City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

Substance use Treatment Provider Network FY-2019 Application Packet

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City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

PROVIDER APPLICATION INSTRUCTIONS

Purpose

The Behavioral Health and Wellness Division is accepting applications to become a City of Albuquerque Substance Use Treatment Provider for FY-2019. It is the intent of the City to continue the development of a Substance Use Treatment Network able to provide high quality, ethical, comprehensive, and evidence-based substance use treatment. The City desires to develop a full continuum of treatment services and ensure that all agencies are clinically appropriate and culturally relevant to meet the needs of those in treatment.

The Behavioral Health and Wellness Division has an open application process to become a member of the City's Substance Use Treatment Provider Network. Only applicants scoring 160 points or above will be considered for a contract. *Agencies currently contracting with the City to provide substance use treatment who score less than 160 will not be eligible to reapply until the next fiscal year (FY-2020), and will need to submit a plan of action to their assigned program specialist detailing how current clients will be transitioned to other voucher agencies to continue their treatment beyond June 30, 2018.* The Department reserves the right to refuse to proceed with the development of a contract at any time if it is in the best interest or convenience of the City.

At the discretion of the City, applications that received a score of 180 or above in Fiscal Years 2017 or 2018 and have had acceptable monitoring visits may only need to complete the Re-Application for FY-2019.

The City will not issue a contract for FY-2019 to any agency with outstanding debt(s) to the City.

Application Forms and Instructions

There is one application for both Adult and Adolescent substance use treatment services. Please mark the appropriate box on the application. In developing your application, be sure to answer **all** questions with **complete** and **thorough** responses.

Applications must be in 12-point font. Each narrative response should be concise, complete, and must not exceed **three (3) single sided pages** in length. Do not delete questions from the application. Provide your answers below the question. To expedite handling, number and collate and **do not** use comb binding. Three ring binders and tabs are acceptable. Appendices or non-required attachments including letters of endorsement, agency brochures, or news clips may be included if copied onto 8 1/2" x 11" paper.

Application Review

Applications will be reviewed by the Behavioral Health and Wellness Division based on the criteria in the table below. A Technical Review will be conducted prior to scoring: Incomplete applications or applications missing documentation may be deemed nonresponsive. A minimum score of 160 is required to be eligible to receive a contract for FY-2019.

Criteria	Maximum Score: Current Providers	Maximum Score: New Providers
Technical Review	25	25
Past Performance	20	NA
Substance Use Treatment Program	60	70
Clinical Supervision/Staff Credentials	20	25
Case Management Services	20	20
Vouchered Services	15	15
Service Mix and ASAM Criteria	40	45

City of Albuquerque
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Provider Application Guides

Please refer to the ***Albuquerque Minimum Standards for Substance Use Treatment,* the *Administrative Requirements for Contracts Awarded under the City of Albuquerque***, and the additional information contained within this FY-2019 Application Packet prior to developing your Applications responses.

Submitting Your Application

Submit one complete original application, including all required attachments. Also submit 5 copies of the application, Appendix, and group schedule. Both the complete original and 5 copies are required for the application to be considered a complete submission. Label the application as **Substance Use Treatment Provider Network Application – FY-2019**. Label one "ORIGINAL" and the other five as "COPY". Please number and collate. **Do not** use comb binding. Three ring binders and tabs are acceptable. Applications must be submitted to the Behavioral Health and Wellness Division and received no later than **4:00 p.m., Friday, June 22, 2018. Applications received after that date and time may not be reviewed until after September 1, 2018.** Mail or hand-deliver your Application Package to the appropriate address shown below:

Hand Deliver:	**Mailing Address:**
City of Albuquerque Dept. of Family & Community Services Behavioral Health and Wellness Division 400 Marquette Avenue N.W. Fifth Floor ~ Room 504 Albuquerque, NM 87102 Attn: Sandra Archuleta	City of Albuquerque Dept. of Family & Community Services Behavioral Health and Wellness Division P.O. Box 1293, Room 504 Albuquerque, NM 87103 Attn: Sandra Archuleta

Applications may be posted on the Behavioral Health and Wellness Division website after contracts have been awarded.

ASAM PATIENT PLACEMENT CRITERIA

LEVEL 0.5 – EARLY INTERVENTION

Early Intervention is an organized service designed to explore and address problems that appear to be related to substance use and to help the individual recognize the harmful consequences of inappropriate substance use. This level is appropriate for individuals who demonstrate problems and risk factors that appear to be related to substance use but do not meet the diagnostic criteria for Substance-Related Disorder as defined in the current *Diagnostic and Statistical Manual of Mental Disorders (DSM).*

Length of Service

Length of Service at Level 0.5 varies according to: (a) an individual's ability to understand the information provided and use of that information to make behavior changes and avoid problems related to substance use or (b) the appearance of new problems arise that require treatment at another level of care.

Required Support Systems

Level 0.5 requires the following Support Systems:

1. Referral for ongoing treatment of substance use or dependence;
2. Referral for medical, psychological or psychiatric services, including assessment; or,
3. Provide case management and/or referral to other social service agencies.

Staff

Level 0.5 staff are trained and knowledgeable about biopsychosocial dimensions of substance use and dependence, the recognition of substance related disorders, alcohol and other drug education, motivational counseling, and the legal and personal consequences of inappropriate substance use.

Interventions
Interventions at this level can include individual, group or family counseling, as well as planned educational experiences that focus on helping the individual to avoid harmful or inappropriate substance use.

LEVEL I – OUTPATIENT TREATMENT

Level I encompasses organized outpatient treatment services in which Substance Use Treatment professionals, including addiction-licensed physicians, provide professionally directed evaluation, treatment and recovery services. Such services are provided in regularly scheduled sessions of (usually) fewer than nine contact hours a week in accordance with the City's required Service Mix. The services follow a defined set of policies and procedures or clinical protocols.

