|  |
| --- |
| **VI. APPLICATION FORMS** |

**COVER SHEET**

**REQUEST FOR PROPOSAL**

**RFP DPH Log# 2019-0908 RFP D/HDSP**

##### CDC DP 18-1815 Improving Health of Americans through the Prevention and Management of Diabetes, Heart Disease and Stroke

**CONNECTICUT DEPARTMENT OF PUBLIC HEALTH**

**Applicant Information**

Applicant Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Legal Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/Town State Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No. FAX No. Email Address:

Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TOTAL PROGRAM COST:** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that to the best of my knowledge and belief, the information contained in this application is true and correct. The application has been duly authorized by the governing body of the applicant, the applicant has the legal authority to apply for this funding, the applicant will comply with applicable state and federal laws and regulations, and that I am a duly authorized signatory for the applicant.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Authorizing Official: Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Typed Name and Title

------------------------------------------------------------------------------------------------------------------

The applicant agency is the agency or organization, which is legally and financially responsible and accountable for the use and disposition of any awarded funds. Please provide the following information:

1. Full legal name of the organization or corporation as it appears on the corporate seal and as registered with the Secretary of State
2. Mailing address
3. Main telephone number
4. Fax number, and email address, if any
5. Principal contact person for the application (person responsible for developing application)
6. Total program cost

The funding application and all required submittals must include the signature of an officer of the applicant agency who has the legal authority to bind the organization. The signature, typed name and position of the authorized official of the applicant agency must be included as well as the date on which the application is signed.

**Applicant Information Form (continuation)**

*PLEASE LIST THE AGENCY CONTACT PERSONS RESPONSIBLE FOR COMPLETION AND SUBMITTAL OF:*

**Contract and Legal Documents/Forms:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name | Title | Tel. No. |
|  |  |  |
| Street | Town | Zip Code |
|  | |  |
| Email | | Fax No. |

**Program Progress Reports:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Name | Title | Tel. No. |
|  |  |  |
| Street | **Town** | Zip Code |
|  | |  |
| Email | | Fax No. |

**Financial Expenditure Reporting Forms:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | |  | | |  |
| Name | | Title | | | Tel. No. |
|  | |  | | |  |
| Street | | Town | | | Zip Code |
|  | | | | |  |
| Email | | | | | Fax No, |
| **Incorporated:** YES NO | | | **Agency Fiscal Year:** | |  |
|  | | | | | |
| **Type of Agency:** PublicPrivate Other, Explain: | | | |  | |
|  | | | |  | |
| Profit Non-Profit | | | |  | |
| **Federal Employer I.D. Number:** |  | | | **Town Code No:** |  |
| **Medicaid Provider Status:** YESNO | | | **Medicaid Number:** | |  |
| **Minority Business Enterprise (MBE):** YESNO | | | | | |
| **Women Business Enterprise (WBE):** YESNO | | | | | |

1. **Budget Summary Instructions**
   1. **Position Schedule #2a**
      1. Complete the schedule for all positions to be funded even if currently vacant.
      2. Complete one Position Schedule #2a for each Program/Fund to be included in the Budget.
   2. **Personnel** (lines #1 - #2)
      1. Line #1 **Salary and Wages:** Enter the total salary charged, as listed on Position Schedule 2a.
      2. Line #2 **Fringe Benefits Line:** Enter the total fringe benefits charged, as listed on Position Schedule 2a.
   3. Line #8 **Contractual (Subcontracts):**  Provide the total of all subcontracts and complete Subcontractor Schedule.
   4. Lines #3 - #7, #9, and #10: Complete categories as appropriate,
   5. Line #11: Other Expenses are any other types of expense that do not fit into the categories listed.

For example: Equipment. Please note that the state’s definition of equipment is tangible personal property with a normal useful life of at least one year and a value of at least $5,000 or more.

