ADAPTIVE MODIFICATION PROGRAM

REQUEST FOR PROPOSALS

For

OCCUPATIONAL THERAPY CONSULTATIONS

CDBG YEAR 42

(July 1, 2016 – December 31, 2017)

RETURN TO:

George Russell
Director of Home Improvement Programs
Philadelphia Housing Development Corporation
1234 Market Street, 17th Floor
(215) 448-2173
george.russell@phila.gov

Proposals are due by 4:00 PM on Friday, May 6, 2016. Any proposals arriving after 4:00 PM for any reason will be rejected.
PHILADELPHIA HOUSING DEVELOPMENT CORPORATION  
ADAPTIVE MODIFICATION PROGRAM  
REQUEST FOR PROPOSALS FOR OCCUPATIONAL THERAPY CONSULTATIONS

This Request for Proposals ("RFP") provides interested providers with the information required to prepare and submit proposals for consideration by the Philadelphia Housing Development Corporation ("PHDC") to satisfy the need for occupational therapy consultations ("OTC") to be provided to the homes of low income, physically disabled residents of Philadelphia enrolled in the Adaptive Modification Program ("AMP").

I. RESPONSE DATE

In order to be considered, proposals must be received by George Russell, AMP Director, Philadelphia Housing Development Corporation, 1234 Market Street, 17th Floor, Philadelphia, PA 19107, on or before 4:00 PM on Friday May 6, 2016.

II. PRE-PROPOSAL BRIEFING

Providers desiring to participate in AMP are strongly urged to attend the RFP Briefing Session being held on Wednesday, April 20, 2016 at 10:00 A.M. in the PHDC Board Room, 1234 Market Street, 17th Floor, Philadelphia, PA.

Topics covered at the briefing will include:
- State of the Program and expected funding levels
- Review of the RFP package, including insurance requirements and critical documents for providers to include
- Contract preparation steps

Contractors are advised that copies of this Request for Proposals will not be available at the Pre-Proposal Briefing.

III. QUESTIONS

Please review this RFP package and bring your questions to the above-mentioned briefing.

Providers may call with questions or arrange appointments with AMP staff to resolve RFP preparation questions. Appointments will be entertained during the period of April 20, 2016 (after the Briefing) to May 5, 2016 (before the due date). Providers should schedule appointments as early as possible as AMP staff may have limited time to meet with providers during this period. Contact names and telephone numbers will be provided at the Briefing. This offer of individual appointments is only available to those providers who attend the Briefing.

IV. PROGRAM DESCRIPTION

The Adaptive Modifications Program provides accessibility modifications, including, but not limited to, exterior wheelchair lifts, stairway elevators, first floor full- and half-bathrooms, railings, increased lighting and kitchen modifications. Services are provided to the homes of low-income Philadelphia residents with permanent physical disabilities and are available to both homeowners and renters. Clients are served on a first-come, first-served basis and generally may only receive services one time through this program. All modifications are recommended by a licensed occupational therapist. General repairs are not included in this program.

PHDC expects to provide 200 visits (consultation or follow up) in CDBG Year 42.
V. **SCOPE OF SERVICES**

A. **Consultations**

a. All clients will be referred by PHDC staff. **Clients will be referred by email only. Provider must have the ability to receive referrals by email with PDF attachments.**

b. The provider will arrange for home visits by an occupational therapist (“OT”) to be completed within a set time frame acceptable to PHDC. The purpose of these visits will be to recommend home modifications to increase independence and/or access to the home and community according to the client’s preference. PHDC may choose to accompany OT on home visits for some cases.

c. The OT will recommend the lowest priced modifications that will meet the client’s needs and the program goals.

d. PHDC will make every reasonable effort to inform provider if a client is hospitalized, institutionalized, removed from the home or unavailable for any other reason. Provider will contact clients prior to scheduled appointments to confirm appointments. PHDC will not reimburse provider for consultations or follow up visits not completed for any reason.

B. **Follow Up Visits**

a. When authorized by PHDC, provider will make follow up visits to clients after the provision of home modifications. The purpose of these visits is not to recommend additional technology or modifications, but rather to ensure client can safely use the modifications and/or equipment provided.

