**CONTRACT COMPLIANCE CHECKLIST and TIME FRAMES**

**AGENCY CONTROL #: SMCDSS/CWS/14-002-S**

**ATTACHMENT: Attachment K**

**SOLICITATION TITLE: After Hours Crisis Line Services**

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| **START-UP ACTIVITIES – IDENTIFY AS DAILY, WEEKLY, MONTHLY, OTHER (as necessary)**  |

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| **Activity** | **Time Frame** | **Evidence of Completion** | **Evidence****Received/Approved****By** | **Date Received / Initials** |
| **Problem Escalation Procedure** | **No less than 10 days prior to the beginning of the Contract** | **Submission of Procedure** | **State Project Manager** |  |
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| **FULL PERFORMANCE ACTIVITIES - DAILY** |
| **Activity** | **Time Frame** | **Evidence Of Completion** | **Evidence Received/Approved****By** | **Date Received / Initials** |
| **Receive & respond to afterhours crisis calls****After Normal Working Hours.**  | **Receipt of after-hours calls as needed. Response within 30 minutes of receiving notification** | **A written report and assessment of each call received due by 9am on the next normal business day. Can be faxed or hand delivered.** |  **State Project Manager** |  |
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| **FULL PERFORMANCE ACTIVITIES - Weekly** |
| **Activity** | **Time Frame** | **Evidence Of Completion** | **Evidence Received/Approved****By** | **Date Received / Initials** |
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| **FULL PERFORMANCE ACTIVITIES -Monthly** |
| **Activity** | **Time Frame** | **Evidence Of Completion** | **Evidence Received/Approved****By** | **Date Received / Initials** |
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| **FULL PERFORMANCE ACTIVITIES – Other (One time only, as requested, etc.)** |
| **Activity** | **Time Frame** | **Evidence Of Completion** | **Evidence Received/Approved****By** | **Date Received / Initials** |
| **Attend court for emergency shelter care hearings and/or adjudicatory hearings** | **As needed** | **Attendance in court/hearing** | **State Project Manager** |  |
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| **Reports** |
| **Report Requirements**  | **Time Frame** | **Reports Sent To** | **Evidence Received/Approved****By** | **Date Received / Initials** |
| **Monthly Schedule of Staff Coverage (Attachment L)** | **10 calendar day prior to the coverage period start date** | **State Project Manager** | **State Project Manager** |  |
| **Monthly Static Long Report (Attachment M)** | **10th of the month following the report month** | **State Project Manager** | **State Project Manager** |  |
| **Monthly Invoice (Attachment N)** | **10th day of the month following the Report month** | **State Project Manager** | **State Project Manager** |  |
| **Adult Protective Services Program Intake Record (Attachment P)** | **No later than 9:00 AM the next regular SMCDSS workday** | **State Project Manager** | **State Project Manager** |  |
| **Child Protective Services Intake Worksheet (Attachment Q)** | **No later than 9:00 AM the next regular SMCDSS workday** | **State Project Manager** | **State Project Manager** |  |
| **Certificate of Insurance** | **Due at each Contract Anniversary date** | **State Project Manager** | **State Project Manager** |  |

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| **Meetings** |
| **Meeting Requirements** | **Frequency of Meetings** | **Location of Meetings** | **Length of Meetings /** | **Date Meeting Held / Initials** |
| **Meeting with State Project Manager** | **As needed** | **SMCDSS** | **T.B.D.** |  |
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| **Contract Close Out** |
| **Activity** | **Time Frame** | **Evidence Of Completion** | **Evidence Received/Approved****By** | **Date Received / Initials** |
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