Level I services are tailored to each client's level of clinical severity and are designed to help the client achieve changes in substance use behaviors. Treatment must address major lifestyle, beliefs, and behavior patterns that have the potential to undermine the goals of treatment or to impair the individual's ability to cope with major life tasks without the non-medical use of substances.

Level I services are appropriate in several different situations:

- Level I may be the initial level of care for a client whose severity of illness warrants this intensity of treatment. Such a client should be able to complete professionally directed addiction treatment at this level. Level of treatment may change based on (a) an unanticipated event causes a change in his or her level of functioning, leading to a reassessment of the appropriateness of this level of care, or (b) there is recurring evidence of the client's inability to use this level of care (such as repeated episodes of drinking or non-medical drug use even after the treatment plan has been reviewed and revised).
- Level I may represent a "step down" from a more intensive level of care for a client whose progress warrants such a transfer, assuming that he or she meets Level I placement criteria.
- Level I may be used for a client who is in the early stages of change and who is not yet ready to commit to full recovery (Dimension 4 issues). For such a client, placement in a more intensive level of care is apt to lead to increased conflict, passive compliance or even leaving treatment.

The relationship between the severity of illness and the intensity of treatment is more clearly seen in Dimensions 1, 2, and 3. On the other hand, increasing the intensity of services solely because of Dimension 4 issues may be counterproductive. An alternative approach is to use Level I services to engage the resistant individual in treatment. If this approach proves successful, the client may no longer require a higher intensity of service, or may be able to better use such services.

Co-Occurring Mental and Substance Related Disorders

Level I services are appropriate for clients with co-occurring disorders if:

1. The clients' disorders are of *moderate severity* (Dimension 3 is very stable or the client is receiving concurrent mental health monitoring) and clients have responded to more intensive treatment services. The co-occurring disorders have been managed an extent that addiction treatment services are assessed as potentially beneficial. However, ongoing monitoring of the client's mental status is required.
2. The clients' disorders are of *high severity* (Dimension 4 indicates a high resistance to change, but client is stable in the other Dimensions) and persist but have stabilized to such an extent that integrated mental

health and substance use treatment services are assessed and may be beneficial. Clients who have severe and persistent mental illness may not have been able to achieve sobriety or to maintain abstinence for a significant period of time (months); however, they are appropriately placed at Level I because they need engagement strategies and intensive Case Management Services.

Length of Service
Duration of treatment varies with the severity of an individual's substance use and response to treatment.

Required Support Systems
Level I clients require the following support systems:
1. Referral, consultation, or onsite medical, psychiatric, psychological, laboratory and toxicology services. Medical and psychiatric consultation should be available in a time frame appropriate to the severity and urgency of the situation;
2. Direct affiliation with, or close coordination through referral to, more intensive levels of care and medication management, and
3. Emergency services available by telephone 24 hours a day, 7 days a week.

Staff
Level I treatment providers are staffed by appropriately licensed treatment professionals, who assess and treat substance-related disorders. Staff are able to obtain and interpret information regarding the client's biopsychosocial needs, and are knowledgeable about the biopsychosocial dimensions of alcohol and other drug disorders, including assessment of the client's stage of readiness to change. Staff are capable of monitoring stabilized mental health problems and recognizing any instability of clients with co-occurring mental health problems.

Interventions
Interventions at this level involve appropriate treatment services, which may include individual and group counseling, motivational enhancement, Medication Assisted Treatment (MAT), family counseling, educational groups, occupational and recreational therapy, or psychotherapy. If a client has a co-occurring disorder, the use psychotropic medication and mental health treatment and the relationship to substance use are addressed as appropriate.

LEVEL II.I - INTENSIVE OUTPATIENT TREATMENT

Intensive outpatient agencies (IOPs) generally provide nine (9) or more hours of structured programming per week, consisting primarily of counseling and education about substance related and mental health problems. The provider facilitates education and treatment services and encourages clients to utilize acquired skills. Providers have the capacity to arrange for medical and psychiatric consultation, psycho-pharmacological consultation, medication management, and 24-hour crisis services. In addition, providers must have the ability to provide case management and/or refer clients to a higher level of care. If the client is stable and requires only monitoring, psychiatric and medical services are addressed through consultation and referral arrangements. Services provided outside the primary agency must be tightly coordinated.

Beyond the essential services, agencies provide psycho-pharmacological assessment and treatment and have the capacity to effectively treat clients who have complex co-occurring disorders.

Co-Occurring Mental and Substance Related Disorders
Level II.I treatment services are appropriate for clients with co-occurring disorders if:
1. The mental health and addiction treatment services are integrated into the intensive outpatient agency.

2. Clients require active mental health services, which should be delivered through Level II.I Dual Diagnosis Capable or Dual Diagnosis Enhanced Programs.

Length of Service
Duration of treatment varies with the severity of the client's illness and his or her response to treatment.

Required Support Systems
Level II.I requires the following support systems:
1. Referral, consultation, or onsite medical, psychiatric, psychological, laboratory and toxicology services. Medical and psychiatric consultation should be available in a time frame appropriate to the severity and urgency of the situation;
2. Direct affiliation with, or close coordination through referral to, more intensive levels of care and medication management;
3. Emergency services available by telephone 24 hours a day, 7 days a week; and
4. Agencies offering Level II.I services must be staffed to treat clients with co-occurring disorders. Minimum staff licensure requirements are LMHC, LMSW or the equivalent, with the appropriate clinical supervision.

