**PROPOSALS 2025-045-7070**

**Juvenile Non-Residential Services**

**for the Dallas County Juvenile Department**

**PROPOSED SERVICE COVER SHEET**

Proposed Service Category: Indicate the service proposed by placing a check mark beside the appropriate category.

|  |  |  |
| --- | --- | --- |
| **#** | **Service Category** | **Indicate Only One (1)**  **Service Category** |
| 1 | Acute Services |  |
| 2 | Art Education Programs: |  |
| 3 | Detention Alternative Program: |  |
| 4 | Family Preservation Program: |  |
| 5 | Gender Specific Mentoring Services for Female Juveniles |  |
| 6 | Gender Specific Mentoring Services for Male Juveniles |  |
| 7 | Intensive Case Management Services: |  |
| 8 | Outpatient Substance Abuse Treatment Services: |  |
| 9 | Probation Violation Response Program: |  |
| 10 | Vocational Training Program: |  |
| 11 | Youth and Family Counseling Services: |  |
| 12 | Other (New and/or Innovative): |  |

Note: If applying under more than one service category, separate proposals must be submitted for each category.

|  |  |
| --- | --- |
| **RESPONDENT’S INFORMATION** | |
| Service Agency: |  |
| Address: |  |
| Authorized Signature Name: |  |
| Person Completing Proposal: |  |
| Phone Number: |  |
| Fax Number: |  |
| Email Address: |  |

**SECTION I. QUESTIONS REGARDING THE SERVICE AGENCY**

Complete the following questionnaire. Applicants should recreate this questionnaire and expand pages, as needed, to completely answer all questions. ***Note: The proposal must include all questions.***

A. Contact Information

|  |  |
| --- | --- |
| Name of Service Agency: |  |
| DBA (if applicable): |  |
| Physical Address: |  |
| P.O. Box: |  |
| County: |  |
| Phone Number(s): |  |
| Fax Number: |  |
|  |  |
| Name of Authorized Signature: |  |
| Title of Authorized Signature: |  |
| Phone Number(s): |  |
| Email Address: |  |

B. Service Agency’s Legal Status (check one below):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Sole Proprietorship: | \_\_\_\_\_\_\_\_ | Partnership: | \_\_\_\_\_\_\_\_ | Owner Full Name: | \_\_\_\_\_\_\_\_ |
| Corporation: | \_\_\_\_\_\_\_\_ | Joint Venture: | \_\_\_\_\_\_\_\_ | Limited Liability Company: | \_\_\_\_\_\_\_\_ |
| Limited Liability Partnership: | \_\_\_\_\_\_\_\_ | S Corporation: | \_\_\_\_\_\_\_\_ |  |  |
| Other (Specify): | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

C. What is the State of incorporation?

D. Does the Service Agency have a non‐profit status?

E. Give the Employer Identification Number (EIN)/Federal Tax Identification Number or Social Security Number for the service agency.

F. Is the service agency in good standing with the Texas Comptroller’s Office? If yes, include a Certificate of Status from the Texas Comptroller’s Office at the end of this section (Section I) of the proposal.

G. Is the service agency in good standing with the Office of the Texas Secretary of State? If yes, include a Certificate of Status from the Texas Secretary of State at the end of this section (Section I) of the proposal.

H. Give the Dun & Bradstreet (D-U-N-S) Number for the Service Agency, if applicable.

I. How many years in business under the present name?

J. How many years has the Service Agency been in business?

K. What is the Service Agency’s primary type or line of business?

L. How many years has the Service Agency provided the proposed service?

M. Discuss the service agency’s philosophy and methodology for addressing the service needs of delinquent and conduct disorder youth.

N. State briefly why your organization believes its proposed program design best meets the objectives of the Dallas County Juvenile Department.

O. How many years has the Service Agency operated at the proposed service delivery location?

P. Give specific details of any civil or criminal litigation pending or contemplated related to staff or facility operations.

Q. Give specific details of any past litigation or investigations (civil or criminal) occurring within the past five (5) years related to staff or facility operations.

R. Is the agency currently under investigation or following a corrective action plan because of allegations of abuse/neglect or in violation of licensing standards? If yes, what reasons?

S. If the Service Agency has contracted with the Dallas County Juvenile Department in previous years but was denied an FY 2022, 2023 and/or 2024 contract because of unsatisfactory performance, what corrective actions have been taken?

