ATTACHMENT B

Proposed Format

- **Steps To Be Taken In Reviewing Program Proposals**
- **Applicant's Proposal Checklist**
- **Program Proposal Request for Funds**
- **Program Proposal Instructions**
- **Evaluation Form**
- **Amendment Sheet (internal document)**

STEPS TO BE TAKEN IN REVIEWING PROGRAM PROPOSALS

Notification of Completed Proposals

Applicants will be instructed to mail one (1) copy of their completed proposal to the DCS County Director, one (1) to the DCS Regional Manager, and a signed original plus one (1) copy to the Regional Child Welfare Service Coordinator that they are proposing to serve. The Child Welfare Service Coordinator will notify the Regional Services Council of all the completed proposals that are received from the providers on or before the submission deadline. Proposals that are not postmarked by the DCS Regional Child Welfare Services Coordinator on the deadline date will not be considered.

Review of Program Proposal

The Child Welfare Service Coordinator will review all proposals to ensure that all proposals are complete according to the checklist. All applicants with incomplete proposals will be provided a copy of the checklist showing items that are missing or that need clarification. The Coordinator will fax checklists indicating missing items to applicants. Applicants will have 5 business days to make any additions/corrections to their proposals and submit them to the Regional Child Welfare Service Coordinator. The Regional Child Welfare Service Coordinator will provide corrected pages of the proposal to the each county DCS Director included in the proposal and the Regional Manager. The Regional Manager will be responsible for providing copies of this information to the Regional Services Council. Corrections/additions received after the 5 day deadline will not be included in the review. The Regional Child Welfare Service Coordinator will review all proposals for completeness.

Scoring and Acceptance of Proposals

The DCS Directors or assigned sub-committee will score each proposal using the criteria established in the Planning Document and determine which proposals will be accepted as part of the regional plan. The DCS Directors will meet with the Regional Manager (RM) to make contract recommendations. The RM will take these recommendations to the Regional Service Council (RSC). If the RSC is not fully operational, the Regional Manager will make this determination and will have final approval for contracts. The Child Welfare Regional Coordinator will assist in this process as determined by the Regional Manager in each region.

Negotiation

The Regional Services Council or assigned sub-committee will identify the points of clarification that need to be made in the submitted proposal prior to accepting the proposal as part of the regional plan. The required revisions to the proposal shall be made within 5 working days of notification.

NOTE: All contractors and subcontractors must register with the Secretary of State of Indiana at least forty five (45) days prior to the date of issuance of procurement solicitation (IC 5-22-16-4).

APPLICANT'S PROPOSAL CHECKLIST

DIRECTIONS: Review your proposal by using the check list. All items must be completed correctly in order for the proposal to be approved by the Region and the State. **PLEASE SIGN ON THE LAST PAGE AND RETURN THE COMPETED CHECK LIST WITH THE PROPOSAL.**

Internal use only A	Check if complete B	ITEM	
	SECTION I: APPLICANT/AGENCY INFORMATION		
		A-I	Self-explanatory (note any missing information)
		J	Proposed funding period complies with the time frame of regional planning (July 1, 2006 through December 31, 2008)
		K	Proposed number of families and/or children and/or clients to be served are clearly stated
		L	Check whether your program serves individual clients or families
		M	Total amount of funds requested clearly stated
		N	Total amount requested with breakdown by Region
		O	Signature/title of applicant's agent - signed (not typed) **in blue ink**
		P	Date submitted to Department of Child Services
	SECTION II: ASSURANCES		
			Assurances - Must be signed by person who signed **(in blue ink)** in Section I, Item O
	SECTION III: BUDGET SUMMARY AND BUDGET JUSTIFICATION WORKSHEETS		
			Documentation of cost calculations must be shown on the Budget Justification Worksheets; verify calculations)
			A- Personnel (1. Salaries & Wages; 2. Fringe Benefits)
		A	Position/Job Title for all staff and supervisor positions
		B	Service-service abbreviation is listed
		C	Number of hours each position is employed and number of hours spent face-to-face with clients/families is identified
		D-F	Salaries and wages for the program are listed by position
		G-H	Fringe Benefits are properly calculated
			3. Consultant and Contract Services
		A-F	Contract Position – all contract positions are noted
			B - Budget Justification Worksheet-Other Direct Costs
		1	Travel expenses (max. $.40 per mile): staff and/or clients
		2	Consumable supplies and printing
		3	Space costs: rent and/or utilities and/or custodial
		4	Insurance
		5	Staff training
		6	Telephone and postage
		7	Rental/lease/purchase of equipment
		8	Other administrative expenses
		9	Other direct costs
			C - Budget Justification Worksheet-Indirect Costs
		1	Accounting services
		2	Other
			D – In-kind Contributions and Other Grants/Income
			In-kind contributions and other grants/income listed by county
	SECTION IV: SERVICE UNIT RATE JUSTIFICATION AND DEFINITION/COST ANALYSIS		
		1	Total adjusted program costs
		2	Total number of Families or Clients to be served
		3	Average amount of funds per Family or Client
		4	Define each billable service unit and rate **as defined in the Program Service Standards** – total of units multiplied by the unit rates should be equal to the total adjusted program costs (or close).
	SECTION V: REGIONAL REQUEST SUMMARY (complete a separate page for each Region to be served)		
		A-D	Self explanatory
		E	Breakdown of proposed services by county, including type of service, number of families or Clients, and public funds requested by county.
	SECTION VI. PROGRAM NARRATIVE AND REQUIRED STATEMENTS		
		A	Problem/Needs Statement - the needs have been described and the problems to be addressed by the program have been stated
		B	Target Population - has been checked for appropriateness for the intent of the program/ Service
		C	Program Objectives and Evaluation

