**ATTACHMENT 1- Application Cover Page**

|  |  |
| --- | --- |
| 1. Applicant Type (select one or both, as applicable) | Early Relational Health CHW  (serving children birth- 5 years)  K-12/school-age Mental Health CHW  (serving children and youth 5-18 years) |
| 1. Organization Name |  |
| 1. Organization Type (select all that apply) | Federally Qualified Health Center (FQHC)  Rural Health Clinic (RHC)  Independent Family Practice  Hospital Associated/Operated Clinic  Indian Health Care Provider/Urban Indian  Organization/Indian Health Service Clinic  Independent Pediatric Practice  Public Health Clinic  Other:       (please explain) |
| 1. Plans currently accepted by organization (select all that apply) | Medicaid without a managed care plan (Fee-for-Service)  Coordinated Care of Washington  Molina Healthcare of Washington  Amerigroup  Community Health Plan of Washington  UnitedHealthcare Community Plan |
| Information regarding clients currently served by the organization | |
| 1. Total number of pediatric clients, age birth through 18: |  |

**Is your application packet complete?** Please check box indicating that your application includes the following:

Application Cover Page (Attachment 1)

Applicant Intake Form (Attachment 2)

Minimum Qualifications (Attachment 3)

CHW Grant Application (Attachment 4)

Letter of Support

Executive Order 18-03 (Attachment 5)

Certifications and Assurances (Attachment 6)

COVID Vaccine Certification (Attachment 7)

**Applicant Attestation-** By checking each box below, you are attesting to the following:

Agree to hire Community Health Worker(s) by April 1, 2023. A three-month extension may be provided if clinic is able to demonstrate workforce capacity constraints to meeting this deadline.

Agree to the roles and responsibilities defined by the Health Care Authority (HCA) regarding job description, as identified in *Exhibit C- CHW Position Description Example*, and deliverables of CHWs and adhere to the distinct CHW roles awarded.

Agree to have a dedicated workstation for each CHW hired with this grant funding.

Agree to have a confidential space available for each CHW hired to meet with families.

Attest that the CHW(s) will receive access and training to the clinic’s EMR/EHR within four weeks after the first day of employment, including capacity to adequately document CHW services.

Agree to identify and make available a consistent supervisor who provides at least one hour of weekly one-to-one supervision and is available throughout clinic hours as needed to offer support, guidance, professional development, and answer the CHW(s)’s questions.

Agree to have CHW(s) employed through this grant participate in DOH’s Pediatric CHW Health Specific Modules related to their distinct role.

Agree to have the CHW(s)’s supervisor participate in four hours of DOH’s Pediatric CHW Health Specific Modules.

Agree to give the CHW(s) time to participate in opportunities to connect with other CHWs participating in the grant program at least once per month, up to two hours.

Agree to submit quarterly focused reports, bi-annual gross reports, and an end of year narrative based on the HCA developed and disseminated CHW reporting template such as Exhibit D- Report Template*. \**

Agree to participate in an external evaluation to include both quantitative and qualitative data.

Agree to participate in any additional reporting as needed for HCA to pursue sustainable funding (e.g., Medicaid Transformation Project 1115 waiver, State Plan Amendment).

Agree to participate in quarterly project meetings as well as ad-hoc one-on-one meetings.

Agree to register for a Statewide Vendor Number (SWV) by January 1, 2023. *(*[Vendor Payee Registration | Office of Financial Management (wa.gov)](https://ofm.wa.gov/it-systems/accounting-systems/statewide-vendorpayee-services/vendor-payee-registration)*)*.

*\*HCA recognizes and honors Tribal data sovereignty principles and requirements for information sharing established by: (i) The National Congress of American Indians and (ii) are reflected in the “Best Practices for AI/AN Data Collection.”*

**On behalf of the Applicant submitting this Application, my name below attests to the accuracy of the above and attached statements and by signing below I certify that, on behalf of the Applicant agency, I am authorized to submit this application to provide the described services.**

