Lakeview Center
BAPTIST HEALTH CARE

Helping people overcome life's challenges

Application Instructions:

Please complete the application in its entirety and submit the following documents along with any additional supporting documentation your agency feels would be beneficial in Lakeview Center's review. Incomplete applications will not be considered. Final determination will be mailed to the applicant within sixty (60) days of receipt of a completed application packet and all required documentation. Press F1 for help with specific questions in the application.

Required Agency Attachments / Documentation for All Providers:

- ☐ Completed Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion
- ☐ Completed Certification Regarding Lobbying
- ☐ Completed Civil Rights Checklist
- ☐ Completed Affidavit of Compliance with Background Screening
- ☐ Copy of the most current Emergency Preparedness Plan
- ☐ Copies of Liability and Workman's Compensation Insurance showing coverage limits and effective dates
- ☐ Organizational Structure
- ☐ Most recent financial audit
- ☐ Copy of any Monitoring Reports
- ☐ Completed Provider Self Evaluation
- ☐ Copy of Accreditation Report & License
- ☐ Board of Directors / Advisory Board
- ☐ Copies of any consultant or management company agreements
- ☐ IRS Form 990

I. Agency Information:

A. General Information

Fill out this section first. The remainder of the application where this information is duplicated will be automatically entered for you.

Legal Agency Name: _____ **Federal Tax ID:** _____

Physical Address: _____
Street Address *Suite #*

_____ -
City *County* *State* *ZIP Code*

Mailing Address: _____
Street Address *Suite #*

_____ -
City *County* *State* *ZIP Code*

Phone: (☐☐☐) ☐☐☐-☐☐☐☐ **Alternate Phone:** (☐☐☐) ☐☐☐-☐☐☐☐ **Fax** (☐☐☐) ☐☐☐-☐☐☐☐ **Alternate Fax:** (☐☐☐) ☐☐☐-☐☐☐☐

Website Address: _____ **How many programs does your agency have?** _____

B. Organization Information

Type of Entity: ☐ **Individual (proprietorship)** ☐ **Partnership** ☐ **Corporation** ☐ **Unincorporated Organization or Association**

Agency Type: ☐ **Non-Profit** ☐ **For-Profit**

Are you currently accredited? ☐ **Yes** ☐ **No** *(Residential Providers only)* **Are you currently licensed:** ☐ **Yes** ☐ **No**

Accrediting Agency: _____ *(If yes)* **License Expiration Date:** ☐☐/☐☐/☐☐☐☐

Expiration Date: ☐☐/☐☐/☐☐☐☐ *(If no)* **Date of licensure application:** ☐☐/☐☐/☐☐☐☐

File a Form 990? ☐ **Yes** ☐ **No** *(If no, please explain)* _____

C. Agency Representative

Agency Executive Director / CEO

Name: _____ **Title** _____

Address: _____
Street Address *Suite*

_____ -
City *County* *State* *Zip*

Email Address: _____ **Phone Number:** (☐☐☐) ☐☐☐-☐☐☐☐ **Fax Number:** (☐☐☐) ☐☐☐-☐☐☐☐

Educational Level: _____ **Tenure with the agency:** _____

Have you ever had disciplinary action or revocation of a professional license, resigned a professional license in lieu of disciplinary action, or been the subject of pending or legal action in the last five (5) years? ☐ **Yes** ☐ **No**
(Explanation required if yes)

_____

Description of child welfare experience including titles, time frames, duties, and locations. *(May attach resume)*

_____

_____

D. Agency Contract Representatives

Agency Official Authorized to Sign Contracts

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** (___) ___-____ **Fax Number:** (___) ___-____

Agency Official Responsible for Contract Administration

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** (___) ___-____ **Fax Number:** (___) ___-____

Agency Chief Financial Officer

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** (___) ___-____ **Fax Number:** (___) ___-____

E. Formal Notices

In addition to the Agency Representatives, formal notices regarding site visits, amendments, terminations, negotiations, and information requests should be directed to:

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** (___) ___-____ **Fax Number:** (___) ___-____

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** (___) ___-____ **Fax Number:** (___) ___-____

Authorized Signature

By my signature, I affirm that the information in this application and the accompanying attachments is true and accurate, and I understand that inaccurate of false statements will be cause for this application to be denied.

