APPENDIX B

EMERGENCY SHELTER CARE (ESC)

RFSQ # 21-0072

REQUIRED FORMS

CONTRACTS REQUIRED FORMS – EXHIBIT 1

PROPOSER'S ORGANIZATION QUESTIONNAIRE/AFFIDAVIT

PROSPECTIVE PROPOSER'S NAME:	**COUNTY WEBVEN NUMBER:**
ADDRESS:	
TELEPHONE NUMBER:	**E-MAIL:**
INTERNAL REVENUE SERVICE EMPLOYER IDENTIFICATION NUMBER:	**CALIFORNIA BUSINESS LICENSE NUMBER:**

1.	**Select the options that best define your firm's business structure:** ☐ **Corporation** ☐ **Limited Liability Company (LLC)** ☐ **Limited Partnership** ☐ **Sole Proprietorship** ☐ **Non-Profit** ☐ **Franchise** ☐ **Resource Family Approval Parent** ☐ **Other (Specify):** _____	**If Corporation or Limited Liability Company (LLC):** Legal Name (as stated in Articles of Incorporation): _____ State of Incorporation: _____ Year of Incorporation: _____ **If Limited Partnership or a Sole Proprietorship:** Name of Proprietor or Managing Partner: _____ **If Other,** specify business structure name: _____ **If Resource Family Approval Parent**, specify the Name: _____
2.	**Is your firm doing business under one or more DBA's?** ☐ **YES** ☐ **NO** ☐ **N/A**	Name: _____ Country of Registration: _____ Year became DBA: _____
3.	**Is your firm wholly/majority owned by, or a subsidiary of another firm?** ☐ **YES** ☐ **NO** ☐ **N/A**	If **YES**, indicate name of Parent Firm and State of Incorporation: Name of Parent Firm: _____ State of Incorporation or Registration of Parent firm: _____
4.	**Has your firm done business as other names within last five (5) years?** ☐ **YES** ☐ **NO** ☐ **N/A**	If **YES**, indicate any other names and the year of name change. Name(s): _____ Year(s) of Name Change: _____

EXHIBIT 1

5.	**List the names of all joint ventures, partners, subcontractors, or others having any right or interest in this contract or the proceeds thereof. If not applicable, state "NONE".**	
6.	**Is your firm involved in any pending acquisition or mergers?** ☐ **YES** ☐ **NO** ☐ **N/A**	If **YES,** please provide additional information regarding the pending merger.
7.	**List all the names and contact information of all individuals legally authorized to commit the Proposer.**	Name: _____ Title: _____ Telephone Number: _____ E-Mail: _____

Prospective Proposer's Name (Print)	**Prospective Co-Proposer's Name (Print)**
Prospective Proposer's Signature	**Prospective Co-Proposer's Signature**
Date	**Date**

CONTRACTS REQUIRED FORMS – EXHIBIT 2

CERTIFICATION OF COMPLIANCE

Proposer certifies compliance with all programs, policies, and ordinances specified in exhibits listed below:

	TITLE	REFERENCE	CERTIFICATIONS
1.	Certification of No Conflict of Interest	LACC 2.180	**Certifies Compliance?** ☐ **Yes** ☐ **No**
2.	Familiarity with the County Lobbyist Ordinance Certification	LACC 2.160	**Certifies Compliance?** ☐ **Yes** ☐ **No**
3.	Zero Tolerance Policy on Human Trafficking Certification	Motion	**Certifies Compliance?** ☐ **Yes** ☐ **No**
4.	Compliance with Fair Chance Employment Hiring Practices Certification	Board Policy 5.250	**Certifies Compliance?** ☐ **Yes** ☐ **No**
5.	Attestation of Willingness to Consider GAIN/START Participants	Board Policy 5.050	**Certifies Compliance?** ☐ **Yes** ☐ **No** **Willing to provide GAIN/START participants access to employee mentoring program?** ☐ **Yes** ☐ **No** ☐ **N/A**
6.	Contractor Employee Jury Service Program Certification Form & Application for Exception	LACC 2.203	**Certifies Compliance?** ☐ **Yes** ☐ **No** **If "No", identify exemption:** ☐ My business does not meet the definition of "contractor" as defined in the Program. ☐ My business is a small business as defined in the Program. ☐ My business is subject to a Collective Bargaining Agreement (attach agreement) that expressly provides that it supersedes all provisions of the Program.
7.	Certification of Compliance with the County's Defaulted Property Tax Reduction Program	LACC 2.206	**Certifies Compliance?** ☐ **Yes** ☐ **No** **If "No", identify the exemption:** _____
8.	Certification of Prospective Proposer or Contractor not operating a child daycare business within the same physical structure or on the same property where ESC Services are being provided.	ESC-SOW 8.6	**Certifies Compliance?** ☐ **Yes** ☐ **No**

