Funding Opportunity Announcement (FOA): FY2026 Plan of Safe Care

FOA Release Date	February 14, 2025
Deadline for Proposal Submission	March 31, 2025, by 12:00pm (EST)
Contract period, if awarded	July 1, 2025 - June 30, 2026
Maximum available (all POSC projects)	$1,000,000
Maximum award for each project	$200,000
Questions concerning these instructions, the application process, proposal requirements, or programmatic issues should be submitted by e-mail to:	Estelline Beamon CAPTA Contracts Specialist Phone: 912-275-2226 Email: Estelline.Beamon@dhs.ga.gov Christine Barbery DFCS Federal Plans Specialist Phone: 470-747-0288 Email: Christine.Barbery@dhs.ga.gov
FOA Informational Webinar Dates (Applicants are required to attend one)	**Monday, March 3, 2025**/ 10:00am EST or **Thursday, March 6, 2025** / 3:00 pm EST
FOA Informational Webinar Registration Link	Click Here to Register for Webinar #1 Click Here to Register for Webinar #2

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Georgia Division of Family and Children Services – Plan of Safe Care program (POSC)

1. OVERVIEW

The Georgia Division of Family and Children Services' (DFCS) mission is to strengthen Georgia by providing individuals and families access to services that promote self-sufficiency, independence and protect Georgia's vulnerable children.

DFCS manages the state's Child Abuse Prevention and Treatment Act (CAPTA) grant, which is administered to states from the federal government. CAPTA provides Federal funding to States in support of prevention, assessment, investigation, prosecution, and treatment activities, and also provides grants to public agencies and nonprofit organizations, including Indian Tribes and Tribal organizations, for demonstration programs and projects. The CAPTA state grant is used to support community-based agencies and organizations committed to reducing the incidence of child abuse and neglect by implementing evidence-based prevention and early intervention techniques to ensure positive outcomes for children and families.

The CAPTA state grant prioritizes projects that support Plans of Safe Care (POSC) for children affected by prenatal substance exposure and their families. In 2016, the Comprehensive Addiction and Recovery Act (CARA) modified the CAPTA legislation to expand POSC to include all infants affected by substance use withdrawals symptoms or a fetal alcohol spectrum disorder and who require services be identified for the family/caregivers of these infants. Requirements emphasize that Plans of Safe Care address the needs of infants who are identified as affected by substance use, experience withdrawal symptoms, or have fetal alcohol spectrum disorders (FASD). It also stipulates development of a service plan for the infant and their family/caregiver. In order to provide an array of services and strong policies to support these infants and their families, diverse stakeholders play critical roles in detecting and responding to their needs. Multi-system collaboration has been identified as a best practice to support affected infants and their families.

A Plan of Safe Care (POSC) is a document that directs services and supports to provide for the safety and well-being of an infant affected by substance use, withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder, including services for the infant and their family/caregiver. A POSC can begin during pregnancy or after the infant's birth. The POSC may be initiated by the health care provider, or a service provider, child welfare agency, or the court system. If the referral is made during the post-partum period, the hospital discharge plans may include a POSC. Once an agency becomes involved in a referral for a substance-exposed infant, the agency becomes a part of their POSC. The POSC should specify the agencies that will provide specific services, describe the communication procedures among the family and provider team, and guide the coordination of services across various agencies with the family.

The purpose of this funding announcement is to solicit proposals for community services to develop, implement, and/or monitor plans of safe care for substance affected infants and their families as outlined in DFCS Child Welfare Policy 19.27 and 20.5. Proposals should include the applicant's intent to perform full or partial POSC services, in partnership with the local health care system, child welfare agency and other family support providers.

Full Plan of Safe Care services include engaging the family and community-based service providers to develop the service plan describing the family's plan and resources, and monitoring progress.

Partial Plan of Safe Care services include providing any services that have been identified as a need on the family's POSC service plan.

NOTE: Due to federal restrictions on CAPTA expenditures, applications that provide foster care services or serve foster care populations will NOT be considered. Additional information on this restriction will be provided during the informational webinar.

2. FUNDING OPPORTUNITY ANNOUCEMENT (FOA) CRITERIA

2a. Eligibility Criteria

This program is open to Georgia state agencies, county or city governments including courts, nonprofit organizations having a 501(c)(3) status with the IRS, and educational institutions who meet Georgia DHS contract eligibility criteria*. For-profit agencies and individuals are ineligible for funding under this FOA.

