**REQUEST FOR PROPOSALS NO. 2025-044-7069**

**Juvenile Residential Treatment Services**

**for the Dallas County Juvenile Department**

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

|  |  |  |
| --- | --- | --- |
| 1 | Chemical Dependency Treatment Facility |  |
| 2 | Child Placing Agency (for therapeutic foster care) |  |
| 3 | Psychiatric Residential Youth Treatment Facility |  |
| 4 | Residential Treatment Center |  |
| 5 | Transitional Living Program |  |
| 6 | Vocational/Trade School |  |

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

***RESPONDENT:***

|  |  |
| --- | --- |
| **Service Agency:** |  |
| **Address:** |  |
| **Authorized Signature Name:** |  |
| **Person Completing Proposal:** |  |
| **Phone Number:** |  |
| **Contact for Notification:** |  |
| **Phone Number:** |  |
| **Fax Number:** |  |
| **Email Address:** |  |

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

* + 1. 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: |  |

* + 1. 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): | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

* + 1. What is the State of incorporation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    2. Does the Service Agency have a non‐profit status? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    3. Employer Identification Number (EIN)/Federal Tax Identification Number or Social Security Number: \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    4. 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.
    5. 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.
    6. Dun & Bradstreet (D-U-N-S) Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
    7. How many years in business under the present name?
    8. How many years has the Service Agency been in business?
    9. What is the Service Agency’s primary type or line of business?
    10. How many years has the Service Agency provided the proposed service?
    11. How many years has the Service Agency operated the proposed facility?
    12. Give specific details of any civil or criminal litigation pending or contemplated related to staff or facility operations.
    13. 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.
    14. Is the facility 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?
    15. If the Service Agency has contracted with the Dallas County Juvenile Department in previous years, but was denied a FY 2022, 2023 and/or 2024 contract because of unsatisfactory performance, what corrective actions have been taken?
    16. List any Juvenile Departments (by County) within the State of Texas with whom the Service Agency currently contracts.
    17. **REFERENCES:**

Respondents shall 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 or other clients (current and/or past) within the past three (3) years.

*Service Agency/Facility Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

|  |  |  |  |
| --- | --- | --- | --- |
| Agency Name: |  | | |
| Contact Person: |  | Title: |  |
| Phone Number: |  | Fax Number: |  |
| Email Address: |  | Contract Duration: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Agency Name: |  | | |
| Contact Person: |  | Title: |  |
| Phone Number: |  | Fax Number: |  |
| Email Address: |  | Contract Duration: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Agency Name: |  | | |
| Contact Person: |  | Title: |  |
| Phone Number: |  | Fax Number: |  |
| Email Address: |  | Contract Duration: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Agency Name: |  | | |
| Contact Person: |  | Title: |  |
| Phone Number: |  | Fax Number: |  |
| Email Address: |  | Contract Duration: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Agency Name: |  | | |
| Contact Person: |  | Title: |  |
| Phone Number: |  | Fax Number: |  |
| Email Address: |  | Contract Duration: |  |

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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 twenty-five percent (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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AI-generated content may be incorrect.

**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; or

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 FACILITY**

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

**FACILITY STAFF**

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

1. Describe the current ethnic makeup of facility staff. Is the ethnic makeup of the staff reflective of the resident population?
2. Discuss challenges to maintain an ethnically diverse staff.
3. Does your agency currently employ bilingual staff? If yes, how many and what languages are spoken by those staff?
4. Of those bilingual staff you employ, how many of them work directly with the youth and their families?

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

1. List key positions and the minimum education and experience requirements for each position.

C. **Staff Training:**

1. What is the required frequency for PREA and sexual victimization/sexual harassment training for facility staff?
2. What is the required frequency for cultural sensitivity/cultural diversity training for staff facility staff?
3. What is the required frequency for emergency behavior intervention training?
4. What is the required frequency for First Aid/CPR certification training?
5. What is the frequency of trauma informed care training?
6. List other mandatory training topics require for facility staff.
7. Describe any specialized training required for non-licensed facility staff responsible for administering medication to youth.

