

**SOLICITATION FOR CONTINUING SERVICES
CS #15-026
ENHANCED CHORE SERVICES**

INTRODUCTION

Polk County, a political subdivision of the State of Florida, seeks the submittal of information from vendors interested in providing enhanced chore services for Polk County. Vendors must submit certificate of insurance and copy of business tax receipt with the required information. Insurance and business tax receipt information must be provided prior to commencement of services. All vendors submitting the required information shall have an opportunity to participate.

SCOPE OF WORK

The objectives are to provide “as needed” enhanced chore services for the Polk County Social Services Division. Polk County will pay for the services at the hourly rate of \$23.00 per hour. All vendors must comply with the rate listed or be subject to removal from the award.

TERM

This is an on-going service and will be reviewed at least annually.

DESCRIPTION OF SERVICES

Enhance chore services are provided in the homes of elderly residents of Polk County.

Enhanced chore is the performance of any house or yard task necessary to provide a clean, sanitary, and safe living environment. This service is beyond the scope of chore due to the level of service needed. The service includes a more intensified, thorough cleaning to address more demanding circumstances. Pest control is a requirement.

Enhanced chore service providers must be licensed home health or hospice agencies and shall be licensed by the Agency for Health Care Administration in accordance with Chapter 400 Parts IV and VI, Florida Statutes. Providers must also comply with all Florida Agricultural laws, and must hold a valid State of Florida Pest Control License.

Providers will be required to provide services to Adult Protective Service referrals within 72 hours or less after service is ordered by Polk County.

SUBMITTAL OF RESPONSES

Interested parties are invited to submit their responses to the Procurement Division. The requested information may be submitted via email to procurement@polk-county.net; via fax to (863) 534-6789; mailed or hand delivered to:

**Polk County Procurement Division
330 West Church St., Room 150
Bartow, Florida 33830
(863) 534-6789
Attn: Mary W. Combee**

SUBMITTALS

Submittals must include the following:

Submittal Sheet
Copy of Agency for Health Care Administration license
Copy of Polk County Business Tax Receipt
Copy of State of Florida Pest Control License
Copy of certification of Contractor and staff applicators (Pest Control)
Insurance Certificate meeting all requirements that are detailed in General Conditions.
Affidavit Certification Immigration Laws
Affidavit of Compliance - Employer

SUBMITTAL SHEET

(Please circle)

We are able to provide enhanced chore services per specifications. Yes No

We are able to provide services to Adult Protective Service referrals with 72 hours or less per specifications. Yes No

FIRM NAME: _____

CONTACT NAME: _____

TITLE: _____

FIRM ADDRESS: _____

PHONE NUMBER: _____

FAX NUMBER: _____

EMAIL ADDRESS: _____

GENERAL CONDITIONS

INDEMNIFICATION

The firm shall, in addition to any other obligation to indemnify the County and to the fullest extent permitted by law, protect, defend, (by counsel reasonably acceptable to County) indemnify and hold harmless the County, their agents, elected officials and employees from and against, including, but not limited to, all claims, actions, liabilities, losses, expenses (including attorney's fees) and costs arising out of any actual or alleged bodily injury, sickness, disease or death, or injury to or destruction of tangible property including the loss of use resulting therefrom, or any other damage or loss arising out of or resulting from or claims to have resulted in whole or in part from any actual or alleged act or omission of the consultant, any subcontractor, anyone directly or indirectly employed by any of them, of anyone for whose acts any of them may be liable in the performance of the work; or violation of law, statute, ordinance, governmental administration order, rule, regulation or infringement of patent rights by the firm in the performance of the work; or liens, claims or actions made by the firm or any subcontractor or other party performing the work.

INSURANCE REQUIREMENTS

Coverage must be provided by an insurer licensed to do business in the State of Florida and must be rated "A VIII" or better by A.M. Best Rating Company for Class VIII financial size category.

Workers' Compensation Insurance providing statutory benefits, including those that may be required by any applicable federal statute. Non-construction industry sole proprietors and partners are automatically exempt by Florida Law from the provisions of Chapter 440, Florida Statutes (Workers' Compensation). The successful vendor must provide a letter stating the exemption status and number of employees.

Admitted in Florida	Yes
Employer's Liability	\$1,000,000
All States Endorsement	Statutory
Voluntary Compensation	Statutory

Commercial General Liability Insurance \$1,000,000 combined single limit of liability for bodily injuries, death, and property damage, and personal injury resulting from any one occurrence, including the following coverages:

Broad Form Commercial General Liability Endorsement to include blanket contractual liability (specifically covering, but not limited to, the contractual obligations assumed by the Firm); Personal Injury (with employment and contractual exclusions deleted) and Broad Form Property Damage coverages; Independent Contractors;

The Certificate Holder must be stated as:

**Polk County a political subdivision of the State of Florida
330 W. Church St. Room 150
Bartow, Florida 33830**

The County must be named as additional insured in regards to General Liability. Waiver of subrogation in favor of Polk County is required for General Liability and Worker's Compensation coverages.