**No organization may participate in this project in any capacity or be a recipient of Federal funds designated for this project if the organization has been debarred or suspended or otherwise found to be ineligible for participation in federal assistance programs or prohibited from receiving a State contract.*

This Funding opportunity Announcement (FOA) is for Plan of Safe Care (POSC) development or monitoring, and for provision of services related to serving this population. Application proposals may include services such as home visiting; transportation and childcare supports for families accessing services; training for hospitals, healthcare providers or court systems; certified peer supports; and similar programs and services. **Applicants are expected to include a statement of support from the county or regional DFCS director demonstrating that the proposal addresses an identified need in the community (see Assurances form).** Applicants are encouraged to be creative in designing their proposal to ensure the children and families affected by prenatal substance use can thrive.

Failure to meet any of the above eligibility requirements may result in disqualification of your proposal application.

2b. Contract Terms

Proposals received by the declared deadline will be reviewed to ensure all necessary worksheets and documentation are completed and included in submitted proposals. Incomplete applications will not be reviewed, and applicants will not be permitted to add information or otherwise update their application after submission unless specifically requested to do so. Communication via telephone, email, and/or fax regarding award notices is prohibited before official notification by the Department. All decisions are final, and no appeals will be considered.

The awarded contract is for a 12-month period, beginning on **July 1, 2025, and ending on June 30, 2026**. All proposed activities must be completed by **June 30, 2026**. Program or project expenses incurred prior to the effective start date are ineligible for reimbursement. The awardee should have sufficient capital to cover the cost of services outlined on the budget for the first 45 days after the commencement of the contract. *Please note: Previous grantees are not guaranteed CAPTA POSC funding.

Approximately **$1,000,000** is available for POSC grants. The maximum award per project is **$200,000.** Applications may be funded in whole or in part. The CAPTA Grant reviewers reserve the right to fund successful applicants at an amount lower than that requested.

Grantees must participate in a mandatory training on POSC and contract deliverables. The training may be in-person or online via webinar. Grantees will be notified of the training date and location upon notification of award.

Payment under the CAPTA contract will be on a reimbursement basis upon completion of identified deliverable. Grantees must submit, at a minimum, a monthly programmatic report and invoice within the first ten (10) calendar days

of each month, supported by appropriate source documentation. Grantees must also participate in quarterly stakeholder calls to discuss process and qualitative outcomes. Grantee agrees to use the *Contract Budget / Monthly Cumulative Expenditure Report* form provided by DHS/DFCS. To be eligible for reimbursement under the CAPTA contract, a cost must be incurred in accordance with the approved budget, applicable Cost Principles, and within the grant period.

A final performance report covering all twelve months activities and outcomes must be submitted no later than **August 15, 2026,** following the close of the grant period. Instructions and guidelines for final performance report will be made available prior to the close of the grant period. Final performance reports shall also include a final Financial Status Report, covering all twelve months of funding.

Performance measures must be identified on the application and include:

Outcome Indicator	POSC Performance Levels
Service Delivery	At least 90% of all families will have a face-to-face contact with the Infant/Caregiver withing 10 days of receiving the referral. At least 95% of referred families will have a POSC document developed within 60 days of receipt of referral.
	At least 95% of the families will be linked with all recommended services outlined in the POSC document. (Yearly target) At least 90% of target population will be satisfied with the service delivery (Yearly target) At least 50% of the referred families will have ongoing engagement for a minimum of 6 months after receipt of referral.

3. PROPOSAL NARRATIVE AND REQUIREMENTS

The narrative is a detailed statement of the work to be undertaken and answers who, what, when, where, why, and how statements about the contract proposal. Each application must describe the proposed target population**,** any measurable changes expected in the target population, the proposed service area including demographic information, other providers in the proposed service area delivering comparable or complimentary services, and a summary of your agency history and experience serving the target population. Additional documents required to support narrative include the Cover, Budget Worksheet (includes a budget narrative), project timeline documents. A**ll** components of the narrative and supporting documents must be completed for the application to be considered complete.

The proposal narrative must be written in 12-point font, Times New Roman, with 1.5 spacing, and should not exceed 14 pages.

Proposal Narrative with the following components:

- Project Summary/Abstract – Summary of the purpose and anticipated outcomes of the project.