C. **Records and Documentation**

a. Written consultation and follow up reports will be completed using forms approved by PHDC (Exhibits “A” and “B”). The information provided will include, but not be limited to:

   a) Client’s physical conditions and nature of disability;
   b) Obstacles in the home that diminish client’s ability to use the home safely;
   c) Recommended changes, if any, to be made to the house; and
   d) Description of what recommended changes will accomplish.

b. Recommendations will be specific, stating location and size of environmental modifications, and manufacturer’s name and model number for any medical equipment or assistive technology.

c. Provider will submit completed evaluation reports within five (5) business days of consultation to designated PHDC staff.

d. Provider must maintain a standardized record keeping system. Client information must be maintained in a confidential manner and records must be kept for a minimum of five (5) years. The record for each client must include:

   a) A copy of the referral form(s) received from PHDC;
   b) A copy of the consultation report;
   c) Individual documentation signed by the client or family member/caregiver documenting each home visit; and
d) A copy of the follow up report

D. Availability & Staffing

a. Contractor will have the ability to complete all consultations and follow up visits within a time frame acceptable to PHDC, and complete not less than five visits per week.

b. Provider will make home visits in all neighborhoods of Philadelphia.

c. Provider will have a method of being contacted immediately at all times during regular business hours.

d. Provider will not subcontract services under its contract with PHDC without the express written consent of PHDC and only to subcontractors who meet all of PHDC’s requirements.

e. PHDC may reject without payment any work that, in PHDC’s sole discretion, does not meet PHDC standards.

E. Supervision

a. All evaluations will be reviewed by a “lead” Occupational Therapist prior to submission to PHDC.

b. Provider will assume responsibility for supervision of its staff as well as subcontracted therapists to assure quality and delivery of services.

VI. OCCUPATIONAL THERAPIST STANDARDS

A. Consultations and Follow Up Visits are to be provided by Occupational Therapists currently licensed without conditions or other restrictions in the Commonwealth of Pennsylvania. Documentation of such licenses, and any claims filed with provider or a regulating agency against any Occupational Therapist provider will use must be provided to PHDC with the response to this RFP.

B. Occupational Therapists shall have at least five years of occupational therapy experience in a home care setting with at least two years of experience in major modifications (wheelchair lifts, barrier-free showers, accessible kitchens and bathrooms.)

C. PHDC reserves the right to request provider to remove individual staff or subcontractors from performing consultations and/or follow up visits to specific PHDC clients or from seeing any PHDC client.

D. All Occupational Therapists, including both provider’s and subcontracted staff (if any), who have not previously worked under an AMP contract are required to attend an orientation session before they can serve any PHDC client. Resumes for all professional staff must be submitted with the response to this RFP.

VII. INSURANCE

A. Minimum insurance requirements for selected providers are shown on the sample insurance certificate attached hereto as Exhibit C. Before submitting a response to this RFP, provider should verify through their insurance carriers that they would be able to obtain the necessary insurance coverage.
B. Only sole proprietors and LLCs without employees, who cannot purchase worker’s compensation insurance, are excluded from carrying worker’s compensation coverage and must complete and submit any and all supporting documentation as requested. All other providers will be required to carry workers compensation insurance.

C. Provider may not use subcontractors who do not carry all required insurance at the levels specified herein and name PHDC and the City of Philadelphia as additional insureds on all liability insurance policies.

D. **PHDC and the City of Philadelphia** must be named as additional insureds on all required liability insurance policies except workers’ compensation and professional liability before contracts can be finalized. All policies will include liability insurance as applicable to the provider’s obligations hereunder. Certificates of insurance showing required coverages must be submitted with the response to this RFP. Endorsements to the liability policies stating that the coverage afforded PHDC and the City of Philadelphia are primary and non-contributory to any other coverage available will be required before a contract is executed.

**VIII. SUBCONTRACTING**

A. Provider may subcontract work under this program to a licensed occupational therapist who meets the above guidelines and insurance requirements. All subcontractors must be listed and identified as subcontractors on the response to this RFP and copies of their licenses and insurance certificates included.