D. **Physical Exams:**

1. At what frequency is facility staff required to undergo a physical examination?
2. At what frequency is tuberculin skin testing (TB/PPD) required of facility staff?
3. Is facility staff subject to random drug testing?

E. **Criminal Background Checks:**

1. Describe the facility’s 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. Is facility staff required to self-report arrests?

F. **Staffing Capabilities:**

1. Discuss the facility’s ability to recruit and screen for highly qualified employees.
2. Discuss the facility’s ability to maintain highly qualified employees.
3. Give the staff turnover rate (percentage) for this facility for calendar year 2024.
4. Discuss the facility’s ability to maintain an ethnically diverse staff that is representative of the youth population served.
5. Discuss the facilities ability to recruit and maintain bilingual staff in all position levels (direct care, treatment, case management, medical, administrative, etc.).

G. **Mandatory Personnel Profile Report:**

1. Complete this form to reflect the makeup of the current personnel of the proposed facility.

**FACILITY NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 Master’s Social Worker: |  |  |  |  |
| Licensed Youth Care Administrator: |  |  |  |  |
| Licensed Sex Offend. Treatment Provider: |  |  |  |  |
| Other (specify): |  |  |  |  |
| Other (specify): |  |  |  |  |
| **Total:** |  |  |  |  |

**EDUCATION/MEDICAL/MENTAL HEALTH CARE PROFESSIONALS:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Professions** | **# Regular Staff** | **# Contract Staff** | **# Agreement** |
| Medical Doctors: |  |  |  |
| Dentists: |  |  |  |
| RNs/LVNs: |  |  |  |
| Psychiatrists: |  |  |  |
| Psychologists: |  |  |  |
| Certified Teachers: |  |  |  |
| Non‐Cert. Teachers: |  |  |  |
| **Total:** |  |  |  |

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

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

**DIRECT CARE STAFF (BY ETHNICITY/GENDER):**

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

**DIRECT CARE STAFF (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 FACILITY POPULATION BY ETHNICITY/GENDER:**

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

**CURRENT FACILITY POPULATION BY REFERRAL SOURCE:**

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

H. **Profile of Facility Personnel/Board of Directors:**

Include the following documentation for the proposed facility in this section:

**BOARD OF DIRECTORS**:

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

**PROPOSED FACILITY**:

1. A flow chart of facility staff.
2. Copies of job descriptions, including minimum qualification for the positions.
3. Copies of all relevant licenses/certificates pertaining to the respective positions.

**SECTION III. FACILITY’S PROGRAM DESIGN**

A. **GENERAL INFORMATION:**

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

1. Proposed Service Levels (check each applicable level):

Moderate \_\_\_\_\_\_ Specialized \_\_\_\_\_\_ Intensive \_\_\_\_\_\_

1. Facility’s Licensed Capacity: # Males: \_\_\_\_\_\_ # Females: \_\_\_\_\_\_
2. Facility’s Licensed Age Range: \_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_ years.
3. Facility’s recommended length of stay: \_\_\_\_\_\_\_\_ months.
4. List characteristics of appropriate referrals:
5. List characteristics of referrals that the facility is unable to admit:
6. Minimum I.Q. of acceptable referrals:
7. Minimum reading level of acceptable referrals:

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

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

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

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

1. Is a psychological examination required before acceptance for admission? If yes, how current must the exam be?
2. Are pre‐placement interviews required before acceptance for admission? If yes, is the Service Agency able to conduct them at the Dallas County Juvenile Detention Center?

15. Describe the facility’s procedure for orientating new admissions (example: supervision level, close observation period, buddy/resident mentor assignments, family contact, etc.).

