

ADMINISTRATIVE OVERVIEW

**I. KEY FACTS**

1. Provider Agency:(Name, Address, Telephone Number, Fax Number, website)
  
2. Agency Contact Person and Title: *(Person completing this tool)*
  
3. Federal Identification Number:
  
4. State in which incorporated:
5. Date of incorporation:
6. Type of corporation:
7. Please check all that would apply to your firm<sup>1</sup>:  
Minority owned\_\_\_\_\_ Women owned\_\_\_\_\_  
Small Business\_\_\_\_\_ Non-profit \_\_\_\_\_  
(Include copy of appropriate state certification.)
8. Other (please describe) \_\_\_\_\_
  
9. Is or has your agency been the subject of state or federal debarment, suspension, or investigation?  
\_\_\_\_\_Yes (If yes, please explain) \_\_\_\_\_No
  
10. Communities serviced by Provider:
  
11. Communities where services will NOT be provided in catchment area:
  
12. List satellite office(s) where client and/or staff records are kept<sup>2</sup>:

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<sup>1</sup> For more information see the following link:  
<http://www.somwba.state.ma.us/Content/certification/regulations.aspx>

<sup>2</sup> EOEA PI-97-55, Client Privacy and Confidentiality

13. Are any of your services subcontracted to other companies or individuals?<sup>3</sup>

Yes \_\_\_\_\_ No \_\_\_\_\_

14. If yes, give details:

15. Describe how you monitor subcontractors for quality assurance:<sup>4</sup>

16. List the days and hours of office operation of:

	Main	Satellite	Other
A.M.			
P.M.			
Days			

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<sup>3</sup> See Assignment and Subcontract section of the Provider Agreement. Subcontracts require prior permission of the ASAP. ASAP Contract citations do not appear by number as the Homemaker and Non-Homemaker contracts have identical language but are numbered differently.

<sup>4</sup> EOEI PI-99-01, Vendor Monitoring Standards; EOEI PI-98-03, Vendor Monitoring, Obj. A.

17. Describe which languages are available and the number of employee who speak them:<sup>5</sup>

	Administrative Staff	Direct Care Staff (e.g. drivers)	Other Staff
Office	language/number	language/number	language/number
Main			
Satellite			
Other			

18. (For joint monitoring only) please list by ASAP agency, the number of current clients by service type:

Name of ASAP	service type	service type	service type	service type	service type	service type	service type	service type

**II. LICENSES, CERTIFICATIONS, ACCREDITATIONS, INSURANCE**

1. Please list and provide copies of all of the above that pertain to your provision of services to the ASAP. This would include local, state, county, and federal requirements, as well as association accreditations.<sup>6</sup>

<sup>5</sup> See EOEA PI-98-03, Performance Outcome Measures, Quality Assurance and Improvement, F. The ASAP is required to, "conduct [a] profile of linguistic and cultural community needs as part of each three-year RFP cycle." This information should be used to match client needs with provider language capacity.

<sup>6</sup> See Licenses, Certifications, Accreditations, Permits section of the Provider Agreement.

2. Before issuing any contract, the ASAP will require the provision of a Certificate of Insurance from insurance companies approved and licensed to do business in Massachusetts and evidencing:<sup>7</sup>

Commercial General Liability and Professional Liability

Minimum Limits: \$1,000,000 each occurrence and \$3,000,000 general aggregate

Automobile Liability

Minimum Limits: \$1,000,000 Combined single limit

Automobile Liability is required if your agency is providing Transportation services of any kind.

**The ASAP must be described as the Certificate Holder and be provided a minimum of 10 days written notice of cancellation.**

**III. WRITTEN POLICIES AND PROCEDURES**

1. Please indicate by an “X” that you have and are in compliance with the following *written* policies and procedures:

	Y	N	N/A	Reviewed (ASAP use only)
Affirmative Action Plan/Policy <sup>8</sup>				
Personnel Policies <sup>9</sup>				
Job Descriptions <sup>10</sup> ( <i>all staff</i> )				
Confidentiality Policy <sup>11</sup>				
Infection Control Plan <sup>12</sup>				

2. Please indicate that you are in compliance with the following procedures:

	Y	N	N/A	Reviewed (ASAP use only)
Title VI, of the Civil Rights Act of 1964 <sup>13</sup>				
Section 504 of the Rehabilitation Act of 1973 <sup>14</sup>				

<sup>7</sup> See the Liability Insurance section of the Provider Agreement.

<sup>8</sup> See Affirmative Action section of Provider Agreement.