**IX. CONTRACT AWARD**

A. PHDC intends to enter into contracts with the provider(s) recommended by the AMP Proposal Review committee.

B. The contract(s) resulting from this RFP will be awarded to the qualified provider(s) whose proposal(s) would be the most advantageous to PHDC.

C. The selected provider(s) will be required to execute a contract document prepared by PHDC. The General Terms and Conditions which will be a part of that document will include, but not be limited to:
   a. Administrative Requirements
   b. Conflicts of Interest
   c. Liability indemnification

D. A copy of the General Terms and Conditions will be available at the scheduled Briefing.

**X. PROPOSAL REQUIREMENTS**

A. Proposals must include the following sections, in order:

   a. **Cover Page** (provided)

   b. **Description of the provider/organization** including:
      a) Primary location
      b) Legal status (corporation, LLC, partnership, sole proprietorship)
      c) State of incorporation or LLC organization, if applicable;
d) Year of incorporation, formation, organization or establishment  
e) Brief description of provider’s history, purpose, goals and objectives

c. **Experience:**  
A complete and detailed description of provider’s experience in providing consultation services for major home modifications, including the types of modifications, the population(s) served, and the program/funding source(s).

d. **Workflow:**  
A narrative description of the provider’s proposed workflow to ensure required timeframes are met.

e. **Staffing**  
Identification of “lead therapist” who will work on this program and all other therapists, both staff and subcontractors. Copies of licenses, resumes and histories of claims and litigation to be included as an appendix.

f. **Certifications (provided):**  
Certification that provider is not on any federal, state or city debarment or suspension listings, that the provider has not used federal funds to influence an employee or Member of Congress in connection with a federal grant, and that provider is in good standing with the City of Philadelphia with regard to any employment, real estate, business or other taxes.

g. **Pricing**  
Unit Prices for the following:

a) OT Consultation  
b) OT Follow Up Consultation  
c) Hourly rate for meetings requested by PHDC (except for initial orientation)  

**ALL OTHER COSTS MUST BE INCLUDED IN ABOVE UNIT COSTS**

**XI. PROPOSAL SUBMISSION**

A. The total response to all questions should be a maximum of 20 pages, excluding attachments, double-spaced with font size no smaller than 12.

B. Three complete copies of proposals should be submitted to:

George Russell  
Director of Home Improvement Programs  
Philadelphia Housing Development Corporation  
1234 Market Street, 17th Floor  
Philadelphia, PA 19107

C. Proposals must be received by Mr. Russell by 4:00 P.M. on Friday, May 6, 2016. PHDC will accept no responsibility for the failure of the US Postal Service or commercial carriers to deliver proposals by the deadline.

D. Any applicant who willingly and knowingly provides false information, as verified by PHDC, will be immediately disqualified from consideration and may be referred to the appropriate authority for possible criminal prosecution.
E. Proposals submitted become the property of PHDC.

XII. EVALUATION CRITERIA

A. A team of PHDC staff (comprising the AMP Proposal Review Committee) will review all proposals received. Responses will be evaluated based on experience of staff, unit price, proposed workflow and prior history with PHDC, if any, and responsiveness to this RFP. The Committee as a whole will make final recommendations.

B. The PHDC Contract Review Committee will review all recommendations made by the AMP Proposal Review Committee before submitting any contract recommendations to PHDC’s Board of Directors.

XIII. RESERVATION OF RIGHTS BY PHDC

A. PHDC, in its sole discretion, reserves the right to reject any and all responses to this RFP and is not bound to adopt any proposal submitted in response to this RFP that is contrary to its best interests.

