



Government of the District of Columbia

HUMAN CARE AGREEMENT CONTRACTOR QUALIFICATIONS RECORD

STATUTORY AND REGULATORY AUTHORITY

The Procurement Practices Human Care Agreement Amendment Act of 2000 (D.C. Law 13-155) authorizes the District of Columbia Chief Procurement Officer, or his or her designee, to award human care agreements for the procurement of social, health, human, and education services directly to individuals in the District. The Human Care Agreement Contractor Qualifications Record (CQR) is an application package that will facilitate the process of pre-qualifying contractors for a human care agreement with the District of Columbia in accordance with D.C. Law 13-155 and Chapter 19, 27 DCMR, the regulations.

GENERAL INSTRUCTIONS

- 1. Please read and complete each section of the Human Care Agreement Contractor Qualifications Record form. All information must be completed in the spaces provided, or marked "N/A."
2. An original signature must be provided in those sections where a signature is required. Copies or a stamped signature is not acceptable.
3. Included in the package that will be provided to you will be a copy of the "Standard Contract Provisions For Use With District of Columbia Government Supply and Services Contracts", dated November 2004. Please read this document carefully before you complete the Contractor's Qualifications Record. The "Standard Contract Provisions For Use With District of Columbia Government Supply and Services Contracts," dated March 2007, will be incorporated by reference into each Human Care Agreement that is entered into between a contractor that will provide human care services and the District of Columbia.
4. Also included in the package that will be provided to you will be forms required by the Department of Small and Local Business Development. You must complete those forms and return them with your package to make it complete and for you to be considered for a Human Care Agreement. The forms are for:
a. Compliance with Section 5 of Mayor's Order 85-85, "Equal Opportunity Obligations in Contracts" and
b. Compliance with Equal Opportunity for Local, Small and Disadvantaged Business Enterprises Amendment Act of 1998, as amended (D.C. Laws 12-268 and 13-169).
5. You may use Section VIII, the "Remarks Section", on page 6, to provide additional information or to expand on information that is provided in response to the request for information.
6. Please include and attach all information, documentation, and data as instructed and required.
7. In those instances where check boxes are provided, please check only the box or boxes which apply.

CHECKLIST

Table with 2 columns and 6 rows of checklist items. Items include: Did you include your Taxpayer Identification Number?, Did you attach a copy of your most recent Financial Statement?, Did you attach the information required in Section III, Disclosure Information, on page 2?, Did you attach a copy of all licenses and certifications, including any specialty certifications?, Did you list all personnel critical to the performance of your Organization in Section VI?, Are you providing a facility? Then, did you attach a copy of the Certificate of Occupancy for each facility?, Did you attach a Certificate of Incorporation, if applicable?, Did you attach a Certificate of Good Standing, if applicable?, Did you attach a copy of your LSDBE certification, if applicable?, Did you attach or include your salary history, if applicable?

FREQUENTLY ASKED QUESTIONS

Table with 2 columns: Question (Q) and Answer (A). Questions include: Can I fax my application for processing?, Is this form available electronically?, Who or what is an Individual?, Who or what is an Organization? Answers provide details on signature requirements, electronic availability, and definitions of individual and organization.



Government of the District of Columbia

HUMAN CARE AGREEMENT CONTRACTOR QUALIFICATIONS RECORD

<b>1. DATE OF FILING</b>  / /	<b>2. FILING TYPE:</b> <input type="checkbox"/> NEW <input type="checkbox"/> UPDATE <input type="checkbox"/> CORRECTION <input type="checkbox"/> REMOVAL	<b>FOR OCP USE ONLY:</b> <b>DATE RECEIVED BY OCP:</b>
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**SECTION I – GENERAL INFORMATION**