Prospective Proposer's Name (Print)	**Prospective Co-Proposer's Name (Print)**
Prospective Proposer's Signature	**Prospective Co-Proposer's Signature**
Date	**Date**

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

EMERGENCY SHELTER CARE (ESC)
PROSPECTIVE PROPOSER INFORMATION AND QUESTIONNAIRE

I. PROSPECTIVE PROPOSER'S PERSONAL INFORMATION:
(Please use the same name indicated on Resource Family Approval Certificate)

NAME (First, Middle, Last):	DATE OF BIRTH (mm/dd/yyyy):	SOCIAL SECURITY NUMBER:

HOME ADDRESS (Number, Apt/Unit #, Street Name, City, State, Zip Code):

MAILING ADDRESS, if different from above (Number, Street Name, City, State, Zip Code):

IS THE MAILING ADDRESS A P.O. BOX?

☐ YES ☐ NO

JUSTIFICATION FOR MAILING ADDRESS:

CA DRIVER'S LICENSE (CDL) NUMBER:	CDL EXPIRATION DATE:

PRIMARY TELEPHONE NUMBER:	ALTERNATE PHONE NUMBER:	EMAIL ADDRESS:

PLEASE ATTACH A COPY OF THE PROSPECTIVE PROPOSER'S CALIFORNIA DRIVER'S LICENSE.

II. PROSPECTIVE CO-PROPOSER'S PERSONAL INFORMATION:
(If applicable, otherwise state "N/A")

NAME (First, Middle, Last):	DATE OF BIRTH (mm/dd/yyyy):	SOCIAL SECURITY NUMBER:

HOME ADDRESS (Number, Apt/Unit #, Street Name, City, State, Zip Code):

MAILING ADDRESS, if different from above (Number, Street Name, City, State, Zip Code):

CA DRIVER'S LICENSE (CDL) NUMBER:	CDL EXPIRATION DATE:

PRIMARY TELEPHONE NUMBER:	ALTERNATE PHONE NUMBER:	EMAIL ADDRESS:

RELATIONSHIP TO PROSPECTIVE PROPOSER:

PLEASE ATTACH A COPY OF THE PROSPECTIVE CO-PROPOSER'S CALIFORNIA DRIVER'S LICENSE.

III. ALTERNATIVE CAREGIVER PERSONAL INFORMATION:

(If applicable, otherwise state "N/A")

NAME (First, Middle, Last):	DATE OF BIRTH (mm/dd/yyyy):

DOES THE ALTERNATIVE CAREGIVER RESIDE WITH THE PROSPECTIVE PROPOSER?

☐ YES ☐ NO

HOME ADDRESS (Number, Apt/Unit #, Street Name, City, State, Zip Code):

MAILING ADDRESS, if different from above (Number, Street Name, City, State, Zip Code):

CA DRIVER'S LICENSE (CDL) NUMBER:	CDL EXPIRATION DATE:

PRIMARY TELEPHONE NUMBER:	ALTERNATE PHONE NUMBER:	EMAIL ADDRESS:

RELATIONSHIP TO PROSPECTIVE PROPOSER:

DOES THE ALTERNATIVE CAREGIVER HAVE A WRITTEN CLEARANCE FROM THE STATE OF CALIFORNIA COMMUNITY CARE LICENSING? (NOTE: A copy of the written clearance from the State of California Community Care Licensing must be attached)

☐ YES ☐ NO

IV. HOUSEHOLD MEMBERS:

Please list all persons who live in your home on a full or part time basis, including the Prospective Proposer, Prospective Co-Proposer (if applicable) and Alternative Caregiver (if applicable)

NAME (FIRST, MIDDLE, LAST):	DATE OF BIRTH (MM/DD/YYYY):	AGE:	RELATIONSHIP TO PROSPECTIVE PROPOSER:	MALE/ FEMALE	LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, AND QUESTIONING	DISABLED VETERAN	RACE/ETHNIC COMPOSITION OF HOUSEHOLD (CHECK ALL THAT APPLY FOR EACH PERSON)
1.			**SELF**	☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO	☐ AFRICAN AMERICAN/BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC/LATINO ☐ NATIVE AMERICAN ☐ SUBCONTINENT ASIAN ☐ WHITE ☐ OTHER (Please explain below)
2.				☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO	☐ AFRICAN AMERICAN/BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC/LATINO ☐ NATIVE AMERICAN ☐ SUBCONTINENT ASIAN ☐ WHITE ☐ OTHER (Please explain below)
3.				☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO	☐ AFRICAN AMERICAN/BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC/LATINO ☐ NATIVE AMERICAN ☐ SUBCONTINENT ASIAN ☐ WHITE ☐ OTHER (Please explain below)

IV. HOUSEHOLD MEMBERS:
Continued

NAME (FIRST, MIDDLE, LAST):	DATE OF BIRTH (MM/DD/YYYY):	AGE:	RELATIONSHIP TO PROSPECTIVE PROPOSER:	MALE/ FEMALE	LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER, AND QUESTIONING	DISABLED VETERAN	RACE/ETHNIC COMPOSITION OF HOUSEHOLD (CHECK ALL THAT APPLY FOR EACH PERSON)
4.				☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO	☐ AFRICAN AMERICAN/BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC/LATINO ☐ NATIVE AMERICAN ☐ SUBCONTINENT ASIAN ☐ WHITE ☐ OTHER (Please explain below) _____
5.				☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO	☐ AFRICAN AMERICAN/BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC/LATINO ☐ NATIVE AMERICAN ☐ SUBCONTINENT ASIAN ☐ WHITE ☐ OTHER (Please explain below) _____
6.				☐ MALE ☐ FEMALE	☐ YES ☐ NO	☐ YES ☐ NO	☐ AFRICAN AMERICAN/BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC/LATINO ☐ NATIVE AMERICAN ☐ SUBCONTINENT ASIAN ☐ WHITE ☐ OTHER (Please explain below) _____

V. EMPLOYMENT (or SELF EMPLOYED):

Do you currently have outside employment? ☐ **YES** ☐ **NO**	**Please state any other income source you have (i.e., Retirement Pension, Social Security, etc.):**

NAME OF EMPLOYER (NOTE: If you are not currently employed, please indicate "N/A"):

EMPLOYER'S ADDRESS (Number, Suite #, Street Name, City, State, Zip Code):

EMPLOYER'S TELEPHONE NUMBER:	**EMPLOYER'S EMAIL ADDRESS:**	**CONTACT NAME:**

NUMBER OF WORK HOURS PER WEEK:

VI. WORK SCHEDULE:

DAYS OF THE WEEK	START TIME (Please indicate)	Check One		END TIME (Please indicate)	Check One	
Sunday		◯ a.m.	◯ p.m.		◯ a.m.	◯ p.m.
Monday		◯ a.m.	◯ p.m.		◯ a.m.	◯ p.m.
Tuesday		◯ a.m.	◯ p.m.		◯ a.m.	◯ p.m.
Wednesday		◯ a.m.	◯ p.m.		◯ a.m.	◯ p.m.
Thursday		◯ a.m.	◯ p.m.		◯ a.m.	◯ p.m.
Friday		◯ a.m.	◯ p.m.		◯ a.m.	◯ p.m.
Saturday		◯ a.m.	◯ p.m.		◯ a.m.	◯ p.m.