T. List any Juvenile Departments (by County) within the State of Texas with whom the Service Agency currently contracts.

U. Describe your organization’s present workload (major projects) outlining the percentage of time available for this project and how the workload will affect the firm’s ability to deliver the services outlined in the proposal.

V**.** Discuss briefly the challenges, potential problems and barriers to success in providing the proposed services to the target population.

W. Explain how the service agency will ensure that the proposed program services are implemented /rendered with fidelity?

X. Discuss any issues which you must address prior to the start of service delivery.

Y. How soon after final execution of the contract will the program start accepting referrals to the services/programming?

Z. **REFERENCE/EXPERIENCE DOCUMENTATION**

Respondents shall use the below form to provide at least five (5) external references that the Respondent has provided similar services as outlined in this solicitation from juvenile probation departments, juvenile courts, child welfare agencies, school districts, city/county government agencies comparable to Dallas/Dallas County or other clients (current and/or past) within the past three (3) years.

**REFERENCE/EXPERIENCE DOCUMENTATION**

**Respondents shall submit one completed form for each of the five (5) references.**

|  |  |
| --- | --- |
| **CONTRACTING AGENCY / FUNDING SOURCE** | |
| **Agency Name:** |  |
| **Address:** |  |
| **City/State/Zip Code:** |  |
| **Contact Person:** |  |
| **Phone:** |  |
| **Fax:** |  |
| **Email:** |  |
| **PROGRAM INFORMATION** | |
| **Program Name:** |  |
| **Service Delivery Address:** |  |
| **City/State/Zip Code:** |  |
| **Length of Operation:** |  |
| **Type of Program:** |  |

**Enter the following data for calendar years 2022 and 2023 of the program’s operation:**

**Reporting Period: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PROGRAM STATISTICS**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Total # of Enrollments.** | **Successful Discharges.** | | **Unsuccessful Discharges.** | | **Avg. Length of Stay For Successful Discharges.** | **Successful Discharges that Recidivated.** | |
| # | % | # | % | **(in Days)** | # | % |
|  |  |  |  |  |  |  |  |

**BREAKDOWN OF POPULATION SERVED BY REFERRAL SOURCE:**

|  |  |  |
| --- | --- | --- |
| **Referral Source** | **#** | **%** |
| **CPS** |  |  |
| **Juvenile Department** |  |  |
| **Schools** |  |  |
| **Parent/Private** |  |  |
| **Texas Youth Commission** |  |  |
| **Truancy Court** |  |  |

**BREAKDOWN OF POPULATION SERVED BY ETHNICITY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Ethnicity** | **#** | **%** | **#** | **%** |
| **African American** |  |  |  |  |
| **White** |  |  |  |  |
| **Hispanic** |  |  |  |  |
| **Other (specify)** |  |  |  |  |
| **Other (specify)** |  |  |  |  |
| **Totals:** |  |  |  |  |

**BREAKDOWN OF POPULATION SERVED BY GENDER**

|  |  |
| --- | --- |
| **Percentage (%) Females:** |  |
| **Percentage (%) Males:** |  |

**AVERAGE AGE AND GRADE OF POPULATION SERVED:**

|  |  |
| --- | --- |
| **Average Age of Youth Served:** |  |
| **Average Grade of Youth Served:** |  |

**GOALS, OBJECTIVES AND PERFORMANCE OUTCOMES:**

|  |  |
| --- | --- |
| **GOAL:** |  |
| **OBJECTIVES:** |  |

|  |  |  |
| --- | --- | --- |
| **#** | **Performance Measures** | **Performance Outcomes** |
| **1** |  |  |
| **2** |  |  |
| **3** |  |  |
| **4** |  |  |
| **5** |  |  |
| **6** |  |  |
| **7** |  |  |
| **8** |  |  |
| **9** |  |  |

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**Dallas County**

**JUVENILE DEPARTMENT**

**AFFIDAVIT OF ELIGIBILITY****CERTIFICATION STATEMENT for FY2025**

Under Section 231.006, of the Family Code, the Contractor certifies that the individual or business entity named in this Contract is not ineligible to receive the specified grant, loan, or payment because of delinquent child support obligations. The Contractor understands that it is the Contractor’s responsibility to verify whether the sole proprietor, partner, shareholder or owner with an ownership interest of at least 25% is a child support obligor who is more than 30 days delinquent on child support payments ordered by a Texas Court under Title 5 of the Texas Family Code.

Under Chapter 171, of the Tax Code, the Contractor certifies that it is not delinquent in its Texas franchise tax payments, or that it is exempt from, or not subject to such a tax.