Internal use only A	Check if complete B	ITEM	
		1	Objectives are measurable, have proposed outcomes stated, and include and are compatible with the overall objectives for the funding as indicated in the program service standards
		2	Provider has agreed to complete the required service provider reports and evaluations
		D	Program Description/Service Delivery Methods
		1	Tasks/activities for achievement of objectives and persons responsible for completion of tasks are clearly described
			Proposed client system, client referral, and client eligilbity requirements are clearly stated. Hours of service deliver convenient and flexible (must be specifically stated for Homemaker, Intensive Family Preservation Service Worker, Parent Aid, and Home Based therapy standards) proposed period between referral of client and initial service contact clearly stated.
		3	Program activities in which clients will participate and/or services they will receive
		4	Client case record and program statistical data collection. Method of providing plans/reports/ documentation to referring local DCS clearly described. Specify that client specific goals/ objectives are clearly stated and shared with the client. Procedures for maintaining client confidentiality stated.
		5	For services that have not been standardized, a copy of the instructions to be given to staff outlining the standards they are to use when determining if a billable service has been performed is attached.
		E	Cultural Diversity and Competency of Staff
		1	Upgrade and maintain cultural knowledge base of staff regarding issues of diversity and cultural competence, particularly with primary populations being served
		2	Description of the engagement and assessment process of the client regarding strengths, goals and self identity
		F	Staffing
		1	Job descriptions and qualifications of personnel assigned to the program are attached
		2	An organizational chart is attached
		3	Any staff positions newly funded under this proposal are identified
		4	Your planned staff development activities' schedule for the program during the year is described
		G	Agency/Applicant's Background, Facilities, Community Relationships -Includes statement(s) regarding routine agency and staff performance evaluation processes (include performance appraisal forms). -Includes statement(s) regarding agency's services accessibility and geographical convenience; appropriat of environment, equipment, service hours, office space, and facility maintenance. -Includes statement(s) regarding agency's formal and informal relationships with other agencies. -Includes statement(s) regarding agency's history of working with the local DCSs, acknowledging overall service coordination is responsibility of local DCS and that any agency treatment activity, therapy, and service plan for a specific client/family will be consistent and compatible with the DCS Cas Informal Adjustment, or Service Referral Agreement.
		H	Program Affiliations – Includes statement(s) regarding agency's qualifications and current licenses, accreditations, affiliations, certifications, etc., pertinent to providing this program.
		SECTION VII: ATTACHMENTS	
		I	Direct Deposit Form
		J	State of Indiana W-9
		K	FSSA Provider Data Form
		L	Minority Business/Women Business Participation Agreement

To my knowledge, the proposal has all of the required components. I understand that I may be asked to provide additional information. If so, I understand that I will be contacted by fax and I will have 5 days to respond with missing or corrected information.

_____

Program Title/Service

_____

Applicant/Agency Name

_____ _____

Signature of Applicant's Agent **Date**

INSTRUCTIONS FOR COMPLETING THE PROPOSAL FOR THE USE OF FEDERAL, STATE AND COUNTY FUNDS 2006-08

GENERAL INSTRUCTIONS

VERY IMPORTANT—If you plan to use the electronic version, please read the following before you start. You may complete this form electronically using the Excel template or you may type directly on a hard copy of the form. You may need to adapt the security on your computer in order to use this electronic template (please refer to the enclosed instructions entitled Adapt Security to Enable Macros in Excel). You are encouraged to use the electronic version of the form so the calculations will be completed for you and information, such as your Agency Name, will be brought forward from sheet to sheet.

Please note as you fill out the electronic version:

- Each page of the budget is a separate worksheet in the electronic file. You can move between sheets by selecting the page number at the bottom of the screen.
- Cells in which you are to enter text or numbers are backlit in yellow. The tab key will move you from cell to cell.
- In addition, you will enter information using drop down boxes, option buttons, and on Pages 4 and 5, there are larger text fields for entering calculations and descriptions of costs. Click on these objects to make your selections or type in text, then click on a yellow field to move on to the next entry. The larger text fields allow you to use tab and enter within the field itself.
- When using drop-down boxes, click on the arrow to display the list of options. You can then either scroll through the list with the mouse, and click on your selection, or you can type in the first letter of your desired selection (repeatedly, as needed) until your desired selection highlights, then press enter.
- When you are ready to print your budget, select "entire workbook" on the print options screen.
- If you try to type in a cell that is restricted, you will receive the following error: "The cell or chart you are trying to change is protected and therefore read only…." This simply means you cannot type in that cell, it is being used for background formatting or automatic calculations.
- If you have technical questions regarding the use of this format, please contact your regional coordinator. All other questions should be submitted in writing before the question deadline.

If you are not using the electronic version: The budget pages will open with Acrobat Reader. Print the pages and then type in the yellow or light gray sections. If you need a free copy of Adobe Acrobat Reader, you may download it from: www.adobe.com

Comprehensive Proposals: A single budget may be submitted for services that are logically linked as part of a larger program (e.g., home based therapy and home based casework services). Otherwise, please submit a separate proposal for each service. Foster/Adoptive/Kinship Caregiver Training and Independent Living Services are examples of programs that must be separate proposals.

Submission of Proposals: You should mail an original proposal (with signatures on Page 1 and 2) plus one copy to each Regional Coordinator. In addition, you must also send a copy to each Regional Manager and County DCS Director you are proposing to serve. Proposals must be postmarked by the due date. If you are completing these forms by using the electronic format, please also include an electronic copy of your budget in your mailing to the Regional Coordinator(s).

SECTION I. APPLICANT/AGENCY INFORMATION

Item A: Program Title/Service: Enter the title or name of the program or service being proposed. Note: It is possible that the responses to "A" and "B" will be the same if it is a single service program and the service provider uses the service component description names listed below for the Program name. If you are not using the electronic format, add this to the top of every succeeding sheet.

Item B: **Service Category to be Provided**: While the form allows for more than one service to be entered per form, the intent of the process is to restrict the services included on the same form to either single services or mutually supportive clusters of services within a single program (for example, a home based program might include homemaker, home based casework, and home based therapy). It is critical to ensure clarity in the documentation of staffing and other resources allocated and the number of clients to be served by each program that budget information for almost all services be documented on separate forms. Independent Living and Foster/Adoptive/Kinship Caregiver Training are required to submit separate proposals.

Select the service category from the drop-down menu (by clicking the down arrow beside the box and scrolling down the list to find the correct service category). If the service you are proposing is not standardized, select "other" and type the service in the box to the right of the drop menu.

The list of available services include:

Service Standard
Adoption—Child Preparation
Adoption—Family Preparation
Adoption – Pre / Post-Placement and Post-Adoption Services
Adoption – Step-Parent Adoption and Custody Studies
Assessment—Parenting/Family Functioning
Chafee IL-Chafee Foster Care Independence Program
Chafee IL-Voluntary Services Caseworker
Chafee IL-Youth Advisory Board
CHINS Parent Support Services
Counseling - Individual / Family
Diagnostic and Evaluation Services
Family Case Conferencing
Foster/Adoptive Kinship Caregiver Training
Foster Family Support Services
Foster Home Studies/Updates/Relicensing Studies
Home Based Casework Services
Home Based Intensive Family Preservation Services
Home-Based Intensive Family Reunification Services
Homemaker / Parent Aid
Parent Education
Prevention Services—Communities for Child Safety
Respite
Substance Abuse Evaluation, Treatment, & Monitoring
Therapy – Functional Family Therapy
Therapy – Home Based Therapy
Visitation Facilitation – Parent/Child/Sibling
Other

Other services identified as appropriate to be funded with these Federal funds include:

Other Family Support Services
Camping
Community Awareness/Education
Foster Parent Recognition Event

If you are not using the electronic format, enter the name of the service you are proposing.

