Mental Health
Recovery Board
Serving Warren & Clinton Counties

Fiscal Year 2026
Pre-Contracting Questionnaire

Notice of Intent for New Providers Deadline: January 3rd, 2025
Submission Deadline: January 14th, 2025

Mental Health Recovery Board
Serving Warren & Clinton Counties

Fiscal Year 2026 Pre-Contracting Questionnaire

Table of Contents

Section I

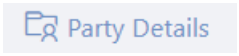
Organization Information

Please fill in the below information both into this document and in the Vendor Portal link from the Dock Contract Management System.

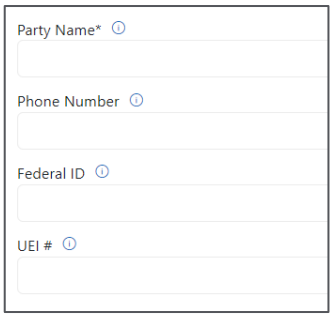
Organization Name:	
Primary Contracting Contact Name:	
Primary Contracting Contact Email:	
Primary Contracting Contact Phone Number:	

Party Details Tab in Vendor Portal

Ensure that the following details are correct on the Party Details Tab. Correct if necessary.

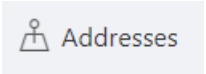


- Party Name
- Phone Number
- Federal Tax ID#
- UEI Number



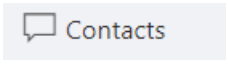
Addresses Tab in Vendor Portal

Ensure that the address in the Addresses tab is the address for the administrative offices. Correct if necessary.



Contacts Tab in Vendor Portal

Ensure that the Contacts tab has at least the Primary Contracting Contact identified above and the CEO. Correct if necessary.



Section I

Organization Contacts

Administrative Team:

CEO Name:	
Title:	
Phone:	
Email:	

CFO Name:	
Title:	
Phone:	
Email:	

COO Name:	
Title:	
Phone:	
Email:	

Compliance Contact:	
Title:	
Phone:	
Email:	

KPI Contact:	
Title:	
Phone:	
Email:	

Billing Contact:	
Title:	
Phone:	
Email:	

Program Team:

Name:	
Title:	
Phone:	
Email:	

Name:	
Title:	
Phone:	
Email:	

Name:	
Title:	
Phone:	
Email:	

Name:	
Title:	
Phone:	
Email:	

Name:	
Title:	
Phone:	
Email:	

Board of Directors:

Chairperson	

Organizational Description

Please provide a brief Organizational History (200 words or less):

Date of Incorporation:	

List of Organization's office sites/addresses where services are/would be provided to Warren/Clinton County Residents:

Address	Phone#	Services available @ Location	Days of Operation	Hours of Operation

If the organization does not currently have a location in Warren and/or Clinton Counties, are there plans to establish one? Please explain.

Current number of Warren and Clinton County clients served by Primary Payor Source**:**

Medicaid:		Private Insurance:	
Medicare:		Other Payor:	

Does your organization utilize Trauma-Informed Care principles? Yes ☐ No ☐

Does your organization take Medicaid insurance? Yes ☐ No ☐

Does your organization take *any* private health insurance? Yes ☐ No ☐

Section I

Accreditation/Certification Information

Attach the most recent copy of any of the applicable accreditations into the Documents Tab in the Vendor Portal. Use the Upload Document button in the portal to submit the document.

Does your agency have National Accreditation?*

☐ Yes ☐ No

If **yes**, which entity? ☐ CARF ☐ COA ☐ JCAHO ☐ Other:

Is your organization certified by the OhioMHAS?*

☐ Yes ☐ No

If **no**, describe your organization:

Is your organization certified by Ohio Recovery Housing?*

☐ Yes ☐ No

*Contract Provider shall submit to MHRBWCC Certificates for all accreditations within 30 days of each renewal.

In the past 2 years, have there been any actions against your organization through a national accreditation body (CARF, COA, JCAHO), OMHAS, or any other state licensing body requiring a corrective action plan, a temporary license, or certification suspension or revocation?