The Contractor also certifies that it is not ineligible to receive state funds as payment for services rendered under the Contract with Dallas County due to other delinquent obligations including, but not limited to student loans, and grants owed.

The Contractor acknowledges that the Contract may be terminated and payment may be withheld if this certificate is inaccurate.

**SIGNED** this \_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_\_.

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

Name of Contractor

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

Signature Authorized Representative Printed Name

**SWORN TO AND SUBSCRIBED** before me on the \_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_\_\_\_\_\_\_.

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

Notary Public

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

Notary’s Printed Name

My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Dallas County**

**JUVENILE DEPARTMENT**

**SYSTEM FOR AWARD MANAGEMENT**

**AFFIDAVIT OF ELIGIBILITY**

**CERTIFICATION STATEMENT for FY2025**

The System for Award Management (SAM), formally Excluded Parties List System (EPLS), exclusion records identify those parties excluded from receiving federal contracts, certain subcontracts, and from certain types of federal financial and non-financial assistance and benefits. Such actions are also commonly known as “suspensions” and “debarments.”

The applicant certifies that the individuals or business entities named in this Proposal are not listed in the SAM exclusion records for either of the following exclusion types:

1. Ineligible (Proceedings Pending).

2. Ineligible (Proceedings Completed).

3. Prohibition/Restriction.

4. Voluntary Exclusion.

The applicant acknowledges that the Contract may be terminated and payment may be withheld if this certificate is inaccurate.

**SIGNED** this \_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_\_\_\_.

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

Name of Vendor

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

Signature Authorized Representative Printed Name

**SWORN TO AND SUBSCRIBED** before me on the \_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_\_\_\_\_.

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

Notary Public

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

Notary’s Printed Name

My Commission Expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECTION II. QUESTIONS REGARDING THE PROPOSED PROGRAM/SERVICE**

|  |  |
| --- | --- |
| **Name of Service Agency:** |  |
| **Service Category:** |  |
| **Program Name:** |  |
|  |  |
| **Physical Address:** |  |
| **P.O. Box:** |  |
| **County:** |  |
| **Phone Number(s):** |  |
| **Fax Number:** |  |
|  |  |
| **Program Director:** |  |
| **Phone Number(s):** |  |
| **Email Address:** |  |
|  |  |
| **Licensing Agency:** |  |
| **Licensing Representative:** |  |
| **Phone Number(s):** |  |
| **Licensing Category:** |  |
| **License/Permit Number:** |  |
| **Date License/Permit Issued:** |  |
|  |  |
| **Certified Medicaid Provider Number:** |  |
|  |  |

**PROGRAM STAFF**

A. **Ethnic Diversity of Facility Staff:**

1. Describe the current ethnic make- up of program staff.

2. Is the ethnic make-up of the staff reflective of the current census population?

3. Discuss anticipated challenges to maintain an ethnically diverse staff.

4. Does your agency currently employ bilingual staff? If yes, how many and what languages are spoken by those staff?

5. Of the bilingual staff currently employed, how many of them work directly with the youth and their families?

B. **Minimum Requirements for Program Staff:**

1. List each position required for the proposed program/service and describe in detail the minimum experience, education, and training required for each respective position.

C. **Staff Training:**

1. The following training topics are required for the Juvenile Departments non-residential services contracts. Use the table to indicate the frequency (annual, bi-annual, monthly, etc.) and the duration (1 hour, 2 hours, etc.) of each training event.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Required Training Topics** | **Frequency** | **Duration** |
| a | Cultural: Diversity/Sensitivity/Responsiveness |  |  |
| b | Emergency Behavior Intervention (De-escalation & Restraint Application) |  |  |
| c | First Aid and Cardiopulmonary Resuscitation (CPR) |  |  |
| d | PREA Concepts/Sexual Victimization and Harassment/Zero Tolerance |  |  |
| e | Code of Ethics |  |  |
| f | Abuse, Neglect and Exploitation (ANE) |  |  |
| g | Trauma Informed Care |  |  |

2. List other mandatory training requirements for program staff and the frequency and duration.

3. Describe the agency’s plan for ensuring that all program staff members receive the required 40 hours of in-service or continuing education training hours, annually.

D. **Program Staffing:**

1. What is the staff/client ratio for programming/services?

E. **Physical Exams:**

1. Is a pre-employment physical examination required for program staff?
2. Are program staff required to submit to random drug tests?

