

THE LACKAWANNA COUNTY AREA AGENCY ON AGING
RFQ 15-16 THROUGH 16-17

**AGENCY SUMMARY
FORM A**

This form should be completed and submitted with the Request for Qualification by the submission date noted in the Annual Request for Qualification for Service Providers.

I. AGENCY INFORMATION		
Agency Name:		
Corporate Address:		
City:	State:	Zip Code:
Phone:		Email:
Services Provided:		
EIN Number:		
*Corporate Officer's Name:		Title:
Corporate Officer's Signature:		

* Person authorized to execute agreements

II. AGENCY DESCRIPTION
In the space below, please provide a brief description of your agency's history, ownership and organizational structure. Include as attachments an organizational chart, applicable licenses and other supporting documents.

III. AGENCY SERVICES

Instructions: In the space below, please list all services provided and the address of service delivery provided by your agency.

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Service Name	Service Location

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**SCOPE OF SERVICES/STATEMENT OF QUALIFICATIONS
FORM B**

I. SERVICE DESCRIPTION

In the space below, please provide a brief description of the proposed service and your agency's qualifications and experience in providing this service. *Include private-pay rates for each service and requested rates from the Lackawanna County Area Agency on Aging.

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II. EMPLOYEE DETAILS

In the space below, please provide the names, experience, qualifications, and applicable licenses held by the individual primarily responsible for servicing the Program and any other person(s) with specialized skills that would be assigned to service the Program.

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FORM C

Instructions: In the space below, please provide a listing of all like or similar service contracts with other governmental/county programs and private/public sectors, including Memorandums of Understanding, to provide services listed on Form A. If no other service contracts exist, please mark N/A in the first space.

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OTHER SERVICE CONTRACTS					
Agency	Contact Person	Service	Contract Dates	Unit Rate	Contract Amount

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**STATEMENT OF ASSURANCES
FORM D**

I ATTEST that [TYPE NAME OF AGENCY] is not currently in violation of any regulatory rules and regulations set forth by the Pennsylvania Department of Public Welfare (DPW), Pennsylvania Department of Aging (PDA), or Pennsylvania Department of Health (PDH) that may have any impact on our agency's operations.

I ATTEST that there are no conflicts of interest to which [TYPE NAME OF AGENCY] would be subject if it were to provide the requested service on behalf of Lackawanna County.

If unable to attest to the above statement, please explain below:

I ATTEST that [TYPE NAME OF AGENCY] is not involved in any current or pending litigation with Lackawanna County or any of its Departments or Authorities.

I ATTEST that [TYPE NAME OF AGENCY] currently carries the following types of insurance coverage:

- Workers' Compensation Insurance
- Commercial General Liability Insurance
- Professional Liability Insurance
- Automobile Insurance