VII. CHILD CARE PLAN:

1. Please describe what childcare plan you have for ESC Services children or youth placed in your home when you are working:

_____

_____

_____

_____

2. Name of Day Care Provider:

VIII. COUNTY CONTRACT HISTORY:

1. Do you have a current or previous ESC Services contract with Los Angeles County?

☐ **YES** ☐ **NO**

	Start Date	End Date
2. If **YES**, please identify the commencement and termination dates of ESC Services contracts you've entered into with Los Angeles County:		

3. Has a Corrective Action Plan (CAP) ever been initiated in your home due to substantiated allegation brought against you by Community Care Licensing and/or by DCFS? ☐ **YES** ☐ **NO**	4. If **YES**, please indicate the **DATE** of the CAP **(mm/dd/yyyy):** _____

5. Please explain the incident:

_____

_____

_____

_____

IX. LICENSES AND CERTIFICATIONS:

1. What is your California State Foster Care License/Resource Family Approval Certificate Number: _____



2. PLEASE ATTACH A COPY OF THE RESOURCE FAMILY APPROVAL CERTIFICATE.

3. How long have you been a Licensed Foster Parent/Approved Resource Parent under your current license/approval?

YEARS: _____ **MONTHS:** _____

4. Do you have six (6) months active experience as a licensed foster parent/approved resource parent with a valid license/approval issued by CDSS/CCL/County?

☐ **YES** ☐ **NO**

5. If **YES**, please provide name of the agency you are/were working under and their contact information:

AGENCY NAME:	**AGENCY ADDRESS (Number, Suite #, Street Name, City, State, Zip Code):**	
TELEPHONE NUMBER:	**EMAIL ADDRESS:**	**CONTACT PERSON:**

6. Have you have ever been a Licensed Foster Parent/Approved Resource Parent in another County or State in the past?

☐ **YES** ☐ **NO**

7. If **YES**, please complete the following:

Previous License/Certificate Number:	
County/State:	
Number of Years with previous License:	

X. HOMEOWNER'S/RENTER'S LIABILITY INSURANCE:

1. Do you own your home? ☐ **YES** ☐ **NO**



2. PLEASE ATTACH A COPY OF THE CERTIFICATE OF HOMEOWNERS' LIABILITY INSURANCE.

OR

3. Do you rent the home you live in? ☐ **YES** ☐ **NO**



4. PLEASE ATTACH A COPY OF THE CERTIFICATE OF RENTER'S LIABILITY INSURANCE.

XI. TRANSPORTATION:

1. Are you willing to provide roundtrip transportation to medical and/or dental appointments for all children or youth placed in your home? This includes appointments scheduled prior to the placement at your home and those scheduled after placement has occurred.

☐ **YES** ☐ **NO**

2. If you stated **"NO"** to Question 1, please state the reason why:

_____

_____

_____

_____

3. If you stated **"YES"** to Question 1, who will be driving?

Only myself: ☐	Myself and Prospective Co-Proposer: ☐	Only Prospective Co-Proposer: ☐

4. If you stated "**YES**" to Question 1, will you drive your own vehicle or someone else's vehicle?

Only my vehicle: ☐	Mine and Prospective Co-Proposer's vehicle: ☐	Only someone else's vehicle: ☐

5. Please provide the following information:

CAR INFORMATION	VEHICLE 1	VEHICLE 2	VEHICLE 3
Legal Owner(s) (First, Middle, Last Name)			
Car Make			
Car Model			
License Plate Number			
Year of Vehicle			
Color of Vehicle			



6. PLEASE ATTACH COPY/COPIES OF CURRENT CAR REGISTRATION(S).



7. PLEASE ATTACH A COPY/COPIES OF PROOF OF AUTOMOBILE INSURANCE.
(NOTE: Please attach copies of proof of automobile insurance policies for licensed drivers residing in your home or whom you may depend on to provide transportation to ESC children).