Item C: **Legal Applicant/Agency Name**: Enter the legal name as registered with the Secretary of State Office, Corporation Section, of the entity that will provide the services. Verification of Secretary of State registration can be gained by calling 317-232-6576 or at www.state.in.us/sos/. Unincorporated individuals or organizations enter the legal name used on tax documents sent to the Internal Revenue Service. If you are not using the electronic format, add this to the top of every succeeding sheet.

Doing Business As: The name under which the agency will be providing services if different from the Legal Name.

Item D: **Chief Executive Officer** of Applicant Agency and Phone number.

Item E: **Financial Officer** of Applicant Agency and Phone number.

Item F: **Contact Person for Proposal**: Enter the name, telephone number and E-mail of the person to be contacted regarding this Request For Funds if it is being completed by an agency or organization. Leave blank if the service is to be provided by an independent contractor.

Item G: **Mailing Address and Fax Number:** Enter the mailing address and fax number (if applicable) to which all correspondence regarding this Request For Funds should be sent.

Item H: **Federal ID# or SS#** : Enter the agency's federal tax identification number if payments for services are to be made to an incorporated agency. Enter the service provider's social security number if the services are to be provided by an independent contractor.

Item I: **Check Applicant's Legal Status:** Click on the circle in front of the description that identifies the legal status of the person(s) or organization submitting this Request For Funds. Independent Contractors who are not incorporated should identify themselves as "Sole Proprietors".
If you are not using the electronic format, fill in the appropriate circle.

Item J: **Proposed funding period**: The dates, July 1, 2006 to December 31, 2008, are pre-printed.

Item K: **Program based on:** Select from the drop down menu whether the service is family or client based.

Item L: **Number to be served:** Enter the number of families or clients to be served.

Item M: **Total Requested Funds**: This amount will be transferred automatically from Page 7 after you complete your budget. If you are not using the electronic version of the form, enter the amount from Page 7 (Item F).

Item N: **Show Breakdown of Total Amount of Public Funds Requested by Region**:
Enter the total dollar amount of public funds requested per each region to be served. If you are using the electronic version of this form, Item N will total all of your regional entries. After completing the rest of the sheets, be sure the total of Item N is equal to Item M.

Item O: **Signature/Title of Agent**: Please use **blue ink** when signing these documents. This item is to include the original signature of the provider if an Independent Contractor is submitting the proposal. If a corporation or other organization is submitting the proposal, it must include the original signature of a person authorized to sign legal documents for the organization and the person's title within the organization. The same person is to sign both Item "O" and the Assurances Page.

Item P: **Date Signed**:

SECTION II. ASSURANCES

Sign, using **blue ink**, and date the assurance page provided to indicate compliance with the statements. Note: The assurances must be signed by the person who signs the proposal (Section I item O).

Item A: Funds Requested Are Unavailable through Existing Funds
The provider must attest that the funds requested will be used to provide additional services to the target client population identified in the Program Specifications Sheet. These funds are not to be used to supplant or replace already existing funds for the proposed services.

Item B: Provider will Meet Federal and State Evaluation and Reporting Requirements
The provider agrees to complete the evaluation and reporting requirements specified in Appendix D of this document.

Item C: Statement of Non-Discrimination
The provider agrees to conform the Title VI of the Federal Civil Rights Act of 1964, as amended, and to Indiana Code 22-9-1-10, as amended and thus assure non-discrimination in Provider practices concerned with staff recruitment, as well as in the provision of services, without distinction as to color, race, religion, sex, handicap, ancestry or national origin.

Item D: These Funds Can Pay Only Those Costs for Service Not Otherwise Paid
The provider is expected to use other sources of income to replace or supplement these funds whenever possible. It is expected that client fees, either court ordered or voluntary, and private insurance will be used to pay part of all the unit cost of services whenever possible. Clients referred to these services are expected to pay for services using the same sliding fee scale as other clients unless the provider is otherwise instructed by the referring caseworker.

Item E: Fees for Groups With Both Title IV-B and Non-Title IV-B Clients
Title IV-B and CFCIP are not to be billed for services provided within such a group if the total per hour income to the service provider for the group equals or exceeds the contracted unit rate. Title IV-B or CFCIP can be billed to supplement group income up to the limits of the contracted rates as they apply to per person per group hour and total group hour billing units.

Item F: Court Appearances
The provider agrees to appear in court as requested by the Local Office of the Department of Child Services. Provision for court appearances needs to be included as part of the Request For Funds proposal.

Item G: Provider and Staff Qualifications
The provider agrees to ensure that the provider and all staff delivering direct services meet the service standards included with the Request for Funds proposal.

Item H: Provider Will Comply with the Local Office of the Department of Child Services Case Plan for the Client
The provider agrees that all services provided to Title IV-B and CFCIP clients will be compatible and consistent with the recorded case plan for the client served that is on file with the Local Office of the Department of Child Services.

Item I: Provider Will Provide Reports as Requested

The provider must provide monthly updates, quarterly reports, and court reports as requested by the Local Office of the Department of Child Services.

Item J: Provider Will Maintain Records

The provider must maintain all case records indicating time spent with the clients and documents provided to the referring Local Office of the Department of Child Services.

Item K: Case Management Responsibility

The provider agrees that the Local Office of the Department of Child Services has the responsibility and final authority for the case management and service coordination for clients referred for service.

Item L: Drug Free Workplace

The provider acknowledges that he/she agrees to provide and maintain a drug free workplace as required by federal law and will sign the "STATE OF INDIANA DRUG FREE WORKPLACE CERTIFICATION" (Drug Free Workplace Act of 1988 45 CFR, Part 76 subpart F.)

Item M: Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions

Item N: Certification Regarding Lobbying

The provider assures and certifies that no federally appropriated funds have been paid, or will be paid, by or on behalf of the provider, to any person for influencing or attempting to influence an officer or employee of any agency, with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

Item O: Non-Collusion Affidavit

The provider must attest that he/she has not directly or indirectly, to the best of his/her knowledge, entered into or offered to enter into any combination, collusion or agreement to receive or pay, and that he/she has not received or paid, any sum of money to other consideration for the execution of this agreement other than that which appears on the face of the agreement.