Print Name: _____ Title: _____

Signature: _____ Date: / /

Application Submission

Please complete the application in its entirety and submit all documents along with any additional supporting documentation your agency feels would be beneficial in Lakeview Center's review. Incomplete applications will not be considered. Final determination will be mailed to the applicant within sixty (60) days of receipt of a completed application packet and all required documentation.

Mail the completed application packet to:

Lakeview Center, Inc.
Finance Dept., Bldg A
Attn: CPS
1221 W. Lakeview Avenue
Pensacola, FL 32501-1836

For LCI Administrative Use Only:

Approved by Contract Manager: _____

☐ Yes ☐ No ☐ Team Review Requested Date: / /

Approved by Contract Administrator: _____

☐ Yes ☐ No ☐ Team Review Requested Date: / /

Referred to Contracts Review Team, Decision

☐ Approved ☐ Denied Date: / /

II. Program / Service Information

Please complete Section II for each program

A. Provider Agency Information (This section is automatically copied from Section I. A. General Information)

Legal Agency Name: _____ **Federal Tax ID:** _____

Physical Address: _____

Suite # -

City *County* *State* *ZIP Code*

Mailing Address: _____

Street Address *Suite #* -

City *County* *State* *ZIP Code*

Phone: ( ) - **Alternate Phone:** ( ) - **Fax** ( ) - **Alternate Fax:** ( ) -

Website Address: _____ **How many programs does your agency have?** _____

B. Program & Service Information

Program Name: _____ **Service Type:** Child Protective Services

Brief Service Description: _____

Program Supervisor: _____ **Title:** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

License Information *(Residential Providers only)*

Licensing Body: _____

License Type: _____

License Number: _____

Expiration Date: / /

Accreditation Information

Accrediting Body: _____

Accreditation Status: _____

Expiration Status: _____

Date of Most Recent Survey: / /

Client Demographics: ☐ **Male** ☐ **Female** **Age Range:** __ **Min Age** __ **Max Age** **Number of Beds:** _____

Program Capacity: _____ **Staffing Pattern:** House Parent (Residential Providers Only)

Shift Times: ____-____ ____-____ ____-____ ____-____ ____-____ ____-____ ____-____

Staffing Explanation: _____

Please provide the names, addresses, and telephone numbers of three (3) individuals who can provide references as to the quality of work / services provided by your organization *(If the agency contracted with other lead agencies, please list)*.

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Has this program been the subject of disciplinary action by any regulatory agency, lead agency, or accrediting organization within the last year? ☐ **Yes** ☐ **No** (*If yes, please explain below, and/or attach additional documentation)*

C. Program Documentation

☐ **A complete service description**
(Includes philosophy and objectives of the organization, a comprehensive description of population to be served, and / or services offered. Can include brochures, pamphlets distributed to the public, etc.)

☐ **Copy of the program budget and budget narrative that includes a projection of monthly income, funding sources, and expenditures**

☐ **Copies of the program's license(s) and licensing summary(ies) -** *For residential services only*

II. Program / Service Information

Attach additional sheets for each program

A. Provider Agency Information

Legal Agency Name: _____ **Federal Tax ID:** _____

Physical Address: _____ *Suite #*

_____ - _____

City *County* *State* *ZIP Code*

Mailing Address: _____

Street Address *Suite #*

_____ - _____

City *County* *State* *ZIP Code*

Phone: ( ) - **Alternate Phone:** ( ) - **Fax** ( ) - **Alternate Fax:** ( ) -

Website Address: _____ **How many programs does your agency have?** _____

B. Program & Service Information

Program Name: _____ **Service Type:** Child Protective Services

Brief Service Description: _____

Program Supervisor: _____ **Title:** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