B. PHDC reserves and may exercise the right to accept or reject any and all proposals and re-issue this RFP at any time prior to execution of a final contract; issue a new RFP with terms and conditions substantially different from those set forth herein; extend the time period for responding to this RFP; or cancel this RFP with or without another notice of RFP. In addition, PHDC reserves and may exercise the following rights and options with respect to this selection process:

   a. Request supplementation, clarification, confirmation or modification to or of any information in the submission;
   b. Supplement, amend, substitute or otherwise modify this RFP at any time prior to selection of one or more applicants for negotiation, and cancel this RFP with or without issuing another RFP;
   c. Request supplements to proposals based on the review of all proposals;
   d. Negotiate any aspect of the proposal, including price;
   e. Conduct personal interviews with applicants to assess compliance with the selection criteria;
   f. Terminate any negotiations at any time;
   g. Accept or reject at any time prior to the execution of a contract, all submissions and/or withdraw this RFP without notice;
   h. Expressly waive any defect or technicality in any proposal;
   i. Solicit new proposals;
   j. Rescind a selection prior to contract execution if PHDC determines in its sole discretion that the proposal does not conform to the specifications of this RFP; and/or
   k. Rescind a selection prior to contract execution if PHDC determines that the specifications contained in this RFP are not in conformity with law or that the process in selection of the applicant was not in conformity with law or with the legal obligations of PHDC.

By submitting a proposal in response to this RFP, an applicant affirmatively indicates acceptance of the terms and conditions of this RFP.
XIV. NON-DISCRIMINATION

A. Equal Opportunity Requirements

Under the authority of Executive Orders No. 03-12, the Office of Economic Opportunity of the City of Philadelphia (the “City”) has established an antidiscrimination policy setting ranges for participation by Minority Business Enterprises (“MBE”), Women Business Enterprises (“WBE”) and Disabled Business Enterprises (“DBE”) in City contracts, which have been adopted by PHDC. The participation ranges for this Request for Proposals are:

- **MBE:** 10% - 20%
- **WBE:** 5% - 10%
- **DSBE:** BEST EFFORTS

These participation ranges serve exclusively as a guide in determining contractor responsibility.

Contractors are expected to make a serious good faith effort to enlist participation from Certified minority, female and disadvantaged disabled owned firms prior to submitting your proposal to PHDC. Contractors must submit the “Solicitation and Commitment Form” to PHDC demonstrating their plan for MBE/WBE participation for approval by the City’s Office of Housing & Community Development (“OHCD”) Compliance Department. In addition, contractors selected will be required to submit an Equal Opportunity Plan for approval by the Office of Equal Opportunity prior to a contract being executed.

B. Reporting Requirements

Contractors are required to file monthly Subcontracting Business Utilization and Employment Opportunity reports with OHCD. Reports must be filed electronically in MS-Excel format.
The following attachments must be included as part of your proposal. Submissions with missing documents will be rejected. Use this form as a checklist to aid in the assembly of your proposal. This form does not need to be returned.

The following documents must be completed, signed and/or provided by all applicants:

1. Cover Sheet
2. Proposal Narrative (max 20 pages)
3. Copy of Business Privilege License
4. Copies of Professional License and Resume for all therapists (staff and subcontractors)
5. Organizational Chart as applicable to this program
6. Tax Status Certification
7. Anti-Lobbying Certification
8. Certification Regarding Debarment
9. Insurance Certificate
10. Solicitation & Commitment Form
11. Minimum Wage Certification
12. W-9
13. Statement of No Pending or Threatened Litigation
14. Conflict of Interest
15. 2015 Federal Tax Return (signed or with electronic postmark)
16. Certification Form

SUPPORTING DOCUMENTS – NON-CURRENT CONTRACTORS: The following documents are required of contractors who have not contracted with AMP in the last two fiscal years (2014-2015 or 2015-2016):

1. Articles of Incorporation and Bylaws; Certificate of Organization or Formation; or Partnership Agreement; or Fictitious Name Registration
2. Company Credit Report from a major credit bureau
PHDC ADAPTIVE MODIFICATION PROGRAM
REQUEST FOR PROPOSALS
COVER SHEET

FIRM NAME: ______________________________________________________

ADDRESS: ______________________________________________________
____________________________________________________________________

TELEPHONE: ___________________________ FAX: ______________________

CONTACT PERSON: __________________________________________________

EMAIL (required) ____________________________ CELL/PAGER: ___________

TYPE OF BUSINESS: ____ Sole Proprietorship   ____ Partnership  ____ Corporation  ____ LLC