B. **DESCRIPTION OF TREATMENT SERVICES:**

1. **Check General Services Provided:**

|  |
| --- |
| \_\_\_\_ Individual Counseling |
| \_\_\_\_ Group Counseling |
| \_\_\_\_ Family Counseling |
| \_\_\_\_ Sex Offender Treatment for Perpetrators |
| \_\_\_\_ Sex Abuse Counseling for Victims |
| \_\_\_\_ Substance Abuse Treatment |
| \_\_\_\_ Substance Abuse Treatment Specifically Targeting Use of Opiates |
| \_\_\_\_ Substance Abuse Treatment Specifically Targeting Use of Inhalants |
| \_\_\_\_ Substance Abuse/Dual Diagnosis Treatment |
| \_\_\_\_ Drug Education/Intervention Counseling |
| \_\_\_\_ Gang Intervention Counseling |
| \_\_\_\_ Anger Management Counseling |
| \_\_\_\_ Domestic Violence Counseling |
| \_\_\_\_ Faith-based services |
| \_\_\_\_ Treatment Counseling for Fire Setters | |
| \_\_\_\_ Accredited Education Program | |
| \_\_\_\_ GED Preparation  \_\_\_\_ GED Testing | |
| \_\_\_\_ Academic Credit Recovery Program | |
| \_\_\_\_ On-Campus School | |
| \_\_\_\_ Off-Campus School | |
| \_\_\_\_ Vocation/Trade Skill Development | |
| \_\_\_\_ Work Experience | |
| \_\_\_\_ Transitional Living | |
| \_\_\_\_ Independent Living | |
| \_\_\_\_ Services for Special Needs Youth with Low IQs | |
| \_\_\_\_ Transportation | |
| \_\_\_\_ Any Services to Meet Needs of Bilingual Youth/ Their Families | |

**Additional Gender-Specific Services for Females:**

|  |
| --- |
| \_\_\_\_ Sex Offender Treatment for Perpetrators |
| \_\_\_\_ Sex Offender Counseling for Victims |
| \_\_\_\_ Substance Abuse/Dual Diagnosis Services |
| \_\_\_\_ Treatment services for Females with High Psychiatric Needs |
| \_\_\_\_ Services for Pregnant Females |
| \_\_\_\_ Services for Young Females and Their Babies |
| \_\_\_\_ Highly Structured Program for Aggressive Females |
| \_\_\_\_ Services for Special Needs Youths with Low IQs |
| \_\_\_\_ Services for Victims of Human/Sex Trafficking |
| \_\_\_\_ Services for Exploitation Offenses (i.e., prostitution) |
| \_\_\_\_ Services for Victims of Domestic Violence |
| Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Additional Gender-Specific Services for Males:**

|  |
| --- |
| \_\_\_\_ Domestic Violence Counseling |
| \_\_\_\_ Substance Abuse/Dual Diagnosis Services |
| \_\_\_\_ Treatment services for Males with High Psychiatric Needs |
| \_\_\_\_ Parent skills training services for teen fathers |
| \_\_\_\_ Treatment for Males: Ages 12 or Younger |
| \_\_\_\_ Structured Program for Aggressive Males |
| \_\_\_\_ Sex Offender Counseling for Victims |
| Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other (Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. Describe any substance abuse treatment services provided at this facility (include the types of group counseling, the frequency of individual, group and family counseling, administering of urinalysis, the required credentials of drug treatment counselor, etc.).
2. Describe any sex offender counseling and/or treatment provided at this facility (including credentials of staff; frequency of sessions; group cognitive behavioral treatment; individual therapy, family therapy, drug intervention, or other therapies to address and treat individual risk factors and problems specific to the juvenile; chaperon training for parents/guardians; family reintegration therapy; and polygraphs, etc.).
3. Describe any life skills training or independent living programming offered at the facility.
4. Describe any teen-parent skills training specifically for males offered at the facility.
5. Describe any teen-parent skills training specifically for females offered at the facility.
6. Describe any services designed to specifically address human/sex trafficking offered at the facility.
7. Describe any services to specifically address exploitation offenses.
8. Describe any services to specifically address domestic violence (victim/perpetrator) issues.
9. Discuss how the facility meets the faith-based needs of residents in residential placement at the facility.
10. List vocation shops offered by the facility, the type of certificate/certification received upon completion pre-requisites for admission into the shops and the average time necessary to successfully complete each shop.
11. Does the discharge plan for youth who participate in vocation shops include job readiness/placement programming or continuing education/training in the youth’s respective vocation upon return to the community? If yes, please explain.
12. Give a description of any other resources available to the facility that will be useful in providing the proposed services (example: community organizations, church groups, colleges/universities, sports organizations, etc.).

