XYZ Care Group

Statement of Qualifications

RFSQ – Mental Health Services Act (MHSA)

DMH030719B1
March 9, 2020

County of Los Angeles Department of Mental Health
Contracts Development and Administration Division
550 South Vermont Avenue, 5th floor, Room 500
Los Angeles, CA 90020

Attention: Solicitations Team

To whom it may concern:

XYZ Care Group (XYZ) is pleased to submit this Statement of Qualifications to qualify for the Master Services Agreement List.

XYZ’s headquarters address is 6543 Sunset Blvd., Los Angeles CA 90020. We can be reached via telephone at (323) 123-4567, via fax at (323) 987-6543, or via email at xyzcaregroup@xyzcaregroup.org.

Roger Xylophone is certified and authorized to sign on behalf of XYZ.

Thank you for considering our qualifications and we look forward to hearing back.

Sincerely,

Roger Xylophone

Roger Xylophone
Chief Executive Officer

3/9/2020
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Minimum Mandatory Qualifications

Letters of Reference

WebVen Identification Number
February 27, 2020

County of Los Angeles Department of Mental Health
Contracts Development and Administration Division
550 South Vermont Avenue, 5th floor, Room 500
Los Angeles, CA 90020

RE: XYZ Care Group – Letter of Reference

To whom it may concern:

I am pleased to submit this letter of reference on behalf of XYZ Care Group (XYZ) and endorse their qualifications to provide culturally linguistically appropriate mental health services in Los Angeles County. Since 2015, we have worked with XYZ to reach out to our target population of Transition Age Youth (TAY). XYZ has an extensive history of delivering Prevention and Early Intervention (PEI) services throughout Southern California.

Please feel free to contact me (323) 101-1010 if you have any additional questions regarding this letter of reference.

Best regards,

Mary Miranda
Mary Miranda
Deputy Director
February 27, 2020

County of Los Angeles Department of Mental Health
Contracts Development and Administration Division
550 South Vermont Avenue, 5th floor, Room 500
Los Angeles, CA 90020

RE: XYZ Care Group – Letter of Reference

To whom it may concern:

I am pleased to submit this letter of reference on behalf of XYZ Care Group (XYZ) and endorse their qualifications to provide culturally linguistically appropriate mental health services in Los Angeles County. Since 2015, we have worked with XYZ to reach out to our target population of Transition Age Youth (TAY). XYZ has an extensive history of delivering Prevention and Early Intervention (PEI) services throughout Southern California.

Please feel free to contact me (323) 101-1010 if you have any additional questions regarding this letter of reference.

Best regards,

Nancy Nguyen
Nancy Nguyen
City Manager
CONSTANT CARE GROUP

February 27, 2020

County of Los Angeles Department of Mental Health
Contracts Development and Administration Division
550 South Vermont Avenue, 5th floor, Room 500
Los Angeles, CA 90020

RE: XYZ Care Group – Letter of Reference

To whom it may concern:

I am pleased to submit this letter of reference on behalf of XYZ Care Group (XYZ) and endorse their qualifications to provide culturally linguistically appropriate mental health services in Los Angeles County. Since 2015, we have worked with XYZ to reach out to our target population of Transition Age Youth (TAY). XYZ has an extensive history of delivering Prevention and Early Intervention (PEI) services throughout Southern California.

Please feel free to contact me (323) 101-1010 if you have any additional questions regarding this letter of reference.

Best regards,

Constance Constantine
Constance Constantine
President
XYZ CARE GROUP

WEBVEN IDENTIFICATION NO. 14411401

Visit https://camisvr.co.la.ca.us/Webven/ to register as a vendor
Section A – Proposer’s Qualifications
REQUIRED FORMS - EXHIBIT 1
PROPOSER’S ORGANIZATION QUESTIONNAIRE/AFFIDAVIT AND CBE INFORMATION

Please complete, sign and date this form. The person signing the form must be authorized to sign on behalf of the Proposer and to bind the applicant in a Contract.

1. Is your firm a corporation or limited liability company (LLC)? □ Yes ☑ No
   If yes, complete:
   Legal Name (found in Articles of Incorporation) XYZ Care Group
   State California Year Inc. 2010

2. If your firm is a limited partnership or a sole proprietorship, state the name of the proprietor or managing partner:

3. Is your firm doing business under one or more DBA’s? □ Yes ☑ No
   If yes, complete:
   Name ___________________________ County of Registration ___________________________
   Year became DBA ___________________________

4. Is your firm wholly/majority owned by, or a subsidiary of another firm? □ Yes ☑ No
   If yes, complete:
   Name of parent firm: ___________________________
   State of incorporation or registration of parent firm: ___________________________

5. Has your firm done business as other names within last five (5) years? □ Yes ☑ No
   If yes, complete:
   Name ___________________________ Year of Name Change ___________________________
   Name ___________________________ Year of Name Change ___________________________

6. Is your firm involved in any pending acquisition or mergers, including the associated company name?
   □ Yes ☑ No If yes, provide information:

Proposer acknowledges and certifies that firm meets and will comply with the Proposer’s Minimum Qualifications as stated in Section 1.4, of this Request for Statement of Qualifications, as listed below.

Check the appropriate boxes:

☑ Yes □ No Proposer must have a minimum of three (3) years’ experience within the last five (5) years providing culturally and linguistically appropriate mental health services as described in Section 1.1. (Scope of Work).

☑ Yes □ No Proposer must register in the County’s WebVen. Proposer may register via the Internet by accessing the County’s home page at: (http://carnisrv.co.la.ca.us/webven/).


LAC-DMH – RFSQ No. DMH030719B1 – MHSA
REQUIRED FORMS
Proposer does not have unresolved questioned cost, as identified by the Auditor-Controller, in an amount over $100,000.00, that are confirmed to be disallowed costs by the contracting County department, and remain unpaid for a period of 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.

I. FIRM/ORGANIZATION INFORMATION: The information requested below is for statistical purposes only. On final analysis and consideration of award, proposer will be selected without regard to race/ethnicity, color, religion, sex, national origin, age, sexual orientation or disability.

