

**RFP Application for Healthy Start Services**

**FY 2023-2028**

**BROWARD HEALTHY START COALITION, INC.**   
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**DATA INPUT FORM**

|  |  |
| --- | --- |
|  | Agency Legal Name:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | CEO Name and Email Address:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Service Applied for:  Healthy Start Prenatal and Infant Pathway and Interconception Care Counseling |
|  | Annual Amount Requested:  $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Proposal Contact Representative (for all communications on this Application):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|

## APPLICATION FOR FUNDING

## Part I

**Section A.** **Applicant Agency Information: Cover Sheet**

|  |  |  |
| --- | --- | --- |
| **Agency Legal Name must match Agency name listed on the Florida Department of State Division of Corporation website:** [**www.sunbiz.org**](http://www.sunbiz.org)  Agency Legal Name: | | |
| Main Administrative Address: | | |
| City & State: | Zip Code: | |
| Telephone Number: | Fax Number: | |
| CEO/Executive Officer:  Email: | Office Phone Number: | |
| Chief Financial Officer:  Email: | Office Phone Number: | |
| Agency RFP Contact Representative: | Office Phone Number: | |
| Agency RFP Contact Email: | Agency RFP Contact Fax Number: | |
| Type of Entity: \_\_\_\_ Corporation \_\_\_\_ Private for-Profit \_\_\_\_ Private Not-for-Profit  Unit of Government \_\_\_\_ Federal \_\_\_\_ State \_\_\_\_ County \_\_\_\_ City \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Licensed to do business in Florida?  Yes No N/A | | 17. Federal Identification Number: |

**Section B. Certification of Accuracy and Compliance**

I do hereby certify that all facts, figures, and representations made in the application(s) are true and correct. Furthermore, all applicable statutes, terms, conditions, regulations, and procedures for program compliance and fiscal control, including but not limited to, those contained in the Bid Solicitation and Core Contract will be implemented to ensure proper accountability of contracts. I certify that the funds requested in this application will not supplant funds that would otherwise be used for the purposes set forth in this project and are a true estimate of the amount needed to operate the proposed program. The filing of this application has been authorized by the contracting entity, and I have been duly authorized to act as the representative of the agency in connection with this application. I also agree to follow all Terms, Conditions, and applicable federal and state statutes. Further, I understand that it is the responsibility of the agency head to obtain from its governing body the authorization for the submission of this application. Evidence of this authorization must be provided within 21 days of notice of award. I further understand that such contract award may be rescinded for failure to provide such documentation. Lastly, I hereby attest that all work contained within this proposal is the unique and original product of the agency I represent and has not been plagiarized or duplicated in any way from another agency’s work product.

**Service Provider Signature (in blue ink)**

**\_\_\_\_\_      \_\_\_\_\_**

Authorized Official’s Signature/Date Authorized Official’s Title**Part II**

**Section A. Agency Detail**

1. Provide a concise description of the Agency, including its history, years of operation, general service mission, and primary services provided. Include (A) Strategy to successfully provide services, (B) Strength of your organization to provide services, (C) Weakness or challenge for providing one or more of the services. *(Limit* *500 words–approx. 1 page)*
2. Provider Service History: \_\_\_ Previous BHSC Provider (Years) \_\_\_\_\_\_\_\_\_

(Check all funded programs that apply) \_\_\_ Existing BHSC Provider

\_\_\_ Existing CSC Provider

\_\_\_ Existing CSAD Provider

\_\_\_ Existing DOH Provider

\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If you have received non-BHSC funding for similar services in the past two to three years, please indicate the funding information in the chart below.

**NOTE**: Add or delete rows as necessary.

|  |  |  |  |
| --- | --- | --- | --- |
| **Funder** | **Annual**  **Amount** | **Contract Period (m/y – m/y)** | **Type of Service** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

1. Is the Agency accredited? \_\_\_\_Yes \_\_\_\_ No If yes, by whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Level of Accreditation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Period of Accreditation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Whether a Not-for-Profit or For-Profit Organization, provide the CEO/Executive Director’s salary: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a Unit of Government, Program Director’s salary:

$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Provide a copy of your organizational chart as an appendix and indicate where the proposed program reports within your agency. The position responsible for the direct supervision of program staff should be clearly noted.
2. What is the Agency’s fiscal year? Beginning: \_\_\_\_\_\_\_\_\_\_\_ Ending: \_\_\_\_\_\_\_\_\_\_\_
3. Attach a copy of your most recent financial audit to your application completed by a CPA registered to do business in the State of Florida and conducted in accordance with Generally Accepted Accounting Principles. Smaller agencies (those agencies with annual revenues less than $500,000) may submit unaudited compiled financial statements prepared by a CPA.
4. Does the Agency carry comprehensive general liability insurance? \_\_\_\_Yes \_\_\_\_ No

If yes, state the amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_

If no, or if the amount is less than $500,000, the Agency must agree to purchase a minimum of $500,000 comprehensive general liability insurance prior to contract execution. Affirm: \_\_\_\_Yes \_\_\_\_ No

1. Does the Agency carry the following types of insurance?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Amount of Coverage |
| Professional |  |  |  |
| Property |  |  |  |
| Auto |  |  |  |

Please indicate whether your agency will be transporting clients: ⬜ Yes ⬜ No

1. If applicable, please attach any previous monitoring reports for similar services completed within the past twelve (12) months including BHSC-funded programs.

If not applicable, please include a statement to that effect.

1. Describe as an attachment any litigation (lawsuits) or regulatory action filed against the Agency in the last three (3) years including case name, case number, court name, and current status.

If no litigation or regulatory action has been filed, provide a statement to that effect.

1. Has the Agency been sanctioned for non-compliance, had a contract rescinded, including corrective action, performance improvement plan with any contract, government law, or regulation within the past three years (3) years?