F. **Criminal Background Checks:**

1. Describe the facility’s internal method for conducting criminal background checks on current and potential employees. Include the frequency of the checks and the agencies (i.e. FBI, State Police, State Abuse and Neglect Central Registry) utilized for the background checks.

2. Explain the agency’s policy requiring program staff to self-report arrests?

G. **Staffing Capabilities:**

1. Discuss the service agency’s ability to recruit and screen for highly qualified employees.

2. Discuss the service agency’s ability to maintain highly qualified employees.

3. Discuss the service agency’s ability to hire and maintain bilingual staff.

4. Give the staff turnover rate (percentage) for the proposed program for calendar year 2024.

H. **MANDATORY PERSONNEL PROFILE REPORT**

Complete this form to reflect the make-up of the current personnel of the proposed program.

**SERVICE AGENCY:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SERVICE CATEGORY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALL STAFF MEMBERS:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Education Level** | **Admin. Staff** | **Direct**  **Care Staff** | **Contract**  **Staff** | **Volunteers/**  **Interns** | **Totals** |
| Ph.D.: |  |  |  |  |  |
| Master’s Degree: |  |  |  |  |  |
| Bachelor’s Degree: |  |  |  |  |  |
| Associate’s Degree: |  |  |  |  |  |
| High School Diploma/GED: |  |  |  |  |  |
| **Totals:** |  |  |  |  |  |

**TREATMENT STAFF:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Type of License** | **Regular**  **Staff** | **Contract**  **Staff** | **Volunteers/ Interns** | **Totals** |
| Licensed Marriage Family Therapist: |  |  |  |  |
| Licensed Professional Counselor: |  |  |  |  |
| Licensed Chemical Dependency Counselor: |  |  |  |  |
| Licensed Masters Social Worker: |  |  |  |  |
| Licensed Sex Offend. Treatment Provider: |  |  |  |  |
| Psychiatrists: |  |  |  |  |
| Psychologists: |  |  |  |  |
| Other (specify): |  |  |  |  |
| Other (specify): |  |  |  |  |
| **Total:** |  |  |  |  |

**EDUCATION PROFESSIONALS:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Professions** | **# Regular Staff** | **# Contract Staff** | **# Agreement** |
| Certified Teachers: |  |  |  |
| Non‐Cert. Teachers: |  |  |  |
| **Total:** |  |  |  |

**ADMINISTRATIVE STAFF (BY ETHNICITY/GENDER)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Gender** | **Females** | | **Males** | |
| **Ethnicity** | **#** | **%** | **#** | **%** |
| African American: |  |  |  |  |
| White: |  |  |  |  |
| Hispanic: |  |  |  |  |
| Other (specify): |  |  |  |  |
| **Totals:** |  |  |  |  |

**ADVOCATES / CASE MANAGERS / COACHES / COUNSELORS / MENTORS**

**(BY ETHNICITY/GENDER):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Gender** | **Females** | | **Males** | |
| **Ethnicity** | **#** | **%** | **#** | **%** |
| African American: |  |  |  |  |
| White: |  |  |  |  |
| Hispanic: |  |  |  |  |
| Other (specify): |  |  |  |  |
| Other (specify): |  |  |  |  |
| **Totals:** |  |  |  |  |

**ADVOCATES/ CASE MANAGERS/COACHES/ COUNSELORS / MENTORS**

**(BY EXPERIENCE):**

|  |  |
| --- | --- |
| **Years of Experience** | **# of Staff Members** |
| 20 years or more: |  |
| 15 years or more: |  |
| 10 years or more: |  |
| 5 years or more: |  |
| 0‐ 4 years or more: |  |
| **Total:** |  |

**TREATMENT STAFF (BY ETHNICITY/GENDER):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Gender** | **Females** | | **Males** | |
| **Ethnicity** | **#** | **%** | **#** | **%** |
| African American: |  |  |  |  |
| White: |  |  |  |  |
| Hispanic: |  |  |  |  |
| Other (specify): |  |  |  |  |
| Other (specify): |  |  |  |  |
| **Totals:** |  |  |  |  |

**CURRENT PROGRAM POPULATION BY ETHNICITY/GENDER**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Gender** | **Females** | | **Males** | |
| **Ethnicity** | **#** | **%** | **#** | **%** |
| African American |  |  |  |  |
| White |  |  |  |  |
| Hispanic |  |  |  |  |
| Other (Specify) |  |  |  |  |
| Other (Specify) |  |  |  |  |
| Totals: |  |  |  |  |