<b>1. NAME OF INDIVIDUAL/ ORGANIZATION</b> a. Name: b. Title: c. Physical Street Address: d. City, State & Zip Code: e. Office Phone: g. E-Mail:		<b>2. TYPE OF ORGANIZATION</b> <i>(Please check the appropriate box.)</i> <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> JOINT VENTURE <input type="checkbox"/> CORPORATION <input type="checkbox"/> GENERAL PARTNERSHIP <input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> LIMITED PARTNERSHIP	
f. Office Facsimile No:		<b>3. STATE OF INCORPORATION</b> <i>(Please check the appropriate box.)</i> <input type="checkbox"/> DISTRICT OF COLUMBIA <input type="checkbox"/> COMMONWEALTH OF VIRGINIA <input type="checkbox"/> STATE OF MARYLAND <input type="checkbox"/> STATE OF DELAWARE <input type="checkbox"/> OTHER: _____ Date Of: _____	
5. SOCIAL SEC. / TAXPAYER ID NO:		<b>3. IS ORGANIZATION?</b> <input type="checkbox"/> FOR PROFIT <input type="checkbox"/> NON-PROFIT	
6. DUNN & Bradstreet No:		<b>7. ARE YOU OR THE ORGANIZATION CERTIFIED IN D.C. AS?</b> <input type="checkbox"/> Small <input type="checkbox"/> Local <input type="checkbox"/> Disadvantaged <input type="checkbox"/> Resident-Owned <input type="checkbox"/> Enterprise Zone <input type="checkbox"/> Longtime Resident	

**SECTION II – FINANCIAL RESPONSIBILITY INFORMATION**

*(Please Provide and Attach a Copy of Your Most Recent Financial Statement.)*

<b>1. Name and Address of Accountant:</b>		<b>2. Name and Address of Financial Institution:</b>	
<b>3. Name and Title of Contact Person:</b>		<b>4. Name and Title of Contact Person:</b>	
<b>5. Telephone No.:</b>	<b>6. Fax No.:</b>	<b>7. Telephone No.:</b>	<b>8. Fax No.:</b>
<b>9. Date Of Attached Financial Statement (Must be Within Last 12 Months):</b>		<b>10. Do You/Organization Owe Any Outstanding District /Federal Taxes:</b> District Taxes: <input type="checkbox"/> NO <input type="checkbox"/> YES - Federal Taxes: <input type="checkbox"/> NO <input type="checkbox"/> YES	

**11. MEDICAID – MEDICARE INFORMATION:**

a. Are You / Organization a Certified Medicaid Provider?  YES  NO Medicaid Number: \_\_\_\_\_ Date: \_\_\_\_\_

b. Are You / Organization a Certified Medicare Provider?  YES  NO Medicare Number: \_\_\_\_\_ Date: \_\_\_\_\_

**SECTION III – DISCLOSURE INFORMATION**

*(If yes to any questions below, please explain fully in REMARKS SECTION, or attach a separate statement. )*

<b>1.</b> Have you or the Organization ever been debarred, suspended or sanctioned from any state or federal program? <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>2.</b> Is your license, or any in the organization currently suspended or restricted in any way? <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>3.</b> Have you or the principals of the Organization ever been, indicted, convicted of or pled guilty to a crime (excluding minor traffic citation), or been imprisoned for a crime in the past 10 years.: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>4.</b> Are there any judgments, or pending civil lawsuits, or investigations against you or the Organization, or its principals?: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>5.</b> Have you or the Organization ever had any outstanding criminal fines, restitution orders, or overpayments identified in the District or any state?: <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>6.</b> Are you, or is anyone in your organization, related by blood or marriage to any individual employed by the District government?: <input type="checkbox"/> YES <input type="checkbox"/> NO

**SECTION IV – ORGANIZATION HISTORY, BACKGROUND AND EXPERIENCE**

**1. List All Contracts With the District Government Within the Past Five (5) Years:**

	Agency	Description of Service	Amount	Dates	Contract Number
A				to	
B				to	
C				to	
D				to	
E				to	

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**2. List All Contracts With Other Governments or Private Institutions Within the Past Five (5) Years:**

	Agency	Description of Service	Amount	Dates	Contract Number
A				to	
B				to	
C				to	
D				to	
E				to	

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**3. If You Are Applying As An INDIVIDUAL, Please List Your Employment Or Work History for past five (5) years:**

	Name of Employer	Address	Duties	Name of Supervisor	Dates of Employment	Telephone
A					to	
B					to	
C					to	
D					to	
E					to	
F					to	

*(Please Use and Attach a Separate Sheet for Salary History and Additional Items.)*

**4. List At Least Five (5) References Familiar With Service Delivery:**

	Name	Title/Position	Affiliation	Telephone	Fax	E-Mail
A						
B						
C						
D						
E						

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**4. ARE YOU A UNITED STATES CITIZEN?**

YES                       NO

**5. ARE YOU A PERMANENT RESIDENT?**

*(Please Attach Documentation To Support)*

YES                       NO

**6. IF YOU ARE NOT A CITIZEN, CAN YOU PROVIDE AND SUBMIT VERIFICATION OF YOUR LEGAL RIGHT TO WORK IN THE UNITED STATES? *(Please Attach Documentation To Support.)***