<table>
<thead>
<tr>
<th>Business Structure:</th>
<th>□ Sole Proprietorship</th>
<th>□ Partnership</th>
<th>□ Corporation</th>
<th>□ Non-Profit</th>
<th>□ Franchise</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Other (Specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Number of Employees (including owners): 10

II. PERCENTAGE OF OWNERSHIP IN FIRM: Please indicate by percentage (%) how ownership of the firm is distributed.

<table>
<thead>
<tr>
<th>Black/African American</th>
<th>Hispanic/Latino</th>
<th>Asian or Pacific Islander</th>
<th>American Indian</th>
<th>Filipino</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td></td>
<td></td>
<td></td>
<td>100%</td>
<td>%</td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
<td></td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

III. CERTIFICATION AS MINORITY, WOMEN, DISADVANTAGED, AND DISABLED VETERAN BUSINESS ENTERPRISES: If your firm is currently certified as a minority, women, disadvantaged or disabled veteran owned business enterprise by a public agency, complete the following and attach a copy of your proof of certification. (Use back of form, if necessary.)

Proposer further acknowledges that if any false, misleading, incomplete, or deceptively unresponsive statements in connection with this SOQ are made, the SOQ may be rejected. The evaluation and determination in this area shall be at the Director's sole judgment and his/her judgment shall be final.

DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.

<table>
<thead>
<tr>
<th>PROPOSER NAME:</th>
<th>XYZ Care Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADDRESS:</td>
<td>6543 Sunset Blvd., Los Angeles CA 90020</td>
</tr>
<tr>
<td>PHONE NUMBER:</td>
<td>(323) 123-4567</td>
</tr>
<tr>
<td>E-MAIL:</td>
<td><a href="mailto:xyzcaregroup@xyzcaregroup.org">xyzcaregroup@xyzcaregroup.org</a></td>
</tr>
<tr>
<td>INTERNAL REVENUE SERVICE EMPLOYER IDENTIFICATION NUMBER:</td>
<td>31-9988776</td>
</tr>
<tr>
<td>CALIFORNIA BUSINESS LICENSE NUMBER:</td>
<td>C1919191</td>
</tr>
<tr>
<td>PROPOSER OFFICIAL NAME AND TITLE (PRINT):</td>
<td>Roger Xylophone</td>
</tr>
<tr>
<td>SIGNATURE:</td>
<td>Roger Xylophone</td>
</tr>
<tr>
<td>DATE:</td>
<td>3/3/2020</td>
</tr>
</tbody>
</table>
Statement of Qualification Narrative Summary

XYZ Care Group (XYZ) was founded by Roger Xylophone in 2010. XYZ specializes in Prevention and Early Intervention (PEI) that aims to prevent and intervene in the early onset of the effects of post-traumatic stress disorder (PTSD) and complex post-traumatic stress disorder (C-PTSD) for underserved cultural populations, youth who are involved in the criminal/juvenile justice systems, and children who are failing or have not graduated high school. These youths reside in foster homes, group homes, probation camps, juvenile hall, prisons, or are experiencing or are at risk of homelessness. These children and youth are in trauma, yet there is a huge disparity in access to service because many have been abused in the foster care system, have not been screened or treated for trauma, and/or misdiagnosed with behavior disorders which are then criminalized.

It is XYZ’s goal to reduce mental health disparities among these populations. XYZ is attempting to introduce a mental health practice and approach that is new to current mental health systems in place by applying a trauma-focused approach, including the utilization of trauma therapy rather than cognitive behavioral therapy to address trauma and mental health issues. XYZ also uses psychobiological practices, such as supporting the release of dopamine and targeting the limbic system to support transformational healing. This innovation allows XYZ to address disparities in access to services, which is accomplished by the strategy of building on community strengths and improving the quality of mental health services by providing services that are culturally congruent, sensitive, and competent.
Conditions that make a child more vulnerable to develop PTSD are present for youth once they enter the social welfare/probation systems, as well as disempowerment, disconnection from others, lack of social supports, and poor/absent communication avenues. XYZ aims to promote resilience and strength, a healthy sense of self, and capacity building to combat low school achievement, school dropout, teenage pregnancy, gang involvement, eating disorders, drug abuse, involvement in crime, and reduce the risk of suicide.

XYZ's program consists of three 2-hour weekly sessions for 12 total weeks. The sessions include music, art, poetry, peer support groups, and other activities. XYZ has a full time case manager, program manager, psychologist, and program facilitators and have worked with Transition Age Youth (TAY) for over 15 years, providing counseling, training, education, and trauma therapy. All staff have lived experience and most have been trained in mental health first aid.

Over the past ten years, XYZ has been able to serve hundreds of youth and young adults with significant outcomes. Participants have graduated from high school, gone on to attend college, started their careers, and started families of their own. Pre-tests and post-tests on individuals that have gone through the program include a number of measures including depression, symptoms of trauma, general self-efficacy, and self-esteem, and the findings have shown that participants score very highly on resilience, self-efficacy, and self-esteem, despite showing symptoms of trauma and depression. The mentoring of peers and adults who have lived experience, and who can continue to be a presence in the lives of those in the program, serves to mitigate the trauma to which they are continually exposed.
XYZ's commitment to its participants has allowed it to do work for eight cities and two counties throughout Southern California, as well as numerous mental health institutions and hospitals, and has become a trusted partner for PEI.
REQUEST FOR STATEMENT OF QUALIFICATIONS
MENTAL HEALTH SERVICES ACT
STATEMENT OF QUALIFICATIONS (SOQ) FORM
RFSQ No. DMH030719B1

<table>
<thead>
<tr>
<th>Proposer Name and Doing Business As (DBA) (If applicable):</th>
</tr>
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<tbody>
<tr>
<td>XYZ Care Group</td>
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</table>

<table>
<thead>
<tr>
<th>Headquarter (HQ) Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6543 Sunset Blvd., Los Angeles CA 90020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supervisorial District of HQ Address:</th>
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<table>
<thead>
<tr>
<th>Service Area of HQ Address:</th>
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<tr>
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<table>
<thead>
<tr>
<th>Name of Director, President or Chief Executive Officer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Roger Xylophone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(323) 123-4567</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E-mail Address:</th>
</tr>
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<tbody>
<tr>
<td><a href="mailto:xyzcaregroup@xyzcaregroup.org">xyzcaregroup@xyzcaregroup.org</a></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Date SOQ Submitted:</th>
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<tbody>
<tr>
<td>3/9/2020</td>
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<table>
<thead>
<tr>
<th>WebVen ID Number:</th>
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<tr>
<td>14411401</td>
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</table>

This serves as an application for the Mental Health Services Act Master Agreement. All details about this Request for Statement of Qualifications are available at:

- LACDMH - [https://dmh.lacounty.gov/contract-opportunities/](https://dmh.lacounty.gov/contract-opportunities/)
- LA County Doing Business With Us - [http://camisvr.co.la.ca.us/lacobids/BidLookUp/BidOpenStart.asp](http://camisvr.co.la.ca.us/lacobids/BidLookUp/BidOpenStart.asp)

To complete the Statement of Qualifications (SOQ), please check off all applicable boxes.