☐ Yes ☐ No

If **yes**, please explain including step(s) taken to resolve the issue(s):

In the past 10 years, has a national accrediting body (CARF, COA, JCAHO), governmental entity (Medicare, Medicaid), or a state licensing authority (OMHAS) suspended, revoked, or terminated their relationship with your organization?

☐ Yes ☐ No

If **yes**, please explain including step(s) taken to resolve the issue(s)

Section I

Insurance Information

Upload evidence of the insurance requirements to the Insurances Tab in the Vendor Portal.

The following insurance is required of *all* Contract Agencies: *Upload current Certificate(s) of Insurance in the Vendor Portal and fill out the coverages below.*

Required Insurance Description	Amount of Agency Coverage in $	
Automotive Liability Insurance – equal to Ohio minimum requirements if vehicles are used to transport clients.		
Workers' Compensation – either through state fund or self-insured.		
General Liability – at least $1,000,000 per occurrence with an annual aggregate limit of at least 3,000,000.		
Professional Liability - single limit coverage in an amount of at least $1,000,000 per occurrence with an annual aggregate limit of at least $3,000,000.		
Employers' Liability – minimum amount of $500,000.		
Employee Dishonesty – recommended coverage either through bond insurance or liability insurance. (If no coverage obtained, the Contract Agency assumes all risk for losses.)		
Directors and Officers Insurance – at least $1,000,000 per occurrence with an annual aggregate of at least 2,000,000.		
Is MHRBWCC identified as an additional named insured of all coverage?	☐ Yes	☐ No

Does your organization have a Claims-made policy?	☐ Yes*	☐ No

*If yes, extended reporting period ("tail") coverage or continuous coverage from date of first contract with MHRBWCC is required. Provide the following: *Attach Tail Coverage endorsement or evidence of continued coverage from first claims-made policy issued while under contract with the Board.*

All Contract Agencies shall submit to MHRBWCC Certificates of Insurance evidencing each type of coverage required and shall provide MHRBWCC with notice of cancellation or non-renewal of any such coverage within 30 days of the time the Agency receives such notice.

Section I

Financial Monitoring/Sub-Recipient Monitoring

A. Financial Audit Information

Most Recent Audit Completed FY or CY ending date:	
Audit Completion date (report date):	
Name of Audit Agency/Firm:	
Name of the Lead Partner on the Audit Engagement:	
How many years have they been Lead Partner on organization's audit?	

1. Attach a copy of your organization's most recent financial audit report in the Documents tab of the Vendor Portal. If already provided to MHRBWCC, specify date submitted:

2. Does your organization receive federal funds? ☐ Yes ☐ No

   If yes, what were the results of previous audits including whether or not a Single Audit was performed in accordance with the Uniform Guidance, and the extent to which the same or similar sub-awards has been audited as a major program.

B. Accounting System/Controls

1. Identify the methods(s) used for financial reporting on your organization level reports and your Financial Statements during Audit (i.e., Cash, Accrual, etc.)

2. How often do you report your financial statements to your board of directors?
   ☐ Monthly ☐ Quarterly ☐ Annually ☐ Other, please explain:

3. What financial software package does the Organization utilize (i.e., Excel, Quickbooks, etc.)?

4. What EHR software/program is being utilized by the Organization?

5. Does your accounting system identify the receipt and expenditure of program funds separately for each grant?
   ☐ Yes ☐ No ☐ Not Sure

6. Does your accounting system provide for the recording of expenditures for each grant/contract by budget cost categories shown in the approved budget?
   ☐ Yes ☐ No ☐ Not Sure

7. Are time distribution records maintained for each employee that specifically identify effort charged to a particular grant or cost objective?
   ☐ Yes ☐ No ☐ Not Sure

8. Does your accounting system include budgetary controls to preclude incurring obligations or costs in excess of total funds available or by budget cost category (e.g., Personnel, Travel, etc.)?
   ☐ Yes ☐ No ☐ Not Sure