FEDERAL EIN / TAX IDENTIFICATION NUMBER: ____________________________

DATE OF INCORPORATION / INITIATION: ________________________________

PHILA BUSINESS PRIVILEGE LICENSE #: ________________________________
(attach copy)

TOTAL STAFF (this business only):
   Administrative/Supervisory: _____ Professional: _____ Clerical: ______

TOTAL GROSS SALES FOR LAST COMPLETED FY (from IRS documents): $________

MBE/WBE/DBE Certified? _____ No _____ Yes (attach certification)

Have any of the company’s principal officers been indicted or convicted of a felony?
   _____ No _____ Yes (please explain circumstances and final disposition on a separate sheet)

SIGNED: _______________________________ DATE: _________________

PRINTED NAME & TITLE: _____________________________________________
TAX STATUS CERTIFICATION REQUEST

Taxpayer Name: ____________________________ Date: _____________________

Taxpayer Trading As: ____________________________________________________

Home Address: ________________________________________________________

Business Address: ______________________________________________________

1. Are you a Registered Taxpayer? Yes [ ] No [ ]
   If so, Philadelphia A/C # or Social Security Number

2. Identify all of your subsidiaries and affiliates:

3. Are you or any of your subsidiaries or your affiliates presently delinquent in any City of Philadelphia School District Taxes, business taxes and/or others taxes? Yes [ ] No [ ]
   If so, what tax(es) and amount(s) owed:

4. Are you or any of your subsidiaries or affiliates presently delinquent in Water and Sewer Changes and/or Philadelphia Gas Works Payments? Yes [ ] No [ ]
   If so, amount owed:

5. Have you or any of your subsidiaries or affiliates been sued by the City of Philadelphia? Yes [ ] No [ ]
   If so, list nature of law suit(s):

6. Are you or any of your subsidiaries or affiliates involved in any other business activity? If so, list company name and describe activity: Yes [ ] No [ ]

7. Do you or any of your subsidiaries or affiliates own real estate? Yes [ ] No [ ]
   If so, list address (es) here or back of this form.

I hereby affirm that the information provided above is true and correct to the best of my knowledge, information and belief; said affirmation being made subject to the penalties prescribed by 18 Pa. C. S. A. Sec. 4904 relating to unsworn falsifications to authorities.

Name: ........................................................................................................

Signature: ____________________________ Date: _____________________
ANTI-LOBBYING CERTIFICATION

I, _____________________, on behalf of ____________________________________ (“Contractor”), hereby certify that I have been duly authorized to execute this Certification on behalf of Contractor and that no Federally-appropriated funds have been paid or will be paid by or on behalf of Contractor to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan or cooperative agreement.

Contractor will provide immediate written notification to PHDC if Contractor learns that the above certification was erroneous when submitted or has become erroneous because of changed circumstances.

On behalf of Contractor, I also certify that Contractor has required, and will continue to require during the term of this Contract, this same certification from its contractors.

I verify and affirm that the statements made in this certification are true and correct in all material ways. I understand that any false statements contained herein are made subject to the penalties of 18 Pa.C.S. § 4904 relating to unsworn falsification to authorities.

________________________________         ________________________________
Witness                              Name:
  Title:
1. The prospective participant certifies, by submission of this proposal, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from participation in this transaction by any Federal, Commonwealth or City department or agency.

2. Where the prospective participant is unable to certify to any of the statements in this certification, such participant shall attach an explanation to this proposal.

BUSINESS NAME: _________________________________________________________________________

DATE: ___________________________ BY:_________________________________________________ Printed Name & Title

______________________________________________

Signature
**SOLICITATION and COMMITMENT FORM (BID)**

**MINORITY / WOMEN and DISABLED BUSINESS ENTERPRISES**

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**LIST BELOW ALL FIRMS THAT WILL BE UTILIZED IN THIS CONTRACT. PLEASE MAKE SURE THEY KNOW THEY WILL BE CALLED BY THE CITY TO CONFIRM THEIR PARTICIPATION. IF WHEN THE CITY CALLS THEY ARE NOT AWARE THEY HAVE BEEN LISTED ON THIS FORM IT WILL DELAY PROJECT APP**