<sup>9</sup> See Commonwealth Terms and Conditions for Human and Social Services, included in the Provider Agreement by reference. See Outstanding Issues not Addressed Herein section of Provider Agreement.

<sup>10</sup> M.G.L. c 149 § 52C, 808 CMR 1.04.

<sup>11</sup> EOEA PI-97-55, Client Privacy and Confidentiality

<sup>12</sup> 29 CFR 1910.1030.

<sup>13</sup> See Non-Discrimination in Employment section of the Provider Agreement.

<sup>14</sup> *ibid.*



**V. CONFIDENTIALITY:**

1. Describe your process to maintain confidentiality:

Pertaining to employees:

Pertaining to clients<sup>23</sup>:

2. Describe your procedure to ensure information concerning a client's AIDS/HIV status is not apparent or accessible and is not released to anyone without specific written consent of client<sup>24</sup>:

**VI. EMPLOYEE RECORDS<sup>25</sup>:**

1. Describe what specific information is included in employee records:

**VII. HIRING PRACTICES<sup>26</sup>:**

1. Describe your process for recruiting, screening, and hiring:
2. What is the basis of promotion and/or wage increase?
3. What employee benefits do you offer?
4. Describe your policy/procedure to ensure that an employee has a current driver's license (if job requirement)<sup>27</sup>:

**VIII. EMPLOYEE ORIENTATION/TRAINING**

1. These are the elements we look for in orientation/training. Please attach your orientation checklist.
  - Grievance procedure<sup>28</sup>
  - Disciplinary procedure<sup>29</sup>

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<sup>23</sup> EOEI PI-97-55

<sup>24</sup> EOEI PI-92-14; M.G.L. c.111, § 70F.

<sup>25</sup> M.G.L. c. 149, § 52C

<sup>26</sup> ASAP Vendor Monitoring Manual.

<sup>27</sup> Provider Agreement, Licenses, Certifications, Accreditation, Permits

<sup>28</sup> Commonwealth Terms and Conditions for Human and Social Services

<sup>29</sup> *ibid.*

- Non-discrimination against individuals with AIDS and HIV<sup>30</sup>
- Maintenance of client confidentiality<sup>31</sup>
- Prohibition of fees or gratuities from clients
- Staff identification (badges and uniforms) if applicable<sup>32</sup>

**IX. MISCELLANEOUS EMPLOYEE PROCEDURES**

1. Describe policy and practices addressing the allegations of cases of theft, loss or damage to client property<sup>33</sup>:
  
2. Describe the policy covering worker’s handling of client’s money:
  
3. Who is responsible in your agency to oversee these policies?
  
4. How do employees acknowledge that they have been informed and will abide by these policies?<sup>34</sup>

**IX. BILLING VERIFICATION**

1. Describe how you verify services delivered to services authorized<sup>35</sup>:

**X. QUALITY ASSURANCE**

1. Describe the policy for handling client’s problems and/or complaints<sup>36</sup>:

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<sup>30</sup> See Non-Discrimination in Service Delivery; Americans with Disabilities Act.

<sup>31</sup> EOEI PI-97-55

<sup>32</sup> ASAP Vendor Monitoring Manual

<sup>33</sup> See Minimum Public Health, Licensing, Registry and Patient Abuse Reporting Compliance section of the Provider Agreement.

<sup>34</sup> ASAP Vendor Monitoring Manual

<sup>35</sup> See Compensation and Services and Authorization of Services sections of the Provider Agreement.

<sup>36</sup> EOEI PI-98-03

2. Who is responsible for this?

3. What is the average time lapsed between referral and the start of service?<sup>37</sup>

Name of Provider employee who completed this form:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONTINUE TO CONTACT INFORMATION ON NEXT PAGE.**

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<sup>37</sup> EOEI PI-98-03



Please fill out this form completely. Use as much space as necessary.

**Provider Name:**

**PRESIDENT/EXECUTIVE DIRECTOR**

Name and Title:

Phone:

Fax:

Email:

**CFO**

**NAME AND TITLE:**

Phone:

Fax:

Email:

**Program Manager (Person in charge of service delivery)**

Name and Title:

Phone:

Fax:

Email:

**OTHER SUPERVISOR**

Name and Title:

Phone:

Fax:

Email:

**PERSON IN CHARGE OF CONTRACTS**

Name and Title:

Phone:

Fax:

Email:

**Service Coordinator(s) (Please include back-up, and specify service area if needed.)**

Name(s) and Title(s):

Phone:

Fax:

Email:

**BILLING COORDINATOR**

Name and Title:

Phone:

Fax:

Email:

**Boston Consortium  
BUSINESS REFERENCE FORM**

PROVIDER NAME:

The bidder must provide 3 business references.