Item P: Service Provider Contract –

The provider agrees to sign a State contract if approved for funding.

SECTION III: BUDGET
PERSONNEL JUSTIFICATION WORKSHEET

Directions for Budget Justification worksheet for personnel costs is as follows: (NOTE: The services for which this proposal is being written may require the appearance of the provider in a court or appeals hearing. Please factor these expenses into the unit rate(s) proposed.)

Item A. Personnel

1. Salaries and Wages
   - A Title of all proposed full-time and part-time positions associated with the delivery of the proposed services including administrative and support staff.

   - B Select the service associated with the position from the dropdown menu. If you are not using the electronic format, abbreviate the service category name as shown below and enter it.

Abbreviation	Service Standard
AP	Assessment -- Parenting / Family Functioning
AS	Adoption -- Pre / Post-Placement and Post-Adoption Services
ASC	Adoption -- Child Preparation
ASF	Adoption -- Family Preparation
CH	CHINS Parent Support Services
CM	Prevention Services -- Communities for Child Safety
CS	Counseling -- Individual / Family
DE	Diagnostic and Evaluation Services
FC	Family Case Conferencing
FF	Therapy -- Functional Family Therapy
FP	Home-Based Casework Services
FPI	Home-Based Intensive Family Preservation Services
FR	Foster Family Support Services
FRI	Home-Based Intensive Family Reunification Services
FT	Foster / Adoptive / Kinship Caregiver Training
HBT	Therapy -- Home-Based Therapy
HM	Homemaker / Parent Aid
HS	Adoption -- Step-Parent Adoption and Custody Studies
HS	Foster Home Studies/Updates/Relicensing Studies
IL	CHAFEE IL -- Chafee Foster Care Independence Program
PE	Parent Education
RS	Respite
SA	Substance Abuse Assessment, Treatment, & Monitoring
VC	CHAFEE IL -- Voluntary Services Caseworker
VS	Visitation Facilitation -- Parent / Child / Sibling
YAB	CHAFEE IL -- Youth Advisory Board
OT	Other

C Average number of hours for program, employed: number of hours per month persons in each listed position will be employed in the proposed program.

Average number of hours for program, face-to-face: number of hours per month spent face-to-face with clients/families.

D Projected monthly salary of each position (including raises if applicable).

E Number of months of the program proposed. (in most cases this will be 30)

F This will be calculated automatically. If you are not using the electronic format, enter the total cost requested for each position. (multiply (D) by (E)).

2. Fringe Benefits

G Enter the rate (percentage of base salary) for the fringe benefits for each program position included in the budget. Fringe benefits include: FICA, vacation and sick days, insurance, retirement, etc.

H This will be calculated automatically. If you are not using the electronic format, enter expense for the fringe benefits for each program position included in the budget (multiply (F) by (G)).

3. Consultant/Contract Services

A. Enter all consultant and contracted services that will be purchased by the applicant in order to provide the proposed services.
C. Enter the number of hours for the entire proposed period.
D. Enter the fee per hour paid to the consultant/contract service provider.
F. This will be calculated automatically. If you are not using the electronic format, enter the total by multiplying (C) by (D).

The totals personnel, fringe and consultant/contract fees will be transferred automatically to Page 7, Budget Summary (A, 1-2 and A, 3). If you are not using the electronic format, please calculate the totals and enter the totals on page 7.

Item B Other Direct Costs

1. Travel Expenses

Computation of travel expenses is to be documented using Budget Justification Worksheet section B. 1. The requested mileage rate may not exceed the State of Indiana rate at .40 per mile. Complete the justification section on the worksheet for all travel costs. Indicate the projected number of miles for staff and clients separately. Also indicate the rate to be paid, and explanation of additional travel expenses and the total dollars budgeted for travel expenses. Example: On Budget Justification Form , estimate the miles to be driven annually and the costs as follows: 20 miles per week x .40 per mile x 1 staff x 52 wks = $416.

Report the proposed Total Staff Travel and the Total Client Travel in the corresponding box. These costs will be transferred to Page 7 Budget Summary (Item B, 1a and 1b). If you are not using the electronic version, please enter these amounts again on page 7.
(Reminder: Click in the box below "Calculations/Descriptions" to begin typing. You may use tab and enter to format your text. Click on a yellow box or another text box when you are done.)

2. Consumable Supplies & Printing

Itemize the costs for Consumable Supplies and Printing. Enter the total amount in the corresponding box. This amount will be transferred to Page 7 Budget Summary Item B, 2 for Consumable Supplies and Printing. If you are not using the electronic version, please enter this amount again on page 7.

3. Space Costs

Itemize the Space costs. Enter the total for Space Costs in this box. This amount will automatically be transferred to Page 7 Budget Summary, (Item B, 3) for Space Costs. If you are not using the electronic version, please enter this amount again on page 7.

4. Insurance

Please note that if funded, the Grantee shall secure and keep in force during the term of the agreement the following insurance coverages:

a. Commercial general liability with minimum liability limits of $1,000,000 per person and $2,000,000 per occurrence and $2,000,000 in the aggregate.

b. Professional errors and omissions, including a three year "tail coverage endorsement" with minimum liability limits of $1,000,000 per occurrence and $2,000,000 in the aggregate.

c. Automobile liability with minimum liability limits of $250,000 per person and $1,000,000 per occurrence.

d. Workers compensation coverage meeting all statutory requirements of IC 22-3-2; and in addition, an "all states endorsement" covering claims occurring outside the State of Indiana if any of the services provided under the agreement involve work outside of the State of Indiana.

e. Property damage insurance in an amount sufficient to provide coverage for any loss of property used by Grantee in connection with services provided under this agreement, not less than $100,000 in the aggregate.

The Grantee's insurance coverage must meet the following additional requirements:

a. Any deductible or self-insured retention amount or other similar obligation under the insurance policies shall be the sole obligation of the Grantee.

b. The State will be defended, indemnified, and held harmless to the full extent of any coverage actually secured by the Grantee in excess of the minimum requirements set forth above. The duty to indemnify the State under this agreement shall not be limited by the insurance required in the agreement.

c. The insurance required in the agreement, through a policy or endorsement, shall include a provision that the policy and endorsements may not be canceled or modified without thirty (30) days' prior written notice to the State.