1. Please check the appropriate box if you are currently a LACDMH Contractor as a:
   - [ ] Legal Entity/Mental Health Services Contractor  Contract No. ___________
   - [ ] Legal Entity/Institution for Mental Disease (IMD) Contractor  Contract No. ___________
   - [ ] Fee-For-Service Individual or Group Contractor  Contract No. ___________
   - [ ] Consultant Contractor - please describe:  Contract No. ___________
   - [ ] Other Contractor N/A - please describe:  Contract No. ___________

2. Please check the appropriate box pertaining to a Settlement Agreement with DMH:
   - [x] No, I do not have a current Settlement Agreement with DMH.
   - [ ] Yes, I do have a current Settlement Agreement with DMH and am aware that there is a moratorium on expansion and/or implementation of any new programs during the Settlement Agreement’s repayment period and that any exemption from this penalty requires justification that this restriction will negatively impact planned program services.

3. Please check the appropriate box for your agency:
   - [ ] For Profit  [x] Nonprofit  [ ] For Profit with a Nonprofit parent company or affiliate

4. Please check all target age groups with whom you have three (3) years’ experience within the last five (5) years. You will be considered only for the target age groups checked below.
   - [ ] Children (0-15)  [x] Transition Age Youth (16-25)  [ ] Adults (26-59)  [ ] Older Adults (60 Years+)

5. Please check all Service Areas (SAs) where you provide services and those SAs where you do not currently provide services, but have an interest in providing services. You will be considered only for SAs checked below.
   - [ ] Service Area 1 (Antelope Valley)
   - [x] Service Area 2 (San Fernando Valley)
   - [x] Service Area 3 (San Gabriel Valley)
   - [x] Service Area 4 (Metro)
   - [ ] Service Area 5 (West Los Angeles)
   - [x] Service Area 6 (South Los Angeles)
   - [x] Service Area 7 (East Los Angeles)
   - [ ] Service Area 8 (South Bay/Harbor)
REQUEST FOR STATEMENT OF QUALIFICATIONS  
MENTAL HEALTH SERVICES ACT  
STATEMENT OF QUALIFICATIONS (SOQ) FORM  
RFSQ No. DMH030719B1

6. As referenced in the RFSQ, Section 1.1. (Scope of Work), below are the following MHSA Service Components and MHSA Infrastructure Components. Please check all categories of service where you have three (3) years' experience within the last five (5) years.

### MHSA Service Component

**Community Services and Supports (CSS)**  
The CSS Plan Consists of the following Six (6) Focal Areas

<table>
<thead>
<tr>
<th>Focal Area</th>
<th>Full Service Partnerships</th>
<th>Recovery, Resilience and Reintegration (RRR)</th>
<th>Alternative Crisis Services</th>
<th>Planning, Outreach and Engagement</th>
<th>Linkage</th>
<th>Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full Service Partnerships (FSP)</td>
<td>Transitional Age Youth (TAY) Drop-In Centers</td>
<td>Residential and Bridging</td>
<td>Outreach and Engagement at the Service Area level</td>
<td>Linkage to County Operated Functions/Programs</td>
<td>MHSA Housing program and other MHSA funded housing</td>
</tr>
<tr>
<td></td>
<td>Field-based mental health services and supports and clinic-based mental health services and supports</td>
<td>Urgent Care Centers</td>
<td>Outreach and Engagement of Underserved and Cultural Communities</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>TAY Supported Employment Services</td>
<td>Enriched Residential Services</td>
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<tr>
<td></td>
<td>Integrated Care Outpatient Programs</td>
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<td></td>
<td>Peer Run Centers, including Peer Run Respite Housing</td>
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<td></td>
<td>Wellness Services</td>
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<td></td>
<td>Probation Camp Services</td>
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</table>

Page 2 of 3
REQUEST FOR STATEMENT OF QUALIFICATIONS
MENTAL HEALTH SERVICES ACT
STATEMENT OF QUALIFICATIONS (SOQ) FORM
RFSQ No. DMH030719B1

<table>
<thead>
<tr>
<th>MHSA Service Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention</td>
</tr>
<tr>
<td>Early Intervention</td>
</tr>
<tr>
<td>Suicide Prevention</td>
</tr>
<tr>
<td>Stigma and Discrimination Reduction</td>
</tr>
<tr>
<td>Outreach for Increasing Recognition of Early Signs of Mental Illness</td>
</tr>
<tr>
<td>Access and Linkage to Treatment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MHSA Service Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovations (INN)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MHSA Infrastructure Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capital Facilities and Technological Needs</td>
</tr>
<tr>
<td>Workforce Education and Training</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation of MHSA Funded Programs</td>
</tr>
</tbody>
</table>

Please sign and attach to this SOQ Short Form the Settlement Agreement justification (if applicable) and all required forms listed under the RFSQ’s Section 2.7 (Preparation and Format of the SOQ) and Section 2.8 (SOQ Submission). Incomplete forms or forms lacking necessary documentation will not be considered.

I hereby acknowledge and confirm understanding that the submission of this SOQ constitutes acknowledgement and acceptance of, and willingness to comply with all terms and conditions of Appendix H – MHSA Master Agreement should a contract be eventually awarded by the County to provide services. Neither the RFSQ nor this SOQ constitutes a Request for Proposal, Request for Services/Work Order solicitation or an offer of a contract.

On behalf of XYZ Care Group

(Proposer’s Name)

I, ____________________________________________, certify that all statements made in this SOQ

(Name of Proposer’s Authorized Official)

submitted by my organization are true and complete to the best of my knowledge and belief. I understand that any false statement(s) of material facts or omissions may be subject to disqualification.