Reference name:

Contact:

Address:

Phone:

Fax/internet address:

Description and dates of commodities and services provided:

Reference name:

Contact:

Address:

Phone:

Fax/internet address:

Description and dates of commodities and services provided:

Reference name:

Contact:

Address:

Phone:

Fax/internet address:

Description and dates of commodities and services provided:

**Regular, Hot Home Delivered Meal Cost Analysis**  
**To individual home or bulk drop off, per day**  
**FY 2018**

Consortium Member Name \_\_\_\_\_

<b>Total Number of Meals</b>	<b>1-200</b>	<b>201-400</b>	<b>401-600</b>	<b>601-800</b>
<b>Raw Food</b>				
<b>Commissary Labor</b>				
<b>Administration</b>				
<b>Transportation (bulk) or</b>				
<b>Transportation to each home</b>				
<b>Profit</b>				
<b>Disposables</b>				
<b>Total</b>				

**Please complete the above chart for each consortium member you are interested in serving. If you are interested in serving all three consortium members, please indicate this.**

**Ethnic, Hot Home Delivered Meal Cost Analysis  
To individual home or bulk drop off, per day  
FY 2018**

Meal style or styles \_\_\_\_\_

Consortium Member Name \_\_\_\_\_

<b>Total Number of Meals</b>	<b>1-200</b>	<b>201-400</b>	<b>401-600</b>	<b>601-800</b>
<b>Raw Food</b>				
<b>Commissary Labor</b>				
<b>Administration</b>				
<b>Transportation (bulk) or</b>				
<b>Transportation to each home</b>				
<b>Profit</b>				
<b>Disposables</b>				
<b>Total</b>				

**Please complete the above chart for each consortium member you are interested in serving. If you are interested in serving all three consortium members, please indicate this.**

**Generic Congregate Meal Cost Analysis  
Bulk Drop Off  
FY 2018**

**Consortium Member Name:** \_\_\_\_\_

<b>Total Number of Meals</b>	<b>1-200</b>	<b>201-400</b>	<b>401-600</b>	<b>601-800</b>
<b>Raw Food</b>				
<b>Commissary Labor</b>				
<b>Administration</b>				
<b>Transportation (bulk)</b>				
<b>Profit</b>				
<b>Disposables</b>				
<b>Total</b>				

**Please complete the above chart for each consortium member you are interested in serving.**

**Ethnic Congregate Meal Cost Analysis  
Bulk Drop Off  
FY 2018**

Menu style or styles: \_\_\_\_\_

Consortium Member Name: \_\_\_\_\_

<b>Total Number of Meals</b>	<b>1-200</b>	<b>201-400</b>	<b>401-600</b>	<b>601-800</b>
<b>Raw Food</b>				
<b>Commissary Labor</b>				
<b>Administration</b>				
<b>Transportation (bulk)</b>				
<b>Profit</b>				
<b>Disposables</b>				
<b>Total</b>				

**Please complete the above chart for each consortium member you are interested in serving.**

### Meals Cost Calculation

5 day menu, must meet the State Nutrition Program Menu Standards. If you are providing Ethnic meals such as Chinese, please indicate changes that fit the cultural needs of the clients such as omitting the bread and giving more rice.

#### Monday

Component	Sample	Food cost
Protein		
Vegetable		
Starch		
Bread		
Margarine		
Dessert		
Milk		

#### Tuesday

Component	Sample	Food cost
Protein		
Vegetable		
Starch		
Bread		
Margarine		
Dessert		
Milk		

#### Wednesday

Component	Sample	Food cost
Protein		
Vegetable		
Starch		
Bread		
Margarine		
Dessert		
Milk		

**Thursday**

Component	Sample	Food cost
Protein		
Vegetable		
Starch		
Bread		
Margarine		
Dessert		
Milk		

**Friday**

Component	Sample	Food cost
Protein		
Vegetable		
Starch		
Bread		
Margarine		
Dessert		
Milk		

Please attach a sample, month long menu for each type of meal that you are bidding on. The month long menu does not need to be analyzed.