License Information *(Residential Providers only)*

Licensing Body: _____

License Type: _____

License Number: _____

Expiration Date: / /

Accreditation Information

Accrediting Body: _____

Accreditation Status: _____

Expiration Status: _____

Date of Most Recent Survey: / /

Client Demographics: ☐ **Male** ☐ **Female** **Age Range:** __ **Min Age** __ **Max Age** **Number of Beds:** _____

Program Capacity: _____ **Staffing Pattern:** House Parent (Residential Providers Only)

Shift Times: ____-____ ____-____ ____-____ ____-____ ____-____ ____-____ ____-____

Staffing Explanation: _____

Please provide the names, addresses, and telephone numbers of three (3) individuals who can provide references as to the quality of work / services provided by your organization *(If the agency contracted with other lead agencies, please list)***.**

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Has this program been the subject of disciplinary action by any regulatory agency, lead agency, or accrediting organization within the last year? ☐ **Yes** ☐ **No** (*If yes, please explain below, and/or attach additional documentation)*

C. Program Documentation

☐ **A complete service description**
(Includes philosophy and objectives of the organization, a comprehensive description of population to be served, and / or services offered. Can include brochures, pamphlets distributed to the public, etc.)

☐ **Copy of the program budget and budget narrative that includes a projection of monthly income, funding sources, and expenditures**

☐ **Copies of the program's license(s) and licensing summary(ies) -** *For residential services only*

II. Program / Service Information

Attach additional sheets for each program

A. Provider Agency Information

Legal Agency Name: _____ **Federal Tax ID:** _____

Physical Address: _____

Suite #

_____ -

City *County* *State* *ZIP Code*

Mailing Address: _____

Street Address *Suite #*

_____ -

City *County* *State* *ZIP Code*

Phone: ( ) - **Alternate Phone:** ( ) - **Fax** ( ) - **Alternate Fax:** ( ) -

Website Address: _____ **How many programs does your agency have?** _____

B. Program & Service Information

Program Name: _____ **Service Type:** Child Protective Services

Brief Service Description: _____

Program Supervisor: _____ **Title:** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

License Information *(Residential Providers only)*

Licensing Body: _____

License Type: _____

License Number: _____

Expiration Date: / /

Accreditation Information

Accrediting Body: _____

Accreditation Status: _____

Expiration Status: _____

Date of Most Recent Survey: / /

Client Demographics: ☐ **Male** ☐ **Female** **Age Range:** __ **Min Age** __ **Max Age** **Number of Beds:** _____

Program Capacity: _____ **Staffing Pattern:** House Parent (Residential Providers Only)

Shift Times: ____-____ ____-____ ____-____ ____-____ ____-____ ____-____ ____-____

Staffing Explanation: _____

Please provide the names, addresses, and telephone numbers of three (3) individuals who can provide references as to the quality of work / services provided by your organization *(If the agency contracted with other lead agencies, please list)***.**

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Has this program been the subject of disciplinary action by any regulatory agency, lead agency, or accrediting organization within the last year? ☐ **Yes** ☐ **No** (*If yes, please explain below, and/or attach additional documentation)*

C. Program Documentation

☐ **A complete service description**
(Includes philosophy and objectives of the organization, a comprehensive description of population to be served, and / or services offered. Can include brochures, pamphlets distributed to the public, etc.)