YES                       NO

**SECTION V – EDUCATION, CREDENTIALS AND LICENSURE**

**1. Please List All Colleges (Undergraduate and Graduate) and Professional Institutions Attended:**

	Chief Study Subject Area	Name of College, University or Professional School	Address and Zip Code	Dates Attended	Date And Type Degree Awarded
A				To	
B				To	
C				To	
D				To	
E				To	

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**2. Please List All Professional Certifications and Licenses (Copies Must Be Attached):**

	License/Certification	Agency/Entity	State	Number	Effective Dates	Date Issued
A					to	
B					to	
C					to	
D					to	
E					to	

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**3. Please List All Speciality, Certifications and Licenses (Copies Must Be Attached):**

	Specialty License/Certification	Agency /Entity	State	Number	Effective Dates	Date Issued
A					to	
B					to	
C					to	
D					to	

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**4. HAVE YOU OR ANY MEMBER OF THE ORGANIZATION EVER HAD ANY LICENSE, CERTIFICATION OR CREDENTIAL REVOKED OR SUSPENDED?  YES  NO**

*(If yes, please explain in REMARKS SECTION, or attach a detailed explanation, including dates, type of license, certification, credential and all circumstances surrounding the event(s).)*

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**5. Please list any hospital affiliations or privileges below:**

	Name of Individuals(s)	Name of Hospital	Address	Type Privilege/Affiliation	Telephone	Fax No.
A						
B						
C						
D						

*(Please Use and Attach a Separate Sheet for Additional Items.)*

**6. HAVE YOU OR ANY MEMBER OF THE ORGANIZATION EVER HAD ANY HOSPITAL PRIVILEGES REVOKED, FOR ANY REASON?  YES  NO**

*(If yes, please explain in REMARKS SECTION, or attach a detailed explanation, including dates, type of license, certification, credential and all circumstances surrounding the event(s).)*

**SECTION VI – SERVICE DATA AND INFORMATION**

1. **GENERAL SERVICE CATEGORIES:** Please Check Each Of The General Service Categories For Which You Or The Organization Are Applying.

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Education (EDS)         | <input type="checkbox"/> Human Services (HUM) | <input type="checkbox"/> Social Services (SOC)        |
| <input type="checkbox"/> Special Education (SED) | <input type="checkbox"/> Mental Health (MEN)  | <input type="checkbox"/> Youth/Juvenile Justice (JUV) |
| <input type="checkbox"/> Health (HTH)            | <input type="checkbox"/> Psychology (PSY)     | <input type="checkbox"/>                              |

2. **POPULATIONS:** Please Check All That Apply For Populations.

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Children & Youth (CYG)             | <input type="checkbox"/> Adults (ADT)                     | <input type="checkbox"/> Developmentally Disabled (DVD) | <input type="checkbox"/> Homeless (HLS)         |
| <input type="checkbox"/> Children & Youth-Detained (CYD)    | <input type="checkbox"/> Adult Forensic-Psychiatric (AFP) | <input type="checkbox"/> Geriatric (GER)                | <input type="checkbox"/> Multicultural (MLT)    |
| <input type="checkbox"/> Children & Youth-Committed (CYC)   | <input type="checkbox"/> Adult Forensic-Correctional (FC) | <input type="checkbox"/> Pregnant Women (PGW)           | <input type="checkbox"/> HIV/AIDS (HIV)         |
| <input type="checkbox"/> Children & Youth-Supervision (CYS) | <input type="checkbox"/> Physically Disabled (DIS)        | <input type="checkbox"/> Hearing Impaired (HIM)         | <input type="checkbox"/> Dually Diagnosed (DUD) |
| <input type="checkbox"/> Special Education (SED)            | <input type="checkbox"/> Mentally Retarded (MRD)          | <input type="checkbox"/> Blind/Visually Impaired (BLD)  | <input type="checkbox"/>                        |

3. **SETTING CODES:** Please Check The Settings Where You Or The Organization Can Or Will Provide Service.

(If You Or The Organization Has A Facility, Then A Certificate of Occupancy Must Be Included and Attached.)