Roger Xylophone

Print Name and Title of Authorized Agency Representative

Signature of Authorized Agency Representative

3/9/2020

SOQ Submission Date

Page 3 of 3
Secretary of State
Statement of Information
(California Nonprofit, Credit Union and
General Cooperative Corporations)

IMPORTANT — Read instructions before completing this form.
Filing Fee — $20.00;
Copy Fees — First page $1.00; each attachment page $0.50;
Certification Fee — $3.00 plus copy fees

1. Corporation Name (Enter the exact name of the corporation as it is recorded with the California Secretary of State)

XYZ Care Group

2. T-Digit Secretary of State File Number

C1919191

3. Business Addresses

a. Mailing Address of Corporation if different than Item 2a

6543 Sunset Blvd

City (no abbreviations) Los Angeles State CA Zip Code 90020

b. Street Address of Corporation (if any) — Do not enter a P.O. Box

6543 Sunset Blvd

City (no abbreviations) Los Angeles State CA Zip Code 90020

4. Officers

The Corporation is required to enter the names and addresses of all three of the officers set forth below. An additional title for Chief Executive Officer or Chief Financial Officer may be added; however, the preprinted titles on this form must not be altered.

a. Chief Executive Officer First Name Roger Middle Name Xylophone Last Name

Address

6543 Sunset Blvd

City (no abbreviations) Los Angeles State CA Zip Code 90020

b. Secretary First Name Timothy Middle Name Tambourine Last Name

Address

6543 Sunset Blvd

City (no abbreviations) Los Angeles State CA Zip Code 90020

c. Chief Financial Officer First Name Hannah Middle Name Harp Last Name

Address

6543 Sunset Blvd

City (no abbreviations) Los Angeles State CA Zip Code 90020

5. Service of Process (Must provide either Individual OR Corporation.)

INDIVIDUAL — Complete Item 5a and 5b only. Must include agent's full name and California street address.

a. California Agent First Name Timothy Middle Name Last Name Tambourine Suffix

b. Street Address (if agent is not a corporation) — Do not enter a P.O. Box

6543 Sunset Blvd

City (no abbreviations) Los Angeles State CA Zip Code 90020

CORPORATION — Complete Item 5c only. Only include the name of the registered agent Corporation.

c. California Registered Corporate Agent's Name (if agent is a corporation) — Do not complete Item 5a or 5b

6. Common Interest Developments

☐ Check here if the corporation is an association formed to manage a common interest development under the Davis-Stirling Common Interest Development Act (California Civil Code section 4000, et seq.) or under the Commercial and Industrial Common Interest Development Act (California Civil Code section 6500, et seq.). The corporation must file a Statement by Common Interest Development Association (Form SI-CID) as required by California Civil Code sections 5405(a) and 6760(a). See instructions.

7. The information contained herein, including in any attachments, is true and correct.

3/3/2020 Roger Xylophone CEO

Date Type or Print Name of Person Completing the Form

2019 California Secretary of State
bsfile.sos.ca.gov
State of California
Secretary of State

CERTIFICATE OF STATUS

ENTITY NAME:
XYZ CARE GROUP

FILE NUMBER: C1919191
FORMATION DATE: 1/30/2010
TYPE: DOMESTIC NONPROFIT CORPORATION
JURISDICTION: CALIFORNIA
STATUS: ACTIVE (GOOD STANDING)

I, ALEX PADILLA, Secretary of State of the State of California, hereby certify:

The records of this office indicate the entity is authorized to exercise all of its powers, rights and privileges in the State of California.

No information is available from this office regarding the financial condition, business activities or practices of the entity.

IN WITNESS WHEREOF, I execute this certificate and affix the Great Seal of the State of California this day of March 03, 2020.

Alex Padilla
ALEX PADILLA
Secretary of State
March 3, 2020

To whom it may concern:

XYZ Care Group has no pending litigation or judgements.

Roger Xylophone
Roger Xylophone
Chief Executive Officer

3/3/2020
Section B – Required Forms
APPENDIX A
REQUIRED FORMS
 TABLE OF CONTENTS

EXHIBITS

1 PROPOSER'S ORGANIZATION QUESTIONNAIRE/AFFIDAVIT AND CBE INFORMATION
2 CERTIFICATION OF NO CONFLICT OF INTEREST
3 PROPOSER'S EQUAL EMPLOYMENT OPPORTUNITY (EEO) CERTIFICATION
4 REQUEST FOR PREFERENCE PROGRAM CONSIDERATION
5 FAMILIARITY WITH THE COUNTY LOBBYIST ORDINANCE CERTIFICATION
6 PROSPECTIVE PROPOSER REFERENCES
7 PROSPECTIVE PROPOSER LIST OF CONTRACTS
8 PROSPECTIVE PROPOSER LIST OF TERMINATED CONTRACTS
9 ATTESTATION OF WILLINGNESS TO CONSIDER GAIN/GROW PARTICIPANTS
10 COUNTY OF LOS ANGELES PROPOSER EMPLOYEE JURY SERVICE PROGRAM CERTIFICATION FORM AND APPLICATION FOR EXCEPTION
11 CHARITABLE CONTRIBUTIONS CERTIFICATION
12 CERTIFICATION OF COMPLIANCE WITH THE COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM
13 ZERO TOLERANCE POLICY ON HUMAN TRAFFICKING CERTIFICATION
14 COMPLIANCE WITH FAIR CHANCE EMPLOYMENT HIRING PRACTICES CERTIFICATION
REQUIRED FORMS - EXHIBIT 1
PROPOSER'S ORGANIZATION QUESTIONNAIRE/AFFIDAVIT AND CBE INFORMATION

Please complete, sign and date this form. The person signing the form must be authorized to sign on behalf of the Proposer and to bind the applicant in a Contract:

1. Is your firm a corporation or limited liability company (LLC)? ☑ Yes ☐ No
   If yes, complete:
   Legal Name (found in Articles of Incorporation) XYZ Care Group
   State California Year Inc. 2010

2. If your firm is a limited partnership or a sole proprietorship, state the name of the proprietor or managing partner:

3. Is your firm doing business under one or more DBA’s? ☐ Yes ☑ No
   If yes, complete:
   Name County of Registration Year became DBA

4. Is your firm wholly/majority owned by, or a subsidiary of another firm? ☐ Yes ☑ No
   If yes, complete:
   Name of parent firm:
   State of incorporation or registration of parent firm:

5. Has your firm done business as other names within last five (5) years? ☐ Yes ☑ No
   If yes, complete:
   Name Year of Name Change
   Name Year of Name Change

6. Is your firm involved in any pending acquisition or mergers, including the associated company name? ☐ Yes ☑ No If yes, provide information:

Proposer acknowledges and certifies that firm meets and will comply with the Proposer’s Minimum Qualifications as stated in Section 1.4, of this Request for Statement of Qualifications, as listed below.

