Ventura County Area Agency on Aging
Vendor Services Application – FY 2016-2017

TO APPLICANTS: PLEASE READ THE VENDOR INFORMATION PACKET BEFORE COMPLETING THE APPLICATION.

Place an ☒ in the box next to the service to be provided.

	PERSONAL SERVICES:
☐	**Chore Services**
☐	**Personal Care Services**
☐	**Homemaker Services**
☐	**Respite Care, In-Home**
☐	**Money Management**
☐	**Home-Delivered Meals**
☐	**Congregate Meals**
☐	**Transportation**

Additional Specs (if applicable):

	EQUIPMENT AND DEVICES
☐	**Minor Home Repairs and Adaptive Equipment and/or Home Modifications and/or Personal Security**
☐	**Communication Devices**
☐	**Non-Medical Equipment**

1.	**Vendor Name:**
	Address:
	Telephone:
	FAX:
	Web Address (if any):
2.	**Vendor SSN# or EIN#:**
	Dun & Bradstreet No. (if any)
3.	**Person Authorized to Submit Application:**
	Name/Title:
	Telephone:
4.	**Vendor Contact Person:**
	Title:
	Telephone:
	E-Mail Address:
5.	**Type of Provider (check one):**

☐ Non-profit Tax Exempt Entity ☐ Individual

☐ For Profit Entity ☐ Unincorporated Group

☐ Government Agency ☐ Other

6. **Service Areas – Check areas you will provide services:**

☐ **ALL OF VENTURA COUNTY – *or:***

West Ventura County:

☐ Camarillo – Somis
☐ Oxnard
☐ Port Hueneme
☐ Ventura – Casitas Springs
☐ Fillmore
☐ Piru
☐ Ojai – Oak View – Meiners Oaks
☐ Santa Paula

East Ventura County:

☐ Moorpark
☐ Newbury Park – Thousand Oaks
☐ Simi Valley

List any areas your firm refuses to serve:

7. List below the rate(s) per unit at which your organization offers to provide services to MSSP/EHP/CCTP clients. For each rate, provide a breakdown of the cost factors that comprise that rate. Also, if the proposed rate is higher than that charged to other agencies please provide a thorough explanation of the reason(s) for the difference.

8. List the days and hours of your organization's service availability.

9. Are there any restrictions or limitations on the availability of your services such as eligibility criteria, minimum number of units or maximum number of units?

☐ **No** ☐ **Yes -** If yes, please explain/describe limitations:

10. If applicable, what type of business and/or professional licenses are held by your organization?

Type	License Number

11. List the number and position titles of all staff (paid and volunteer) to be involved in providing services to MSSP/EHP/CCTP clients. List professional certificates, licenses, degrees, etc., where appropriate (i.e., R.N., Nurse Practitioner, Medical Doctor, MSW, etc.).

#	Position Title	Paid?	Certificates/Licenses/Degrees

12. List the number and position titles of all staff (paid and volunteer) to be involved in the administrative and fiscal tasks related to the provision of services to MSSP/EHP/CCTP clients. List professional degrees and certificates, etc., where appropriate (i.e., MBA, CPA, MPH).

#	Position Title	Paid?	Certificates/Licenses/Degrees

13. Describe the organization's general fiscal methods and procedures, (i.e., "double entry bookkeeping by CPA two hours per day," or "computerized accounting system with four full-time fiscal staff," etc.).

14. List the carrier name, carrier number, policy number and coverage limits for each type of insurance your organization maintains. *See attachment for insurance requirements.* **Please attach a copy of the current certificate of proof of coverage:**

Type	Carrier Name	Carrier Number	Policy Number	Coverage
Comprehensive/ General Liability				
Professional Liability/Malpractice				
Performance				
Auto				
General Fidelity Bond				
Workers' Compensation				
Products Liability				
Other				

15. Summarize your organization's experience in the provision of services to our client population.

16. List the name and contact information of two or more organizations/individuals, which have used your service and can comment on your organization's experience and quality of service provision.

17. **I certify that the above is true to the best of my knowledge.**

Authorized Signature: _____

Print Name:	
Title:	
Phone Number:	
Email:	
Date:	