

ATTACHMENT A

Mandatory Requirements Checklist

Specialized Residential Services for Adults with Serious Mental Illness
Request for Proposal

Issued By	St. Clair County Community Mental Health Authority
RFP Number	01-FY2027
Issue Date	October 16, 2026
Proposal Due	December 16, 2026

Michigan Specialized Residential Services - Serious Mental Illness (SMI)

Respondents must complete this checklist and include it with their proposal. Unless otherwise indicated, failure to meet a mandatory requirement may result in the proposal being determined non-responsive. For requirements to be completed prior to implementation, provide an explanation and anticipated completion date.

#	Mandatory Requirement	Yes	No	Pending / N/A
1	Organization is legally authorized to conduct business in Michigan.	☐	☐	☐
2	Organization is appropriately licensed or will obtain appropriate Michigan Adult Foster Care (AFC) licensure prior to serving individuals, when AFC licensure is applicable.	☐	☐	☐
3	Organization agrees to maintain all licenses, certifications, registrations, enrollments, and approvals required for the proposed services.	☐	☐	☐
4	Organization has demonstrated experience serving adults with serious mental illness and/or comparable complex behavioral health needs.	☐	☐	☐
5	Organization agrees to comply with applicable Michigan Mental Health Code requirements.	☐	☐	☐
6	Organization agrees to comply with applicable Michigan Department of Health and Human Services (MDHHS) requirements.	☐	☐	☐
7	Organization agrees to comply with applicable Medicaid requirements, including relevant provisions of the current MDHHS Medicaid Provider Manual.	☐	☐	☐
8	Organization agrees to comply with applicable federal Home and Community-Based Services (HCBS) requirements.	☐	☐	☐
9	Organization agrees to comply with applicable Recipient Rights requirements.	☐	☐	☐
10	Organization can provide residential staffing and supervision twenty-four (24) hours per day, seven (7) days per week based upon assessed individual needs.	☐	☐	☐
11	Organization will maintain sufficient staffing to meet the needs identified in each individual's Person-Centered Plan (PCP).	☐	☐	☐
12	Organization will ensure staff meet applicable qualification, background-check, exclusion-screening, training, and competency requirements before independently providing services.	☐	☐	☐
13	Organization maintains or will implement policies for medication administration, management, documentation, storage, error reporting, and psychiatric medication coordination.	☐	☐	☐
14	Organization maintains or will implement procedures for psychiatric and medical emergencies.	☐	☐	☐
15	Organization maintains or will implement crisis prevention, suicide-risk response, intervention, and verbal de-escalation procedures appropriate to an SMI population.	☐	☐	☐
16	Organization maintains or will implement required incident reporting procedures.	☐	☐	☐

#	Mandatory Requirement	Yes	No	Pending / N/A
17	Organization agrees to immediately report suspected abuse, neglect, exploitation, or other Recipient Rights concerns in accordance with applicable requirements.	☐	☐	☐
18	Organization will maintain appropriate emergency preparedness, evacuation, fire safety, and disaster response procedures.	☐	☐	☐
19	Organization will maintain appropriate transportation arrangements for individuals served.	☐	☐	☐
20	Organization agrees to support community integration and individual choice consistent with HCBS and Person-Centered Planning requirements.	☐	☐	☐
21	Organization agrees to coordinate with CMH staff, psychiatric and behavioral health providers, medical providers, guardians when applicable, hospitals, crisis services, and other support-team members.	☐	☐	☐
22	Organization maintains appropriate confidentiality and HIPAA policies and procedures.	☐	☐	☐
23	Organization agrees to maintain documentation necessary to support services delivered and amounts billed.	☐	☐	☐
24	Organization agrees to participate in CMH, PIHP, MDHHS, OIG or other governing/funding agency provider monitoring, audits, quality reviews, investigations, and corrective action activities.	☐	☐	☐
25	Organization agrees to provide CMH and other authorized entities reasonable access to records and facilities as required for monitoring and oversight.	☐	☐	☐
26	Organization maintains or will obtain required professional, general liability, workers' compensation, automobile, and other insurance coverage required by CMH.	☐	☐	☐
27	Organization has sufficient financial and administrative capacity to operate the proposed program.	☐	☐	☐
28	Organization agrees to comply with applicable credentialing and provider enrollment requirements.	☐	☐	☐
29	Organization has submitted a complete staffing plan, including overnight, supervisory, call-off, vacancy, and on-call coverage.	☐	☐	☐
30	Organization has submitted a complete SMI training and competency plan.	☐	☐	☐
31	Organization has submitted a complete implementation/readiness plan.	☐	☐	☐
32	Organization has submitted the required financial proposal.	☐	☐	☐
33	Organization has provided the required professional references.	☐	☐	☐
34	Organization agrees that acceptance of a placement represents its determination that it has the capacity to appropriately meet the individual's assessed residential support needs based on information reasonably available at admission.	☐	☐	☐
35	Organization agrees to make reasonable efforts to preserve placements when psychiatric symptoms, hospitalization, medication changes, behavioral challenges, or temporary increased support needs occur within the anticipated SMI population.	☐	☐	☐

#	Mandatory Requirement	Yes	No	Pending / N/A
36	Organization agrees to participate in transition planning and will not discontinue services without appropriate coordination and notice except when immediate action is required for health or safety.	☐	☐	☐
37	Organization agrees that psychiatric hospitalization alone will not constitute automatic grounds for discharge or refusal to return to the residence.	☐	☐	☐
38	Organization agrees not to routinely rely on emergency departments, inpatient psychiatric units, crisis services, law enforcement, families, or guardians as substitutes for adequate residential staffing or routine program responsibilities.	☐	☐	☐

Explanation of Any No, Pending, or N/A Response *(use additional pages if needed)*

Requirement #: _____

Explanation:

Anticipated Resolution/Completion Date, if applicable: _____

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Explanation:

Anticipated Resolution/Completion Date, if applicable: _____

Requirement #: _____

Explanation:

Anticipated Resolution/Completion Date, if applicable: _____

Respondent Certification

By signing below, the respondent certifies that the information provided in this Attachment is accurate and acknowledges that compliance with applicable requirements will be a continuing condition of any agreement resulting from this RFP.

Authorized Representative (printed): _____

Title: _____

Signature: _____

Date: _____

Contact Information (phone and email): _____