PROVIDER'S QUESTIONAIRE (PC)

All Providers must complete the following questionnaire. If necessary, additional sheets may be used to complete the answers. The Provider may submit marketing materials to further demonstrate its experience level, or may provide any other additional information that may be helpful.

1. Name and address of Provider (Corporate Office):

   _____

   _____

   _____

   Telephone Number: _____

2. Name & Title of Administrator:

   _____

   _____

3. Location (address) of all offices or facilities where work under this contract would be performed:

   _____

   _____

   _____

4. Form of Business (check each one that applies):

   _____ Public Non-Profit

   _____ Private Non-Profit

   _____ Corporation

   _____ Partnership

   _____ Public for Profit

   _____ Private for Profit

   _____ Individual Proprietor

5. Since regulations prohibit Adams County Office for Aging, Inc. from contracting with a Provider that exercises a mandatory retirement policy, please disclose whether or not your organization has a mandatory retirement policy.

_____

_____

_____

_____

6. Number of years providing type of services for which this proposal is being submitted:

_____

7. Has Provider ever been awarded a similar contract for any government body or entity?

_____ YES _____ NO

8. Are you serving or have you provided services of the size and scope described in these specifications?

_____ YES _____ NO

If yes, explain: _____

_____

_____

9. Has Provider ever defaulted on a contract or failed to complete any services similar to those under this RFP?

_____ YES _____ NO

If yes, please explain: _____

_____

_____

10. Has Provider ever terminated a contract for services similar to those under this RFP?

_____ YES _____ NO

If yes, please explain: _____

_____

_____

11. Has Provider ever been declared ineligible or barred from submitting bids for any governmental contracts?

_____ YES _____ NO

If yes, please explain: _____

_____

_____

12. Has the Provider or any of its Principals, Officers, or present or former employees, ever been found by the Equal Employment Opportunity Commission, any federal court or administrative agency, to have discriminated against any person because of race, color, national origin, religious creed, age, sex, or disability?

_____ YES _____ NO

If yes, please explain: _____

_____

_____

13. Has the Provider or any of its Principals, Officers, or present or formal employees, ever been found by the PA Human Relations Commission, state courts, administrative agency, or related entities in any other state, to have discriminated against any person because of race, color, national origin, religious creed, age, sex or disability?

_____ YES _____ NO

If yes, please explain: _____

_____

_____

14. Does the Provider have any outstanding unsatisfied judgments or tax liens filed against the Provider, or any lawsuit pending against the Provider?

    _____ YES _____ NO

    If yes, please explain: _____

    _____

    _____

15. Please list any background and experience of the Provider's Principals and Officers that you feel demonstrate the Provider's ability to perform these services:

    _____

    _____

    _____

16. Please list at least three (3) purchaser organizations with whom you have done or are currently doing business, submitting the following information:

    a. Name and address of business for whom work was performed
    b. Dates work was performed
    c. Name, address and telephone number of supervisor or contact person
    d. Description of the nature of work performed, length of service
    e. If previous purchaser, describe the reason(s) for service termination per purchaser

    _____

    _____

    _____

    _____

    _____

17. List and attach a copy of all current Provider licenses and/or certifications, if applicable. Including Provider License (when appropriate) your Home Care Agency issued by PA Department of Health.

_____

_____

_____

18. Attach a copy of the Provider's most recent audit.

19. List Provider's IRS Identification Number:

_____

The undersigned lawfully authorized official of the Provider hereby certifies that the above information is true and correct, and authorizes and requests any person, firm or corporation to furnish any information requested by Adams County Office for Aging, Inc. for verification of such information.

Date: _____

_____
Authorized Signature

_____
Printed Name and Title