**CURRENT PROGRAM POPULATION BY REFERRAL SOURCE**

|  |  |  |
| --- | --- | --- |
| **Referral Source** | **#** | **%** |
| Child Protective Services: |  |  |
| Juvenile Departments: |  |  |
| TJJD: |  |  |
| School Districts: |  |  |
| Parent/Private: |  |  |

I. **PROFILE OF PROGRAM PERSONNEL/BOARD OF DIRECTORS**

***NOTE: The proposal must include all questions.* Provide only the documentation requested below. Do not include a narrative or unrequested documents.**

**INCLUDE IN THIS SECTION:**

1. A list of the Service Agency’s Board of Directors (include address, occupations and ethnicity).

2. A flow chart for program staff.

3. A resume for each current staff member who will be assigned to the proposed program (including but not limited to: fulltime, part time, contract staff, volunteers, and interns, etc.).

4. At the end of this section, include the job description for all positions related to the proposed program/service, including, but not limited to: administrators, clerical, professional, frontline/childcare workers, advocates, case workers, drivers, clinicians, etc.

**SECTION III. QUESTIONS REGARDING THE PROPOSED PROGRAM/SERVICE DESIGN**

***NOTE: The proposal must include all questions.***

A. **General Information**

1. Is the program design a researched based, nationally recognized, or best practice model?  If yes, please provide the name of the model, web address and other contact information.

2. If applicable, discuss the process for obtaining the license/certification required to implement the program model.

3. Where else is this model being implemented nationally and within the state of Texas?

4. What is the targeted gender to be served by the proposed program?

5. What is the targeted age range to be served by the proposed program?

6. What is the targeted risk level to be served by the proposed program?

7. How does your program address the identified criminogenic and/or acute needs identified on the *Solicitated* Services?

8. What additional criminogenic needs are addressed by the proposed program?

9. What additional acute needs are addressed by the proposed program?

10. What is the recommended length of stay for the proposed program?

11. List characteristics of appropriate referrals to the proposed program.

12. List characteristics of referrals that the proposed program is unable to admit.

13. Minimum I.Q. of acceptable referrals.

14. Minimum reading level of acceptable referrals:

15. Is a psychological examination required before acceptance for admission? If yes, how current must the exam be?

16. Are pre‐placement interviews required before acceptance for admission?

17. If the proposed service includes counseling or therapy, please identify and describe in detail, the specific curriculum(s) or counseling/therapy theories to be utilized during service delivery.

B. **Intake/Enrollment/Assessment Process**

1. Give a description of the intake/enrollment process including but not limited to: When and where will it occur? How long will it take? Who are the required participants? What will the process entail?

2. Describe the tool which will be utilized to assess the needs of youth/families referred for services.

C. **Discharge Criteria**

1. What is the program’s recommended length of stay?

2. List the criteria for successful discharges?

3. List the criteria for unsuccessful discharges?

D. **Hours of Operation**

1. What are the local agency’s office hours?

2. What is the weekly schedule for programming/service delivery?

3. If the program requires flexible scheduling, describe the minimum service hours with each client and the criteria that will be used to determine the schedule.

4. Will the service delivery schedule change during summer months? If yes, how?

5. List the holidays for which the operation will close in observance of.

E. **Program Capacity**

1. What is the proposed program’s maximum capacity for active cases?

F. **Location of Service Delivery**

1. Give the street address of the location where services will be delivered.

2. Give a physical description of the service delivery location.

3. What geographical areas will the program serve? Utilize Table A, in Section 4.4 (Geographical Locations) of the RFP to identify the specific quadrant to be served.

G. **Transportation**

1. Is transportation provided to clients? If yes, by what means?

2. If transportation is provided only on an as needed basis, explain what criteria are used to determine need.

3. Is your facility accessible by mass transit? If yes, what is its distance from facility?

4. If transportation will be provided to program participants, explain the program’s strategy for ensuring that program participants are transported home before 9:30pm.

5. Give specific details of your agency’s protocol to ensure that adequate insurance coverage is maintained on vehicles that are utilized to transport program participants during service delivery.

6. Give specific details of the agency’s policy and protocols for ensuring that vehicles utilized to transport program participants are properly maintained in good working condition, with a functioning safety restraint for each occupant.

7. Give specific details of the agency’s policy and protocols for ensuring that current State-mandated vehicle inspection/registrations are maintained on all vehicles utilized to transport program participants during service delivery.