\_\_\_Yes \_\_\_ No \_\_\_ N/A

If yes, please provide a summary of the findings with any explanatory information you would like considered and attach a labeled copy of the report to this application.

If no, provide a statement to that effect.

**Section B. Organizational Capability**

1. Briefly describe the organization’s history receiving maternal child health (MCH) funding, knowledge of the MCH system in Broward County, and any involvement with the Children’s Strategic Plan’s MCH Committees. (*Limit to 250 words-approx. ½ page)*
2. Briefly describe the organization’s experience in the delivery of Healthy Start services in Broward County since the new model implementation in 2019. Please be specific as to the services provided. (*Limit to 250 words-approx. ½ page)*
3. If no Healthy Start services have been provided by the organization, describe the organization’s experience in the delivery of home visitation or other services to pregnant women and infants, birth to age 12 months in Broward County during the past five (5) years. Also describe, if applicable, the organization’s experience in the delivery of similar services, within the past five (5) years. (*Limit to 250 words-approx. ½ page)*
4. Briefly describe the organization’s knowledge of the most pressing challenges facing maternal child health. Please provide a perspective of the local data trends and challenges in achieving success. (*Limit to 250 words-approx. ½ page)*
5. Briefly describe the significance of the Social Determinants of Health and their impact on maternal child health and how your organization will address those determinants in the program. (*Limit to 250 words-approx. ½ page)*
6. Describe the organization’s experience in the implementation of intakes, assessments, and screening tools to identify specific risk factors that involve mental health/depression, domestic violence, substance use, tobacco use, and infant developmental delays. (*Limit to 150 words-approx. ¼ page)*
7. Describe the organization’s knowledge and experience in the provision of Interconception Care Counseling (ICC), including family planning services and prevention of unintended pregnancies. (*Limit to 150 words-approx. ¼ page)*
8. Identify the days of the week and hours of operation, and how the schedule meets the needs of the families. Be specific in terms of being able to offer a flexible work schedule. (*Limit to 150 words-approx. ¼ page)*
9. Relationships with support services that are available in Broward County are necessary for the success of a program. Describe other existing support services that are available in the community you plan to serve. Demonstrate your knowledge of those services and how your program will fit into that continuum of care. Describe the history of successful community collaboration. (*Limit to 250 words-approx. ½ page)*
10. All agencies funded under this funding mechanism will be required to develop and implement a Cultural Competence plan. This plan must address culturally sensitive outreach efforts and human resource development. Discuss your commitment to a culturally competent system of care. Please attach your agency’s Cultural Competence plan. *(Limit 250 words-approx. ½ page)*
11. Please list the Broward zip codes and any service locations (ie: medical offices, clinics, etc.) you propose to serve if awarded funding. *(Limit to 125 words-approx. ¼ page)*

**Section C. Proposed Staff Information**

1. Describe how the program will be staffed. List all positions that will be providing direct and support services. Include the number of Staff in each position, position title (which should match your budget narratives), minimum education (including degree area), experience requirements, primary duties, and the percent of each position’s time that will be devoted to this program. Service Provider requirements for Healthy Start Services are outlined in ***Attachment C1*** and must be adhered to.

**NOTE**: Add or delete rows as necessary.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **# of FTE Positions** | **Position** | **Education** | **Experience** | **Duties** | **% of Time Devoted to Position** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

1. If not a current Healthy Start Prenatal and Infant Pathways provider with BHSC, please include a timeline for hiring and training of staff that ensures services will be fully implemented and operational no later than October 1, 2023, with a three-month start up period between July 1, 2023, and September 30, 2023. *(Limit 250 words-approx. ½ page)*
2. Identify strategies to efficiently recruit staff that will be linguistically and culturally competent to serve the English, Spanish, and Creole-speaking populations. *(Limit 125 words-approx. ¼ page)*
3. Describe the organization’s practices in training, onboarding, and supervising staff and knowledge of implementing reflective supervision with home visitors. *(Limit 250 words-approx. ½ page)*
4. Consistency is important to the success of services. Explain what efforts you will make to maintain staff and reduce turnover of trained, qualified, and experienced staff within the program. Include historical turnover information for your organization and current staff recruitment and retention efforts. If a current BHSC provider, include historical turnover information for your Healthy Start Program within the past two years and length of staff vacancies. *(Limit 250 words-approx. ½ page)*

## Part III

**Section A. Additional RFP Application Requirements**

1. Client engagement and retention is a strong indicator of success. Describe the organization’s protocols to achieve a high rate of acceptance and strategies for engaging and maintaining clients, during the required services periods. Explain in detail how you plan to engage, retain clients in services and include innovative practices in this section. *(Limit 250 words-approx. ½ page)*

## Part IV

**Section A. Performance Measures**

The following signature indicates there has been a review and understanding of the eighteen (18) Performance Measures listed on ATTACHMENT C of this RFP.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Name/Date Title

**Section B. Budget**

1. Program Budget Summary (See **ATTACHMENT G)**
2. Program Budget Narrative for Requested Funding (See **ATTACHMENT G)**

**Note:**

|  |  |
| --- | --- |
| **Copies of the following must be provided prior to contract execution, as applicable, but do not need to be attached to the application:** | |
| A. | Client Non-Discrimination Policy |
| B. | Certificate as Corporation licensed to do business in Florida |
| C. | Internal Revenue Service Letter certifying 501(c)3 status (if NPO) |
| D. | List of Agency’s Board of Directors and Meeting Dates |
| E. | Equal Employment Opportunity Policy |
| F. | Affirmative Action Policy |
| G. | Americans with Disabilities Act Policy |
| H. | Drug-Free Workplace Policy |

END OF TEXT