Staff
Level II.I treatment providers are staffed by appropriately licensed treatment professionals, who assess and treat substance related disorders. Staff are able to obtain and interpret information regarding the client's biopsychosocial needs, and are knowledgeable about the biopsychosocial dimensions of alcohol and other drug disorders, including assessment of the client's stage of readiness to change. Staff are capable of and trained to understand the signs and symptoms of mental disorders and to understand and explain the uses of psychotropic medications and their interactions with substance related disorders.

Interventions
Interventions at this level involve appropriate treatment services, which may include individual and group counseling, motivational enhancement, Medication Assisted Treatment (MAT), family counseling, educational groups, occupational and recreational therapy, or psychotherapy. If a client has a co-occurring disorder, the use of psychotropic medication, mental health treatment, and the relationship to substance use are addressed.

REQUIRED SERVICE MIX

EARLY INTERVENTION (LEVEL .5)
Early Intervention/Education level of care is to explore and address problems or risk factors that are related to substance use and to help the client recognize the harmful consequences of inappropriate substance use. Each agency that offers Early Intervention/Education needs to use an established and recognized curriculum. Services are intended to run at least 90 days in length for the average client. Each agency serving clients appropriate for Level .5 should, *at a minimum,* adhere to the following:

1. **Initial Service Plan.** Each client shall have an initial service plan created at the time of intake**.** The service plan shall be reviewed, signed, and dated by the client, counselor and clinical supervisor. The client must be provided with an Initial Service Plan within 30 calendar days of intake and updated as clinically indicated.
2. **Early Intervention Session.** Each client shall participate in a minimum of one education group per week, but services are not limited to education groups. If fewer sessions are clinically indicated for a client, this must be justified and documented in the client's record.

3. **Case Management Services.** Each client shall have access, as clinically indicated, to appropriate education, vocational, health, and social services as indicated through the ASA, and Initial Service Plan. If a client is in need of Case Management, as evidenced by the ASA and Initial Service Plan, the agency must provide the non-counseling services on site, or through facilitated referrals. Services and/or facilitated referrals shall be documented in accordance with the Minimum Standards.
4. **Discharge Planning.** The agency must demonstrate Discharge Planning has occurred with clients prior to termination of treatment to put closure on the treatment process and plan for Aftercare support needed to maintain stability and sobriety. Services are provided by the agency after the voucher has expired, including Aftercare, as necessary.
5. **Discharge Summary.** The agency shall complete a Discharge Summary for each client upon discharge from Early Intervention Services.

OUTPATIENT TREATMENT (LEVEL I)

Provide individual, group or family counseling for an average period of 90 to120 days that address major lifestyle, beliefs, and behavioral patterns that have the potential to result in addiction or substance use or to impair the individual's ability to cope with major life tasks without the non-medical use of substances. Services are provided in regularly scheduled sessions of usually fewer than nine (9) contact hours per week, but not less than once a week. If fewer or more sessions are clinically indicated for a client, this must be justified and documented in the client's record. Each agency serving clients appropriate for Level I should, *at a minimum,* adhere to the following:

1. **Treatment Plan.** An Individualized Treatment Plan shall be developed within 30 calendar days of intake. The Treatment Plan shall be reviewed and signed by the client, counselor, and clinical supervisor. The Treatment Plan shall be reviewed, updated and signed by client, counselor, and clinical supervisor not less than quarterly.
2. **Counseling Session.** Each client shall participate in a minimum of one individual, group or family counseling session not less than once a week, with a minimum of two individual sessions per month. If fewer sessions are clinically indicated for a client, this must be justified and documented in the client's record.
3. **Case Management Services.** Each client shall have access, as clinically indicated, to appropriate education, vocational, health, and social services as indicated through the ASA, Individualized Treatment Plan, and Case Management assessment and/or service plan. If a client is in need of Case Management, the agency must provide the non-counseling services on site, or through facilitated referrals. Services and/or facilitated referrals shall be documented in accordance with the Minimum Standards.
4. **Discharge Planning.** The agency must demonstrate Discharge Planning has occurred with clients prior to termination of treatment to put closure on the treatment process and plan for Aftercare support needed to maintain stability and sobriety. Services are provided by the agency after the voucher has expired, including Aftercare, as necessary.
5. **Discharge Summary.** The agency shall complete a Discharge Summary for each client upon discharge from treatment.

INTENSIVE OUTPATIENT TREATMENT AGENCIES (LEVEL II.I)

Provide individual, group or family counseling and education about substance-related and mental health problems, with an intensity of nine (9) or more hours of structured programming being offered per week and the client receiving six (6) or more hours of services per week, and a frequency of not less than three (3) times per

week for an average of 60 days; once the client reaches the point that Level II.I services are no longer appropriate, the change in service level must be documented in the client's record. Level II.I services have the capacity to arrange for medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24-hour crisis services. The client's needs for psychiatric and medical services are addressed through consultation and referral arrangements if the client is stable and requires only maintenance monitoring. Level II.I agencies must have licensed mental health clinicians on staff or contract to see Level II.I clients. If fewer or more sessions are clinically indicated for a client, this must be justified and documented in the client record.