8. **If someone else will be driving,** please provide that person's information and attach a copy of the following: (If applicable, otherwise state "N/A")

NAME (First, Middle, Last):		**DATE OF BIRTH (mm/dd/yyyy):**
HOME ADDRESS (Number, Apt/Unit #, Street Name, City, State, Zip Code):		
MAILING ADDRESS, if different from above (Number, Street Name, City, State, Zip Code):		
CA DRIVER'S LICENSE (CDL) NUMBER:	**CDL EXPIRATION DATE:**	
PRIMARY TELEPHONE NUMBER:	**ALTERNATE PHONE NUMBER:**	**EMAIL ADDRESS:**
RELATIONSHIP TO PROSPECTIVE PROPOSER:		



9. PLEASE ATTACH A COPY OF PROOF OF AUTOMOBILE INSURANCE (for person listed on Number 8).

DECLARATION:
I declare under penalty of perjury under the laws of the State of California that the above information is true and correct.

Prospective Proposer's Name (Print)	Prospective Co-Proposer's Name (Print)
Prospective Proposer's Signature	Prospective Co-Proposer's Signature
Date	Date

For County Use Only:

1. Number of beds approved by the DCFS Child Welfare Services Case Management System (CWS/CMS): ☐

I certify that the following are TRUE and CORRECT:

2. Prospective Proposer does not have any substantiated **or** open non-compliance findings or investigations with any County, State, Federal, or out-of-state government agency that remain unresolved:

   ☐ **YES** ☐ **NO**

3. Prospective Proposer is not on "**Do Not Use**" or a "**Hold**" with an adverse status with Los Angeles County or any other county:

   ☐ **YES** ☐ **NO**

ESC Program Staff Name and Title (Print)	Signature	Date

CONTRACTS REQUIRED FORMS – EXHIBIT 4

PROPOSER'S DEBARMENT HISTORY AND LIST OF TERMINATED CONTRACTS

Proposer's Name: _____

1. DEBARMENT HISTORY (Check one)	YES	NO
Proposer is currently debarred by a public entity	☐	☐
If yes, please provide the name of the public entity:		
2. LIST OF TERMINATED CONTRACTS (Check one)	**YES**	**NO**
Proposer has contracts that have been terminated in the past three (3) years.	☐	☐

If yes, please list all contracts that have been terminated prior to expiration within the last three (3) years.

Service: _____ Name of Entity: _____
Address: _____
Contact: _____ Telephone: _____
Email: _____
Termination Date: _____ Name/Contract No: _____
Reason for Termination: _____
_____

Service: _____ Name of Entity: _____
Address: _____
Contact: _____ Telephone: _____
Email: _____
Termination Date: _____ Name/Contract No: _____
Reason for Termination: _____
_____

Service: _____ Name of Entity: _____
Address: _____
Contact: _____ Telephone: _____
Email: _____
Termination Date: _____ Name/Contract No: _____
Reason for Termination: _____
_____

Service: _____ Name of Entity: _____
Address: _____
Contact: _____ Telephone: _____
Email: _____
Termination Date: _____ Name/Contract No: _____
Reason for Termination: _____
_____

EXHIBIT 5

EMERGENCY SHELTER CARE SERVICES
PROSPECTIVE PROPOSER'S DECLARATION

Emergency Shelter Care Services Contractor

☐ I, _____, (Approved Resource Parent's Name) hereby certifies that the information submitted by Prospective Proposer named above in response to Los Angeles County's Request for Statement of Qualification (RFSQ) for Emergency Shelter Care Services for the Department of Children and Family Services is true to the best of Prospective Proposer's information and belief.

☐ I, _____, (Approved Resource Parent's Legal Name) hereby offers to perform the services, the scope of which is set forth in the above-identified RFSQ for Los Angeles County under all the terms and conditions specified in the Contract included therein and agrees that this offer will remain irrevocable up to and including 30 days following the RFSQ submission due date stated in the RFSQ, Paragraph 1, Solicitation Information and Minimum Requirements.

DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION SUBMITTED IN EXHIBITS 1-8 IS TRUE AND CORRECT.

Prospective Proposer's Name (Print)	Prospective Proposer's Signature	Date

Emergency Shelter Care Service Co-Contractor (if applicable)

☐ I, _____, (Approved Co-Resource Parent's Name) hereby certifies that the information submitted by Prospective Proposer named above in response to Los Angeles County's Request for Statement of Qualification (RFSQ) for Emergency Shelter Care Services for the Department of Children and Family Services is true to the best of Prospective Proposer's information and belief.

☐ I, _____, (Approved Co-Resource Parent's Legal Name) hereby offers to perform the services, the scope of which is set forth in the above-identified RFSQ for Los Angeles County under all the terms and conditions specified in the Contract included therein and agrees that this offer will remain irrevocable up to and including 30 days following the RFSQ submission due date stated in the RFSQ, Paragraph 1, Solicitation Information and Minimum Requirements.

DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE INFORMATION SUBMITTED IN EXHIBITS 1-8 IS TRUE AND CORRECT.

Prospective Co-Proposer's Name (Print)	Prospective Co-Proposer's Signature	Date

REQUIRED FORM

MINIMUM REQUIREMENTS

Proposer acknowledges and certifies that it meets and will comply with the Proposer's Minimum Qualifications indicted below and as stated in **Paragraph 3.0** of this **Emergency Shelter Care (ESC)** services **Request for Statement of Qualifications (RFSQ).**

NO.	MINIMUM REQUIREMENTS	Complies with Minimum Requirement	
		YES	NO
1.	Prospective Proposer possesses a valid resource family home certification approved by the County.	☐	☐
2.	Prospective Proposer has a minimum of six (6) months experience, within the past two (2) years, providing direct care services to foster youth.	☐	☐
3.	Prospective Proposer does not have any substantiated **or** open non-compliance findings or investigations with any County, State, Federal, or out-of-state government agency that remain unresolved. **Note**: The Prospective Proposer must disclose any such non-compliance findings or investigations that can be construed as being unresolved.	☐	☐
4.	Prospective Proposer is **not** on **"Do Not Use"** or a **"Hold"** with an adverse status with Los Angeles County or any other county.	☐	☐
5.	Prospective Proposer does **not** operate a child daycare service within the same physical structure or on the same property where ESC services are provided and is willing to certify to that affect.	☐	☐
6.	Prospective Proposer must pass and submit a home-visit evaluation and participate in an orientation prior to placement of any child or youth.	☐	☐
7.	Prospective Proposer does not have unresolved questioned costs identified by the Auditor-Controller, if licensed resource parent(s) compliance with a County contract has been reviewed by the Department of the Auditor-Controller within the last 10 years, in an amount over $100,000.00, that are confirmed to be disallowed costs by the contracting County department, and remain unpaid for six months or more from the date of disallowance, unless such disallowed costs are the subject of current good faith negotiations to resolve the disallowed costs, in the opinion of the County.	☐	☐

DECLARATION:

I declare under penalty of perjury under the laws of the State of California that the above information is true and correct.

Prospective Proposer's Name (Print)	**Prospective Co-Proposer's Name (Print)**
Prospective Proposer's Signature	**Prospective Co-Proposer's Signature**
Date	**Date**

EXHIBIT 7

EMERGENCY SHELTER CARE SERVICES

PRICING SCHEDULE

Contractor hereby agrees to perform the services, the scope of which is set forth in the Emergency Shelter Care (ESC) Services Contract for the County of Los Angeles, under all of the terms and conditions specified in the Statement of Work, Exhibits, Performance Requirements Summary, Attachments and Contract.

Prices include all applicable charges and costs associated with receipt, delivery, confirmation, and any other costs necessary in the performance of all tasks outlined in the Statement of Work, Exhibits, Performance Requirements Summary, Attachments, and Contract.