State may require Grantee to provide a bond or insurance coverage for all persons who will be handling funds or property received or disbursed as a result of the agreement, or who may carry out the duties specified in this agreement, in an amount equal to one-half (1/2) of the total funding provided to Grantee under this agreement or $250,000, whichever is less, to be effective for the period of the agreement plus three (3) years for purposes of discovery. Grantee's coverage must provide protection against losses resulting from criminal acts and wrongful performance of the duties specified herein and must specify the State of Indiana as an obligee or additional insured. Grantee shall immediately notify State if said bond or insurance is cancelled or modified in amount of coverage. In the event of cancellation, State shall make no further disbursements until certification is provided by a bonding or insurance company that the provisions set forth in this section have been satisfied. State may at its discretion require Grantee to furnish additional or different bond or insurance coverage.

Please note: if you are selected for funding the contract will require your agency to list the State as an additional insured party on the policy of insurance and provide to the State certificates of insurance stating the types of coverage, limits of liability and expiration dates of Grantee's policies.

Please enter the total amount budgeted for insurance. This amount will automatically be transferred to Page 7 Budget Summary (Item B, 4) for Insurance. If you are not using the electronic version, please enter this amount again on page 7.

5. Staff Training

This is usually computed by the percentage that the proposed IV-B or CFCIP funding is of the total agency budget for staff training. Include training of direct service staff, if applicable. Itemize these costs and enter the total amount in this box. This amount will be automatically transferred to Page 7 Budget Summary, (Item B, 5). If you are not using the electronic version, please enter these amounts again on page 7.

6. Telephone and Postage

Enter these costs in appropriate boxes. The total will calculate automatically and transfer to Page 7 Budget Summary, (Item B, 6). If you are not using the electronic version, please enter the total in the appropriate box and enter it again on page 7.

7. Rental/Lease/Prorated Share of Equipment Purchase

Itemize these costs in this box and enter the total budgeted amount. This amount will automatically transfer to Page 7 Budget Summary, (Item B, 7). If you are not using the electronic version, please enter this amount again on page 7.

8. Other Administrative Expenses

Document any other administrative expenses that will be incurred as a direct result of providing the proposed services. Itemize these costs and enter the total. This amount will automatically transfer to Page 7, Budget Summary, (Item B, 8). If you are not using the electronic version, please enter this amount again on page 7.

9. Other Direct Costs

Document the request for any other allowable expenses that will be incurred as a direct result of providing the proposed service. Do not include any expenses that could be documented in other specified sections of the proposed budget. Itemize these costs and enter the total amount in this box. This amount will automatically transfer to Budget Summary, (Item B, 9). If you are not using the electronic version, please enter this amount again on page 7.

Item C: Indirect Costs

Enter the total indirect costs on budget. This requires that all indirect costs such as accounting services, general custodial services, or other overhead related services to the program be itemized and justified on the budget worksheet. Use additional pages as needed for explanation. Enter the amount for Total Accounting Costs and Total Other Indirect Costs in the appropriate boxes. These amounts will automatically transfer to Page 7 Budget Summary (Items C, 1 and C, 2). If you are not using the electronic version, please enter these amounts again on page 7.

Item D: Inkind Contributions and Other Grants/Income (Page 6) on Budget Summary

Please enter any inkind contributions or other grants/income associated with the proposed service. It is assumed that funds listed in this section will be used to reduce the per unit for services to be contracted. The totals will be calculated automatically and transferred to Page 7 Budget Summary (Item E). If you are not using the electronic version, please total the inkind contributions and other grants/income and enter it at the bottom of this page. Transfer that same amount to Page 7.

EXPLANATION OF SECTION III: BUDGET SUMMARY SHEET

Item A and B. Personnel and Other Direct Costs
All of the amounts on this page should have been transferred from the Budget Justification Worksheets. Please verify that all amounts are correct. Use the previous instructions for Budget Justification Worksheets, for verification. If you are using the electronic version and the numbers are not correct, please check to be sure you entered the costs in the appropriate yellow "total" box on page 3, 4 and 5. Contact your Regional Coordinator for technical assistance using this format.

Item C. Indirect Costs (Actual Indirect Cost percentage): Please enter the indirect cost percentage. This is calculated automatically. If you are not using the electronic format, calculate the percentage of indirect costs by dividing the total indirect costs by the Total Program Costs. Enter the percentage on page 7 and page 5, item C.

D. Total Program Costs: The amount should be the sum of all program costs. This total is to include all known and anticipated costs required to provide the services described in this proposal.

a. **Total In-Kind and Other Funds:** This amount should have been transferred from Page 6.

F. Adjusted Program Costs: This amount is calculated automatically. If you are not using the electronic format, please enter this amount by subtracting (E) from (D).

SECTION IV: SERVICE UNIT RATE JUSTIFICATION AND DEFINITION/COST ANALYSIS

2. **Adjusted Program Costs:** The amount displayed is automatically transferred from Page 7, Item F. If you are not using the electronic format, please enter the amount from Page 7, Item F.

3. **Total Number of Clients/Families to be served:** This number is automatically transferred from Page 1, Item L. If you are not using the electronic format, please enter the amount from Page 1, Item L.

4. **Average Amount of Requested Funds by Client/Family:** This number is calculated automatically. If you are not using the electronic format, divide (1) by (2).

4a. **Total of page 8a:** The amount displayed is automatically calculated by adding the "Total Cost of Proposed Services" column on page 8a. If you are not using the electronic format, enter the sum of page 8a.
4b. **Total of page 8b:** The amount displayed is automatically calculated by summing the "Total Cost of Proposed Services" column on page 8b. If you are not using the electronic format, enter the sum of page 8b.
4t. **Total of 8a and 8b:** The amount displayed is automatically calculated by adding 4a to 4b. If you are not using the electronic format, enter the sum of 4a and 4b. When you have completed page 8a and 8b, be sure that this amount matches (as close as possible) the Adjusted Program Costs.

5. **Define Each Billable Unit and Rate:** Select the service from the first drop down menu. Please note that several services have been combined in this box. For example, all adoption services are combined as well as Independent Living services.