C. Property Standards & Procurement Standards

1. Does your property management system(s) provide for maintaining:
   a) a description of the equipment
   b) an identification number
   c) source of the property, including the award number
   d) where title vests
   e) acquisition date
   f) federal share of property costs
   g) location and condition of the property
   h) acquisition cost
   i) ultimate disposition information

   ☐ Yes ☐ No ☐ Not Sure

2. Does your organization maintain written procurement procedures which
   a) avoid unnecessary purchases
   b) provide an analysis of lease and purchase alternatives
   c) provide a process for soliciting goods and services

   ☐ Yes ☐ No ☐ Not Sure

3. Does your procurement system provide for selection on a competitive basis and documentation of cost or price analysis for each procurement action?
   ☐ Yes ☐ No ☐ Not Sure

D. Monitoring

1. Key Performance Indicators:

Most Recent Audited Period
(example June 30, XXXX or December 31, XXXX):

Please provide the following information (in $) for the period indicated above. Ratios are calculated using in-form programming and do not require manual calculation.

Current Assets:	
Current Liabilities:	
Total Liabilities:	
Total Net Assets/Equity (without donor restrictions):	
Total Revenue (without donor restrictions):	
Total Expenses (without donor restrictions):	
Total Management & General Costs (non-program):	
Total Current Revenue from MHRBWCC:	

Ratios	Calculation	Benchmark	Result
1. Current Ratio	$\frac{Current\ Assets}{Current\ Liabilities}$	> 1.50	
2. Debt to Equity Ratio	$\frac{Total\ Liabilities}{Total\ Net\ Assets\ (Equity)}$	< 1.50	
3. Administrative Costs to Expenses	$\frac{Total\ Administrative\ Costs}{Total\ Expenses}$	< 20%	
4. Revenue to Expenses	$\frac{Total\ Revenue}{Total\ Expenses}$	> 1	
5. Net Asset Reserve (# months)	$\frac{Total\ Net\ Assets\ (Equity)}{Total\ Expenses/12}$	$\geq$ 3	
6. Percent of Funding from MHRBWCC	$\frac{Total\ Rev.\ from\ MHRBWCC}{Total\ Revenue}$	< 70%	

If any of the above benchmarks are not met (in red), please provide a brief explanation:

2. Complexity:

a) Does your Organization intend on using any funds received from the MHRBWCC to meet any of your matching requirements? ☐ Yes ☐ No

If "Yes", please provide details (i.e. – **Funding Source, Amount, etc.**):

b) Does your Organization receive any Federal awards directly from a Federal awarding agency?

☐ Yes ☐ No

If Yes, please list:

c) Identify any additional examples of relevant experience with federal awards and compliance with federal award/subaward requirements, if applicable: ☐ N/A

3. Organizational/System Changes:

a) Have there been changes in the accounting or computer systems in the past 12 months and/or any anticipated changes in the foreseeable future?

☐ Yes ☐ No

If yes, describe:

b) Have there been changes in the EHR computer system in the past 12 months and/or any anticipated changes in the foreseeable future?

☐ Yes ☐ No

If yes, describe:

c) Have there been changes in management (i.e. – CEO, CFO, etc.) in the past 12 months and/or any anticipated changes in the foreseeable future (i.e. – planned retirements)?

☐ Yes ☐ No

If yes, describe:

d) Has the Organization undergone a re-organization, re-structuring or downsizing in the past 12 months and/or any anticipated changes in the foreseeable future?

☐ Yes ☐ No

If yes, describe:

e) Identify major changes in policies or procedures in the past 12 months and/or any anticipated changes in the foreseeable future? (i.e. funding priorities, organization operations)

If yes, describe:

f) Is there any known potential for a significant reduction of, or a termination of, current funding within your organization or any other issues that may cause concern about program or organization viability? (i.e., grant expiration, potential serious financial loss exposures, bad debt, etc.). ☐ Yes ☐ No

If yes, provide details including corrective actions taken and the effectiveness of those actions:

4. Management/Personnel Stability:

a) Does the administrative staff (CEO, CFO) have at least three (3) years' experience in their current position with the organization, or at least five (5) years' experience in a comparable position in the field? **Please list staff and number of years.**

b) What was the Organization's average staff turnover rate during CY24?