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PHILADELPHIA CODE CHAPTER 17-1300 CERTIFICATION
MINIMUM WAGE / BENEFIT ORDINANCE

Section A: Gross Receipts

Contractor, _________________________________________________ certifies that Contractor’s gross receipts are:

___ $1,000,000 per year or less
   (Skip to Signature line)

___ in excess of $1,000,000 per year
   (Complete Section B)

Section B: Minimum Wage

Contractor certifies that all employees working on this PHDC program will be paid a minimum of $11.94 per hour, excluding benefits. Employees being paid less than $11.94 per hour should be listed below:

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_____________________________________________  ________________________
Signature                                                   Date

Printed Name & Title
Form W-9

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:

- Individual/solo proprietor
- C Corporation
- S Corporation
- Partnership
- Trust/estate
- Limited liability company. Enter the tax classification (C = C corporation, S = S corporation, P = partnership)
- Exempt payee

Other (see instructions)

Address (number, street, and apt. or suite no.)

City, state, and ZIP code

List account number(s) here (optional)

Part I  Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 3.

Note: If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II  Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

3. I am a U.S. citizen or other U.S. person (defined below).

Certification Instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Sign Here

Signature of U.S. person

Date

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners’ share of effectively connected income.

Cat. No. 10231X

Form W-9 (Rev. 12-2011)
STATEMENT OF NO PENDING OR THREATENED LITIGATION

Other than as attached, there is no pending or threatened litigation, claim, consent order, settlement agreement, investigation, challenge or other proceedings being brought by applicant, and/or any business associate of applicant against the City of Philadelphia or any of its departments, its Office of Housing and Community Development ("OHCD"), Philadelphia Housing Development Corporation ("PHDC"), the Philadelphia Redevelopment Authority ("PRA") or the Philadelphia Industrial Development Corporation ("PIDC").

A business associate includes, but may not be limited to: officers, directors, partners, employees, lenders, lessors and consultants. Depending on the circumstances, business associates may also include shareholders, landlords, sellers of real estate, agents, representatives, subsidiaries, affiliates or joint ventures. Applicants are encouraged to use a broad definition of "business associate" when completing this and other questions where that term is used.

On an attached sheet, list the following information regarding any pending or threatened litigation, claim, consent order, settlement agreement, investigation, challenge or other proceeding: name(s) of parties, type of proceeding, claim, etc; status of proceeding, claim, etc.

NAME (print): ________________________________

TITLE:: ________________________________________

COMPANY: ______________________________________

SIGNATURE: ____________________________________

DATE: _________________________________________
CONFLICT OF INTEREST

Applicants for assistance involving Community Development Block Grant (“CDBG”) funds are required to comply with federal regulations regarding conflicts of interest. The regulations affect the following groups of people:

   a) Employees, consultants and officers of the City of Philadelphia and its quasi-city agencies and departments;
   b) Elected or appointed officials of the City of Philadelphia, the Commonwealth of Pennsylvania or the federal government of the United States; and
   c) Employees, consultants or officers of any firm receiving CDBG program funds.

You must answer the following questions to determine if a conflict of interest exists:

1. Are you now, or have you been within the preceding year in one of the categories (a, b or c) described above?

   Yes _________   No _________

2. Is any member of your family or your spouse’s family now or have they been within the preceding year in one of the categories (a, b or c) described above? (Family members include spouses, parents, siblings and children.)

   Yes _________   No _________

3. Is any business associate (see prior definition) of yours now or have they been within the preceding year in one of the categories (a, b or c) described above?

   Yes _________   No _________

SIGNATURE: ___________________________________________   DATE: ______________

TITLE: _____________________________   COMPANY: ____________________________
CERTIFICATION

I hereby declare that I have not used any position of influence to be selected to receive assistance under a city housing program. Further, I do hereby declare that I have filed the foregoing Proposal and do hereby certify that the statements made in the foregoing application as well as in all forms and documents that are attached are true and correct to the best of my knowledge, information and belief. I understand that false statements made herein are subject to the penalties of 18 Pa C.S.A. 4904, relating to unsworn falsification to authorities.