1. **Staffing.** Agencies offering Level II.1 services must be staffed to treat clients with co-occurring disorders. Minimum staff licensure requirements are LMHC, LMSW or the equivalent, with the appropriate clinical supervision.
2. **Treatment Plan.** An individualized Treatment Plan shall be developed within 30 calendar days of admission. For Level II.1 clients the treatment plan shall be reviewed, and signed, by the client, counselor, and clinical supervisor. The Treatment Plan shall be reviewed, updated and signed by the counselor, client and clinical supervisor not less than quarterly.
3. **Counseling Session.** Each client shall participate in a minimum of one individual, group or family Counseling Session three times per week, with a minimum of one (1) individual session per week, and two (2) group sessions per week. If fewer sessions are clinically indicated for a client, this must be justified and documented in the client record.
6. **Case Management Services.** Each client shall have access, as clinically indicated, to appropriate education, vocational, health, and social services as indicated through the ASA, Individualized Treatment Plan, and Case Management assessment and/or service plan. If a client is in need of Case Management, the agency must provide the non-counseling services on site, or through facilitated referrals. Services and/or facilitated referrals shall be documented in accordance with the Minimum Standards.
4. **Discharge Planning.** The agency must demonstrate Discharge Planning has occurred with clients prior to termination of treatment to put closure on the treatment process and plan for Aftercare support needed to maintain stability and sobriety. Services are provided by the agency after the voucher has expired, including Aftercare, as necessary.
5. **Discharge Summary.** The agency shall complete a Discharge Summary for each client upon discharge from treatment.

City of Albuquerque
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APPLICATION CHECKLIST

Agency Name:_____

Submit this completed checklist with the Application. If you are not submitting all items on this checklist, indicate "N/A" on the line next to the number. **All lines must be completed.**

____1. Signed Application Summary and Certification Form.

____2. One original Application and applicable appendix.

____3. Five copies of the Application, appendix and group schedule.

____4. Insurance Certificates. See Insurance Coverage Instructions. Pages 15-16.
- All agencies not covered by New Mexico Tort Claims Act shall provide original certificates of insurance.
- On the Certificate of Liability Insurance, list the "City of Albuquerque" as Additional Insured, in the Description of Operations box
- Identify "Risk Manager, City of Albuquerque" as the certificate holder.
- Indicate 30 days for the Cancellation Notice.

____5. Registration Certificate from the New Mexico Taxation and Revenue Department or, proof of an exemption from payment of Federal Income Tax pursuant to the Internal Revenue Code of 1954 [26 U.S.C. Section 501(c)(3)] must be included in the Application.

____6. Copies of all applicable business licenses including, but not limited to, current City of Albuquerque Business Registration license, etc.

____7. Verification of Substance Use licensure for all current clinical staff/contractors in compliance with the State of New Mexico Substance Use Counselor Act, chapter 61, Laws of 1996, HB 790: Article 9A of the New Mexico Counseling and Therapy Practice Act: section 61-9A-14.2 Substance Use Intern, requirements for licensure; 61-9A-14.3 Alcohol and drug use counselor, requirements for licensure; and 61-9A-16 Temporary licensure.

____8. A letter of assurance regarding current compliance with all applicable rules and regulations of the Americans with Disabilities Act of 1990, PL 101-336 (42 U.S.C. Section 12101, et seq.) See http://www.ada.gov and http://www.access-board.gov and Section 504 of the Rehabilitation Act (29 U.S.C. Section 794) https://www.hhs.gov/sites/default/files/knowyourrights504adafactsheet.pdf for additional information.

____9. Certification of Non-Profit Incorporation.

____10. Articles of Incorporation.

____11. Current By-laws.

____12. List of Current Board Members (Non-profit and government agencies only).

____13. Organization Chart.

____14. Accounting Policies and Procedures. Clearly identify agency's billing and filing procedures.

____15. Personnel Policies and Procedures.

____16. Operating Standards/Program Policies and Procedures.

____17. Conflict of Interest Statement (Non-Profit Only).

____18. Certificate of Good Standing.

____19. HIPAA Compliant Confidentiality Policies.

____20. Completed W-9. See page 11 or http://www.cabq.gov/dfa/onlineservices/modified-w9-supplier-form.

____21. Drug-Free Workplace Statement. Attached.

____22. Copies of clinical supervisor's workshop attendance as required by State Regulations. See http://www.nmcpr.state.nm.us/nmac/parts/title16/16.027.0019.htm for additional information.

____23. Copy of Clinical Supervision.

____24. Signed copy of Certification of Receipt of *Minimum Standards* and *Administrative Requirements.* Page 21.

____25. Copy of Group Schedule offered at agency.

____26. Provide evidence of additional funding sources to support Question 13 of the Application.

____27. Copy of sliding fee schedule if applicable.

____28. Completed Application Checklist.

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

CITY OF ALBUQUERQUE

Substitute W-9 & Supplier Information Form

SECTION 1

NAME (as shown on your income tax return). Name is required on this line; do not leave this line blank.

BUSINESS NAME/ disregarded entity name, if different from above.

PRIMARY ADDRESS (number, street, and apt or suite no)	**REMITTANCE ADDRESS** (number, street, and apt or suite no)
CITY, STATE, and ZIP CODE	**CITY, STATE, and ZIP**
PHONE	

SOCIAL SECURITY NUMBER OR **EMPLOYER IDENTIFICATION NUMBER** **New Mexico CRS TAX ID (if applicable)**

TAX CLASSIFICATION (check only one)

- ☐ INDIVIDUAL/SOLE PROPRIETOR or single-member LLC
- ☐ C CORPORATION
- ☐ S CORPORATION
- ☐ PARTNERSHIP
- ☐ TRUST/ESTATE
- ☐ LIMITED LIABILITY COMPANY– Enter the tax classification (C=C Corporation, S=S Corporation, P=Partnership) _____

→ Note: For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single- member owner.

- ☐ Other (see instructions)

EXEMPTIONS (codes apply to certain entities, not individuals; see instructions)

EXEMPT PAYEE CODE (if any) _____

EXEMPTION FROM FATCA REPORTING CODE (if any) _____

CERTIFICATION

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined in the instructions); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because of underreporting interest or dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.

The Internal Revenue Service does not require your consent to any provision on this document other than the certifications required to avoid backup withholding.