# of employees leaving for any reason between 1/1/24 and 12/31/24	
# of employees on 1/1/24	
# of employees on 12/31/24	
$Turnover\ Rate = \frac{\#\ Employees\ Leaving}{Average\ (\#\ Employees\ Beginning, \#\ Employees\ End)}$	

c) How many positions were budgeted for Warren/Clinton Counties?

d) How many of these Warren/Clinton County positions were filled on December 31, 2024?

e) Optional: Provide any observations or explanation regarding CY24 turnover/vacancies:

5. Irregularities:

a) Is the Organization aware of any of the following at the Organization or with its sub-contractors?

1) Fraud	☐ Yes	☐ No
2) Waste	☐ Yes	☐ No
3) Abuse	☐ Yes	☐ No

If so, what are the proposed or actual actions?

b) Has Organization been suspended, debarred, or determined ineligible from entering into contracts with any department or other agency of the Federal Government, or received a notice of proposed debarment or suspension? ☐ Yes ☐ No

Organization agrees to provide immediate notice to MHRBWCC if it is suspended, debarred, or declared ineligible by any department or other agency of the Federal Government at any time while under contract. ☐ I Agree

c) Pursuant to ORC 9.24, does the organization have a certified, unresolved finding(s) for recovery with the Auditor of State or received notice of proposed finding for recovery? ☐ Yes ☐ No

Organization agrees to provide immediate notice to MHRBWCC if it has a finding for recovery from the Auditor of State at any time while under contract ☐ I Agree

Consumer Outcomes and Satisfaction

Pursuant to OAC 5122-28-04, each provider shall collect data on consumer outcomes and satisfaction with services in order to improve its ability to provide quality mental health and addiction services.

Upload a copy of your organization's most recent Consumer Satisfaction report in the Documents Tab of Vendor Portal in Dock.

Client Rights and Grievance Procedure

Pursuant to OAC 5122-26-18, each OMHAS certified provider shall have a written policy/procedure for client rights and grievances. MHRBWCC must ensure this policy/procedure is in compliance per OAC 5122:2-1-02. If applicable, provide the written policies and procedures related to seclusion and restraint pursuant to OAC 5122-26-16.

Upload a copy of the most recent Client Rights/Grievance Policy/Procedure *in the Documents Tab of Vendor Portal*. If applicable, upload a copy of the most recent Seclusion, Restraint, and Time-Out Policy/Procedure in the *Documents Tab of Vendor Portal*.

The Client Rights Policy and Grievance Procedure is to be posted in each location in which services are provided, unless the location is not under control of the provider (i.e., a shared location such as a school, jail, etc. and where it is not feasible for provider to do so). The Client Rights Officer's name, location, hours and contact information shall be included. Where can the posting(s) be found in Warren/Clinton County sites (specify by site/location)?

If not posted, specify plans to come into compliance:

Section I

List Number of Grievances reported/ resolved in your Organization during **CY24** involving Warren or Clinton County Residents:

Types of Grievances by Client Rights Categories	Number of Grievances Received	Number of Grievances Resolved	FOR REFERENCE: Category aligns with the following Client Rights:		
			Community Provider	Residential Class 1 Provider	Residential Class 2/3 Provider
Right to Dignity and Respect			1, 2, 3	5, 6, 7, 8, 20, 21, 29	5, 6, 7, 8, 21, 22, 30
Right to Informed Choice and Treatment			4, 5, 6, 12, 13, 20	14, 18, 19, 22, 30	14, 19, 20, 23, 31
Right to Freedom			7, 8, 9	9, 10, 11, 24, 26, 25, 28, 29, 31, 32	9, 10, 11, 25, 26, 28, 29, 32, 33
Right to Personal Liberties			10, 11, 14, 15, 21	12, 13, 15, 16, 17, 23	12, 13, 15, 16, 17, 18, 24
Right to Freely Exercise All Rights			16, 17, 18	1, 2, 3, 4, 27	1, 2, 3, 4, 27
Service Improvement and Environment					
Other: (Housing, Employment, Custody, etc.)					