Check the appropriate boxes:

☑ Yes ☐ No Proposer must have a minimum of three (3) years’ experience within the last five (5) years providing culturally and linguistically appropriate mental health services as described in Section 1.1. (Scope of Work).

☑ Yes ☐ No Proposer must register in the County’s WebVen. Proposer may register via the Internet by accessing the County’s home page at: (http://camisvr.co.la.ca.us/webven/).

Proposer does not have unresolved questioned cost, as identified by the Auditor-Controller, in an amount over $100,000.00, that are confirmed to be disallowed costs by the contracting County department, and remain unpaid for a period of 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.

I. FIRM/ORGANIZATION INFORMATION: The information requested below is for statistical purposes only. On final analysis and consideration of award, proposer will be selected without regard to race/ethnicity, color, religion, sex, national origin, age, sexual orientation or disability.

<table>
<thead>
<tr>
<th>Business Structure:</th>
<th>Sole Proprietorship</th>
<th>Partnership</th>
<th>Corporation</th>
<th>Non-Profit</th>
<th>Franchise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (Specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Number of Employees (Including owners): 10

Race/Ethnic Composition of Firm. Distribute the above total number of individuals into the following categories:

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black/African American</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Indian</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Filipino</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

II. PERCENTAGE OF OWNERSHIP IN FIRM: Please indicate by percentage (%) how ownership of the firm is distributed.

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black/African American</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>American Indian</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Filipino</td>
<td>100</td>
<td>%</td>
</tr>
<tr>
<td>White</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

III. CERTIFICATION AS MINORITY, WOMEN, DISADVANTAGED, AND DISABLED VETERAN BUSINESS ENTERPRISES: If your firm is currently certified as a minority, women, disadvantaged or disabled veteran owned business enterprise by a public agency, complete the following and attach a copy of your proof of certification. (Use back of form, if necessary.)

<table>
<thead>
<tr>
<th>Minority Name</th>
<th>Males</th>
<th>Females</th>
<th>Disadvantaged</th>
<th>Disabled</th>
<th>Veteran</th>
</tr>
</thead>
</table>

Proposer further acknowledges that if any false, misleading, incomplete, or deceptively unresponsive statements in connection with this SOQ are made, the SOQ may be rejected. The evaluation and determination in this area shall be at the Director's sole judgment and his/her judgment shall be final.

DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.

PROPOSER NAME: XYZ Care Group

ADDRESS: 6543 Sunset Blvd., Los Angeles CA 90020

PHONE NUMBER: (323) 123-4567

E-MAIL: xyzcaregroup@xyzcaregroup.org

INTERNAL REVENUE SERVICE EMPLOYER IDENTIFICATION NUMBER: 31-9988776

PROPOSER OFFICIAL NAME AND TITLE (PRINT): Roger Xylophone

SIGNATURE: Roger Xylophone

COUNTRY WEBVEN NUMBER: 14411401

CALIFORNIA BUSINESS LICENSE NUMBER: C1919191

DATE: 3/3/2020

LAC-DMH – RFSQ No. DMH030719B1 – MHSA

REQUIRED FORMS
REQUIRED FORMS - EXHIBIT 2
CERTIFICATION OF NO CONFLICT OF INTEREST

The Los Angeles County Code, Section 2.180.010, provides as follows:

CONTRACTS PROHIBITED

Notwithstanding any other section of this Code, the County shall not contract with, and shall reject any SOQs submitted by, the persons or entities specified below, unless the Board of Supervisors finds that special circumstances exist which justify the approval of such contract:

1. Employees of the County or of public agencies for which the Board of Supervisors is the governing body;

2. Profit-making firms or businesses in which employees described in number 1 serve as officers, principals, partners, or major shareholders;

3. Persons who, within the immediately preceding 12 months, came within the provisions of number 1, and who:
   a. Were employed in positions of substantial responsibility in the area of service to be performed by the contract; or
   b. Participated in any way in developing the contract or its service specifications; and

4. Profit-making firms or businesses in which the former employees, described in number 3, serve as officers, principals, partners, or major shareholders.

Contracts submitted to the Board of Supervisors for approval or ratification shall be accompanied by an assurance by the submitting department, district or agency that the provisions of this section have not been violated.

XYZ Care Group

Proposer Name

Roger Xylophone

Proposer Official Title

Roger Xylophone

Official's Signature
 REQUIRED FORMS - EXHIBIT 3
PROPOSER'S EEO CERTIFICATION

XYZ Care Group

Company Name

6543 Sunset Blvd., Los Angeles CA 90020

Address

31-9988776

Internal Revenue Service Employer Identification Number

GENERAL

In accordance with provisions of the County Code of the County of Los Angeles, the Proposer certifies and agrees that all persons employed by such firm, its affiliates, subsidiaries, or holding companies are and will be treated equally by the firm without regard to or because of race, religion, ancestry, national origin, or sex and in compliance with all anti-discrimination laws of the United States of America and the State of California.

CERTIFICATION

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Proposer has written policy statement prohibiting discrimination in all phases of employment.</td>
<td>✓</td>
</tr>
<tr>
<td>2.</td>
<td>Proposer periodically conducts a self-analysis or utilization analysis of its work force.</td>
<td>✓</td>
</tr>
<tr>
<td>3.</td>
<td>Proposer has a system for determining if its employment practices are discriminatory against protected groups.</td>
<td>✓</td>
</tr>
<tr>
<td>4.</td>
<td>When areas are identified in employment practices, Proposer has a system for taking reasonable corrective action to include establishment of goal and/or timetables.</td>
<td>✓</td>
</tr>
</tbody>
</table>

Roger Xylophone

Signature

Date 3/3/2020

Roger Xylophone

Name and Title of Signer (please print)
REQUIRED FORMS - EXHIBIT 4
REQUEST FOR PREFERENCE CONSIDERATION

INSTRUCTIONS: Businesses requesting preference consideration must complete and return this form for proper consideration of the bid. Businesses may request consideration for one or more preference programs. Check all certifications that apply.*

I MEET ALL OF THE REQUIREMENTS AND REQUEST THIS BID BE CONSIDERED FOR THE PREFERENCE PROGRAM(S) SELECTED BELOW. A COPY OF THE CERTIFICATION LETTER ISSUED BY THE DEPARTMENT OF CONSUMER AND BUSINESS AFFAIRS (DCBA) IS ATTACHED.