|  |  |  |
| --- | --- | --- |
| **SIGNATURE** | **NAME AND TITLE** | **DATE** |
|  |  |  |

ATTACHMENT 2– Applicant Intake Form

Every box must be filled out, if applicable

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **1. IDENTIFYING INFORMATION** | | | | | | | |
| 1. Applicant Legal Name: | | | | |  | | |
| 1. DBA or Facility Name: | | | | |  | | |
| 1. WA Uniform Business Identifier (UBI) Number: | | | | |  | | |
| 1. Taxpayer Identification Number (TIN): | | | | |  | | |
| 1. Unique Entity ID Number (UEI) | | | | |  | | |
| 1. Statewide Vendor Number (SWV) | | | | |  | | |
| G) Are you a woman, minority or veteran owned business or a small business? If yes, please provide certification number: | | | | | |  | |
| H) \*If the Applicant does not have a UBI number, the Applicant must confirm that it will become licensed in Washington within 30 calendar days of being selected as the Apparent Successful Applicant. By signing below, the Applicant indicates their agreement to Section 1, Identifying Information, Subsection H of this form. | | | | | | | |
| Authorized Signature | | | Name / Title | | | | Date |
|  | | |  | | | |  |
| **2. APPLICANT ADDRESS** | | | | | | | |
| 1. Number, Street, Apartment, Suite: | |  | | | | | |
| 1. City, State, Zip Code + 4: | |  | | | | | |
| 1. Email Address: | |  | | | | | |
| 1. Phone Number: | |  | | | | | |
| **3. APPLICANT PRIMARY CONTACT** | | | | | | | |
| 1. Full Name: | |  | | | | | |
| 1. Job Title: | |  | | | | | |
| 1. Email Address: | |  | | | | | |
| 1. Phone Number: | |  | | | | | |
| Authorized to Sign Contracts? | Yes | | | No. If “No” is selected, Section Four (4) is REQUIRED. | | | |
| **4. APPLICANT SIGNATORY** | | | | | | | |
| 1. Full Name: | |  | | | | | |
| 1. Job Title: | |  | | | | | |
| 1. Email Address: | |  | | | | | |
| 1. Phone Number: | |  | | | | | |
| **5. CLINICAL CHAMPION CONTACT** | | | | | | | |
| 1. Full Name: | |  | | | | | |
| 1. Job Title: | |  | | | | | |
| 1. Email Address: | |  | | | | | |
| 1. Phone Number: | |  | | | | | |

ATTACHMENT 3 – Minimum Qualifications

Applicant must attest that they meet all of the following requirements by following instructions below and including with Application packet.

The following are the minimum qualifications for Applicants. Applicants must be able to answer **“YES”** to **ALL** of the following qualifications listed below to pass and to move forward to the Application evaluation process.

Check or click in the box if your organization qualifies.

### Licensed to do business in the state of Washington or provide a commitment that it will become licensed in Washington State within 30 calendar days of being selected as an Apparent Successful Applicant.

**YES**

### Must be a primary care setting serving children and youth.

**YES**

### Must accept Apple Health coverage without a managed care plan (also known as fee-for-service) when Apple Health pays the provider directly.

**YES**

|  |  |
| --- | --- |
|  | |
| SIGNATURE OF APPLICANT AUTHORIZED REPRESENTATIVE | |
|  | |
| TITLE | DATE |

ATTACHMENT 4– CHW Grant Application

1. **PRIORITY QUESTIONS**
   1. Percent of pediatric clients aged birth through 18 that are enrolled in Medicaid:

0-20%

21-40%

41-60%

61-80%

81-100%

* 1. Percent of pediatric population who have a preferred language other than English:

0-20%

21-40%

41-60%

61-80%

81-100%

* 1. Percent of pediatric population who identify racially/ethnically as non-white (i.e., American Indian/Alaska Native, Asian, Black/African American, Native Hawaiian/Pacific Islander, Latino/Hispanic, Multiracial) in your clinic:

0-20%

21-40%

41-60%

61-80%

81-100%

* 1. Location of Services (select all counties Applicant plans to utilize the CHW in)

