Attachment B
Client History Form Revision 1
Placement and Residential Services
710-25-047

Attachment B

Placement and Residential Services

Instructions: This form is intended to help the State gain a more complete understanding of each Respondent's experience. This form **must** be completed completely and accurately.

The State reserves the right to verify the accuracy of these answers by contacting any of the listed clients, and all applicable clients **must** be listed. Omission of a client will constitute a failure to complete this form.

For purposes of this form, the "client" is not an individual but the entity which held the contract. By way of explanation, in the Contract resulting from this RFQ, Arkansas DHS will be the client. For each listed client, Respondents may (but are not required) provide the contact information for a person at the client entity who is knowledgeable of the named project. If the State contacts clients listed on this form, the State reserves the right to contact the listed individual or another person at the listed client.

The boxes below each prompt will expand if necessary. The form **must** be signed (please see the final page) by the same signatory who signed the Response Signature Page.

Therapeutic Foster Care

1. Please describe your ability to provide trauma-informed mental health services for clients placed in therapeutic foster care.

2. Please describe your ability to provide twenty-four (24)-hour, seven (7) days a week mobile crisis intervention in the home and community setting.

Qualified Residential Treatment Program

3. Please submit a detailed program description outlining your evidence-based trauma-informed treatment model.

In-Patient Care Specialized Services

4. Please list clients where you (the prime contractor only) served as the **prime contractor** for providing in-patient care specialized services for at least seven (7) years to severe-needs clients up to twenty-one (21) years of age, such as those with traumatic brain injuries, or other diagnoses that require a high-level of medical based care. Such services will vary depending on the needs of the client but can include: twenty-four (24) hour trachea care, suctioning, maintenance of gastric tube and feeds, bowel and bladder management (colostomy/ileostomy), and impaired communication and mobility. For each client, please specify the organization/agency/division (not individual clients served). Please briefly describe the scope of the contract including all services provided, the duration of services, and the population served. If there are no contracts which meet this definition, please state "none."

Authorized Signature: _____ **Title:** _____

Printed/Typed Name: _____ **Date:** _____