

PROVIDER’S QUESTIONNAIRE (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 _____ Public for Profit
_____ Private Non-Profit _____ Private for Profit
_____ Corporation _____ Individual Proprietor
_____ Partnership

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