Adams  Grays Harbor  Pierce

Asotin  Island  San Juan

Benton  Jefferson  Skagit

Chelan  King  Skamania

Clallam  Kitsap  Snohomish

Clark  Kittitas  Spokane

Columbia  Klickitat  Stevens

Cowlitz  Lewis  Thurston

Douglas  Lincoln  Wahkiakum

Ferry  Mason  Walla Walla

Franklin  Okanogan  Whatcom

Garfield  Pacific  Whitman

Grant  Pend Oreille  Yakima

1. **NARRATIVE QUESTIONS** (not to exceed 8 pages)
   1. Please describe the current roles and disciplines represented on your care team, and how you plan to integrate CHWs into your clinic team. What activities are you planning to support collaboration, including but not limited to participation in care coordination/case conferences, lunch and learns, appointments, and outreach. How do you plan to support this vision in practice?
   2. Please describe how your team, including organizational leadership (staff and board, if applicable) is reflective of the diversity of Washington state and representative of communities who experience health disparities. Further, what are the steps and approaches you are taking to address health equity and increase organizational diversity in your clinic/organization?
   3. Given CHWs are often individuals who reflect the diverse identities and cultures of communities, and the project priority of supporting underrepresented communities, please describe how your organization, clinic team, and CHW supervisor intend to address issues of structural racism experienced by CHWs and those they work with, including policies, practices, organizational training, and response/support to reported incidences of racism and discrimination.
   4. Please describe your plan for training and orienting your current clinic staff to the new CHW role in care team within six months of award announcement.
   5. Please describe your organization’s experience with Community Health Workers or similar roles (i.e., Outreach Workers), including identified supervisor’s experience providing supervision and experience working with non-clinical staff and community-based workforce. How do you see the CHW role supporting children, youth, and families outside of the clinic setting?
   6. Please describe how a CHW will enhance the services you offer at your clinic/organization. What are the goals and priorities to address your patient population/community needs that you envision the CHW role contributing to? What are the core responsibilities the CHW would hold in your clinic?
   7. Please describe your orientation approach, timeline, and plan for CHW(s) hired for this grant. What learning opportunities will you provide regarding your clinic and team (such as policies/procedures, clinic culture and norms, clinic team roles/responsibilities, building good relationships, standards of care)? Further, what training and support will you offer to prepare CHW(s) to deliver care prior to meeting with children, youth, and families (such as resource review, training/professional development, observation and coaching, and clinic shadowing)?
   8. Please describe how much of the CHW's time you anticipate will be allocated to the following activities per week:
      1. Activities outside of the clinic in community;
      2. Providing direct services to families;
      3. Allocation to in-person services versus. virtual/phone delivery; and
      4. Paperwork, documentation, and other administrative duties.

**Letter of Support**

(Insert letter here)

ATTACHMENT 5 – Executive Order 18-03

**Contractor Certification  
Executive Order 18-03 – Workers’ Rights  
Washington State Goods & Services Contracts**

*Pursuant to the Washington State Governor’s Executive Order 18-03 (dated June 12, 2018), the Washington State Health Care Authority is seeking to contract with qualified entities and business owners who certify that their employees are not, as a condition of employment, subject to mandatory individual arbitration clauses and class or collective action waivers.*

| Solicitation No.: | RFA# 2022HCA24 |
| --- | --- |

I hereby certify, on behalf of the firm identified below, as follows (check one):

* **No Mandatory Individual Arbitration Clauses and Class or Collective Action Waivers for Employees**. This firm does NOT require its employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waivers.

or

* **Mandatory Individual Arbitration Clauses and Class or Collective Action Waivers for Employees**. This firm requires its employees, as a condition of employment, to sign or agree to mandatory individual arbitration clauses or class or collective action waivers.

I hereby certify, under penalty of perjury under the laws of the State of Washington, that the certifications herein are true and correct and that I am authorized to make these certifications on behalf of the firm listed herein.

|  |  |
| --- | --- |
| Firm Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of Contractor/Bidder – Print full legal entity name of firm | |
| By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of authorized person  Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Title of person signing certificate  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name of person making certifications for firm  Place: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print city and state where signed |

**ATTACHMENT 6 – Certifications and Assurances**

I/we make the following certifications and assurances as a required element of the Application to which it is attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or continuation of the related contract:

1. I/we declare that all answers and statements made in the Application are true and correct.
2. The prices and/or cost data have been determined independently, without consultation, communication, or agreement with others for the purpose of restricting competition. However, I/we may freely join with other persons or organizations for the purpose of presenting a single Application.
3. The attached Application is a firm offer for a period of 120 days following receipt, and it may be accepted by HCA without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 120-day period.
4. In preparing this Application, I/we have not been assisted by any current or former employee of the state of Washington whose duties relate (or did relate) to this Application or prospective contract, and who was assisting in other than his or her official, public capacity. If there are exceptions to these assurances, I/we have described them in full detail on a separate page attached to this document.
5. I/we understand that HCA will not reimburse me/us for any costs incurred in the preparation of this Application. All Applications become the property of HCA, and I/we claim no proprietary right to the ideas, writings, items, or samples, unless so stated in this Application.
6. Unless otherwise required by law, the prices and/or cost data which have been submitted have not been knowingly disclosed by the Applicant and will not knowingly be disclosed by him/her prior to opening, directly or indirectly, to any other Applicant or to any competitor.
7. I/we agree that submission of the attached Application constitutes acceptance of the solicitation contents and the attached sample contract and general terms and conditions. If there are any exceptions to these terms, I/we have described those exceptions in detail on a page attached to this document.
8. No attempt has been made or will be made by the Applicant to induce any other person or firm to submit or not to submit an Application for the purpose of restricting competition.
9. I/we grant HCA the right to contact references and other, who may have pertinent information regarding the ability of the Applicant and the lead staff person to perform the services contemplated by this RFA.
10. If any staff member(s) who will perform work on this contract has retired from the State of Washington under the provisions of the 2008 Early Retirement Factors legislation, his/her name(s) is noted on a separately attached page.