NAME (print): __________________________________________________________

TITLE::  ________________________________________________________________

COMPANY:  ___________________________________________________________

SIGNATURE:  ___________________________________________________________

DATE:  __________________________________________________________________
EXHIBIT A – CONSULTATION FORM

PHILADELPHIA HOUSING DEVELOPMENT CORPORATION
ADAPTIVE MODIFICATION PROGRAM
OCCUPATIONAL THERAPY CONSULTATION

Referral Date: _______________ Evaluation Date: _______________

Date Rec’d by Provider: _______________

1. DEMOGRAPHIC INFORMATION:

Client: _______________________________ Phone: _______________ ZIP: ______

Address: _______________________________ PCG: __________________________

Anticipated Problems serving this household: ______________________________________________________

Reason for visit: ___________________________________________________________________________________

2. HOUSEHOLD COMPOSITION & MEDICAL INFORMATION:

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Relate</th>
<th>Ht/Wt</th>
<th>Arth</th>
<th>DM</th>
<th>CVA</th>
<th>Respiratory</th>
<th>Ortho</th>
<th>Heart</th>
<th>Mental Status</th>
<th>HTN</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Assistance Available: __________________________________________________________________________________

3. FUNCTIONAL DEFICITS RESULTING FROM MEDICAL PROBLEMS:

<table>
<thead>
<tr>
<th>SENSORY</th>
<th>Does the client have:</th>
<th>No</th>
<th>Yes</th>
<th>Yes, but compensates</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Vision loss (can’t see steps, can’t see small print or numbers etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hearing loss (can’t hear doorbell, telephone, smoke alarm etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHYSICAL/ ACTIVITY</td>
<td></td>
<td>Yes</td>
<td>Yes, but with difficulty</td>
<td>Comment</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>-------</td>
<td>-----</td>
<td>--------------------------</td>
<td>---------</td>
<td></td>
</tr>
<tr>
<td>Can the client...</td>
<td>No</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grasp (doorknobs, grab bars, cabinet handles, etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reach (into cabinets, to open door from w/c etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bend (to get into tub, pick up items, or access low cabinets etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lift (commode bucket, laundry basket, food tray etc.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICAL/ TRANSFERS</th>
<th></th>
<th>Yes</th>
<th>Level</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>What type of transfer does the client perform?</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stand-Pivot-Sit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer board/slide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent lift</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sit to Stand</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PHYSICAL/ MOBILITY</th>
<th>Method</th>
<th>Device used</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Method of mobility for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interior of home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exterior of home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steps in and out of home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steps to 2nd floor/basement</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADL and IADL Status</th>
<th>I</th>
<th>Min A</th>
<th>Mod A</th>
<th>Max A</th>
<th>D</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the level of assistance for each?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Hygiene</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cooking</td>
<td></td>
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<td></td>
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<tr>
<td>Laundry</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shopping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. **HOME ASSESSMENT:**

Living Situation: _____ story ________________  
Condition: G   F   P

Front Entrance: ________________________________

____________________

Doorbell: ______ yes  ____ no  ____ broken
Can client answer door in a timely manner? _____ yes  ____ no

Rear Entrance: ________________________________  Used for: ________________________________

Bedroom: _____ 1st floor  ____ 2nd floor  _____ 3rd floor

Bathroom: _____ old fashioned tub  ____ OH shower  _____ vanity  ____ std toilet G  P
_____ modern tub  ____ HH shower  _____ sink  ____ H/C toilet
_____ faucets: G  P  ____ stall shower  _____ no sink

Kitchen: sink faucets: G  P

Comments on kitchen set-up/accessibility  ____ satisfactory  ____ unsatisfactory

Steps: _____ 1st to 2nd  _____ 2nd to 3rd

<table>
<thead>
<tr>
<th></th>
<th>straight or curved</th>
<th>wood banister</th>
<th>iron banister</th>
<th>second railing</th>
<th>number of steps</th>
<th>width of steps</th>
<th>condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interior</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Location of Washer: _____ 1st floor  ____ basement  ____ none
Location of Dryer: _____ 1st floor  ____ basement  ____ none