☐ **Copy of the program budget and budget narrative that includes a projection of monthly income, funding sources, and expenditures**

☐ **Copies of the program's license(s) and licensing summary(ies) -** *For residential services only*

II. Program / Service Information

Attach additional sheets for each program

A. Provider Agency Information

Legal Agency Name: _____ **Federal Tax ID:** _____

Physical Address: _____

Suite #

_____ -

City *County* *State* *ZIP Code*

Mailing Address: _____

Street Address *Suite #*

_____ -

City *County* *State* *ZIP Code*

Phone: ( ) - **Alternate Phone:** ( ) - **Fax** ( ) - **Alternate Fax:** ( ) -

Website Address: _____ **How many programs does your agency have?** _____

B. Program & Service Information

Program Name: _____ **Service Type:** Child Protective Services

Brief Service Description: _____

Program Supervisor: _____ **Title:** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

License Information *(Residential Providers only)*

Licensing Body: _____

License Type: _____

License Number: _____

Expiration Date: / /

Accreditation Information

Accrediting Body: _____

Accreditation Status: _____

Expiration Status: _____

Date of Most Recent Survey: / /

Client Demographics: ☐ **Male** ☐ **Female** **Age Range:** __ **Min Age** __ **Max Age** **Number of Beds:** _____

Program Capacity: _____ **Staffing Pattern:** House Parent (Residential Providers Only)

Shift Times: ____-____ ____-____ ____-____ ____-____ ____-____ ____-____ ____-____

Staffing Explanation: _____

Please provide the names, addresses, and telephone numbers of three (3) individuals who can provide references as to the quality of work / services provided by your organization *(If the agency contracted with other lead agencies, please list)***.**

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Has this program been the subject of disciplinary action by any regulatory agency, lead agency, or accrediting organization within the last year? ☐ **Yes** ☐ **No** (*If yes, please explain below, and/or attach additional documentation)*

C. Program Documentation

☐ **A complete service description**
(Includes philosophy and objectives of the organization, a comprehensive description of population to be served, and / or services offered. Can include brochures, pamphlets distributed to the public, etc.)

☐ **Copy of the program budget and budget narrative that includes a projection of monthly income, funding sources, and expenditures**

☐ **Copies of the program's license(s) and licensing summary(ies) -** *For residential services only*

II. Program / Service Information

Attach additional sheets for each program

A. Provider Agency Information

Legal Agency Name: _____ **Federal Tax ID:** _____

Physical Address: _____

Suite #

_____ -

City *County* *State* *ZIP Code*

Mailing Address: _____

Street Address *Suite #*

_____ -

City *County* *State* *ZIP Code*

Phone: ( ) - **Alternate Phone:** ( ) - **Fax** ( ) - **Alternate Fax:** ( ) -

Website Address: _____ **How many programs does your agency have?** _____

B. Program & Service Information

Program Name: _____ **Service Type:** Child Protective Services

Brief Service Description: _____

Program Supervisor: _____ **Title:** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

License Information *(Residential Providers only)*

Licensing Body: _____

License Type: _____

License Number: _____

Expiration Date: / /

Accreditation Information

Accrediting Body: _____

Accreditation Status: _____

Expiration Status: _____

Date of Most Recent Survey: / /

Client Demographics: ☐ **Male** ☐ **Female** **Age Range:** __ **Min Age** __ **Max Age** **Number of Beds:** _____

Program Capacity: _____ **Staffing Pattern:** House Parent (Residential Providers Only)

Shift Times: ____-____ ____-____ ____-____ ____-____ ____-____ ____-____ ____-____

Staffing Explanation: _____

Please provide the names, addresses, and telephone numbers of three (3) individuals who can provide references as to the quality of work / services provided by your organization *(If the agency contracted with other lead agencies, please list)***.**

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Has this program been the subject of disciplinary action by any regulatory agency, lead agency, or accrediting organization within the last year? ☐ **Yes** ☐ **No** (*If yes, please explain below, and/or attach additional documentation)*

C. Program Documentation

☐ **A complete service description**
(Includes philosophy and objectives of the organization, a comprehensive description of population to be served, and / or services offered. Can include brochures, pamphlets distributed to the public, etc.)