- Target Population & Assessment of Need – The target population are infants who have been affected* by prenatal substance exposure and their families. Narrative should provide relevant demographic characteristics, geographic location, etc., and identify the need that the project seeks to address. The

assessment of need should draw on existing research data and where appropriate include specific information based on the applicant's prior work. The applicant should identify any gaps that will be addressed through its proposed project.

*Prenatal Exposure – Affected

An infant "affected" by prenatal exposure to substance use means:

- The infant is experiencing symptoms of withdrawal, or exhibiting harmful effects in his/her physical appearance or functioning due to exposure to substances (legal or illegal); or
- The infant has tested positive for the presence of a substance or a metabolite thereof in his/her body, blood, urine or meconium; or
- The infant has symptoms of a Fetal Alcohol Spectrum Disorder; or
- The mother testing positive for illegal substances at the birth of the infant; or
- The mother testing positive for prescription drugs due to misuse at the birth of the infant; or
- The mother self-disclosed at the birth of the infant a substance or alcohol use problem and use during pregnancy.

- Project Description -Describe the work to be undertaken and explain how the proposed project will address the identified needs of the target population. The description of work should include the specific deliverables and outcomes that will be achieved by the end of the grant period. Identify whether your agency will be completing full POSC or Partial POSC activities. Include the key individuals who will be working on project activities and describe their roles and responsibilities. Indicate if any subcontractors will be utilized.

- Goals & Objectives – List measurable goals and objectives related to the development, implementation, and/or monitoring of POSC. Goals identify the overall effects your program will have on the target population while objectives identify the steps that will be taken to accomplish your goals. The goals and objectives should be specific, realistic, and quantifiable.

- Alignment with Best Practices – Indicate whether proposed project or activities is based on best practices for meeting the identified needs within the target population. Does the proposed approach build on similar projects or other work in Georgia (or nationwide, if applicable) addressing similar needs? If the project is not based on existing best practices, describe the logic used to develop the project and explain why you think it will be successful.

- Qualifications - Describe the training or qualifications of your organization relevant to the ability to complete the proposed project or activities, including experience and expertise in the field of substance use disorders and/or child abuse and neglect. Describe your organization's ability to access or collaborate with the various professional disciplines in the development, implementation, or evaluation of plans of safe care. Describe experience and expertise in the development of similar activities. Provide information on personnel responsible for administrative oversight. Describe their role(s), responsibilities, and qualifications.

- Project Timeline – Identify the project activities and implementation timeline that will be included in the proposed project and provide anticipated dates for completion. Activities should reflect a sequential approach to achieving the deliverables and outcomes identified in the Project Description.

- Outcomes & Evaluation Plan – Explain how you will determine whether the project is successful and how data will be collected. Identify any additional performance measures that will be used to track progress toward goals and objectives.

- Budget Worksheet - The Budget Worksheet should provide a clear budget outline and include a budget narrative with details and justification for all costs necessary to implement support project or activities. The Budget Narrative should explain each corresponding line item on the Budget Worksheet to justify the expense and explain how you arrived at the projected dollar amounts. Line items include: Salaries; Benefits; Travel; Operating; Contractual; Other.

- Assurances – The DFCS Acknowledgement form should be completed by the applicant and acknowledged by the DFCS county director for the primary service area (county) where services will be provided for the target population.

4. PREPARING AND SUBMITTING A PROPOSAL

All proposals MUST be submitted electronically via upload to The Proposal Solution website

Applicant identification on all forms should be consistent with its full legal name. Applicant and authorized officers and their titles MUST be identified consistently on all required documents, forms, and screenshots.

To obtain a unique proposal ID and submit a proposal:

1. **Go to: theproposalsolution.com**

2. **Select "Request Password and Proposal ID#**

3. **Enter Authorization Code for project**

FY2026 CAPTA Plan of Safe Care
Authorization Code: xxxxxxxx

4. **Complete registration using Applicant legal name, organization status, contact information, fiscal agent information (if applicable).**

5. **If an applicant plans on submitting multiple proposals, multiple requests using the same authorization code should be submitted.**

6. **FY2026 POSC FOA and all proposal or compliance forms and templates are available on the site, after logging in as instructed above and selecting the green "upload documents" button. Notification**

7. **Applicants will be notified of their application status by email April 30, 2025.**

Questions regarding proposals should be directed to:

Estelline Beamon, CAPTA Contracts Specialist
Phone: 912-275-2226 Email: Estelline.Beamon@dhs.ga.gov

PROPOSAL SUBMISSION DEADLINE

Monday, March 31, 2025, at 12:00 noon EST

Application Checklist
Plan of Safe Care

Do not include the Application Checklist in your proposal. Keep as a record of the documents completed.