## Home Delivered Meals Service Specific Survey

### I. General Policies and Procedures

A. Do you prepare the following meals?

	yes	no	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Holidays
Hot										
Cold										
Frozen										
Holidays										
Emergency										
Ethnic/ Religious										
Special: pureed										
diabetic										
renal										
vegetarian										
other: (describe)										

B. During what hours are meals delivered?

C. If weekend and holiday meals are not delivered on the day they are to be eaten, state when and how these meals are delivered<sup>38</sup>:

D. Describe how you ensure your meals are kept at an adequate temperature from departure from your food preparation facility to arrival at client's home<sup>39</sup>:

<sup>38</sup> EOEK Kitchen Food Handling and Sanitation Standards, Section 5

<sup>39</sup> EOEK Nutrition Standards, Section 3

E. Describe your procedure for preparing and delivering meals *during* a snowstorm or other emergency:

F. Do you have a procedure for providing emergency food supplies *in advance of* an emergency?<sup>40</sup>      Yes      No      If yes, please describe procedure:

G. Describe your procedure for sending ASAP agency the menu and informing the agency of any substantial changes to the menu<sup>41</sup>:

H. Describe the procedures used by the meals program to accept a referral for home delivered meals:

I. Please describe health inspections of your facility and forward copy(ies) of results of most recent inspection(s)<sup>42</sup>:

J. Describe your policy to notify ASAP agency when service is altered from that which was authorized<sup>43</sup>:

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<sup>40</sup> EOEI Menu Policies, Section B 9

<sup>41</sup> EOEI Menu Policies, Sections 4 and 6

<sup>42</sup> EOEI Kitchen Food Handling and Sanitation Requirements, Non-Homemaker Provider Agreement, Section 1.1

<sup>43</sup> Non-Homemaker Provider Agreement, Section 6

- K. Describe procedures if client isn't home at time of meal delivery<sup>44</sup>:
- II. Personnel Procedures
- A. Describe criteria for selection of the following; not all titles may be applicable:
- Site Manager:
- Drivers:
- Coordinators:
- B. Describe procedure for orientation and training for personnel and by whom<sup>45</sup>:
- Describe how you address sensitivity to elders to these employees<sup>46</sup>:
- Describe training of drivers regarding role of daily check-in on client status, including handling client's non-responsiveness, notifying staff supervisor and ASAP immediately of client absence from home, or non-responsiveness to driver contact<sup>47</sup>:

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<sup>44</sup> ASAP Vendor Monitoring Manual

<sup>45</sup> ASAP Vendor Monitoring Manual

<sup>46</sup> *ibid.*

<sup>47</sup> *ibid.*

C. Describe procedure for supervision for personnel how often and by whom<sup>48</sup>:

D. Describe your policy in determining driver's current status registry motor vehicle report<sup>49</sup>:

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<sup>48</sup> *ibid.*

<sup>49</sup> Non-Homemaker Provider Agreement, Section 1.1

Name of Provider employee who completed this form:

Signature:

Date:

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**Boston Consortium RFR 2018  
Computer Hardware/Software Minimum Requirements Certification**

<b>System Requirements</b>	
<b>Operating System:</b>	Windows 7 / Windows 8.1 / Windows 10
<b>Browser:</b>	<u>Certified</u> : Internet Explorer 11
<b>Processor:</b>	2.0 GHZ processor or better
<b>RAM:</b>	2 GB (minimum) 4 GB (recommended)
<b>Screen Resolution:</b>	Minimum: 1024x768 (1280x1024 is ideal)
<b>Internet Access:*</b>	40-45 Kbps (kilobytes per second) (recommended for each concurrent user)
<b>Maximum Latency:</b>	100ms or less
<b>Microsoft:</b>	<u>Certified</u> : Microsoft Office 2003, 2007, and 2013, InfoPath 2003 and 2007  <u>Supported</u> : Microsoft Office 2007, 2010, and 2013, InfoPath 2010  Note that Microsoft Office 2013 is supported only for Windows 10 at this time

Other Important IT requirements:

- Antivirus Software installed. (Symantec, TrendMicro, MacAfee, etc.)
- Encryption software for email communication (Zixmail, Cisco, etc.)
- Secure Backup system or software (Carbonite or HIPAA Compliant online backup software)

**Please note: Organizations awarded contracts through this procurement will be required to provide and maintain all necessary functionality, hardware and software to meet industry standards, as outlined above, including:**

- a. Standard office software (word processing, spreadsheets, databases, e-mail communication, etc.) and operating systems on desktop, and licensed for all staff users; and
- b. Internet connectivity and the appropriate internet capacity to support the Contract.

**By signing this form, Provider is certifying that it meets the requirements outline above. If the Provider is unable to attest to a particular requirement, the Provider shall submit an explanation and plan to comply with this requirement.**

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**Provider's Authorized Signature**  
**Date**

**Printed Name**

**Plan to Meet Requirements:** \_\_\_\_\_, does not currently meet the  
**Computer/Software requirements outlined above. Following is**\_\_\_\_\_ **plan to**  
**comply with this requirement:**

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