☐ **Copy of the program budget and budget narrative that includes a projection of monthly income, funding sources, and expenditures**

☐ **Copies of the program's license(s) and licensing summary(ies) -** *For residential services only*

II. Program / Service Information

Attach additional sheets for each program

A. Provider Agency Information

Legal Agency Name: _____ **Federal Tax ID:** _____

Physical Address: _____

Suite #

_____ -

City *County* *State* *ZIP Code*

Mailing Address: _____

Street Address *Suite #*

_____ -

City *County* *State* *ZIP Code*

Phone: ( ) - **Alternate Phone:** ( ) - **Fax** ( ) - **Alternate Fax:** ( ) -

Website Address: _____ **How many programs does your agency have?** _____

B. Program & Service Information

Program Name: _____ **Service Type:** Child Protective Services

Brief Service Description: _____

Program Supervisor: _____ **Title:** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

License Information *(Residential Providers only)*

Licensing Body: _____

License Type: _____

License Number: _____

Expiration Date: / /

Accreditation Information

Accrediting Body: _____

Accreditation Status: _____

Expiration Status: _____

Date of Most Recent Survey: / /

Client Demographics: ☐ **Male** ☐ **Female** **Age Range:** __ **Min Age** __ **Max Age** **Number of Beds:** _____

Program Capacity: _____ **Staffing Pattern:** House Parent (Residential Providers Only)

Shift Times: ____-____ ____-____ ____-____ ____-____ ____-____ ____-____ ____-____

Staffing Explanation: _____

Please provide the names, addresses, and telephone numbers of three (3) individuals who can provide references as to the quality of work / services provided by your organization *(If the agency contracted with other lead agencies, please list)***.**

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Has this program been the subject of disciplinary action by any regulatory agency, lead agency, or accrediting organization within the last year? ☐ **Yes** ☐ **No** (*If yes, please explain below, and/or attach additional documentation)*

C. Program Documentation

☐ **A complete service description**
(Includes philosophy and objectives of the organization, a comprehensive description of population to be served, and / or services offered. Can include brochures, pamphlets distributed to the public, etc.)

☐ **Copy of the program budget and budget narrative that includes a projection of monthly income, funding sources, and expenditures**

☐ **Copies of the program's license(s) and licensing summary(ies) -** *For residential services only*

II. Program / Service Information

Attach additional sheets for each program

A. Provider Agency Information

Legal Agency Name: _____ **Federal Tax ID:** _____

Physical Address: _____

Suite #

_____ -

City *County* *State* *ZIP Code*

Mailing Address: _____

Street Address *Suite #*

_____ -

City *County* *State* *ZIP Code*

Phone: ( ) - **Alternate Phone:** ( ) - **Fax** ( ) - **Alternate Fax:** ( ) -

Website Address: _____ **How many programs does your agency have?** _____

B. Program & Service Information

Program Name: _____ **Service Type:** Child Protective Services

Brief Service Description: _____

Program Supervisor: _____ **Title:** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

License Information *(Residential Providers only)*

Licensing Body: _____

License Type: _____

License Number: _____

Expiration Date: / /

Accreditation Information

Accrediting Body: _____

Accreditation Status: _____

Expiration Status: _____

Date of Most Recent Survey: / /

Client Demographics: ☐ **Male** ☐ **Female** **Age Range:** __ **Min Age** __ **Max Age** **Number of Beds:** _____

Program Capacity: _____ **Staffing Pattern:** House Parent (Residential Providers Only)

Shift Times: ____-____ ____-____ ____-____ ____-____ ____-____ ____-____ ____-____

Staffing Explanation: _____

Please provide the names, addresses, and telephone numbers of three (3) individuals who can provide references as to the quality of work / services provided by your organization *(If the agency contracted with other lead agencies, please list)***.**

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Name: _____ **Title** _____

Address: _____

Email Address: _____ **Phone Number:** ( ) - **Fax Number:** ( ) -

Has this program been the subject of disciplinary action by any regulatory agency, lead agency, or accrediting organization within the last year? ☐ **Yes** ☐ **No** (*If yes, please explain below, and/or attach additional documentation)*

C. Program Documentation

☐ **A complete service description**
(Includes philosophy and objectives of the organization, a comprehensive description of population to be served, and / or services offered. Can include brochures, pamphlets distributed to the public, etc.)