When saving final documents, include proposal prefix and ID number followed by an underscore and the designated document name. No spaces.

ALL APPLICANTS: REQUIRED PROPOSAL DOCUMENTS		
Document	**Label as (file name for upload) Must include unique proposal ID**	**File type (extension)**
Application Cover	POSCxxxxx_Cover	.pdf
Proposal Narrative	POSCxxxxx _Narrative	.docx
Project Timeline	POSCxxxxx _Timeline	.docx
Assurances (DFCS Acknowledgement)	POSCxxxxx _Assurances	.pdf
Budget (includes Budget Narrative)	POSCxxxxx_Budget	.xlsx
ALL APPLICANTS: REQUIRED COMPLIANCE DOCUMENTS		
Tax Compliance	POSCxxxxx _Tax	.docx
Supplier Change Request Form (upload first two pages only)	POSCxxxxx _SCR	.pdf
W9 (upload signed first page only)	POSCxxxxx _w9	.pdf
Criminal Records Certification	POSCxxxxx _CRC	.pdf
Security and Immigration Affidavit Claim of Exemption **OR** Security and Immigration Information Compliance Affidavit	POSCxxxxx _SECIM	.pdf
Pre-Award Risk Assessment	POSCxxxxx _Risk	.xlsx
SAM/Excluded Parties Screenshot	POSCxxxxx _SAM	.pdf
Certificate of Liability Insurance (provide current COI)	POSCxxxxx _COI	.pdf
Applicant Audit, if required, or Balance Sheet & Certified Statement of Financial Activities	POSCxxxxx_Audit	.pdf
NON-PROFIT APPLICANTS ONLY: ADDITIONAL REQUIRED COMPLIANCE DOCUMENTS		
Corporate Resolution (use template provided)	POSCxxxxx _CorpRes	.pdf
GA Secretary of State Registration (provide current screenshot)	POSCxxxxx _SOS	.pdf
PUBLIC ENTITY APPLICANTS ONLY: ADDITIONAL REQUIRED COMPLIANCE DOCUMENTS		
Authorization for Public Entity (use template provided)	POSCxxxxx _Authorization	.pdf
FISCAL AGENTS ONLY: ADDITIONAL REQUIRED COMPLIANCE DOCUMENTS		
Fiscal Agent Audit	POSCxxxxx_FiscalAudit	.pdf
MOU or Agreement with Fiscal Agent	POSCxxxxx_FiscalAgreement	.pdf

PROPOSAL SUBMISSION DEADLINE:
Monday, March 31, 2025, at 12:00 NOON EST

Preparing Proposal Documents

The following documents are REQUIRED for ALL proposals.

Applicant name should be the legal entity name and consistently labeled on all forms and documents submitted with proposal.

- **Non-Profits- record applicant name exactly as it appears on the Georgia Secretary of State registration**
- **Public Entities- record applicant name exactly as it appears on the Federal Excluded Parties List (SAM.gov registration)**

Use the corresponding form or template for each document.
Upload file using the file name as indicated on the application checklist.

APPLICATION COVER

- Download form and complete all fields as directed.
- Record Applicant (agency, school, school district, government agency) legal name. For non-profits, record agency name exactly as it appears on your Georgia Secretary of State registration screenshot.
- Applicant fiscal information should be consistent with information provided on corresponding compliance forms
- Application Cover must be signed by an officer authorized by the corporate resolution (for non-profits), or Authorization (for public entities)
  - Authorized signing officer must be identified by name and title indicated on Georgia Secretary of State registration (for non-profits), or as indicated on the Authorization (for public entities).
- Please keep the application cover limited to 1 page.
- Print, sign, scan before uploading final pdf as indicated on application checklist.

NARRATIVE

- Download form and complete as directed. Respond to all questions. If any question is not applicable, record N/A in the space for a response.
- Respond to each question in the individual space provided. Boxes will expand as you type. Be clear. Be concise. Be comprehensive. Avoid including information that is not relevant to the question.

Budget

- Download excel file and complete budget spreadsheet and budget narrative. An example budget narrative is included for reference.

PROJECT TIMELINE

- Download form and complete, elaborating on monthly deliverables including estimated referrals, anticipated services or follow up services provided, anticipated caseloads, and include any applicable reporting or summary reports that will need to be completed for each period.