SIGNATURE of U.S. person	**DATE**
PRINT NAME	**TITLE**

SECTION 2: BUSINESS DEMOGRAPHICS

Please select all that apply:

☐ **Local Business** - Maintains its principal office and place of business within the Greater Albuquerque Metropolitan Area (City of Albuquerque or Bernalillo County) and ownership resides 51% here.

☐ **Doing Business Locally** - Does not maintain its principal office here, but maintains a storefront in the Greater Albuquerque Area and employs one or more Albuquerque residents.

☐ **Neither of the Above Apply**

Please provide a 6-digit **NAICS Code:** ___ ___ ___ ___ ___ ___
(See below for more information)

Please select all that apply:

☐ **MBE** - Minority Business Enterprise Owned (at least 51% owned and controlled by one or more minorities or, in the case of a publicly-owned business, at least 51% of the stock of which is owned by one or more minorities).

If your business is minority owned, please specify the race of minority owner(s):

- ☐ % American Indian or Alaska Native
- ☐ % Asian
- ☐ % Black or African American
- ☐ % Hispanic
- ☐ % Native Hawaiian or Other Pacific Islander
- ☐ % White

If your business is woman owned, specify the % of female owner(s):

- ☐ % Female

PURCHASE ORDERS DELIVERY (COMPLETE ONLY IF YOU ACCEPT POs)
PLEASE CHECK ONE OF THE BOXES UNDER INVOICE SUBMISSION FOR METHOD OF PURCHASE ORDER DELIVERY

INVOICE SUBMISSION (please check one)	Provide a "Remit to" Email Address:	PO (Contact Information, Full Name and Position)
☐ Electronic – Transcepta		
☐ Electronic - Email	Provide an "Order From" Email Address:	

Please return completed document to: City of Albuquerque Purchasing Division, PO Box 1293, Albuquerque, NM 87103

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

W-9 Instructions

Section 1- Supplier Information

Information on how to fill-out Section 1 can be found at: https://www.irs.gov/pub/irs-pdf/fw9.pdf

Section 2 – Business Demographics

A. Select all for which the business has self-certified or for which it believes it is eligible.
B. The Greater Albuquerque Metropolitan Area includes all locations within the City of Albuquerque and Bernalillo County.
C. A local business is a business with its principal office and place of business in the Greater Albuquerque Metropolitan Area.
D. A principal office is the main or home office of the business as identified in tax returns, business licenses and other official business documents.
E. A place of business is a location where the business conducts its daily operations, for the general public, if applicable.
F. Minority is defined to include Hispanic Americans, Black Americans, Native Americans, Asian-Pacific Americans, Asian-Indian Americans, Female, or belonging to groups found to be economically and socially disadvantaged by the U.S. Small Business Administration.

The State of New Mexico and the U.S. Federal Government have their own certification programs. State of New Mexico Certifications Include: State Resident Business; State Resident Contractor; Resident Veteran Business; and Resident Veteran Contractor. More information can be found at:

http://www.tax.newmexico.gov/Businesses/in-state-veteran-preference-certification.aspx

Federal Certifications include: SBE (Small Business Enterprise with SBA); MBE (Minority Business Enterprise); WBE (Women Business Enterprise); VOSB (Veteran-Owned Small Business). More information can be found at: www.sba.gov

Section 3- Purchase Order Acceptance

A. To obtain purchase orders and procurement contracts electronically, suppliers must provide a current e-mail address. Please selected one of the boxes under **INVOICE SUBMISSION** for Purchase Order delivery method. Purchase order can be sent via email address or through Transcepta.

B. Transcepta, is an electronic purchase order and invoicing system that delivers purchase orders from the City to suppliers and in turn, receives inbound invoices, purchase order acknowledgements and advance shipping notices from City suppliers. Transcepta also provides a portal for suppliers to check document processing. To participate in Transcepta follow the instructions at http://connect.transcepta.com/abq/

C. NAICS stands for the North American Industry Classification System (NAICS) is the standard used by Federal statistical agencies in classifying business establishments for the purpose of collecting, analyzing, and publishing statistical data related to the U.S. business economy. More information about the NAICS industry codes can be found at http://www.census.gov/eos/www/naics/

Please return completed document to:

City of Albuquerque Purchasing Division
PO Box 1293
Albuquerque, NM 87103

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

DRUG-FREE WORKPLACE REQUIREMENT CERTIFICATION FORM

The agency certifies that it will provide a drug-free workplace by:

1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the agency's workplace, and specifying the actions that will be taken against employees for violation of such prohibition;

2. Establishing a drug-free awareness program to inform employees of:
   a. The dangers of drug use in the workplace;
   b. The agency's policy of maintaining a drug-free workplace;
   c. Any available drug counseling, rehabilitation, and employee assistance programs; and
   d. The penalties imposed upon employees for drug use violations occurring in the workplace;

3. Making it a requirement that each employee to be engaged in the performance of an agreement with the City is given a copy of the agency's drug-free workplace statement;

4. Notifying each employer that as a condition of employment under the City's agreement, that employee will:
   a. Abide by the terms of the agency's drug-free workplace statement, and
   b. Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace, no later than five (5) days after such conviction;

5. Notifying the City of Albuquerque, Department of Family & Community Services within ten (10) days after receiving an employee notice or otherwise receiving actual notice of a conviction of an employee for a violation of the drug statute that occurred in the workplace;

6. Taking one of the following actions within thirty (30) days of receiving notice of an employee's drug statute conviction for a violation occurring in the workplace:
   a. Taking personnel action against such an employee, up to and including termination or
   b. Requiring such employee to participate satisfactorily at a drug use assistance or rehabilitation program approved for such purposes by a Federal, State or local health, law enforcement, or other appropriate agency; and

7. Making a good faith effort to continue to maintain a drug-free workplace through the implementation of the above requirements.