Briefly describe grievances received and resolution:

How many grievances resulted in some sort of Quality Improvement at the Provider Level?

Briefly list/describe client rights quality improvement initiatives implemented in **CY24** to address client grievances?

Section II – FY26 Service Interest

If your organization received funding from MHRBWCC in FY25, complete **Section II-A**.
If the organization did not receive FY25 funding, complete **Section II-B**.

Section II-A - Existing Provider Service Interest

If the organization receives funding from MHRBWCC during FY25, please complete Section II-A.

Part I

Are you proposing any alterations in the service array across full continuum (Prevention, Treatment and Recovery) from the FY25 Plans (discontinuing, adding, altering or reducing services)?

☐ **No** – Proceed to Part 3

☐ **Yes** – Please describe in Part 2 below

Part 2

Continue to the following pages to describe any proposed service discontinuations, new services, alterations to existing services, or reduction in existing services.

- Any proposed substantial change to the amount, scope, or ability of a client to access a service requires written notification to MHRBWCC no later than 120 days prior to the end of the FY25 contract (required by current contract). **Please note:** Documentation included with this Pre-Contracting Questionnaire, if applicable, does not fulfill this requirement; a separate, written notice must be provided to MHRBWCC in accordance with the requirements of Ohio Revised Code 340.036(D).
- For any New/Altered Services, please ensure alignment with the MHRBWCC Prioritization of Services White Paper.
- If there are no proposed alterations in the service array, please leave the page blank. For example, if you are only planning to discontinue a service, do not fill out the addition, altering, or reducing pages.

Section II – FY26 Service Interest

Discontinuation

If you are proposing <u>discontinuing</u> a current service, please identify which service(s) and provide rationale for proposed discontinuance:

Service(s):

Rationale for proposed discontinuance:

Anticipated Impact of proposed discontinuance, including estimated # of unduplicated individuals who would be impacted annually:

Planned date of discontinuance:

Section II – FY26 Service Interest

New

If you are proposing a <u>new</u> service, please provide the following detail:

Briefly explain the proposed new service and any unique program characteristics, including Target Population and Admission Criteria:

Evidence Based or Promising Practices to be used:

Has the organization provided this service previously? If so, for how long and where?

Estimated # of unduplicated individuals who would be served by the program annually (capacity):

Estimated Cost for proposed program:

Staffing Plan (include number, type, and licensure of staff required and planned recruitment strategies):

Planned Start date:

Section II – FY26 Service Interest

Alteration

If you are proposing an altered service, please provide the following detail:

Which service are you proposing to alter:

Briefly explain the proposed changes including, but not limited to, program characteristics/delivery, Target Population, Admission Criteria, etc.:

Evidence Based or Promising Practices changes, if applicable:

Anticipated Impact of proposed alteration, including estimated # of unduplicated individuals who would be impacted annually (capacity):

Cost implications of the altered service (i.e., more/less funding needed and how much):

Staffing Implications (how will this altered service impact current and future staffing):

Planned Start date of altered program:

Section II – FY26 Service Interest

Reduction

If you are proposing a <u>reduced</u> service, please provide the following detail:

Which service are you proposing to reduce:

Briefly explain the proposed reductions including, but not limited to, program characteristics/delivery, Target Population, Admission Criteria, etc.:

What system of care implications are anticipated as a result:

Estimate # of unduplicated individuals who would be impacted by this change annually:

Cost implications of the reduced service (i.e., what is the reduced funding amount needed):

Staffing Implications (how will this reduced service impact current staffing):