* 1. **Audit Costs:** The cost of audits made in accordance with OMB Circular A133 (Federal Single Audit) are allowable charges to Federal awards. The cost of State Single Audits (CGS 4-23 to 4-236) are allowable charges to State awards. Audit costs are allowable to the extent that they represent a pro-rata share of the cost of such audit. Audit costs charged to Department of Public Health contracts **must be budgeted, reported and justified as an audit cost line item within the Administrative and General Cost category.**
  2. **Administrative and General Costs,** Line Item #12
     1. Are defined as those costs that have been incurred for the overall executive and administrative offices of the organization or other expenses of a general nature that do not relate solely to any major cost objective of the overall organization. Examples of A&G costs include salaries of executive directors, administrative & financial personnel, accounting, auditing, management information systems, proportional office costs such as building occupancy, telephone, equipment, and office supplies. Please review the OPM website on Cost Standards for more information at: <http://www.opm.state.ct.us/finance/pos_standards/coststandards.htm>.
     2. **Administrative and General Costs** must be itemized on the Budget Justification Schedule. Costs that have a separate line item in the Budget Summary may not be duplicated as an Administrative and General Cost. For example, if the Budget Summary includes an amount for telephone costs, this cannot also be included as an Administrative and General Cost.
  3. **Other Program Income** list any other program income, if appropriate, such as in-kind contributions, fees collected, or other funding sources and include brief explanation on Budget Justification.
  4. **Multiple Funding Period Contracts:** Please complete a full budget for each Funding Period of the contract, clearly indicating the Period on each form. Absent other instructions, assume level funding for the second year.

1. **Budget Justification Schedule B**
   1. Please provide a brief explanation for each line item listed on the Budget Summary. This must include a detailed breakdown of the components that make up the line item and any calculation used to compute the amount.

|  |  |  |
| --- | --- | --- |
| **Line Item (Description)** | **Amount** | **Justification - Breakdown of Costs** |
| **Travel** | $730 | 1,659 miles @ .44 = $730.00 outreach workers going to meetings and site visits. |

* 1. For contractors who have subcontracts, a brief description of the purpose of each subcontract must be provided. Use additional sheets as necessary.

1. **Subcontractor Schedule A--Detail**
   1. All subcontractors used by each program must be included, if it is not known who the subcontractor will be, an estimated amount and whatever budget detail is anticipated should be provided. (Submit the actual detail when it is available). A separate subcontractor schedule must be completed for each program included in the contract. For example: The contract is providing both a Needle Exchange program and an AIDS Prevention Education Program and Subcontractor “A” is providing services to both program there must be a separate budget for Subcontractor “A” for each.
   2. Detail of Each Subcontractor:
      1. Choose a category below for each subcontract using the basis by which it is paid:

A. Budget Basis  B. Fee for Service  C. Hourly Rate.

* + 1. Choose whether the subcontractor is a minority or woman owned business:
    2. MBE  WBE  Neither
    3. Provide the detail for each subcontract just as for the primary contract budget referencing the corresponding program of the contract. Detail must be provided for each subcontractor listed in the Summary.

Note: If space allowed is not sufficient for large or complex subcontract budgets, the primary Budget Summary format may be copied and used instead.

**Applicant Name**

**FUNDING PERIOD: 6/30/2019 – 6/29/2020 Year 1**

**Budget Summary**

|  |  |  |
| --- | --- | --- |
| **Program:** |  |  |
| **Fund:** | **22907** | **TOTAL** |
|  |  |  |
| **1. Salaries & Wages** |  |  |
| **2. Fringe Benefits** |  |  |
| **3. Travel** |  |  |
| **4. Training** |  |  |
| **5. Educational Materials** |  |  |
| **6. Office Supplies** |  |  |
| **7. Medical Materials** |  |  |
| **8. Contractual**  **(Sub-Contracts)\*\*** |  |  |
| **9. Telephone** |  |  |
| **10. Advertising** |  |  |
| **11. Other Expenses (list)** |  |  |
| **a.** |  |  |
| **b.** |  |  |
| **c.** |  |  |
| **d.** |  |  |
| **e.** |  |  |
| **f.** |  |  |
| **g.** |  |  |
| **h.** |  |  |
| **i.** |  |  |
| **12. Administrative and General Costs** |  |  |
| **Total DPH Grant** |  |  |
|  |  |  |
| **Other Program Income** |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

\*\*Complete Sub-contractor Schedule A

**Applicant Name**

**FUNDING PERIOD: June 30, 2019 – June 29, 2020 Year 1**

**Budget Justification Schedule B**

**Program/Site:**

|  |  |  |
| --- | --- | --- |
| **Line Item (Description)** | **Amount** | **Justification including Breakdown of Costs** |
|  |  |  |
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**Applicant Name**

**FUNDING PERIOD: June 30, 2019 – June 29, 2020**

**Position Schedule #2a**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Position Description and Staff Person Assigned** | **Site/ Location** | **Hours wk/ wks per Year** | **Hourly Rate** | **Total Salary Charged** | **Fringe Benefit Rate %** | **Total Fringe Benefits** |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| 1. Position:   Name: |  | / |  |  | % |  |
| **Totals** |  |  |  |  |  |  |

**\*Attach resumes and job descriptions for all Professional Staff**

**Subcontractor Schedule A-Detail**

**Applicant Name**

**BUDGET PERIOD: June 30, 2019 – June 29, 2020**

**#1**

Subcontractor Name:

Address:

Telephone: (     ) (     -     )

Select One: **A**  Budget Basis **B**  Fee-for-Service **C**  Hourly Rate

Indicate One:  MBE  WBE  Neither

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Program:** | **Name** | | **Name** | | **Total** |
| **Fund:** | **SID 1** | **SID 2** | **SID 1** | **SID 2** |  |
| Line Item(s) |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **Total Subcontract Amount:** |  |  |  |  |  |

**#2**

Subcontractor Name:

Address:

Telephone: (     ) (     -     )

Select One: **A**  Budget Basis **B**  Fee-for-Service **C**  Hourly Rate

Indicate One:  MBE  WBE  Neither

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Program:** | **Name** | | **Name** | | **Total** |
| **Fund:** | **SID 1** | **SID 2** | **SID 1** | **SID 2** |  |
| Line Item(s) |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **Total Subcontract Amount:** |  |  |  |  |  |

**#3**

Subcontractor Name:

Address:

Telephone: (     ) (     -     )

Select One: **A**  Budget Basis **B**  Fee-for-Service **C**  Hourly Rate

Indicate One:  MBE  WBE  Neither

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Program:** | **Name** | | **Name** | | **Total** |
| **Fund:** | **SID 1** | **SID 2** | **SID 1** | **SID 2** |  |
| Line Item(s) |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| **Total Subcontract Amount:** |  |  |  |  |  |

**Applicant Name:**

**(Maximum 10 sides of paper – 5 sheets double sided for year 1 work plan table and narrative for years 2-4)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Services to be Provided (See Section III: Service Requirements)** | **Activities** | **Staff Responsible** | **Deliverables** | **Time Frame Quarter 1,2,3, or 4** |
| In-the-field, hands-on technical assistance to each of the four (4) health care organizations (HCOs) selected to implement Category A and B strategies for CDC18-1815 as outlined above in the HCO tasks |  |  |  |  |
| A baseline practice assessment tool for selected HCOs to evaluate each HCO’s practice baseline to implement strategies and work toward CDC18-1815 objectives and goals. |  |  |  |  |
| A technical assistance plan for each HCO based on baseline practice assessment. |  |  |  |  |
| Active hands-on, in the field support to each HCO in accordance with their individual TA plans |  |  |  |  |
| Access to in-house or procured Subject matter expertise in the implementation of SMBP, MTM, DSME/S, DSMP and LCPLCP |  |  |  |  |
| Coordination of SMEs in accordance with each HCOs TA plan to:  1) Implement comprehensive MTM for patients with diabetes, hypertension and/or high blood cholesterol including establishing collaborative practice agreements,  2) Implement of SMBP protocols and programming  3) Develop strategies for sustainability for DSME/S (or DSMP) and Lifestyle Change Program, SMBP and MTM. |  |  |  |  |
| Assistance as needed to HCOs to engage with their EHR/HIT vendor to establish or enhance retrieval, management and utilization of data from the HCO’s EHRs to improve patient identification, referral tracking, patient health outcomes and measuring provider outcomes for patients with prediabetes, uncontrolled diabetes, uncontrolled or undiagnosed hypertension or high blood cholesterol. |  |  |  |  |
| Provide the HCOs needed technical assistance with:  1) establishing in-house or effective referral processes to CDC-recognized Lifestyle Change Programs.  2) establishing in-house or effective referral processes to ADA/AADE Diabetes Self-Management Education/Support program  *\*3) establishing an in house SMRC DSMP or effective referral process to such a program in the community.*  *\*for those HCOs opting for this additional activity* |  |  |  |  |

|  |  |
| --- | --- |
| armbear | **STATE OF CONNECTICUT**  **CONSULTING AGREEMENT AFFIDAVIT** |

*Affidavit to accompany a State contract for the purchase of goods and services with a value of $50,000 or more in a calendar or fiscal year, pursuant to Connecticut General Statutes §§ 4a-81(a) and 4a-81(b)*

**INSTRUCTIONS:**

**If the bidder or vendor has entered into a consulting agreement, as defined by Connecticut General Statutes § 4a-81(b)(1):**  Complete all sections of the form. If the bidder or contractor has entered into more than one such consulting agreement, use a separate form for each agreement. Sign and date the form in the presence of a Commissioner of the Superior Court or Notary Public. **If the bidder or contractor has not entered into a consulting agreement, as defined by Connecticut General Statutes § 4a-81(b)(1):** Complete only the shaded section of the form. Sign and date the form in the presence of a Commissioner of the Superior Court or Notary Public.