APPROVED BED CAPACITY	
1. Licensed/Approved Capacity (Number of Beds): ___	**2.** DCFS/ESC Approved Capacity (Number of Beds): ___

Please check one of the following boxes:	
☐ **NEW CONTRACT**	☐ **AMENDMENT TO CHANGE BED CAPACITY**

EMERGENCY SHELTER CARE PRICING SCHEDULE

Bed Placement Category	Monthly Rate Per Available Bed	Number of Available Beds [1,2]			Monthly Cost for Available Beds	Annual Cost for Available Beds
		Male	Female	Both		
1. Number of Cribs for Infants, ages 0-2[3,6]	$400					
2. Number of Beds for Children, ages 3-20	$400					
3. Number of Beds for Sibling Group, ages 0-20 [4]	$400					
4. Number of Beds for Teen Mother, including crib in 4a. [5]	$600					
4a. Number of Cribs for Teen Mother's Infant(s) [6]						
				Monthly Total:		
				Annual Total:		

[1] The total number of beds cannot exceed the bed capacity per your Resource Family Approval (RFA) certificate and in Title 22 Regulations (SOW, Section 9.8.2, 1).
[2] If a bed vacancy exceeds 60 days, CPM reserves the right to withhold the Monthly Bed Availability rate payment and place the bed on "off call" status until a placement is secured (SOW, Section 9.8.4).
[3] The infant crib is counted as a bed and included in the bed count stated on the RFA certificate (SOW, Section 9.8.2, 2).
[4] A minimum of two beds must be available for sibling groups with a maximum of two children per bedroom (SOW, Section 9.8.2, 3).
[5] Rate includes one bed for the teen mother and a separate crib for the infant in the same bedroom (SOW, Section 9.8.2, 4).
[6] A separate crib is required for each infant (SOW, Section 9.8.2, 5).

CONTRACTOR'S NAME (Print)	**CO-CONTRACTOR'S NAME (Print)**
CONTRACTOR'S SIGNATURE	**CO-CONTRACTOR'S SIGNATURE**
Date	**Date**

For DCFS Contracts Administration Division Use Only:

Pricing Schedule Effective Date: _____

Contract Analyst Name (Print)	**Signature**	**Date**

EXHIBIT 8

EMERGENCY SHELTER CARE
LINE ITEM BUDGET

CONTRACTOR NAME: _____

CO-CONTRACTOR NAME: _____

This budget shall contain Contractor's proposed monthly expenses to provide Emergency Shelter Care (ESC) services, based on the number of available ESC beds, and the category of these available beds that Contractor has entered into agreement with COUNTY.

A. ESTIMATED TOTAL MONTHLY HOUSEHOLD INCOME (excluding ESC Contract Revenue):	**$**

B. Monthly Household Expenses		
Mortgage or Rent	**$**	
Homeowner's (or Renter's) Liability Insurance	**$**	
Automobile Insurance	**$**	
Utilities (Water, Power, Gas, etc.)	**$**	
Telephone/Communication (i.e., Cell Phone, Wi-Fi)	**$**	
Food (Groceries)	**$**	
Total Monthly Household Expenses:	**$**	

C. Estimated Monthly ESC Beds Expenses		
1. Linen for ESC Beds	**$**	
2. Laundry Items for ESC Beds	**$**	
3. Other Items to maintain availability of ESC Beds (List Additional Items Below):		
a.	**$**	
b.	**$**	
c.	**$**	
Total Estimated Monthly ESC Beds Expenses:	**$**	

D. TOTAL MONTHLY EXPENSES (Add Total Monthly Household Expenses and Total Estimated Monthly ESC Beds Expenses):	**$**
E. TOTAL MONTHLY NET INCOME (A minus D):	**$**

Prospective Contractor's Name (Print)	**Prospective Co-Contractor's Name (Print)**
Prospective Contractor's Signature	**Prospective Co-Contractor's Signature**
Date	**Date**

FOR COUNTY USE ONLY

☐ I have reviewed the above ESC Line Item Budget for accuracy and appropriateness of expenditures.

ESC Program Staff Name and Title (Print)	**Signature**	**Date**