Planned Start date of reduction:

Section II – FY26 Service Interest

Part 3

Please detail any additions/deletions of Procedure codes you are requesting on the Agency Offeror Form. (This may be detailed here in narrative form OR marked up FY25 Offeror Form may be uploaded separately in the Documents Tab of Vendor Portal in Dock)

For any Fidelity-Based Services, please provide the following information

Service Name	Last Score	Date of Last Review	Name of Reviewing Entity

Section II-B - New Organization Service Interest

*If you need more room to provide information, please upload additional information in a separate document not to exceed **3 pages**.*

Part 1

When proposing a service, please refer to the MHRBWCC Prioritization of Services White Paper

Briefly explain the proposed service and any unique program characteristics, including Target Population and Admission Criteria:

Identify Fidelity, Evidence Based or Promising Practice(s) to be used:

Briefly describe the implementation plan:

Staffing Plan (include number/type of staff required and planned recruitment strategies):

Has the organization provided this service previously? If so, for how long and where?

Estimated # of unduplicated individuals who would be served by the program annually (capacity):

Section II – FY26 Service Interest

Part 2

Purchase of Service funding: Specify the CPT Procedure Codes organization is proposing to bill (Should align with OMHAS certification; MHRBWCC pays at Medicaid rates after all insurance coverage has been billed to fullest extent):

Grant/Cost funding requested for the following services:

***All proposed Grant-Funded Services must have a completed Grant Position Budget Form submitted with the PCQ**

Rationale/Explanation of funding request (i.e., what formula or assumptions were used to derive the funding request above):

Total funding request (dollar amount) for FY26 (MHRBWCC reimburses clinical services at Medicaid rates for Warren/Clinton County Residents based upon Sliding Fee Scale eligibility-calculations available upon request):

Purchase of Service	$ _____
Grant/Cost Funding	$ _____
TOTAL Request	$ _____

Section III – Certification

This page can be signed electronically or scanned and uploaded as an additional file.

Checklist of Attachments Uploaded

- ☐ **National Accreditation Certificate** (if applicable) in Documents Tab
- ☐ **OMHAS Certificate(s)** for each site (if applicable) in Documents Tab
- ☐ **Ohio Recovery Housing Certification(s)** for each site (if applicable) in Documents Tab
- ☐ **Insurance Certificate(s)** (as applicable-see Insurance Section) in Insurance Tab:
    - ☐ General Liability Insurance
    - ☐ Certificate of Professional Liability Insurance
    - ☐ Certificate of Employers' Liability Insurance
    - ☐ Certificate of Automobile Insurance
    - ☐ Verification of OBWC Certificate of Premium Payment
    - ☐ Certificate of Employee Dishonesty Insurance Coverage
    - ☐ Certificate of Directors and Officers Insurance
    - ☐ Claims-Made Insurance Policy (if applicable)
- ☐ **Most Recent Financial Audit** in Documents Tab
- ☐ **Most Recent Outcomes Report** in Documents Tab
- ☐ **Most Recent Satisfaction Survey Report** in Documents Tab
- ☐ **Current Client Rights/Grievance Policy/Procedure** in Documents Tab
- ☐ **Current Seclusion/Restraint/Time-Out Policy/Procedure** (if applicable) in Documents Tab
- ☐ **Grant Funded Positions Form** (if applicable) in Documents Tab
- ☐ **Completed Pre-Contracting Questionnaire** in Documents Tab

NOTE: Should funding be awarded, the following will require completion and submission (due in late June):

- FY26 OMHAS Agreement and Assurances Attachment 4 - Standard Affirmation and Disclosure Executive Order 2011-12K
- Any additional attachments to the FY26 OMHAS Agreement and Assurances requiring provider completion and submission.

Executive Director/CEO Certification/Signature

I hereby attest that this document is a true and complete reflection of our organization and the services/project(s) being proposed for funding.

Executive Director/CEO Name

Executive Director/CEO Signature

Date