Notation on the certificate reflecting the additional insured status and the waiver of subrogation or copies of the endorsements must be provided to verify requirements. "For all work performed for the County" must be noted on the certificate.

The acceptable form of the certificate of insurance shall be the industry standard ACORD certificate

Certificate of insurance must be submitted with response.

PUBLIC ENTITY CRIMES STATEMENT

A person or affiliate who has been placed on the convicted vendor list following a conviction for a public entity crime may not submit a bid/proposal on a contract to provide any goods or services to a public entity; may not submit a bid on a contract with a public entity for the construction or repair of a public building or public work; may not submit bids on leases of real property to a public entity; may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity; and may not transact business with any public entity in excess of the threshold amount provided in Section 287.017, for CATEGORY TWO for a period of 36 months from the date of being placed on the convicted vendor list. By submitting the required information, the vendor hereby certifies that they have complied with said statute.

**AFFIDAVIT CERTIFICATION
IMMIGRATION LAWS**

SOLICITATION NO.: CS 15-026

PROJECT NAME: Enhanced Chore Services

POLK COUNTY WILL NOT INTENTIONALLY AWARD COUNTY CONTRACTS TO ANY CONTRACTOR WHO KNOWINGLY EMPLOYS UNAUTHORIZED ALIEN WORKERS, CONSTITUTING A VIOLATION OF THE EMPLOYMENT PROVISIONS CONTAINED IN 8 U.S.C. SECTION 1324 a(e) {SECTION 274A(e) OF THE IMMIGRATION AND NATIONALITY ACT ("INA").

POLK COUNTY MAY CONSIDER THE EMPLOYMENT BY ANY CONTRACTOR OF UNAUTHORIZED ALIENS A VIOLATION OF SECTION 274A(e) OF THE INA. **SUCH VIOLATION BY THE RECIPIENT OF THE EMPLOYMENT PROVISIONS CONTAINED IN SECTION 274A(e) OF THE INA SHALL BE GROUNDS FOR UNILATERAL CANCELLATION OF THE CONTRACT BY POLK COUNTY.**

BIDDER ATTESTS THAT THEY ARE FULLY COMPLIANT WITH ALL APPLICABLE IMMIGRATION LAWS (SPECIFICALLY TO THE 1986 IMMIGRATION ACT AND SUBSEQUENT AMENDMENTS).

Company Name: _____

Signature Title Date

STATE OF: _____

COUNTY OF: _____

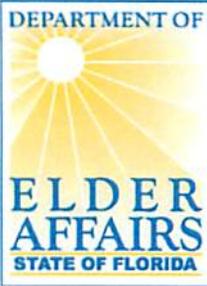
The foregoing instrument was signed and acknowledged before me this ____ day of _____, 20____,
by _____ who has produced
(Print or Type Name)

_____ as identification.
(Type of Identification and Number)

Notary Public Signature

Printed Name of Notary Public

Notary Commission Number/Expiration



BACKGROUND SCREENING

Affidavit of Compliance - Employer

AUTHORITY: This form is required annually of all employers to comply with the attestation requirements set forth in section 435.05(3), Florida Statutes.

- The term "employer" means any person or entity required by law to conduct background screening, including but not limited to, Area Agencies on Aging, Aging Resource Centers, Aging and Disability Resource Centers, Lead Agencies, Long-Term Care Ombudsman Program, Serving Health Insurance Needs of Elders Program, Service Providers, Diversion Providers, and any other person or entity which hires employees or has volunteers in service who meet the definition of a direct service provider. See §§ 435.02, 430.0402, Fla. Stat.
- A direct service provider is "a person 18 years of age or older who, pursuant to a program to provide services to the elderly, has direct, face-to-face contact with a client while providing services to the client and has access to the client's living area, funds, personal property, or personal identification information as defined in s. 817.568. The term includes coordinators, managers, and supervisors of residential facilities; and volunteers." § 430.0402(1)(b), Fla. Stat.

ATTESTATION:

As the duly authorized representative of _____
Employer Name

located at _____
Street Address City State ZIP code

I, _____ do hereby affirm under penalty of perjury
Name of Representative

that the above named employer is in compliance with the provisions of Chapter 435 and section 430.0402, Florida Statutes, regarding level 2 background screening.

Signature of Representative

Date

STATE OF FLORIDA, COUNTY OF _____

Sworn to (or affirmed) and subscribed before me this ____ day of _____, 20____, by _____ (Name of Representative) who is personally known to me or produced _____ as proof of identification.

Print, Type, or Stamp Commissioned Name of Notary Public

Notary Public