H. **Meals / Snacks**

1. Describe meals and snacks to be served to program participants.

2. Is food prepared on-site?

I. **Family Services**

1. Excluding family therapy/counseling, describe services offered to the family while the youth is in enrolled in the program.

2. Describe any follow‐up services available to the youth and family after the youth discharges from the facility.

J. **Behavior Modification Model**

1. Describe the behavior modification model (example: point/level system) utilized by the program.

K. **Emergency Behavior Intervention (De-Escalation/Restraint)**

1. Discuss in detail the emergency behavior intervention (EBI) model utilized by the program.

2. Does the program have certified trainers of the utilized EBI model on staff?

3. Discuss the program’s procedures following restraint applications (example: physical examination of the youth for possible injuries, individual counseling regarding the incident/restraint, required notifications and documentation of the incident, etc.).

4. Does the program utilize any type of mechanical restraints for emergency behavior intervention? If yes, please describe the type(s) utilized.

5. Does the program utilize seclusion rooms as a part of emergency behavior intervention? If yes, please describe the room and give policy and procedures related to its use.

L. **PROGRAM OUTLINE**

***NOTE: The proposal must include all questions.***

Using the format provided below, identify up to five (5) of the most important program components that will help the program achieve the measurable outcomes. Give a brief description of the component, the objective of the component and the frequency that the component will be offered to program participants each week.

1. Name of Program Component:

Frequency Each Week:

Component Objective:

Component Activities/Topics:

Required Participants:

2. Name of Program Component:

Frequency Each Week:

Component Objective:

Component Activities/Topics:

Required Participants:

3. Name of Program Component:

Frequency Each Week:

Component Objective:

Component Activities/Topics:

Required Participants:

4. Name of Program Component:

Frequency Each Week:

Component Objective:

Component Activities/Topics:

Required Participants:

5. Program Component:

Frequency Each Week:

Component Objective:

Component Activities/Topics

Required Participants:

M. **INTERNAL PERFORMANCE EVALUATION PROCESS**

Provide a response to the following questions:

1. Discuss the top three (3) criminogenic needs of youth served by the proposed program during the period of 01/01/2023 through 12/31/2024 and the vendor’s success in meeting those needs.
2. What was the proposed program’s successful discharge percentage rate for the period of 01/01/2023 through 12/31/2024?
3. What was the proposed program’s  rate of recidivism for successfully discharged youth for the period of  01/01/2023 through 06/30/2024?
4. Give the projected annual average rate of successfully discharged youth for the proposed program/service.
5. Give the projected annual average rate of recidivism for the proposed program’s successfully discharged youth.
6. Describe the agency’s internal method of evaluating the effectiveness and fidelity of the proposed program/service.  Include performance measures and target outcomes utilized by the agency to evaluate the program.
7. Describe how data is collected for the evaluation process and the frequency of the data collection process.

N. **FACILITY INSPECTIONS AND LICENSES**

Provide the following documentation for the proposed facility:

1. Copy of certificate of occupancy.

2. Copy of current Fire Inspection.

3. Copy current sanitation inspection.

4. Copy of Service Agency license or certification documentation (TDFPS, TDSHS, TJJD, Juvenile Board, etc.).

5. Diagram/map of the facility campus.

6. Floor plan for the location of service delivery.

**SECTION IV. PROPOSAL EXCEPTIONS**

An “exception” is defined as the Respondent’s inability or unwillingness to meet a term, condition, specification, or requirement in the manner specified in the RFP. Other than exceptions that are stated on this form, the Proposal shall be deemed to agree to comply with all terms, conditions, specifications, and requirements of this RFP.

Identify all exceptions taken by specifically referencing the relevant section(s) of the RFP. Explain each exception in detail. Include any proposed alternative and the benefit/impact of the proposed alternative solution.

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| **Exception Taken (RFP Section):** |  |
| **Explanation:** |  |
| **Proposed Alternative Solution:** |  |

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| **Exception Taken (RFP Section):** |  |
| **Explanation:** |  |
| **Proposed Alternative Solution:** |  |

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| **Exception Taken (RFP Section):** |  |
| **Explanation:** |  |
| **Proposed Alternative Solution:** |  |

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| **Proposed Alternative Solution:** |  |

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| **Exception Taken (RFP Section):** |  |
| **Explanation:** |  |
| **Proposed Alternative Solution:** |  |