Submit completed form to the awarding State agency with bid or proposal. For a sole source award, submit completed form to the awarding State agency at the time of contract execution.

This affidavit must be amended if there is any change in the information contained in the most recently filed affidavit not later than (i) thirty days after the effective date of any such change or (ii) upon the submittal of any new bid or proposal, whichever is earlier.

**AFFIDAVIT:** [Number of Affidavits Sworn and Subscribed On This Day: \_\_\_\_\_]

I, the undersigned, hereby swear that I am a principal or key personnel of the bidder or contractor awarded a contract, as described in Connecticut General Statutes § 4a-81(b), or that I am the individual awarded such a contract who is authorized to execute such contract. I further swear that I have not entered into any consulting agreement in connection with such contract, **except for the agreement listed below**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consultant’s Name and Title Name of Firm (if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start Date End Date Cost

Description of Services Provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the consultant a former State employee or former public official? ⬜ YES ⬜ NO

If YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Former State Agency Termination Date of Employment

Sworn as true to the best of my knowledge and belief, subject to the penalties of false statement.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Printed Name of Bidder or Vendor | **Signature of Chief Official or Individual** | **Date** |
|  |  |  |
|  |  | Dept. of Public Health |
|  | Printed Name (of above) | Awarding State Agency |

**Sworn and subscribed before me on this \_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_ .**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Commissioner of the Superior Court**

**or Notary Public**

**NOTIFICATION TO BIDDERS**

The contract to be awarded is subject to contract compliance requirements mandated by Sections 4a-60 and 4a-60a of the Connecticut General Statutes; and, when the awarding agency is the State, Sections 46a-71 (d) and 46a-81i (d) of the Connecticut General Statutes. There are Contract Compliance Regulations codified at Section 46a-68j-21 through 46a-68j-43 of the Regulations of Connecticut State agencies, which establish a procedure for the awarding of all contracts covered by Sections 4a-60 and 46a-71 (d) of the Connecticut General Statutes.

According to Section 46a-68j-30 (9) of the Contract Compliance Regulations, every agency awarding a contract subject to the contract compliance requirements has an obligation to “aggressively solicit the participation of legitimate minority business enterprises as bidders, contractors, subcontractors and suppliers of materials.” “Minority Business Enterprise” is defined in Section 4a-60 of the Connecticut General Statutes as a business wherein fifty-one percent or more of the capital stock, or assets belong to a person or persons: “(1) Who are active in the daily affairs of the enterprise; (2) Who have the power to direct the management and policies of the enterprise; and, (3) Who are members of a minority, as such term is defined in subsection (a) of Section 32-9n.” “Minority” groups are defined in Section 32-9n of the Connecticut General Statutes as “(1) Black Americans ... (2) Hispanic Americans ... (3) Women ... (4) Asian Pacific Americans and Pacific Islanders; or (5) American Indians.” The above definitions apply to the contract compliance requirements by virtue of Section 46a-68j-21 (11) of the Contract Compliance Regulations.

The awarding agency will consider the following factors when reviewing the bidder’s qualifications under the contract compliance requirements.

1. the bidder’s success in implementing an affirmative action plan;
2. the bidder’s success in developing an apprenticeship program complying with Sections 46a-68-1 to 46a-68-18 of the Connecticut General Statutes, inclusive;
3. the bidder’s promise to develop and implement a successful affirmative action plan;
4. the bidder’s submission of EEO-1 data indicating the composition of its workforce is at or near parity when compared to the racial and sexual composition of the workforce in the relevant labor market area; and,
5. the bidder’s promise to set aside a portion of the contract for legitimate minority business enterprises. See Section 46a-68j-30 (10) (E) of the Contract Compliance Regulations.

**INSTRUCTION**: Bidder must sign acknowledgment below line and return acknowledgment to Awarding Agency along with the bid proposal.

The undersigned acknowledges receiving and reading a copy of the “Notification to Bidders” form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature DATE

On behalf of:

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **WORKFORCE ANALYSIS** | | | | | | | | | | | | | | | | | |
| Contractor Name: | | | | | | | | Total Number of CT employees: | | | | | | | | | |
| Address: | | | | | | | | Full Time: | | | | Part Time: | | | | | |
|  | | | | | | | |  | | | | | | | | | |
| Complete the following Workforce Analysis for employees on Connecticut worksites who are: | | | | | | | | | | | | | | | | | |
| Job Categories | Overall Totals  (sum of all cols. male & female) | White  (not of Hispanic Origin) | | Black  (not of Hispanic Origin) | | Hispanic | | | Asian or Pacific Islander | | American Indian or Alaskan Native | | | | | People with  Disabilities | |
|  | | Male | Female | Male | Female | Male | | Female | Male | Female | Male | | Female | | | Male | Female |
| Officials &  Managers | |  |  |  |  |  | |  |  |  |  | |  | | |  |  |
| Professionals | |  |  |  |  |  | |  |  |  |  | |  | | |  |  |
| Technicians | |  |  |  |  |  | |  |  |  |  | |  | | |  |  |
| Office &  Clerical | |  |  |  |  |  | |  |  |  |  | |  | | |  |  |
| Craft Workers  (skilled) | |  |  |  |  |  | |  |  |  |  | |  | | |  |  |
| Operatives  (semi-skilled) | |  |  |  |  |  | |  |  |  |  | |  | | |  |  |
| Laborers  (unskilled) | |  |  |  |  |  | |  |  |  |  | |  | | |  |  |
| Service Workers | |  |  |  |  |  | |  |  |  |  | |  | | |  |  |
| Totals Above | |  |  |  |  |  | |  |  |  |  | |  | | |  |  |
| Totals 1 year Ago | |  |  |  |  |  | |  |  |  |  | |  | | |  |  |
| FORMAL ON-THE-JOB TRAINEES (Enter figures for the same categories as are shown above) | | | | | | | | | | | | | | | | | |
| Apprentices | |  |  |  |  |  | |  |  |  |  | |  | |  | |  |
| Trainees | |  |  |  |  |  | |  |  |  |  | |  | |  | |  |
| EMPLOYMENT FIGURES WERE OBTAINED FROM: | | | | | | | Visual Check: | | | Employment Records | | | | Other: | | | |
|  | | | | | | | | | | | | | | | | | |
| 1. Have you successfully implemented an Affirmative Action Plan?  YES  NO  Date of implementation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If the answer is “No”, explain.  1. a) Do you promise to develop and implement a successful Affirmative Action?  YES  NO  Not Applicable Explanation:  2. Have you successfully developed an apprenticeship program complying with Sec. 46a-68-1 to 46a-68-18 of the Connecticut Department of Labor Regulations, inclusive:  YES  NO  Not Applicable Explanation: | | | | | | | | | | | | | | | | | |
| 3. According to EEO-1 data, is the composition of your work force at or near parity when compared with the racial and sexual composition of the work force in the relevant labor market area?  YES  NO Explanation: | | | | | | | | | | | | | | | | | |

4. If you plan to subcontract, will you set aside a portion of the contract for legitimate minority business enterprises?

YES  NO Explanation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contractor’s Authorized Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| armbear | **STATE OF CONNECTICUT Form C**  **NONDISCRIMINATION CERTIFICATION — Affidavit 7/8/09**  **By Entity**  **For Contracts Valued at $50,000 or More** |
|  |  |

*Documentation in the form of an affidavit signed under penalty of false statement by a chief executive officer, president, chairperson, member, or other corporate officer duly authorized to adopt corporate, company, or partnership policy that certifies the contractor complies with the nondiscrimination agreements and warranties under Connecticut General Statutes §§ 4a-60(a)(1) and 4a-60a(a)(1), as amended*

**INSTRUCTIONS:**

For use by an entity (corporation, limited liability company, or partnership) when entering into any contract type with the State of Connecticut valued at $50,000 or more for any year of the contract. Complete all sections of the form. Sign form in the presence of a Commissioner of Superior Court or Notary Public. Submit to the awarding State agency prior to contract execution.

**AFFIDAVIT:**

I, the undersigned, am over the age of eighteen (18) and understand and appreciate the obligations of an oath.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| I am |  | of |  | , an entity |  |
|  | Signatory’s Title |  | Name of Entity |  | |

|  |  |
| --- | --- |
| duly formed and existing under the laws of |  |
|  | Name of State or Commonwealth |

I certify that I am authorized to execute and deliver this affidavit on behalf of

|  |  |  |
| --- | --- | --- |
|  | and that |  |
| Name of Entity |  | Name of Entity |

has a policy in place that complies with the nondiscrimination agreements and warranties of Connecticut

General Statutes §§ 4a-60(a)(1)and 4a-60a(a)(1), as amended.

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |
| Authorized Signature |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Printed Name |  |  |  |
|  |  |  |  |

**Sworn and subscribed to before me on this** \_\_\_\_\_\_ **day of** \_\_\_\_\_\_\_\_\_\_\_\_**, \_\_\_\_\_\_\_\_\_\_\_.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Commissioner of the Superior Court/ Commission Expiration Date**

**Notary Public**