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Addiction Treatment Facility (ADF) | <input type="checkbox"/> Foster Care Home (FCH)          | <input type="checkbox"/> Homeless Shelter (HOS)        | <input type="checkbox"/> Nursing Care Facility (NCF)         |
| <input type="checkbox"/> Ambulatory Care/Surg Center (AMB)  | <input type="checkbox"/> Detention Facility–Youth (DFY)  | <input type="checkbox"/> In the Field (FLD)            | <input type="checkbox"/> Outpatient Clinic (OTC)             |
| <input type="checkbox"/> Child Development Center (CDC)     | <input type="checkbox"/> Detention Facility –Adult (DFA) | <input type="checkbox"/> Inpatient-Psychiatric (INP)   | <input type="checkbox"/> Private Home (PRH)                  |
| <input type="checkbox"/> Comm Day Program (CDP)             | <input type="checkbox"/> Dialysis Center (DIA)           | <input type="checkbox"/> Inpatient-Medical (INM)       | <input type="checkbox"/> Provider's Office or Facility (POF) |
| <input type="checkbox"/> Comm Health Center (CHC)           | <input type="checkbox"/> Group Home –Youth (YGH)         | <input type="checkbox"/> Intermed Care Center-MR (IMR) | <input type="checkbox"/> School (SCH)                        |
| <input type="checkbox"/> Comm Residential Facility (CRF)    | <input type="checkbox"/> Group Home-MR (MGH)             | <input type="checkbox"/> Laboratory (LAB)              | <input type="checkbox"/>                                     |
| <input type="checkbox"/> Crisis Center (CRC)                |  |  |  |

4. **SPECIFIC SERVICE CATEGORIES:** Please Check the Specific Service Categories That Apply To You or The Organization in which you are qualified, including licenses, or certified, to provide services:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Addiction Treatment Services (ADT)          | <input type="checkbox"/> Dental Services (DEN)               | <input type="checkbox"/> Personal Care Services (PCS)        |
| <input type="checkbox"/> Allergy (ALG)                               | <input type="checkbox"/> Dialysis Services (DIA)             | <input type="checkbox"/> Physical Therapy (PTH)              |
| <input type="checkbox"/> Addiction Treatment Services (ADT)          | <input type="checkbox"/> Early Childhood Intervention (ECI)  | <input type="checkbox"/> Podiatry (POD)                      |
| <input type="checkbox"/> Assessment/Diagnosis (ASS)                  | <input type="checkbox"/> EPSDT Screening (EPS)               | <input type="checkbox"/> Pre-Natal Services (PNA)            |
| <input type="checkbox"/> Audiology (AUD)                             | <input type="checkbox"/> Family Services (FAM)               | <input type="checkbox"/> Psychological Services (PSC)        |
| <input type="checkbox"/> Assessment Diagnosis (ASD)                  | <input type="checkbox"/> Homemaker Services (HOM)            | <input type="checkbox"/> Pyschiatric (PSY)                   |
| <input type="checkbox"/> Birthing Services (BIR)                     | <input type="checkbox"/> Dental Hygienist (DHY)              | <input type="checkbox"/> Recreation Therapy (RTH)            |
| <input type="checkbox"/> Case Management-Family Services (CMF)       | <input type="checkbox"/> Laboratory Screening Services (LAB) | <input type="checkbox"/> Respiratory Care Services (RES)     |
| <input type="checkbox"/> Case Management-Medical (CMM)               | <input type="checkbox"/> Mental Health (MEN)                 | <input type="checkbox"/> Respite Care (RSC)                  |
| <input type="checkbox"/> Case Management-Social (CMS)                | <input type="checkbox"/> Midwiifery (MID)                    | <input type="checkbox"/> Supported Employment Services (SES) |
| <input type="checkbox"/> Child Care Services (DAY)                   | <input type="checkbox"/> Music Therapy (MTH)                 | <input type="checkbox"/> Social Worker Services (SWS)        |
| <input type="checkbox"/> Chore Services (CHR)                        | <input type="checkbox"/> Neurology (NEU)                     | <input type="checkbox"/> Speech Therapy (STH)                |
| <input type="checkbox"/> Consulting (CON)                            | <input type="checkbox"/> Nutrition and Dietary (NUT)         | <input type="checkbox"/> Transportation Services (TRS)       |
| <input type="checkbox"/> Counseling Services (CSL)                   | <input type="checkbox"/> Occupational Therapy (OTH)          | <input type="checkbox"/> Visiting Nurse (home) (VIS)         |
| <input type="checkbox"/> Crisis Intervention Services (CRI)          | <input type="checkbox"/> Optometry (OPT)                     | <input type="checkbox"/> Vocational Rehabilitation (VOC)     |
| <input type="checkbox"/> Day Treatment Services (Habilitation) (DTR) | <input type="checkbox"/> Pediatric (PED)                     | <input type="checkbox"/>                                     |