☐ Request for Local Small Business Enterprise (LSBE) Program Preference

☐ Certified by the State of California as a small business and has had its principal place of business located in Los Angeles County for at least one (1) year; or

☐ Certified as a LSBE with other certifying agencies under DCBA’s inclusion policy that has its principal place of business located in Los Angeles County and has revenues and employee size that meet the State’s Department of General Services requirements; and

☐ Certified as a LSBE by the DCBA.

☐ Request for Social Enterprise (SE) Program Preference

☐ A business that has been in operation for at least one year providing transitional or permanent employment to a Transitional Workforce or providing social, environmental and/or human justice services; and

☐ Certified as a SE business by the DCBA.

☐ Request for Disabled Veterans Business Enterprise (DVBE) Program Preference

☐ Certified by the State of California, or

☐ Certified by U.S. Department of Veterans Affairs as a DVBE; or

☐ Certified as a DVBE with other certifying agencies under DCBA’s inclusion policy that meets the criteria set forth by: the State of California as a DVBE or is verified as a service-disabled veteran-owned small business by the Veterans Administration; and

☐ Certified as a DVBE by the DCBA.

*BUSINESS UNDERSTANDS THAT ONLY ONE OF THE ABOVE PREFERENCES WILL APPLY. IN NO INSTANCE SHALL ANY OF THE ABOVE LISTED PREFERENCES PRICE OR SCORING PREFERENCE BE COMBINED WITH ANY OTHER COUNTY PROGRAM TO EXCEED FIFTEEN PERCENT (15%) IN RESPONSE TO ANY COUNTY SOLICITATION.

DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.

☐ DCBA certification is attached.

<table>
<thead>
<tr>
<th>Name of Firm</th>
<th>XYZ Care Group</th>
<th>County Webvan No.</th>
<th>14411401</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print Name:</td>
<td>Roger Xylophone</td>
<td>Title:</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Signature:</td>
<td>Roger Xylophone</td>
<td>Date:</td>
<td>3/3/2020</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reviewer’s Signature</th>
<th>Approved</th>
<th>Disapproved</th>
<th>Date</th>
</tr>
</thead>
</table>

LAC-DMH – RFSQ No. DMH030719B1 – MHSA
REQUIRED FORMS

25.
REQUIRED FORMS - EXHIBIT 5
FAMILIARITY WITH THE COUNTY
LOBBYIST ORDINANCE CERTIFICATION

The Proposer certifies that:

1) it is familiar with the terms of the County of Los Angeles Lobbyist Ordinance, Los Angeles Code Chapter 2.160;

2) that all persons acting on behalf of the Proposer organization have and will comply with it during the proposal process; and

3) it is not on the County's Executive Office's List of Terminated Registered Lobbyists.

Signature: ______________________ Date: ________________

3/3/2020
REQUIRED FORMS - EXHIBIT 6
PROSPECTIVE PROPOSER REFERENCES

Proposer's Name: XYZ Care Group

List three (3) references where the same or similar scope of services were provided in order to meet the Minimum Mandatory Qualifications stated in the RFSQ. Refer to Sections 1.4 and 2.7.3 of the RFSQ.

<table>
<thead>
<tr>
<th>1. Name of Firm</th>
<th>Address of Firm</th>
<th>Contact Person</th>
<th>Telephone #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALIFORNIA DEPARTMENT OF PUBLIC HEALTH</td>
<td>123 E Street, Sacramento CA 96000</td>
<td>Mary Miranda</td>
<td>(123) 456-7890</td>
<td>( )</td>
</tr>
<tr>
<td>Name or Contract No.</td>
<td># of Years / Term of Contract</td>
<td></td>
<td>Type of Service</td>
<td>Dollar Amt.</td>
</tr>
<tr>
<td>PEI #12345</td>
<td>3</td>
<td>PEI Services</td>
<td></td>
<td>$10,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Name of Firm</th>
<th>Address of Firm</th>
<th>Contact Person</th>
<th>Telephone #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>CITY OF SOUTH EL MONTE</td>
<td>321 Durfee Rd., South El Monte, CA 92000</td>
<td>Nancy Nguyen</td>
<td>(626) 123-4567</td>
<td>( )</td>
</tr>
<tr>
<td>Name or Contract No.</td>
<td># of Years / Term of Contract</td>
<td></td>
<td>Type of Service</td>
<td>Dollar Amt.</td>
</tr>
<tr>
<td>PEI #54321</td>
<td>4</td>
<td>PEI Services</td>
<td></td>
<td>$5,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Name of Firm</th>
<th>Address of Firm</th>
<th>Contact Person</th>
<th>Telephone #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSTANT CARE GROUP</td>
<td>6543 Cesar Chavez Blvd., Los Angeles CA 90032</td>
<td>Constance Constantine</td>
<td>(323) 678-9012</td>
<td>( )</td>
</tr>
<tr>
<td>Name or Contract No.</td>
<td># of Years / Term of Contract</td>
<td></td>
<td>Type of Service</td>
<td>Dollar Amt.</td>
</tr>
<tr>
<td>PEI #10101</td>
<td>5</td>
<td>PEI Services</td>
<td></td>
<td>$7,500</td>
</tr>
</tbody>
</table>
**REQUIRED FORMS - EXHIBIT 7**

**PROSPECTIVE PROPOSER LIST OF CONTRACTS**

Proposer's Name: **XYZ Care Group**

List of all public entities for which the Proposer has provided service within the last three (3) years. Refer to Section 2.7.3 of the RFSQ. Use additional sheets if necessary.

<table>
<thead>
<tr>
<th></th>
<th>Name of Firm</th>
<th>Address of Firm</th>
<th>Contact Person</th>
<th>Telephone #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PEI #23232</td>
<td>1001 3rd Street, Santa Monica, CA 92000</td>
<td>Sally Surfer</td>
<td>(323) 232-3223</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Amounts are not to exceed $15,000.**
# REQUIRED FORMS - EXHIBIT 8
## PROSPECTIVE PROPOSER LIST OF TERMINATED CONTRACTS

**Proposer's Name:** XYZ Care Group

List all contracts that have been terminated within the past three (3) years. Use additional sheets if necessary.