Service Drop-down menu:

AP	Assessment -- Parenting/Family Functioning
AS	Adoption Services
CA	Community Awareness
CC	Child Care
CH	CHINS Parent Support

CM	Communities for Child Safety
CS	Counseling Services
DE	Diagnostic & Evaluation
FC	Family Case Conferencing
FF	Functional Family Therapy
FP	Home-Based Casework Services
FPI	Home-Based Intensive Family Preservation
FR	Foster Family Support Services
FRI	Home-Based Intensive Family Reunification
FT	Foster Training
HB	Home-Based Therapy
HM	Homemaker
HS	Home Studies
IL	Chafee Foster Care Independence Program
PE	Parent Education
RS	Respite Services
SA	Substance Abuse Services
VS	Visitation Facilitation

The next drop down menu will include the service unit definitions that are approved for the selected service. Select the unit rate definition you are proposing from the second drop down menu. If you are not using the electronic format, abbreviate the service in the first box (using the abbreviation listed below), enter the unit definition as defined in the service standards in the second box , and enter the units in the third box, as indicated in the following example:

Service	Unit Definition	
HM	HM – Homemaker-Face to Face	Hour
HM	HM24 - Case conference	Hour
HM	HM24A – Collateral Contacts	Hour
HM	HM50A – Court Time	Hour
HM	HM52 – Travel Time	Hour
HM	HM53 – No Show	Occurrence
HM	HM97 – Interpreter Services	Actual Cost

Please note, the codes listed before the definition (e.g., HM24) are for Coordinator use when setting up contract paperwork. If you are not using the electronic version of the form, please type the definitions from the service standards and do not be concerned about the codes.
If you are proposing for a service that is not standardized, you should type the units and definitions at the bottom of Page 8b where the service is listed as "other". It is important to keep in mind that if your application is approved for a service contract, you shall only submit claim vouchers on the basis of these defined service units.

Enter the number of units you are proposing (column A) and the unit rate (column B). The total will be automatically calculated and summed at the bottom of the screen. If you have more services than will fit on page 8a, enter them on page 8b. If you are not using the electronic format, please multiply column A by column B and enter that amount in column C. Add up the amounts in column C. The sum of column C should be equal to Adjusted Program Costs (as close as possible). In the electronic version, the total of the page 8a and 8b will be automatically transferred the top of page 8a as item 4t. You can compare this total to the Adjusted Program Costs to be sure they are equal.

It is very important that the service provider and the staff of the Department of Child Services understand what services are to be provided based on this proposal. Shared understanding is also enhanced when the language used in defining the units of service is consistent with the language an

agency uses in internal provider documents that define for staff the services/activities that they are to document for billing. If you are proposing for a service which is not standardized, please attach copies of the instructions to be given to staff outlining the standards they are to use when determining if a billable service has been performed.

NOTE: The Regional Service Council or Regional Manager will decide whether or not to accept services described within this proposal. On a separate page, please identify any unit components of service costs that are affected by the number of counties using the service or the total amount of funding/service unit components purchased. Identify the cost per unit of service impact, if any, of increases or decreases in the number of units to be provided. We expect that for some services, efficiencies can be achieved by providing larger volumes of service. Please document such conditions along with the lower unit rates that will result with increased service volumes.

Section V BUDGET REGIONAL REQUEST SUMMARY

Complete a separate page 9 for each region to be served by this proposal. If you need additional copies of page 9, those are available as a separate template.
Purpose: The purpose of this form is to allow the applicant to specify the counties to be served. Within each county, the applicant is to specify the projected total number clients/families for each county, and the funds requested for each service.

Item A: **Region to be Served**
Enter the name of the Region for which services are being proposed as part of this Request for Funds. A map of the Regions and Counties has been enclosed for your reference.

Item B: **Program Director**
Specify the names, **email address,** and **telephone numbers** of the program director(s) responsible for the proposed services within each Region.

Item C: **Mailing Address**
Enter the mailing address of the program director for the Region, if this address is different from the address listed in Section I. Item E.

Item D: **Email Address**

Item E: **Breakdown of Public Funds Requested by County** Enter the total amount of public funds requested by County to be served.

Service: For each county, list all of the services to be offered. Please be sure this is consistent with Section I, Item B.

Total Number of Families/Clients: Enter the number of families/clients in that county who will receive that particular service.

Public Funds Requested: Enter the amount of public funds requested by county.

IMPORTANT NOTE: After completing the budget, make sure...
A. The total of all regional requests (sum of all page 9's) equals the total on Page 1, Item M.
B. The total amount on Page 1, Item M equals Item N.

SECTION VI: APPLICATION NARRATIVE (IL Programs should use instructions Section VII)

Electronic Format: A Microsoft Word Form is available on which to complete the narrative section of your Child Welfare Program proposal. This form includes all required statements. If you choose not to use the Form, please be sure to follow the outline below and include all required statements.

Provide information describing the proposed program and required statements/attachments as outlined in Items A-G. The program must be consistent with the objectives, target population, and service needs identified in the Program Service Standards sheet. No outdated material shall appear in the proposal. Once a program proposal has been approved for a contract, no changes can be made in the program without approval from the Regional Service Council.

Please Note: If you are including more than one service in a proposal, be sure you provide information about each service in the narrative.

Item A: Problem/Needs Assessment

Describe the needs of the target population and the problem(s) to be addressed by the proposed program.

Item B: Target Population for IV-B Funded Services

Specify the number and type of clients to be served, their demographic characteristics, and the geographic boundaries for the program. See Service Standards for more information on target populations

Item C: Program Objectives and Evaluation

The objectives must be compatible with the objectives identified on the Program Service Standards. Additional objectives may be added. Program objectives must state measurable terms (using either number of clients or percentages of clients), identify outcomes, and specify time frames for achievement. These program objectives will be used in the evaluation of the service provider's contract performance and program's effectiveness.

Provide a statement that the applicant agrees to complete program evaluations using the enclosed format and procedures as defined by the Department of Child Services.

NOTE: Completion of the evaluations require that client information be collected from the start of the program. The applicant may wish to modify existing forms for client records to include the information requested.

Item D: Program Description/Service Delivery Methods

1. In detailed chronological order, outline tasks, activities, and procedures for achievement of the program's objectives, and indicate those responsible for completion of tasks within the stated time frames.
2. Outline the proposed client system, client referral, and any client eligibility requirements, as well as methods of interagency coordination.
3. Outline in logical progression, the program activities in which clients will participate and/or services they will receive.
4. Describe client case record and program statistical data collection procedures. Client case records should include a) client demographics; b) client needs/problems clearly stated; c) client specific goals/objectives clearly stated and shared with the client; d) progress notes; e) regularly scheduled progress reports to the DCS; and f) closing summary, clearly indicating client/family disposition. **Note: An outline of the format and content of the progress notes, reports and closing summary and the anticipated time-line for submitting these to local DCS's must be included in the proposal**. Describe proposed method of providing timely client service plans and progress reports or documentation of service plans and progress reports or

documentation of services to referring DCS. Outline procedures for maintaining client confidentiality.