C. **RESIDENT MEDICAL AND MENTAL HEALTH CARE:**

1. Describe the process utilized by residents to report medical complaints including, but not limited to, the expected timeframe in which the staff should respond the resident’s complaint.
2. Describe how medical and dental services are obtained (include name and address of providers).
3. Will the facility assist with locally obtaining Medicaid certification for all youth placed in its care? If yes, please explain the process for obtaining the Medicaid certification including, but not limited to, the turnaround time and information needed to start the process.
4. Does the facility contract with Medicaid providers? \_\_\_\_\_\_ Yes \_\_\_\_\_\_ No
5. Describe how psychological and psychiatric services are obtained (include name and address of providers).
6. What is the frequency of psychiatric consultations for youth receiving psychotropic medications?
7. Explain the facility’s policy for obtaining authorization to administer prescribed medications to residents.

D. **EDUCATION SERVICES:**

1. Describe the facility’s education component. List names and addresses of all schools utilized and indicate grades for each***.***
2. For off-campus education components, describe the facility’s relationship with the school and support provided to the youth and the school during the education process.
3. For facilities with off-campus education components, please explain the facility’s protocols for monitoring, preventing and addressing incidents that occur away from the facility on the school campus.
4. Describe any credit recovery programs available to youth while in placement at the facility.
5. Describe any GED preparation and testing programs available to residents while in placement at the facility.

E. **FAMILY VISITATION AND TELEPHONE CONTACTS:**

1. Describe the facility’s policy regarding family visitation and telephone contacts with family members. Discuss the frequency of such contacts and any related stipulations.
2. Does the facility currently utilize video conferencing for family contacts?
3. Describe assistance offered to the family for visitation while the youth is in placement at the facility?

F. **FAMILY SERVICES:**

1. Excluding family therapy, describe services offered to the family while the youth is in placement at the facility.
2. Describe any follow‐up services available to the youth and family after the youth discharges from the facility.

G. **BEHAVIOR MODIFICATION MODEL:**

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

H. **EMERGENCY BEHAVIOR INTERVENTION:**

1. Discuss in detail the emergency behavior intervention (EBI) model utilized by the facility.
2. Does the facility have certified trainers of the utilized EBI model on staff?
3. Discuss the facility’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 facility utilize any type of mechanical restraints for emergency behavior intervention? If yes, please describe the type(s) utilized.
5. Does the facility 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.

I. **COMPLAINTS/GRIEVANCES:**

1. Describe the process used by residents to file grievances or complaints.
2. Which staff is responsible for responding to grievances?
3. What is the timeframe in which the staff is expected to respond the resident’s complaint?
4. Are the residents allowed to have private conversations with the probation officer?

J. **PRISON RAPE ELIMINATION ACT:**

1. Describe the facility’s policy and procedures for compliance with PREA including, but not limited to: certification of the facility, staff training, informing residents of the rights and zero tolerance for sexual abuse/harassment, incident reporting, maintaining and reporting of sexual victimization incident incidents, related posters/signage, use of video cameras, gender-specific supervision protocols, etc.