We (circle one) **are / are not** submitting proposed Contract exceptions. (See Section 3.6, Contract and General Terms & Conditions.) If Contract exceptions are being submitted, I/we have attached them to this form.

**On behalf of the Applicant submitting this Application, my name below attests to the accuracy of the above statement. *If electronic, also include*: We are submitting a scanned signature of this form with our Application.**

|  |  |
| --- | --- |
|  | |
| SIGNATURE OF APPLICANT AUTHORIZED REPRESENTATIVE | |
|  | |
| TITLE | DATE |

ATTACHMENT 7 – COVID Vaccine Certification

Contractor Certification

**Proclamation 21-14 - COVID-19 Vaccination Certification**

*To reduce the spread of COVID-19, Washington state Governor Jay Inslee, pursuant to emergency powers authorized in* [*RCW 43.06.220*](https://app.leg.wa.gov/RCW/default.aspx?cite=43.06.220)*, issued* [*Proclamation 21-14 – COVID-19 Vaccination Requirement*](https://www.governor.wa.gov/sites/default/files/proclamations/21-14%20-%20COVID-19%20Vax%20Washington%20%28tmp%29.pdf) *(dated August 9, 2021), as amended by* [*Proclamation 21-14.1 – COVID-19 Vaccination Requirement*](https://www.governor.wa.gov/sites/default/files/proclamations/21-14.1%20-%20COVID-19%20Vax%20Washington%20Amendment.pdf) *(dated August 20, 2021) and as may be amended thereafter. The Proclamation requires contractors who have goods, services, or public works contracts with a Washington state agency to ensure that their personnel (including subcontractors) who perform contract activities on-site comply with the COVID-19 vaccination requirements, unless exempted as prescribed by the Proclamation.*

**HCA Solicitation – RFA# 2022HCA24**

I hereby certify, on behalf of the firm identified below, as follows (check one):

* *COVID-19 CONTRACTOR VACCINATION PROCLAMATION COMPLIANCE*. Contractor:
  1. Has reviewed and understands Contractor’s obligations as set forth in [*Proclamation 21-14 – COVID-19 Vaccination Requirement*](https://www.governor.wa.gov/sites/default/files/proclamations/21-14%20-%20COVID-19%20Vax%20Washington%20%28tmp%29.pdf) *(dated August 9, 2021), as amended by* [*Proclamation 21-14.1 – COVID-19*](https://www.governor.wa.gov/sites/default/files/proclamations/21-14.1%20-%20COVID-19%20Vax%20Washington%20Amendment.pdf)[*Vaccination Requirement*](https://www.governor.wa.gov/sites/default/files/proclamations/21-14.1%20-%20COVID-19%20Vax%20Washington%20Amendment.pdf) *(dated August 20, 2021); and*
  2. Contractor personnel (including subcontractors) who are subject to the vaccination requirement in the above-referenced Proclamation will provide Agency proof of full vaccination against COVID-19 *or* appropriate exemption for which a reasonable accommodation has been provided.

OR

* *CONTRACTOR IS NOT ABLE TO PERFORM IN COMPLIANCE WITH THE VACCINATION PROCLAMATION*. Contractor is not able to perform the contract obligations in compliance with the above- referenced Proclamation.

I hereby certify, under penalty of perjury under the laws of the State of Washington, that the certifications herein are true and correct and that I am authorized to make these certifications on behalf of the firm listed herein.

|  |  |
| --- | --- |
| Firm Name: |  |
|  | PRINT FULL LEGAL ENTITY NAME OF FIRM |
| Signed By: |  |
|  | SIGNATURE OF AUTHORIZED REPRESENTATIVE |
| Title: |  |
|  | TITLE OF AUTHORIZED REPRESENTATIVE SIGNING |
| Date: |  |