8. The agency also certifies that the agency's drug-free workplace requirements will apply to all locations where services are offered under the agreement with the City of Albuquerque. Such locations are identified as follows:

Name of Agency: _____ Street Address: _____
City: _____ State: _____ Zip: _____ E-mail: _____
Typed Name of Authorized Agency Official: _____ Title: _____
Signature of Authorized Agency Official: _____ Date Signed: _____

City of Albuquerque
Department of Family & Community Services
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Cert ID xxxx

ACORD™ CERTIFICATE OF LIABILITY INSURANCE — DATE (MM/DD/YYYY): 1/1/2009

PRODUCER	THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.	
Hudson & Muma, Inc. 4600 Coolidge Highway Royal Oak MI 48072 (248) 549-3519	INSURERS AFFORDING COVERAGE	NAIC #
INSURED	INSURER A: Sample Insurance Company	
Sample Film Producer	INSURER B: Sample Insurance Company	
1111 Thomas Ave Berkeley CA 99999	INSURER C:	
	INSURER D:	
	INSURER E:	

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
B		GENERAL LIABILITY X COMMERCIAL GENERAL LIABILITY CLAIMS MADE [X] OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC	121456789	1/01/2009	1/01/2010	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 50,000 $ 5,000 $ 1,000,000 $ 2,000,000 $ 1,000,000
A		AUTOMOBILE LIABILITY X ANY AUTO ALL OWNED AUTOS SCHEDULED AUTOS X HIRED AUTOS X NON-OWNED AUTOS	23456789	1/01/2009	1/01/2010	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
		GARAGE LIABILITY ANY AUTO				AUTO ONLY - EA ACCIDENT OTHER THAN AUTO ONLY: EA ACC AGG	$ $ $
		EXCESS/UMBRELLA LIABILITY OCCUR CLAIMS MADE DEDUCTIBLE RETENTION $				EACH OCCURRENCE AGGREGATE	$ $ $ $ $
A		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below	34567891	1/01/2009	1/01/2010	X WC STATU-TORY LIMITS / OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 500,000 $ 500,000 $ 500,000
B		OTHER PROPERTY	456789123	1/01/2009	1/01/2010	(see DESCRIPTION if coverage applies to this certificate.)	

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

Sample Certificate Holder is named as Additional Insured and Loss Payee as their interests may appear....

CERTIFICATE HOLDER	CANCELLATION
Sample Certificate Holder 1234 Main Street Royal Oak MI 48073	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES. AUTHORIZED REPRESENTATIVE

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City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

INSURANCE COVERAGE INSTRUCTIONS

The Contractor shall procure and maintain at its expense until final payment by the City for services covered by the Agreement, insurance in the kinds and amounts hereinafter provided with insurance companies authorized to do business in the State of New Mexico, covering all operations under this Agreement, whether performed by it or its agents. Before commencing the Services, the Contractor shall furnish to the City a certificate(s) in a form satisfactory to the City showing that it has complied with this section. All certificates of insurance shall provide thirty (30) days written notice be given to Director, Risk Management Department, City of Albuquerque, P.O. Box 1293, Albuquerque, New Mexico 87103, before a policy is canceled, materially changed, or not renewed. Various types of required insurance may be written in one or more policies. **With respect to all coverages required other than professional liability or workers' compensation, the City shall be named an additional insured.** All coverages afforded shall be primary with respect to operations provided. Kinds and amounts of insurance required are as follows:

A. Commercial General Liability Insurance. A commercial general liability insurance policy with combined limits of liability for bodily injury or property damage as follows:

$1,000,000	Per Occurrence
$1,000,000	Policy Aggregate
$1,000,000	Products Liability/Completed Operations
$1,000,000	Personal and Advertising Injury
$ 50,000	Fire - Legal
$ 5,000	Medical Payments

Said policy of insurance must include coverage for all operations performed for the City by the Contractor, and contractual liability coverage shall specifically insure the hold harmless provisions of this Agreement.

B. Automobile Liability Insurance. An automobile liability policy with liability limits in amounts not less than $1,000,000 combined single limit of liability for bodily injury, including death, and property damage in any one occurrence. Said policy of insurance must include coverage for the use of all owned, non-owned, hired automobiles, vehicles and other equipment both on and off work.

C. Workers' Compensation Insurance. Workers' Compensation Insurance for its employees in accordance with the provisions of the Workers' Compensations Act of the State of New Mexico. If you are not required to carry Workers' Compensation coverage, you will need to sign and return the Worker's Comp Statement enclosed in this packet.

D. Professional Liability: Professional liability shall be maintained for all staff providing substance use services in an amount not less than $1,000,000 combined single limit of liability per occurrence with a general aggregate of $1,000,000.

E. Increased Limits. If, during the term of this Agreement, the City requires the Contractor to increase the maximum limits of any insurance required herein, an appropriate adjustment in the Contractor's compensation will be made.

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

INSURANCE COVERAGE INSTRUCTIONS-continued

The Behavioral Health and Wellness Division must have original certificates for all Comprehensive, General Liability, Auto and Property Insurance, Workers' Compensation, and Professional Liability. Workers' Compensation coverage can be noted on the same certificate as other insurance, or on a separate form. Have your agent mail the certificates to the **Department of Family & Community Services, Attn: Behavioral Health and Wellness Division, P.O. Box 1293, Albuquerque, NM 87103** so that we may attach the certificates to the final contracts for processing. The Risk Manager shall be named the certificate holder.

For your reference page 14 is a sample certificate that is acceptable. Please use this as a guide when submitting your certificate of insurance. Submission of insurance certificates properly completed will expedite the processing of your contract.