K. **PROPOSED MINIMUM SERVICES BY SERVICE LEVEL:**

(Complete a separate form for each service level proposed)

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| **Proposed Service Level:** |  |
| **Proposed Reimburse Rate for Service Level:** |  |

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| Check those services listed below which will be provided at the above indicated proposed Service Level. Complete Sections 5 and 6 below according to the above indicated Service Level. | | | | | |
| **1. Medical Care** | | | | | |
|  | Routine health care, as needed. | | | | |
|  | Contractual arrangements with health care providers. | | | | |
|  | Access to appropriate laboratory and pharmacy services provided. | | | | |
|  | Staff trained in administering psychotropic medications. | | | | |
|  | Medical and nursing services available on a 24-hour on call basis. | | | | |
|  | Twenty-four (24) hour on-duty nursing services. | | | | |
| **2.** **Recreational Activities and Leisure Time** | | | | | |
|  | Supervision of recreation and leisure time activities. | | | | |
|  | Structured recreational activities and leisure time. | | | | |
|  | Daily schedule of structured recreational activities and leisure time. | | | | |
|  | Therapeutically-designed recreational activities and leisure time. | | | | |
|  | Individual recreation plans designed by inter‐disciplinary team of professionals. | | | | |
| **3. Education** | | | | | |
|  | Free, appropriate public education through a local public school district or charter school. | | | | |
|  | Educational and related services coordinated with the youth’s treatment plan. | | | | |
|  | Educational services offered on‐campus, as needed | | | | |
| **4. Therapeutic Interventions and Case Management** | | | | | |
|  | Consistency, reassurance, regular parenting and activities designed to develop normalized social skills. | | | | |
|  | Therapeutic interventions within the milieu designed to improve the youth’s functioning. | | | | |
|  | Formalized behavioral programs implemented by professional staff or paraprofessional staff under the direct supervision of professional staff. | | | | |
|  | Treatment plans written by professional staff with minimum qualifications of: | | | | |
|  | Treatment planning addressing all waking hours. | | | | |
|  | Treatment planning and implementation supervised by inter‐disciplinary team of professionals. | | | | |
|  | Psychiatric consultation at admission, treatment reviews, discharge and monthly medication reviews. | | | | |
|  | Psychological testing, as needed. | | | | |
| **5. Formalized Interactions Between Professional Staff and Youth/Family** | | | | | |
| Professional Interaction | | # Sessions Per Month | Length of Each Session | | Minimum Qualification of Therapist/Counselor |
| Individual therapy: | |  |  | |  |
| Group Therapy: | |  |  | |  |
| Family Therapy: | |  |  | |  |
| **Alternative:** Use the below space to explain why and how formalized interactions between professional staff and youth/family will be interchanged base on the needs of the youth/family. | | | | | |
|  | | | | | |
| **6. Proposed Staff to Youth Ratio for Proposed Service Level** | | | | | |
| Staff to Youth Ratio During Wake Hours: | | | |  | |
| Staff to Youth Ratio During Sleep Hours: | | | |  | |
| Minimum awake staff at all times: | | | |  | |

L. **FACILITY PERFORMANCE DATA**

All information provided must be within the time of 01/01/2022 to 12/31/ 2024. Please list the timeframe dates from which this information is being provided: From \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_. List each Texas County with whom the facility contracted during this time and fill in the requested information for each county.

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| **Texas County Name** | **Total # of Admits** | **Total # of Successful Discharges** | **Total # of Unsuccessful Discharges** | **Total # of Discharges** | **Avg. Length of Stay for Successful Discharges (in Days)** | **# of Successful that Recidivated** | **# of Substantiated Claims of Abuse/Neglect** |
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M. **INTERNAL PERFORMANCE EVALUATION PROCESS:**

1. What was the facility’s successful discharge percentage rate for the period of 01/01/2023 through 12/31/2024?
2. Discuss the top three (3) criminogenic needs of youth placed at the facility during the period of 01/01/2023 through 12/31/2024 and the facility’s success in meeting those needs.
3. Estimate the percentage of DCJD referrals that will be successfully discharged from this facility under the proposed contract.
4. Describe the agency’s internal method of evaluating the facility’s performance and the effectiveness of the proposed service. Include performance measures and target outcomes utilized by the facility to evaluate the effectiveness of the program.
5. 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 each building on the facility campus.

**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):** |  |
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| **Proposed Alternative Solution:** |  |