Would client benefit from relocation of laundry facilities? _____ yes  ____ no
6. EQUIPMENT CURRENTLY USED:
   _____ Cane  _____ Wheelchair  _____ Bathroom Equipment
   _____ Walker  _____ Scooter  _____ Commode
   _____ Crutches  _____ Stairglide  _____ Hospital Bed
   _____ Other _________________________________________________________________________

7. INITIAL REQUEST:
   _____ Bathroom Mods / Equipment  _____ 1st floor pwdr room  _____ wheelchair lift / ramp
   _____ railings  _____ 1st floor full bath  _____ other (specify):
   _____ intercom / door release  _____ stairglide  __________________________

8. PROBLEMS:
   _____ Lack of support to safely bathe  __________________________
   _____ Lack of support:  _____ front entrance
                                rear entrance
   __________________________
   __________________________
   __________________________
   __________________________
   __________________________
   __________________________

ADDITIONAL COMMENTS:_________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
9. RECOMMENDATIONS:

<table>
<thead>
<tr>
<th>Item #</th>
<th>Price</th>
<th>Description</th>
<th>Location</th>
<th>L Ascend</th>
<th>R Ascend</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Party Wall</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Int Step</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Ext Front</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Ext Rear</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Basement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MODIFICATIONS & MECHANICAL EQUIPMENT:

- Bathroom:  
  - 18” grab bar  
  - 24” grab bar  
  - HHS sliding HHS bar hook at seated level diverter valve  
  - Tub mat check plumbing: toilet sink tub  

Consumer __________________________ Occupational Therapist, Registered/Licensed __________________________
EXHIBIT B
OT FOLLOW UP FORM

PHILADELPHIA HOUSING DEVELOPMENT CORPORATION
ADAPTIVE MODIFICATION PROGRAM
OCCUPATIONAL THERAPY FOLLOW UP

Evaluation Date: _______________ Follow Up Date: _______________

1. DEMOGRAPHIC INFORMATION:

Client: _______________________________ Phone: _______________ ZIP: __________
Address: _______________________________ PCG: ____________________________

2. INITIAL RECOMMENDATIONS:

_____ Bathroom Mods / Equipment _____ 1st floor pwdr/bath _____ wheelchair lift / ramp
_____ railings _____ kitchen _____ other (specify)
_____ intercom / door release _____ stairglide __________________________

3. EQUIPMENT / MODIFICATIONS RECEIVED (if different from recommendations, why?):

4. EQUIPMENT/MODIFICATIONS RECEIVED

Using the above broad categories (section 2), complete a separate section on the next page for each modification category received. Use additional pages as necessary.
Category #1: ________________________________

a. Is the consumer using the modification?
   _____Yes  _____ No  why not______________________________

b. Is the consumer using the modification safely?
   _____Yes  _____ No  why not______________________________

c. Is the consumer having any difficulties using the modification?
   _____Yes  _____ No  why not______________________________

d. Does the modification serve the purpose you and the consumer had planned?
   _____Yes  _____ No  why not______________________________

Category #2: ________________________________

a. Is the consumer using the modification?
   _____Yes  _____ No  why not______________________________

b. Is the consumer using the modification safely?
   _____Yes  _____ No  why not______________________________

c. Is the consumer having any difficulties using the modification?
   _____Yes  _____ No  why not______________________________

d. Does the modification serve the purpose you and the consumer had planned?
   _____Yes  _____ No  why not______________________________

Category #3: ________________________________

a. Is the consumer using the modification?
   _____Yes  _____ No  why not______________________________

b. Is the consumer using the modification safely?
   _____Yes  _____ No  why not______________________________

c. Is the consumer having any difficulties using the modification?
   _____Yes  _____ No  why not______________________________

d. Does the modification serve the purpose you and the consumer had planned?
   _____Yes  _____ No  why not______________________________
5. ADDITIONAL COMMENTS AND RECOMMENDATIONS:

    *Note: Recommendations should only address the specific goals of the initial evaluation.*

_________________________________________
Occupational Therapist, Registered/Licensed
FOR USE AS NEEDED.....

If there is anything in particular that the Program should learn from this case and/or share with other therapists, please indicate below.