EXHIBIT D.1
COVER LETTER

RFP No. 2022.01.BHTC

This portion of the RFP will not be scored. Please complete this form as part of your submission to the RFP and include answers for each requirement directly on this sheet. If you do not have information for one or more sections, enter N/A or "none". Please do not leave any section blank.

Bidders who do not meet minimum eligibility and qualifications shall be deemed non-responsive and will not receive further consideration. Please attach any licenses, certifications, or other documents that provide proof of eligibility and qualifications. If you do not have documents to attach, please explain how you do and/or will meet requirements under each section.

1. ORGANIZATION INFORMATION

Legal Name of Organization (per the IRS)**:**	
DBA Name of Organization (if applicable)**:**	
Historic Name(s) of Organization (same ownership only)**:**	

Street Address:					
Address Line 2:					
City:		State:		Zip:	
RFP Contact:		Title:			
Phone:		Email:			

Organization TIN (primary):	Select one: ☐ For profit ☐ Non-profit
Organization UBI:	Organization DUNS:

Ownership Type (select one):	☐ Sole proprietorship	☐ City/County/State owned
	☐ Corporation/LLC/Partnership	☐ Federally owned

Organization Contacts (As Applicable)	**Name**	**Phone**	**Email**
Executive Director/CEO/President:			
Financial Manager/CFO:			
Clinical Director:			
Contracts Manager:			

2. PRIORITY AREAS OF NEED (check all that apply)

☐ PREVENTION
☐ COMMUNITY EDUCATION, EARLY INTERVENTION, AND SCREENING
☐ OUTPATIENT AND COMMUNITY BASED SERVICES
☐ CRISIS AND INPATIENT SERVICES
☐ SERVICES FOR JUSTICE INVOLVED
☐ HOUSING SUPPORTS

3. BIDDER ELIGIBLITY

1. If Bidders are requesting funding for behavioral health treatment, they must employ individuals who are licensed by the WA State Department of Health to perform services within the scope and expertise of the services being proposed. Please explain how your agency fulfills this requirement:

2. If the Bidder applying is a Behavioral Health Agency and requesting funding for behavioral health treatment, they must be currently licensed by the WA State Department of Health. Please provide current license number:

3. If the Bidder is currently under contract with another department in PCHS, the contract must be in good standing and not under any performance improvement or corrective action plans in order to submit a proposal. Please list all current contracts with PCHS and current performance improvement or corrective action plans in place, if any:

4. Has the Bidder, Bidder's personnel, or any proposed subcontractors under this contract have a history of being found guilty of patience abuse or neglect by any state regulatory or accreditation entity within the past five (5) years? ☐ YES / ☐ NO

   If yes, please explain:

5. Has the Bidder, Bidder's personnel, or any proposed subcontractor under this contract had their certification and/or license revoked within the past five (5) years? ☐ YES / ☐ NO

   If yes, please explain:

4. EMPLOYEE CREDENTIALING

1. **Please indicate the method utilized to ensure that each license/certification (and all other credentials) of individuals rendering services for your organization is renewed before expiration:**

   ☐ Online directly with the appropriate State and/or Federal licensure or certification board

   ☐ Obtaining a current copy of the license/certification

   ☐ Background check agency, contracted organization, or vendor

   ☐ Other process (please describe):

   ☐ No process or N/A if not requesting funding for treatment or services requiring license/certification (please explain):

2. Please indicate the method utilized to ensure that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service, and that no individuals convicted or a felony for a healthcare related crime are rendering services:

☐ Federal and/or State Criminal Background Check(s)

☐ Background check agency, contracted organization, or vendor

☐ Search a State 'Misconduct Registry' or equivalent

☐ Other process (please describe):

☐ No process (please explain):

5. ORGANIZATION DISCLOSURE

Question	Response
1. Does your organization or any of its authorized representatives currently have any pending legal actions (excluding medical malpractice and misdemeanors)? If yes, explain:	☐ NO ☐ YES
2. Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned, or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, or military? If yes, please explain:	☐ NO ☐ YES
3. At any time has any license or certification held by the organization ever been revoked, denied or suspended, or has the organization ever voluntarily surrendered any license or certification while under investigation, or are there are actions or investigations currently under way which may lead to one of these outcomes? If yes, please explain:	☐ NO ☐ YES
4. Has your organization's liability insurance coverage ever been restricted, limited, denied, not renewed, or special rates for any reasons other than the carrier's termination of operations in the state? If yes, please explain:	☐ NO ☐ YES
5. At any time, has any third-party payer ever revoked, reduced, denied, or suspended your organization's participation due to quality-of-care issues? If yes, please explain:	☐ NO ☐ YES

6. Does your organization currently employ any person who has been or is currently excluded from participation in a federal government program (e.g., Medicare, Medicaid)? If yes, please explain:	☐ NO ☐ YES

The individual executing this Attestation is duly authorized and has the proper authority and proper authorization to execute this Attestation and does so with the intent to fully bind Facility/Agency to the truthfulness of its answers.

Signature:____

Printed Name: __________________________________ Date: __________________