5. **LICENSURE AND CERTIFICATION CATEGORIES:** Please Check All of the Licensure and Certification categories that Apply to You or the Organization in which you are qualified, And Are Licensed Or Certified To Provide Services:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acupuncture Therapist (ACC)              | <input type="checkbox"/> Massage Therapy (MAS)          | <input type="checkbox"/> Physician (DOC)               |
| <input type="checkbox"/> Advanced Practice Registered Nurse (ARN) | <input type="checkbox"/> Naturopathy (NAT)              | <input type="checkbox"/> Physician Assistant (PAS)     |
| <input type="checkbox"/> Architect (ARC)                          | <input type="checkbox"/> Nurse-Anesthetist (RNA)        | <input type="checkbox"/> Podiatrist (POD)              |
| <input type="checkbox"/> Audiologist (AUD)                        | <input type="checkbox"/> Nurse-Midwife (RNM)            | <input type="checkbox"/> Practical Nursing (LPN)       |
| <input type="checkbox"/> Certificate of Occupancy (COO)           | <input type="checkbox"/> Nurse Practitioner (RNP)       | <input type="checkbox"/> Professional Counseling (PRO) |
| <input type="checkbox"/> Child Development (CHD)                  | <input type="checkbox"/> Nutritionist & Dietician (NUT) | <input type="checkbox"/> Psychologist (PSC)            |
| <input type="checkbox"/> Dental Hygienist (DHY)                   | <input type="checkbox"/> Obstetrician (OBS)             | <input type="checkbox"/> Pyschiatrist (PSY)            |
| <input type="checkbox"/> Dentist (DEN)                            | <input type="checkbox"/> Occupational Therapist (OTH)   | <input type="checkbox"/> Registered Nurse (RNN)        |
| <input type="checkbox"/> Chiropractor (CHP)                       | <input type="checkbox"/> Optometrist (OPT)              | <input type="checkbox"/> Respiratory Care (RES)        |
| <input type="checkbox"/> Foster Care Provider (FOS)               | <input type="checkbox"/> Opthomology (OPG)              | <input type="checkbox"/> Social Worker-Clinical (SWC)  |
| <input type="checkbox"/> Funeral Directors (FUN)                  | <input type="checkbox"/> Pharmacist (PHM)               | <input type="checkbox"/> Social Worker (SWS)           |
| <input type="checkbox"/> Gynecology (GYN)                         | <input type="checkbox"/> Physical Therapist (PTH)       | <input type="checkbox"/>                               |

6. **LANGUAGE SKILLS:** Please Check All that Apply for Your Or The Organization's Language Skills:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> English (ENG)                      | <input type="checkbox"/> French (FRN)         | <input type="checkbox"/> Chinese–Cantonese (CCA)   |
| <input type="checkbox"/> Spanish (SPN)                      | <input type="checkbox"/> Haitian Creole (CRE) | <input type="checkbox"/> Chinese-Mandarin (CMA)    |
| <input type="checkbox"/> International/Universal Sign (SGN) | <input type="checkbox"/> Vietnamese (VTN)     | <input type="checkbox"/> Ethiopian (Amharic) (AMH) |
| <input type="checkbox"/> Italian (ITL)                      | <input type="checkbox"/> Korean (KOR)         | <input type="checkbox"/>                           |

**SECTION VII – PERSONNEL CRITICAL TO ORGANIZATION PERFORMANCE**

1. Please list All of the Personnel In your Organization Who Are Critical To organization Performance. Please List Officers, Clinical Directors, Medical Directors, Service Supervisors, and Sub-Contractors Essential to the Performance of Services in this Qualifications Record and Attach Resumes Coded to this Section. Attach Any Copies of Licenses, Certifications, or Credentials Where Applicable.:

	Name	Title/Position	Affiliation	Telephone	Fax	E-Mail
A						
B						
C						
D						

**SECTION VIII – REMARKS SECTION**

1. Please use this section to respond to or to continue to respond to any previous question, or request for information. In addition, please feel free to use this section to provide additional information vital to determining your or the organizations qualifications to enter into a Human Care Service Agreement with the District of Columbia

**SECTION IX – CERTIFICATIONS AND INCORPORATIONS BY REFERENCE**

1. **DRUG-FREE WORKPLACE CERTIFICATION:** *Please provide Certification That You Or The Organization Does Or Will Operate In A Drug-Free Manner.*

I/We, \_\_\_\_\_ of \_\_\_\_\_

Hereby give, affirm and provide certification that I/We have received and have read the requirements on having and maintaining a Drug-Free Workplace in the District of Columbia, agree to be bound by those requirements and the remedies stated in the requirements, and further certify that I/We realize that making a false, fictitious, or fraudulent certification may render the maker subject to prosecution under Title 18, United States Code, Section 1001.