NOTE: The services for which the proposal is being written may require the appearance of the provider in a court or appeals hearing. As part of the service agreement the provider acknowledges and agrees to appear if deemed necessary.

Item E. Cultural Diversity and Competency of Staff

In addition to the cultural patterns of the hiring practices of the agency indicated in the attached resumes of all current staff, the following will be addressed in the narrative:

1. ongoing efforts for maintaining and upgrading the cultural knowledge base of all staff regarding issues of diversity and cultural competency, particularly regarding the primary populations of clients being served by describing any training that staff have attended or other opportunities available to support these concepts. The populations may be identified based on economic status, race, ethnicity, gender, age, physical ability, religious beliefs and practices, or sexual orientation;
2. a description of the engagement and assessment process of the client including client strengths; development of goals and their view of the future; how clients self identify related to gender, race experiences and how the client presents the problems; and the physical, emotional, economic, spiritual, familial, and formal and informal resources and how this is supported in the context of supervision;
3. a description of how cultural issues are included in agency policies, procedures, vision, values, goals, mission statements, strategic plans, program design and outcomes and the ongoing process to periodically reevaluate these critical elements.

Item F: Staffing

All agencies are to describe the proposed staffing pattern for this program. This description needs to include the following:

1. an organizational chart
2. job descriptions and qualifications (education, experience with target population, certifications, etc.) of all personnel assigned to the proposed program;
3. an identification of any staff positions which will be newly funded under this proposal and any training which will be given to staff for this program
4. a description of your planned staff development activities scheduled for the program during the year
5. if the proposal is written for an independent contract, a complete resume of the contractor

Item G: Agency/Applicant's Background, Facilities and Community Relationships

Provide a statement regarding your routine agency and staff performance evaluation process.

Facilities: Provide a statement that the agency's services are accessible and geographically convenient for the clients. Provide a statement on appropriateness of environment, equipment, service hours, and office space and facility maintenance for the delivery of service to the target population.

Relationship: Provide a statement of the agency's formal and informal relationships with other agencies to ensure continuity and comprehensiveness of services to all clients.

Provide a statement on history of working cooperatively with DCS and/or other community based child serving organizations. Provide a statement acknowledging overall service coordination (case management) is the responsibility of the local DCS. Also, acknowledge that

any agency treatment activity, therapy, and service plan for a specific client/family will be compatible and consistent with the DCS case plan, informal adjustment or SRA.

Item H: Provide a statement regarding the agency's qualifications, certifications, or affiliations pertinent to providing this program.

SECTION VII: APPLICATION NARRATIVE FOR CHAFEE FOSTER CARE INDEPENDENCE PROGRAM (CFCIP), VOLUNTARY SERVICES CASEWORKER AND YOUTH ADVISORY BOARD

Electronic Format: A Microsoft Word Form has is available on which to complete the narrative section of your Independent Living Program proposal. This form includes all required statements. If you choose not to use the Form, please be sure to follow the outline below and include all required statements.

Provide information describing the proposed program and required statements/attachments as outlined in Items A-G. The program must be consistent with the objectives, target population, and service needs identified in the Program Service Standards. No outdated material shall appear in the proposal. Once a program proposal has been approved for a contract, no changes can be made in the program without approval from the Regional Services Council.

Item A: Problem/Needs Assessment

Describe the needs of the target population and the problem(s) to be addressed by the proposed program.

Item B: Target Population for Chafee Independent Living Program

Specify the number and type of clients to be served, their demographic characteristics, and the geographic boundaries for the program.
See Service Standards for information on target populations.

Item C: Program Objectives and Evaluation

The objectives must be compatible with the objectives identified on the Program Service Standards. Additional objectives may be added. Program objectives must state measurable terms (using either number of clients or percentages of clients), identify outcomes, and specify time frames for achievement. These program objectives will be used in the evaluation of the service provider's contract performance and program's effectiveness.

Independent Living Outcome Measures Report

The State is requiring that all independent living service providers complete the online Chafee Assessment at www.chafee.org. Every provider will complete an Independent Chafee Assessment following six months of service and at case closure.

Provide a statement that the applicant agrees to complete mid-year and year-end program evaluations as well as the Outcome Measures Reports using the format and procedures as defined by the DCS.

Provide statement of agency's client evaluation and any independent living assessment that will be used. Please note the Ansell-Casey Life Skills Assessment at www.caseylifeskills.org is the only assessment tool approved for use.

Item D: Program Description/Service Delivery Methods:

1. In chronological order, outline tasks, activities, and procedures for achievement of the program's objectives, and indicate those responsible for completion of tasks within the stated time frames.
2. Outline the proposed client system, client referral, and any client eligibility requirements, as well as methods of interagency coordination.
   - Provide a statement that the applicant agrees to submit the Outcome Measures Report on each client served.
   - Describe the Mentoring services that will be made available for all appropriate youth as defined in the Program Service Standards who do not already have an identified mentor, including screening process and plan for oversight of the mentor relationship.
   - If proposing to coordinate a Youth Advisory Board(s), provide a statement outlining procedures for recruiting YAB members and implementing a plan to include the entire area(s) to be served, also describe agency compliance with Billing Units, see Service Standards.
3. Outline in logical progression, the program activities in which clients will participate and/or services they will receive.
4. Describe client case record and program statistical data collection procedures. Client case records should include a) client demographics; b) client needs/problems clearly stated; c) client specific goals/objectives clearly stated and shared with the client; d) progress notes; and e) closing summary, clearly indicating client/family disposition.

An outline of the format and content of the progress notes, reports and closing summary and the anticipated time-line for submitting these to local DCS's must be included in the proposal. Describe proposed method of providing timely client service plans and progress reports or documentation of service plans and progress reports or documentation of services to referring DCS. Describe procedures for maintaining client confidentiality.

NOTE: The services for which the proposal is being written may require the appearance of the provider in a court or appeals hearing. As part of the service agreement the provider acknowledges and agrees to appear if deemed necessary.

Item E. Cultural Diversity and Competency of Staff

In addition to the cultural patterns of the hiring practices of the agency indicated in the attached resumes of all current staff, the following will be addressed in the narrative:

1. ongoing efforts for maintaining and upgrading the cultural knowledge base of all staff regarding issues of diversity and cultural competency, particularly regarding the primary populations of clients being served by describing any training that staff have attended or other opportunities available to support these concepts. The populations may be identified based on economic status, race, ethnicity, gender, age, physical ability, religious beliefs and practices, or sexual orientation;
2. a description of the engagement and assessment process of the client including client strengths; development of goals and their view of the future; how clients self identify related to gender, race experiences and how the client presents the problems; and the physical, emotional, economic, spiritual, familial, and formal and informal resources and how this is supported in the context of supervision;
3. a description of how cultural issues are included in agency policies, procedures, vision, values, goals, mission statements, strategic plans, program design and outcomes and the ongoing process to periodically reevaluate these critical elements.