☐ **Copy of the program budget and budget narrative that includes a projection of monthly income, funding sources, and expenditures**

☐ **Copies of the program's license(s) and licensing summary(ies) -** *For residential services only*

CERTIFICATION REGARDING LOBBYING

Certification for Contracts, Grants, Loans and Cooperative Agreements

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form –LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

This certification is effective January 1, ____ through December 31, ____

Signature of Authorized Individual	**Date**
Name of Authorized Individual	**Title**

Name of Organization

Address of Organization

Contract Number(s)

Notarization of Certification

State of Florida, County of _____

Sworn to (or affirmed) and subscribed before me this _____ **day of** _____ **, 20** _____ **by**

_____

[Notary Seal Here]

_____
Signature of Notary Public-State of Florida

_____
Name of Notary Typed, Printed, or Stamped

Personally Known ☐ **Yes** ☐ **No** **or Produced Identification** ☐ **Yes** ☐ **No** **Type of Identification Produced** _____

CERTIFICATION REGARDING DEBARMENT,
SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987 Federal Register (52 Fed. Reg., pages 20360 – 20369).

INSTRUCTIONS

1. Each provider whose contract/subcontract equals or exceeds $25,000 in federal monies must sign this certification prior to execution of each contract/subcontract. Additionally, providers who audit federal programs must also sign, regardless of the contract amount. Children & Families cannot contract with these types of providers if they are debarred or suspended by the federal government.

2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.

3. The provider shall provide immediate written notice to the contract manager at any time the provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms “debarred”, “suspended”, “ineligible”, “person”, “principal”, and “voluntarily excluded”, as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the contract manager for assistance in obtaining a copy of those regulations.

5. The provider agrees by submitting this certification that, it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the Federal Government.

6. The provider further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will equal or exceed $25,000 in federal monies, to submit a signed copy of this certification.

7. The Department of Children and Families may rely upon a certification of a provider that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.

8. This signed certification must be kept in the contract manager’s contract file. Subcontractor’s certifications must be kept at the contractor’s business location.

---

(1) The prospective provider certifies, by signing this certification, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.

(2) Where the prospective provider is unable to certify to any of the statements in this certification, such prospective provider shall attach an explanation to this certification.

This certification is effective January 1, ____ through December 31, ____.

_____	_____
Signature	**Date**
_____	_____
Name	**Title**

Notarization of Certification

State of Florida, County of _____

Sworn to (or affirmed) and subscribed before me this _____ **day of** _____ **, 20** _____ **by**

_____

_____

[Notary Seal Here] **Signature of Notary Public-State of Florida**

_____

Name of Notary Typed, Printed, or Stamped

Personally Known ☐ **Yes** ☐ **No** **or Produced Identification** ☐ **Yes** ☐ **No** **Type of Identification Produced** _____

FLORIDA DEPARTMENT OF CHILDREN & FAMILIES

CIVIL RIGHTS COMPLIANCE CHECKLIST

Program/Provider/Facility:	County:	Region/District:
Street Address:	Completed By:	
City, State, Zip Code: , ,	Date:	Telephone: ( ) -

PART I.

1. Briefly describe the geographic area served by the program/facility and the type of service provides: Lakeview Center, Inc. is a comprehensive mental health facility providing services in the four county area of Florida's Circuit 1. Services include behavioral health, child welfare and vocational services.

2. POPULATION OF AREA SERVED.			Source of data:				
Total #	% White	% Black	% Hispanic	% Other	% Female	# Male	

3. STAFF CURRENTLY EMPLOYED.			Effective date:				
Total #	% White	% Black	% Hispanic	% Other	% Female	# Male	% Handicap

4. CLIENTS CURRENTLY ENROLLED OR REGISTERED.				Effective date:			
Total #	% White	% Black	% Hispanic	% Other	% Female	# Male	% Over 40 Yrs

5. ADVISORY OR GOVERNING BOARD, IF APPLICABLE.							
Total #	% White	% Black	% Hispanic	% Other	% Female	# Male	

PART II. USE A SEPARATE SHEET OF PAPER FOR ANY EXPLANATION REQUIRING MORE SPACE.