Name (Please Print)	Title	Signature	Date
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*(May be signed on behalf of individual or organization.)*

2. **STANDARD CONTRACT PROVISIONS FOR USE WITH DISTRICT OF COLUMBIA SUPPLY AND SERVICES CONTRACTS:** *Please provide Certification That You Or The Organization Agree To Be Bound By the Standard Contract Provisions of the District of Columbia.*

I/We, \_\_\_\_\_ of \_\_\_\_\_

Hereby give, affirm and provide certification that I/we have received and have read the Standard Contract Provisions For Use With District of Columbia Government and Supply Contracts ("Standard Contract Provisions"), dated November 2004, and agree to be bound by all of the provisions, including The requirements of the Occupational Safety and Health Act of 1970 (as amended), the Service Contract Act of 1965 (41 U.S.C. 351-358), the Buy America Act (41 U.S.C.), and the Non-Discrimination provisions. Further, I/We agree and understand that the Standard Contract Provisions shall be Incorporated by reference into any contract or agreement that shall be signed between Me, or My Organization, and the District of Columbia.

Name (Please Print)	Title	Signature	Date
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3. **INFORMATION CONSENT:** *Please Provide Certification That You Or The Organization Provide Consent To The District To Obtain Additional Information As Needed.*

I/We, \_\_\_\_\_ of \_\_\_\_\_

Hereby give, provide and express my consent for representatives of the Office of Contracting and Procurement, Government of the District of Columbia, to obtain any information from any professional organization, business entity, individual, government agency, or academic institution concerning the Professional license status or certification referenced in this document. This material shall be held, maintained and updated by the Office of Contracting and Procurement. I further understand that the Office of Contracting and Procurement will use this information solely for internal purposes pertaining to the evaluation of the qualifications of individuals and organizations to provide human care services, as appropriate, in the District of Columbia.

Name (Please Print)	Title	Signature	Date
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GOVERNMENT OF THE DISTRICT OF COLUMBIA  
OFFICE OF THE CHIEF FINANCIAL OFFICER  
OFFICE OF TAX AND REVENUE



**TAX CERTIFICATION AFFIDAVIT**

**THIS AFFIDAVIT IS TO BE COMPLETED ONLY BY THOSE WHO ARE REGISTERED TO CONDUCT BUSINESS IN THE DISTRICT OF COLUMBIA.**

Date: \_\_\_\_\_

Name of Organization/Entity: \_\_\_\_\_

Address: \_\_\_\_\_

Business Telephone No.: \_\_\_\_\_

Principal Officer:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Soc. Sec. No.: \_\_\_\_\_

Federal Identification No.: \_\_\_\_\_

Contract No.: \_\_\_\_\_

Unemployment Insurance Account No.: \_\_\_\_\_

I hereby certify that:

- I have complied with the applicable tax filing and licensing requirements of the District of Columbia.
- The following information is true and correct concerning tax compliance for the following taxes for the past five (5) years:

	Current	Not Current	Not Applicable
District: Sales and Use	( )	( )	( )
Employer Withholding	( )	( )	( )
Ball Park Fee	( )	( )	( )
Corporation Franchise	( )	( )	( )
Unincorporated Franchise	( )	( )	( )
Personal Property	( )	( )	( )
Real Property	( )	( )	( )
Individual Income	( )	( )	( )

The Office of Tax and Revenue is hereby authorized to verify the above information with the appropriate government authorities. The penalty for making false statements is a fine not to exceed \$5,000.00, imprisonment for not more than 180 days, or both, as prescribed by D.C. Official Code § 47-4106.

This affidavit must be notarized and becomes void if not submitted within 90 days of the date notarized.

\_\_\_\_\_  
Signature of Authorizing Agent

\_\_\_\_\_  
Title

\_\_\_\_\_  
Print Name

Notary: DISTRICT OF COLUMBIA, ss:

Subscribed and sworn before me this \_\_\_\_\_ day of \_\_\_\_\_ Month and Year

Notary Public: \_\_\_\_\_

My Commission Expires: \_\_\_\_\_