<table>
<thead>
<tr>
<th>Name of Firm</th>
<th>Address of Firm</th>
<th>Contact Person</th>
<th>Telephone #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carefully Caring</td>
<td>800 Firestone Blvd, Downey CA 90240</td>
<td>Karen Karsten</td>
<td>(310) 222-2222</td>
<td>(      )</td>
</tr>
<tr>
<td>Name or Contract No.</td>
<td>Reason for Termination:</td>
<td>Contract expired</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEI #47474</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Firm</th>
<th>Address of Firm</th>
<th>Contact Person</th>
<th>Telephone #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Anthony</td>
<td>3333 Atlantic Blvd, Monterey Park, CA 94000</td>
<td>Reverend Lovejoy</td>
<td>(213) 676-6677</td>
<td>(      )</td>
</tr>
<tr>
<td>Name or Contract No.</td>
<td>Reason for Termination:</td>
<td>Contract expired</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEI #66776</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Firm</th>
<th>Address of Firm</th>
<th>Contact Person</th>
<th>Telephone #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name or Contract No.</td>
<td>Reason for Termination:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Firm</th>
<th>Address of Firm</th>
<th>Contact Person</th>
<th>Telephone #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name or Contract No.</td>
<td>Reason for Termination:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Firm</th>
<th>Address of Firm</th>
<th>Contact Person</th>
<th>Telephone #</th>
<th>Fax #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name or Contract No.</td>
<td>Reason for Termination:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
REQUIRED FORMS - EXHIBIT 9
ATTESTATION OF WILLINGNESS TO CONSIDER GAIN/GROW PARTICIPANTS

As a threshold requirement for consideration for contract award, Proposer shall demonstrate a proven record for hiring GAIN/GROW participants or shall attest to a willingness to consider GAIN/GROW participants for any future employment opening if they meet the minimum qualifications for that opening. Additionally, Proposer shall attest to a willingness to provide employed GAIN/GROW participants access to the Proposer’s employee mentoring program, if available, to assist these individuals in obtaining permanent employment and/or promotional opportunities.

To report all job openings with job requirements to obtain qualified GAIN/GROW participants as potential employment candidates, Proposer shall email: GAINGROW@DPSS.LACOUNTY.GOV and BSERVICES@WDACS.LACOUNTY.GOV.

Proposers unable to meet this requirement shall not be considered for contract award.

Proposer shall complete all of the following information, sign where indicated below, and return this form with any resumes and/or fixed price bid being submitted:

A. Proposer has a proven record of hiring GAIN/GROW participants.

☐ YES (subject to verification by County) ☑ NO

B. Proposer is willing to provide DPSS with all job openings and job requirements to consider GAIN/GROW participants for any future employment openings if the GAIN/GROW participant meets the minimum qualifications for the opening. “Consider” means that Proposer is willing to interview qualified GAIN/GROW participants.

☑ YES ☐ NO

C. Proposer is willing to provide employed GAIN/GROW participants access to its employee-mentoring program, if available.

☐ YES ☐ NO ☑ N/A (Program not available)

Proposer Organization: XYZ Care Group

Signature: Roger Xylophone

Print Name: Roger Xylophone

Title: Chief Executive Officer Date: 3/3/2020

Telephone No.: (323) 123-4567 Fax No.: (323) 987-6543
REQUIRED FORMS - EXHIBIT 10
COUNTY OF LOS ANGELES PROPOSER EMPLOYEE JURY SERVICE PROGRAM
CERTIFICATION FORM AND APPLICATION FOR EXCEPTION

The County's solicitation for this Request for Statement of Qualifications is subject to the County of Los Angeles Proposer Employee Jury Service Program (Program), Los Angeles County Code, Chapter 2.203. All Proposers must complete this form to either certify compliance or request an exception from the Program requirements. Upon review of the submitted form, the County department will determine, in its sole discretion, whether the Proposer is given an exemption from the Program.

Company Name: XYZ Care Group
Company Address: 6543 Sunset Blvd.
City: Los Angeles State: CA Zip Code: 90020
Telephone Number: (323) 123-4567
RFSQ - MHSA (RFSQ No. DMH030719B1)

If you believe the Jury Service Program does not apply to your business, check the appropriate box in Part I (attach documentation to support your claim); or, complete Part II to certify compliance with the Program. Whether you complete Part I or Part II, please sign and date this form below.

Part I: Jury Service Program is Not Applicable to My Business
☐ My business does not meet the definition of "proposer," as defined in the Program, as it has not received an aggregate sum of $50,000 or more in any 12-month period under one or more County contracts or subcontracts (this exception is not available if the contract itself will exceed $50,000). I understand that the exception will be lost and I must comply with the Program if my revenues from the County exceed an aggregate sum of $50,000 in any 12-month period.
☐ My business is a small business as defined in the Program. It 1) has ten or fewer employees; and, 2) has annual gross revenues in the preceding twelve months which, if added to the annual amount of this contract, are $500,000 or less; and, 3) is not an affiliate or subsidiary of a business dominant in its field of operation, as defined below. I understand that the exception will be lost and I must comply with the Program if the number of employees in my business and my gross annual revenues exceed the above limits.

"Dominant in its field of operation" means having more than ten employees and annual gross revenues in the preceding twelve months, which, if added to the annual amount of the contract awarded, exceed $500,000.

"Affiliate or subsidiary of a business dominant in its field of operation" means a business which is at least 20 percent owned by a business dominant in its field of operation, or by partners, officers, directors, majority stockholders, or their equivalent, of a business dominant in that field of operation.

☐ My business is subject to a Collective Bargaining Agreement (attach agreement) that expressly provides that it supersedes all provisions of the Program.

OR

Part II: Certification of Compliance
☒ My business has and adheres to a written policy that provides, on an annual basis, no less than five days of regular pay for actual jury service for full-time employees of the business who are also California residents, or my company will have and adhere to such a policy prior to award of the contract.