Item F: Staffing:

Describe the proposed staffing pattern for this program. Include an organizational chart, job descriptions and qualifications (education, experience with target population, certifications, etc.) of personnel assigned to the proposed program. Ensure that all staff

meet the minimum qualification guidelines in the Service Standards. Identify any staff positions, which will be newly funded under this proposal, and any training which will be given to staff for this program. Describe your planned staff development activities schedule for the program during the year. If the proposal is written for an independent contractor, submit a complete resume.

Provide a statement ensuring compliance with minimum qualifications for Mentors (see service standards).

Item G: Agency/Applicant's Background, Facilities and Community Relationships.

1. Provide a statement regarding your routine agency and staff performance evaluation process.

2. Facilities – Provide a statement that the agency's services are accessible and geographically convenient for the clients. Provide a statement on appropriateness of environment, equipment, service hours, office space and facility maintenance for the delivery of service to the target population.

3. Relationship – Provide a statement of the agency's formal and informal relationships with other agencies to ensure continuity and comprehensiveness of services to all clients.

4. Provide a statement on history of working cooperatively with Local Office of Family and Children and/or other community based child serving organizations.

5. Provide a statement acknowledging overall service coordination (case management) is the responsibility of the Department of Child Services. Also, acknowledge that any agency treatment activity, therapy, and service plan for a specific client/family will be compatible and consistent with the DCS case plan, informal adjustment or SRA.

Item H: Provide a statement regarding the agency's qualifications, certifications, or affiliations pertinent to providing this program.

SCORE SHEET
Child Welfare Community Based Services for FY 2006 - 2008

Agency/Provider Name: _____

Printed Name of Evaluation Team Member: _____ **SCORE**

1. Clearly documents MBE/WBE participation or waiver is included. **SCORE PASS/FAIL** | |
2. Forms entitled "Request for Funds", "Assurances", "Personnel Justification Worksheet", "Budget Justification Worksheet", and "Regional Request Summary" are complete per instructions and *are signed in blue ink.* **SCORE 0 through 10** | |
3. Billable service units are clearly defined. **SCORE 0 through 5** | |
4. Proposed rates are usual and customary with the type of service, qualifications of staff and geographic location of families to be served. **SCORE 0 through 15** | |
5. Target Populations for all services are compatible with the Program Service Standards of proposed services. **SCORE 0 through 5** | |
6. Program Objectives are consistent with the Program Service Standards for all proposed services. **SCORE 0 through 5** | |
7. Narrative is clear and consistent in describing the proposed programs, services and service delivery methods and is supportive of the identified target populations and the service objectives. **SCORE 0 through 5** | |
8. Job descriptions *or resumes* are present, clear and sufficiently detailed for all direct service and supervisory positions (responsibilities, supervision, etc.) **SCORE 0 through 5** | |
9. Procedures for maintaining client confidentiality are stated, acceptable and include the use of information release or exchange forms to be signed by clients. **SCORE 0 through 5** | |
10. Proposal clearly states that services are accessible (no waiting lists), as needed and are accessible based on the needs of the family and/or by direction of the local DCS (including location of services). **SCORE 0 through 5** | |
11. Proposal clearly describes a process for ensuring the implementation of timely service, including the time period from receipt of referral to the initial family contact. **SCORE 0 through 5** | |
12. Proposal adequately documents protocols to ensure timely delivery and expected content for the Progress, termination and court reports as required by each local DCS. (Sample outlines or forms are provided.) **SCORE 0 through 5** | |
13. Upon hire, proposed staff receive an orientation that supports the concept of culturally competent service delivery. The proposal includes clear plans for ongoing training for staff to enhance skill development and knowledge to enhance the cultural competency of staff. **SCORE 0 through 5** | |
14. Proposal clearly documents acceptable billing processes including documenting services, documentation of eligibility, internal checks for accuracy and timeliness of billing. **SCORE 0 through 5** | |
15. Proposal documents that Agency historically has had an acceptable working relationship with the local DCS or other community agencies, if there is no prior relationship with the DCS. **SCORE 0 through 20** | |

TOTAL SCORE 100 points | |

Comments (please use reverse side for additional comments):

Completed by: _____ **Date:** _____

Instructions for Evaluating Proposals

Your participation as an Evaluation Team Member is critical to the success of selecting needed services and successful providers of services for the families and children served by the local offices of the Department of Child Services. Below you will find instructions for completion of the score sheets to assist you in scoring the proposals that have been submitted.

1. MBE/WBE indicates Minority Business Enterprise and Women's Business Enterprise is included or if unable to meet this requirement, a waiver form is completed and attached.

2. Please complete on score sheet for each proposal reviewed.

3. Remember to rate each statement listed on the score sheet.

4. If you believe the proposal meets none of the standards described in the statement, mark as "0".

5. Other ratings should be used to quantify other levels of standards met.

6. Please note that if the proposal does not pass the minority business enterprise/women owned business enterprise participation standard, the proposal will not be funded.

7. A proposal passes the MBE/WBE if it includes either a MBE/WBE plan or waiver. If neither is present, it fails.

8. The leader of the scoring meeting will collect the evaluations completed by all evaluating team members and the confidentiality forms signed by each member and return these documents to Central Office.

Thank you for your participation in this important process!

AMENDMENT REQUEST FORM
TITLE IV-B AND INDEPENDENT LIVING

DATE: _____

REQUESTOR'S NAME: _____

CONTRACT NUMBER: _____

CPID NUMBER:_____

DOLLAR AMOUNT CHANGE:

SERVICE CODE	INCREASE	DECREASE	TOTAL DOLLAR AMOUNT

ADD OR REMOVE COMPONENTS:

SERVICE CODE	ADD COMPONENT	REMOVE COMPONENT	RATE	UNIT DEFINITION

RATE CHANGE:

SERVICE CODE	COMPONENT	RATE	UNIT DEFINITION

JUSTIFICATION FOR AMENDMENT:

_____
_____
_____

All Dollar amount Amendment Requests must be accompanied by a revised 660

Regional Coordinator	Date	Regional Manager	Date	Program Manager	Date
_____	_____	_____	_____	_____	_____

Department of Child Services
Regional Plan for Child Welfare Services 07/01/06 through 06/30/08