6. Is an Assurance of Compliance on file with the Department of Children and Families? If NA or NO, explain. N/A ☐ YES ☐ NO ☐

7. Compare staff composition to the population. Are staff representative of the population? If NA or NO, explain. N/A ☐ YES ☐ NO ☐

8. Compare client composition to the population. Are race/sex characteristics representative of the population? If NA or NO, explain. N/A ☐ YES ☐ NO ☐

9. Are eligibility requirements for services applied to clients and applicants without regard to race, color, national origin, sex, age, religion or disability? If NA or NO, explain? N/A ☐ YES ☐ NO ☐

10. Do recruitment and notification materials advise applicants, employees and recipients of your non-discrimination policy? If NA or NO, explain. N/A ☐ YES ☐ NO ☐

11. For in-patient services, are room assignments made without regard to race, color, national origin, or disability? If NA or NO, explain. N/A ☐ YES ☐ NO ☐

12. Is the program / facility accessible to non-English speaking clients? If NA or NO, explain — N/A ☐ YES ☐ NO ☐

13. Are employees, applicants and participants informed of their protection against discrimination? If YES, how? Verbal ☐ Written ☐ Poster ☐ If NA, or NO, explain. — N/A ☐ YES ☐ NO ☐

14. Is the program / facility physically accessible to mobility, hearing and sight-impaired individuals? If NA or NO, explain. — N/A ☐ YES ☐ NO ☐

PART III. THE FOLLOWING QUESTIONS APPLY TO PROGRAMS AND FACILITIES WITH 15 OR MORE EMPLOYEES.

15. Has a self-evaluation been conducted to identify any barriers to serving disabled individuals, and to make any necessary modifications? If NO, explain. — YES ☐ NO ☐

16. Is there an established grievance procedure that incorporates due process into the resolution of complaints? If NO, explain. — YES ☐ NO ☐

17. Has a person been designated to coordinate Section 504 compliance activities? If NO, explain. — YES ☐ NO ☐

18. Do recruitment and notification materials advise applicants, employees and participants of nondiscrimination on the basis of disability? If NO, explain. — YES ☐ NO ☐

19. Are auxiliary aids available to assure accessibility of services to hearing and sight impaired individuals? If NO, explain. — YES ☐ NO ☐

PART VI. USE A SEPARATE SHEET OF PAPER FOR ANY EXPLANATION REQUIRING MORE SPACE.

20. Do you have a written affirmative action plan? If NO, explain. — YES ☐ NO ☐

DEPARTMENT OF CHILDREN AND FAMILIES USE ONLY		
Reviewed By:		In Compliance: YES ☐ NO ☐
Program Office:		Date Notice of Corrective Action Sent: / /
Date: / /	Telephone: ( ) -	Date Response Due: / /
On-Site ☐	Desk Review ☐	Date Response Received: / /

AFFIDAVIT OF COMPLIANCE
Background Screening Requirements for Child Caring Agencies and Child Placing Agencies

DESIGNATE EMPLOYEE BACKGROUND SCREENING STATUS AS:
C – CLEARED = Clearance Letter on File S – SUBMITTED = Results Pending
T – TRANSFER = Transfer From Other Facility

Incomplete forms will be returned and will delay the contracting process.

				Status (Check One)			
Name	SS#	Date of Hire	Date Screening Submitted	C	S	T	5yr Re-screen Date
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /
	- -	/ /	/ /				/ /

(Attach additional sheets if necessary)

I, _____, Applicant of Child Caring Agency / Child Placing Agency do hereby affirm under penalty of perjury that all child care personnel meet the statutory requirements for background screening.

Sworn to and subscribed before me this ____ day of _____, ____.

_____ Notary Public, State of Florida

My Commission Expires __/__/____

_____
Signature of Affiant