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

Print Name: Roger Xylophone
Title: Chief Executive Officer
Signature: Roger Xylophone
Date: 3/3/2020

LAC-DMH – RFSQ No. DMH030719B1 – MHSA
REQUIRED FORMS
REQUIRED FORMS - EXHIBIT 11
CHARITABLE CONTRIBUTIONS CERTIFICATION

XYZ Care Group

Company Name

6543 Sunset Blvd., Los Angeles CA 90020

Address

31-9988776

Internal Revenue Service Employer Identification Number

California Registry of Charitable Trusts "CT" number (if applicable)

The Nonprofit Integrity Act (SB 1262, Chapter 919) added requirements to California’s Supervision of Trustees and Fundraisers for Charitable Purposes Act which regulates those receiving and raising charitable contributions.

Check the Certification below that is applicable to your company.

☑ Proposer has examined its activities and determined that it does not now receive or raise charitable contributions regulated under California’s Supervision of Trustees and Fundraisers for Charitable Purposes Act. If Proposer engages in activities subjecting it to those laws during the term of a County contract, it will timely comply with them and provide County a copy of its initial registration with the California State Attorney General’s Registry of Charitable Trusts when filed.

☑ Proposer is registered with the California Registry of Charitable Trusts under the CT number listed above and is in compliance with its registration and reporting requirements under California law. Attached is a copy of its most recent filing with the Registry of Charitable Trusts as required by Title 11 California Code of Regulations, sections 300-301 and Government Code sections 12585-12586.

Roger Xylophone

Signature

3/3/2020

Date

Roger Xylophone, Chief Executive Officer

Name and Title of Signer (please print)

LAC-DMH – RFSQ No. DMH030719B1 – MHSA
REQUIRED FORMS
REQUIRED FORMS - EXHIBIT 12
CERTIFICATION OF COMPLIANCE WITH THE COUNTY'S DEFRAULTED PROPERTY TAX REDUCTION PROGRAM

<table>
<thead>
<tr>
<th>Company Name:</th>
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</thead>
<tbody>
<tr>
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</tr>
<tr>
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<tr>
<td>State:</td>
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</tr>
<tr>
<td>Zip Code:</td>
<td>90020</td>
</tr>
<tr>
<td>Telephone Number:</td>
<td>(323) 123-4567</td>
</tr>
<tr>
<td>Email address:</td>
<td><a href="mailto:xyzcaregroup@xyzcaregroup.org">xyzcaregroup@xyzcaregroup.org</a></td>
</tr>
<tr>
<td>RFSQ - MHSA (RFSQ No. DMH030719B1)</td>
<td></td>
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</tbody>
</table>

The Proposer certifies that:

☑️ It is familiar with the terms of the County of Los Angeles Defaulted Property Tax Reduction Program, Los Angeles County Code Chapter 2.206; AND

To the best of its knowledge, after a reasonable inquiry, the Proposer is not in default, as that term is defined in Los Angeles County Code Section 2.206.020.E, on any Los Angeles County property tax obligation; AND

The Proposer agrees to comply with the County's Defaulted Property Tax Reduction Program during the term of any awarded contract.

- OR -

☐ I am exempt from the County of Los Angeles Defaulted Property Tax Reduction Program, pursuant to Los Angeles County Code Section 2.206.060, for the following reason:

________________________________________________________________________

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

<table>
<thead>
<tr>
<th>Print Name:</th>
<th>Roger Xylophone</th>
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<tbody>
<tr>
<td>Title:</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Signature:</td>
<td>__________________________</td>
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REQUIRED FORMS - EXHIBIT 13
ZERO TOLERANCE POLICY ON HUMAN TRAFFICKING
CERTIFICATION

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RFSQ - MHSA (RFSQ No. DMH030719B1)

PROPOSER CERTIFICATION

Los Angeles County has taken significant steps to protect victims of human trafficking by establishing a zero tolerance policy on human trafficking that prohibits proposers found to have engaged in human trafficking from receiving contract awards or performing services under a County contract.

Proposer acknowledges and certifies compliance with Section 8.53 (Compliance with County's Zero Tolerance Policy on Human Trafficking) of the proposed Contract and agrees that proposer or a member of his staff performing work under the proposed Contract will be in compliance. Proposer further acknowledges that noncompliance with the County's Zero Tolerance Policy on Human Trafficking may result in rejection of any proposal, or cancellation of any resultant Contract, at the sole judgment of the County.

I declare under penalty of perjury under the laws of the State of California that the information herein is true and correct and that I am authorized to represent this company.

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<th>Roger Xylophone</th>
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REQUIRED FORMS - EXHIBIT 14

COMPLIANCE WITH FAIR CHANCE EMPLOYMENT HIRING PRACTICES CERTIFICATION

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RFSQ - MHSA (RFSQ No. DMH030719B1)

PROPOSER CERTIFICATION

The Los Angeles County Board of Supervisors approved a Fair Chance Employment Policy in an effort to remove job barriers for individuals with criminal records. The policy requires businesses that contract with the County to comply with fair chance employment hiring practices set forth in California Government Code Section 12952, Employment Discrimination: Conviction History (California Government Code Section 12952), effective January 1, 2018.

Proposer acknowledges and certifies compliance with fair chance employment hiring practices set forth in California Government Code Section 12952 and agrees that proposer and staff performing work under the Contract will be in compliance. Proposer further acknowledges that noncompliance with fair chance employment practices set forth in California Government Code Section 12952 may result in rejection of any proposal, or termination of any resultant Contract, at the sole judgment of the County.

I declare under penalty of perjury under the laws of the State of California that the information herein is true and correct and that I am authorized to represent this company.

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<tbody>
<tr>
<td>Roger Xylophone</td>
<td>3/3/2020</td>
</tr>
</tbody>
</table>
Section C – Attestation of Insurability
ATTESTATION OF INSURABILITY

March 3, 2020

XYZ Care Group (XYZ), through its Chief Executive Officer, Roger Xylophone, attests that XYZ will comply with the insurance requirements contained in Appendix H – Sample Master Agreement, subparagraph 8.22 and that XYZ shall procure, maintain, and provide to the County proof of insurance coverage for all the programs of insurance along with associated amounts specified in Appendix H – Sample Master Agreement, subparagraph 8.23 and 8.24 should XYZ be awarded a contract through a Request for Service or Work Order Solicitation.

I hereby state and affirm that the foregoing attestation is true and correct.

Roger Xylophone  3/3/2020
Roger Xylophone
Chief Executive Officer
Section D – Proof of Licenses
INCLUDE ALL APPLICABLE LICENSES