Contractors funded through the Department of Family and Community Services must have current Certificates of Insurance on file with the City.

If you have any questions, please contact the Behavioral Health and Wellness Division at (505) 768-2865.

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

CERTIFICATION OF WORKERS' COMPENSATION APPLICABILITY

I, _____, hereby certify that I employ less than three employees and/or contractors and am therefore not subject to the provisions of the Workers' Compensation Act of the State of New Mexico. I further certify that should I employ three or more persons during the term of my contract with the City, I will comply with the provisions of the New Mexico Workers' Compensation Act and provide proof of such compliance to the City of Albuquerque.

Name of Agency: _____

Typed Name of Authorized Official of the Agency: _____

Title: _____

Signature: _____ Date Signed: _____

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

WAIVER OF AUTOMOBILE INSURANCE REQUEST

I,_____ hereby certify that neither I, nor employees or contractors employed by this agency, use vehicles in other than a commuting capacity. I further certify that should I, or any employees or contractors employed by this agency, use vehicles in any manner other than a commuting capacity, the agency will comply with the City of Albuquerque's Automobile Insurance requirements.

Name of Agency: _____

Typed Name of Authorized Official of the Agency: _____

Title: _____

Signature: _____ Date Signed: _____

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

REPRESENTATIONS AND CERTIFICATIONS

The undersigned HEREBY GIVE ASSURANCE THAT:

The applicant agency named below will comply and act in accordance with all Federal laws and Executive Orders relating to the enforcement of civil rights, including but not limited to, Federal Code, Title 5, USCA 7142, Sub-Chapter 11, Anti-discrimination in Employment, and Executive Order number 11246, Equal Opportunity in Employment; and

The applicant agency named below will comply with all New Mexico State Statutes and City Ordinances regarding enforcement of civil rights; and

No funds awarded as a result of this request will be used for sectarian religious purposes, specifically that (a) there shall be no religious test for admission for services; (b) there shall be no requirement for attendance of religious services; (c) there shall be no inquiry as to a client's religious preference or affiliations; (d) there shall be no proselytizing; and (e) services provided shall be essentially secular, however, eligible activities, as determined by the fund source, and inherently religious activities may occur in the same structure so long as the religious activity is voluntarily and separated in time and/or location.

Name of Agency: _____

Typed Name of Authorized Official of the Agency: _____

Title: _____

Signature: _____ Date Signed: _____

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

DEBARMENT, SUSPENSION, INELIGIBILITY AND EXCLUSION CERTIFICATION

I certify that the agency has not been debarred, suspended or otherwise found ineligible to receive funds by any agency of the executive branch of the federal government.

I further certify that should any notice of debarment, suspension, ineligibility or exclusion be received by the agency, the City of Albuquerque, Department of Family & Community Services will be notified immediately.

Name of Agency: _____

Typed Name of Authorized Official of the Agency: _____

Title: _____

Signature: _____ Date Signed: _____

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

CERTIFICATION OF RECEIPT OF
MINIMUM STANDARDS AND ADMINISTRATIVE REQUIREMENTS

The undersigned HEREBY CERTIFY THAT:

1. The agency/organization has been made aware that the ***Albuquerque Minimum Standards for Substance Use Treatment and Prevention Services***, *Department of Family and Community Services, Division of Health & Human Services, revised January 2009*, can be viewed at: https://www.cabq.gov/family/documents/minimumstandardsfy09final.pdf/view

2. The agency named below will adhere to the *Minimum Standards* in its operation of City-funded programs;

3. The agency/organization has been made aware that the ***Administrative Requirements for Contracts Awarded Under the City of Albuquerque***, *Department of Family and Community Services, issued September 2010*; can be viewed and downloaded at: http://www.cabq.gov/family/documents/AdminRequirementsSept2010FINAL.pdf

4. The agency/organization named below will adhere to the *Administrative Requirements* in its operation of City-funded programs.

Name of Agency: _____

Typed Name of Authorized Official of the Agency: _____

Title: _____

Signature: _____ Date Signed: _____

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

ALBUQUERQUE PAY EQUITY INITIATIVE FORMS & INSTRUCTIONS

Information about the Albuquerque Pay Equity Initiative
Businesses seeking new contracts with the City of Albuquerque will be required to comply with the requirements of City Ordinance 13-59.

- Download the Pay Equity Employee Data spreadsheet
- Download instructions on how to fill out the Pay Equity Employee Data Spreadsheet
- Download instructions (with visuals) on how to fill out the Pay Equity Employee Data Spreadsheet
- View the Preference Certification flow chart
- View Ordinance 17-33
- View Ordinance 15-47
- View Ordinance 13-59

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

APPLICATION SUMMARY AND CERTIFICATION FORM

1. Agency Name:

2. Mailing Address (Include City, State, & Zip Code)	3. Agency Contact & Telephone Number

4. City Program Name:
Substance Use Treatment Provider Network

5. Due Date:	6. Date Submitted:
XXXXXX for priority status	

7. Title of Applicant's Project and Brief Description:

---

8. Certification: It is understood and agreed by the undersigned that: 1) Any funds awarded as a result of this request are to be expended for the purposes set forth herein and in accordance with all applicable Federal, State, and City regulations and restrictions; and 2) the undersigned hereby gives assurances that this proposal has been prepared according to the policies and procedures of the above named Agency, obtained all necessary approvals by its governing body prior to submission, the material presented is factual and accurate to the best of her/his knowledge, and that s/he has been duly authorized by action of the governing body to bind the organization. The undersigned also hereby gives assurances that the agency will adhere to the ***Minimum Standards*** and the ***Administrative Requirements*** in its operation of City funded programs.		
a. Typed Name of Authorized Official of the Agency:	b. Title	c. Telephone Number
d. Signature of Authorized Official of the Agency:		e. Date Signed:

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

NOTE: INCLUDE THIS COMPLETED FORM AS PAGE 1 OF THE APPLICATION.

