Laboratory Screening Services (LAB) | <input type="checkbox"/> Respiratory Care Services (RES)     |
| <input type="checkbox"/> Case Management-Medical (CMM)               | <input type="checkbox"/> Mental Health (MEN)                 | <input type="checkbox"/> Respite Care (RSC)                  |
| <input type="checkbox"/> Case Management-Social (CMS)                | <input type="checkbox"/> Midwifery (MID)                     | <input type="checkbox"/> Supported Employment Services (SES) |
| <input type="checkbox"/> Childcare Services (DAY)                    | <input type="checkbox"/> Music Therapy (MTH)                 | <input type="checkbox"/> Social Worker Services (SWS)        |
| <input type="checkbox"/> Chore Services (CHR)                        | <input type="checkbox"/> Neurology (NEU)                     | <input type="checkbox"/> Speech Therapy (STH)                |
| <input type="checkbox"/> Consulting (CON)                            | <input type="checkbox"/> Nutrition and Dietary (NUT)         | <input type="checkbox"/> Transportation Services (TRS)       |
| <input type="checkbox"/> Counseling Services (CSL)                   | <input type="checkbox"/> Occupational Therapy (OTH)          | <input type="checkbox"/> Visiting Nurse (home) (VIS)         |
| <input type="checkbox"/> Day Treatment Services (Habilitation) (DTR) | <input type="checkbox"/> Pediatric (PED)                     |  |

**5. LICENSURE AND CERTIFICATION CATEGORIES:** please check all of the licensure and certification categories that apply to you or the organization in which you are qualified, and are licensed or certified to provide services:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acupuncture Therapist (ACC)              | <input type="checkbox"/> Massage Therapy (MAS)          | <input type="checkbox"/> Physician (DOC)               |
| <input type="checkbox"/> Advanced Practice Registered Nurse (ARN) | <input type="checkbox"/> Naturopathy (NAT)              | <input type="checkbox"/> Physician Assistant (PAS)     |
| <input type="checkbox"/> Architect (ARC)                          | <input type="checkbox"/> Nurse-Anesthetist (RNA)        | <input type="checkbox"/> Podiatrist (POD)              |
| <input type="checkbox"/> Audiologist (AUD)                        | <input type="checkbox"/> Nurse-Midwife (RNM)            | <input type="checkbox"/> Practical Nursing (LPN)       |
| <input type="checkbox"/> Certificate of Occupancy (COO)           | <input type="checkbox"/> Nurse Practitioner (RNP)       | <input type="checkbox"/> Professional Counseling (PRO) |
| <input type="checkbox"/> Child Development (CHD)                  | <input type="checkbox"/> Nutritionist & Dietician (NUT) | <input type="checkbox"/> Psychologist (PSC)            |
| <input type="checkbox"/> Dental Hygienist (DHY)                   | <input type="checkbox"/> Obstetrician (OBS)             | <input type="checkbox"/> Psychiatrist (PSY)            |
| <input type="checkbox"/> Dentist (DEN)                            | <input type="checkbox"/> Occupational Therapist (OTH)   | <input type="checkbox"/> Registered Nurse (RNN)        |
| <input type="checkbox"/> Chiropractor (CHP)                       | <input type="checkbox"/> Optometrist (OPT)              | <input type="checkbox"/> Respiratory Care (RES)        |
| <input type="checkbox"/> Foster Care/Host Home Provider (FOS)     | <input type="checkbox"/> Ophthalmology (OPG)            | <input type="checkbox"/> Social Worker-Clinical (SWC)  |
| <input type="checkbox"/> Funeral Directors (FUN)                  | <input type="checkbox"/> Pharmacist (PHM)               | <input type="checkbox"/> Social Worker (SWS)           |
| <input type="checkbox"/> Gynecology (GYN)                         | <input type="checkbox"/> Physical Therapist (PTH)       |  |

**6. LANGUAGE SKILLS:** Please Check All that Apply for Your Or The Organization's Language Skills:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> English (ENG)                      | <input type="checkbox"/> French (FRN)             | <input type="checkbox"/> Chinese–Cantonese (CCA)   |
| <input type="checkbox"/> Spanish (SPN)                      | <input type="checkbox"/> Haitian Creole (CRE)     | <input type="checkbox"/> Chinese-Mandarin (CMA)    |
| <input type="checkbox"/> International/Universal Sign (SGN) | <input type="checkbox"/> Vietnamese (VTN)         | <input type="checkbox"/> Ethiopian (Amharic) (AMH) |
| <input type="checkbox"/> American Sign Language (ASL)       | <input checked="" type="checkbox"/> Italian (ITL) | <input type="checkbox"/> Korean (KOR)              |

SECTION VII – PERSONNEL CRITICAL TO ORGANIZATION PERFORMANCE

1. Please list All of the Personnel In your Organization Who Are Critical To organization Performance. Please List Officers, Clinical Directors, Medical Directors, Service Supervisors, and Sub-Contractors Essential to the Performance of Services in this Qualifications Record and Attach Resumes Coded to this Section. Attach Any Copies of Licenses, Certifications, or Credentials Where Applicable.:

	Name	Title/Position	Affiliation	Telephone	Fax	E-Mail
A						
B						
C						
D						

SECTION VIII- REMARKS

Please use the remainder of this section to respond to or to continue to respond to any previous question, or request for information. In addition, please feel free to use this section to provide additional information vital to determining your or the organization’s qualifications to enter into a Human Care Agreement with the District of Columbia.