FY-2019 PROVIDER APPLICATION

Complete the Application below, providing concise and complete responses. Questions should be directed to Sandra Archuleta, Community Outreach Coordinator, Behavioral Health and Wellness Division at (505) 768-2865 or saarchuleta@cabq.gov.

Type of Application: ☐ **Adult** ☐ **Adolescent**

Levels of Care: ☐ **Level .5** ☐ **Level I** ☐ **Level II**

1. Agency Information

Agency Name: _____

Number of Years Established as an Agency: _____

Administrator: _____

Address: _____

_____

Telephone #: _____ Fax #: _____

E-Mail Address: _____ Website Address: _____

Contact for Billing: _____ Telephone #: _____

2. Languages in which therapeutic services can be provided: (Circle all that apply.)

_____English _____Spanish _____ASL _____Other languages (Specify): _____

3. Please indicate the days of the week and the hours that you provide services:

Hours of Operation			Hours You Admit Clients		
Monday	____a.m.	____p.m.	Monday	____a.m.	____p.m.
Tuesday	____a.m.	____p.m.	Tuesday	____a.m.	____p.m.
Wednesday	____a.m.	____p.m.	Wednesday	____a.m.	____p.m.
Thursday	____a.m.	____p.m.	Thursday	____a.m.	____p.m.
Friday	____a.m.	____p.m.	Friday	____a.m.	____p.m.
Saturday	____a.m.	____p.m.	Saturday	____a.m.	____p.m.
Sunday	____a.m.	____p.m.	Sunday	____a.m.	____p.m.

4. Substance Use Treatment Program

a. Describe your Substance Use Treatment program as you would describe it to a new client, including the agency's philosophy toward substance use treatment.

b. Are there any substances for which your agency DOES NOT provide treatment?

c. Describe Recovery Support Services either provided at or through an MOU with your agency.

5. Clinical Staffing

a. Identify Clinical Supervisors in your organization. Complete table below.

Name	Licensure Level	Years of Experience at this Level

b. Explain the process you use to adhere to the *Minimum Standards* regarding clinical supervision activities. Include a copy of your clinical supervision workshops and a copy of the agency's clinical supervision policy if applicable.

c. List all staff that provide services including substance use treatment, case manager, and mental health, in the table below. Add additional lines in the table as necessary.

Staff	Title	Licensure	Years At This Licensure Level	Substance Use Training	Other Certifications

6. Populations Served

a. Specify any population your agency prefers to work with and is staffed and specifically trained to treat.

b. Specify any populations that your agency prefers not to work with or is not staffed/trained to treat.

c. Describe how your agency provides specific treatment for any special populations and describe what training your staff has received to work with this specific population.

d. For adolescent Applications only: What qualifies your agency to provide treatment to adolescents?

7. Case Management

a. Describe how your agency determines a client is in need of Case Management Services.

b. Describe the case management services that are provided on site.

c. Describe in detail how your case managers assist clients in accessing services.

8. Mental Health Services

a. Does your agency provide mental health services with licensed and qualified mental health practitioners?
Yes □ No □ If Yes, please complete 8b & 8c. If No, go to 9.

b. Please check all mental health services that your agency provides to clients.

□ Mental Health Assessment/Diagnosis □ Mental Health Therapy (Not substance use Tx.)
□ Psychotropic Medication Evaluation □ Psychological Testing Services

c. For each item checked above, please provide a description of how the services are provided.

9. Children and Adolescent Safety (only applicable for Adolescent Applications)

a. Please describe how your agency provides for adolescent safety if both adults and adolescents are treated at the same site.

10. Vouchered Services

a. Since City voucher funds are not intended to cover an entire course of treatment, the City is looking for evidence that agencies are able to leverage funds to sustain client's in treatment. Please list specifically what measures your agency takes to continue treatment for clients once the voucher funds have been expended.

11. Discharge Planning and Aftercare

a. Describe your agency's discharge planning procedures to ensure successful discharge of clients. Include a copy of the agency's discharge planning policy.

b. Does your agency provide aftercare services on site? If yes, describe how you ensure client is engaged in aftercare (groups, life skills, peer support etc.).

12. Include the Proposal Summary and Certification Form (page 22 of this Application packet) as the first page to this Application with all appropriate signatures. Applications without this form will not be accepted.

City of Albuquerque
Department of Family & Community Services
Behavioral Health & Wellness Division

APPENDIX A

ASAM CRITERIA AND REQUIRED SERVICE MIX

Provide a SEPARATE Appendix A for Type of Application and each Level of Treatment for which you are applying.

1. **Type of Application**
   (check ONE only – use another Appendix A if applying for both):

   ☐ **Adult**
   ☐ **Adolescent**

2. **Identify Level of Treatment**
   (check ONE only – use a separate Appendix A for each level applying for):

   ☐ **Level .5**
   ☐ **Level I**
   ☐ **Level II.I**

3. **Please review pages 3-6 in this Application Packet. Based on the ASAM Criteria detailed on pages 3-6, and at www.ASAM.org; describe how your agency meets or exceeds that ASAM Criteria for the level of care marked above.**

4. **Please review pages 6-8 in this Application Packet. Based on the required Service Mix detailed on pages 6-8, describe how your agency meets or exceeds the required Service Mix for the level of care marked above.**

5. **FOR ADOLESCENT APPLICATIONS ONLY: How does your treatment methodology differ between your adolescent and adult substance use treatment programs, for the specific level of care addressed on this Appendix?**