Required Compliance Documents
All Applicants

W9

Download W-9 Form and Instructions.

- Must use the latest revised version of W-9 provided on theproposalsolution.com
- Line 1 should be Agency Name, exactly as it appears on SOS Registration (or Authorization for Public Entities)
- **Line 2 should be left blank** unless otherwise indicated on your SOS Registration (as a DBA designation)
- Complete 3-7 as applicable to your agency.
- Enter 9-digit EIN (must match Tax Compliance form)
  Note: Also transfer this number to the corresponding space on the Application Cover.
- W9 must be signed and dated
  - Note: W9 can be signed by anyone in organization; it does not have to be the same individual authorized by resolution.
- Save as PDF and upload as indicated on the application checklist.

Scan and submit only the 1-page W-9 "Request for Taxpayer Identification Number and Certification".
Please do not include the instructions in your submission.

SYSTEM AWARD MANAGEMENT (SAM.gov) Screenshot

ALL Applicants MUST obtain a current screenshot from the Federal System for Award Management (SAM) demonstrating that the Applicant (non-profit or public entity):

1. Is registered (new or renewed) in the federal system (Expiration date fall within contract period)
2. Is identified as having an "active registration' and
3. Has no "active exclusions' that renders them ineligible for awards that include federal funds.

- Go to: https://www.sam.gov/SAM/
- Select 'Search' option form menu bar.
- Select 'Domain: Entity Information/All Entity Information'
- Select 'Filter By/Keyword Search/Exact Phrase' and enter full legal name of Applicant.

Search results MUST confirm:

- 'Active' registration
- Expiration date within the FY2026 contract year (October 1, 2025-September 30, 2026).
- Unique Entity Identifier should be consistent with number reported on Application Cover.
- Date of search results MUST be displayed on screenshot.
- From a laptop or desktop, print a pdf of the search results. Save pdf as identified on checklist.

Screenshots taken with a mobile device or tablet may not upload to the submission site and may result in a 'failure to upload' error.

Using a name that is not consistent with your state and federal registration will result in 'no matches found' message. *This result does not satisfy the requirement and may result in disqualification.*

If search indicates that there is an exclusion, Applicant is not eligible for award consideration until exclusion has been resolved. An updated screenshot would be required to confirm resolution of exclusion.

SAM.GOV®

[redacted] INC.

Unique Entity ID [redacted]	CAGE / NCAGE [redacted]	Purpose of Registration **Federal Assistance Awards Only**
Registration Status **Active Registration**	Expiration Date **Mar 4, 2025**	
Physical Address [redacted] [redacted]ia 30188-6403 **United States**	Mailing Address [redacted] [redacted]Georgia 30188 **United States**	
Business Information		
Doing Business as [redacted]	Division Name **(blank)**	Division Number **(blank)**
Congressional District **Georgia 11**	State / Country of Incorporation **Georgia / United States**	URL [redacted]
Registration Dates		
Activation Date **Mar 6, 2024**	Submission Date **Mar 4, 2024**	Initial Registration Date **Jul 15, 2005**
Entity Dates		
Entity Start Date **Jan 1, 1989**	Fiscal Year End Close Date **Sep 30**	
Immediate Owner		
CAGE **(blank)**	Legal Business Name **(blank)**	
Highest Level Owner		
CAGE **(blank)**	Legal Business Name **(blank)**	
Executive Compensation		

SECURITY IMMIGRATION & COMPLIANCE (E-VERIFY) AFFIDAVIT

Purpose: To verify that agency meets security and immigration compliance

- Download form and complete as directed.
- Record Federal Work Authorization User Identification number (E-Verify #).
  Note: Also transfer this number to the corresponding space on the Application Cover.
- Record Date of Authorization (date that E-Verify # was issued to agency).
- Enter name of Agency as "Name of Contractor".
- Form must be signed by an officer authorized by the Corporate Resolution (or Authorization for public entities).
- Title of officer must match designation indicated on Georgia Secretary of State website screenshot or Authorization.
- Form must be notarized and contain notary signature, commission expiration date, and notary seal.
- Scan, save as a pdf, and identify as indicated on the application checklist.

A scanned copy of notarized form is required to be submitted with the proposal.

Keep original on file as it will be required to prepare contract, if proposal is selected for funding.

CRIMINAL HISTORY INVESTIGATIONS

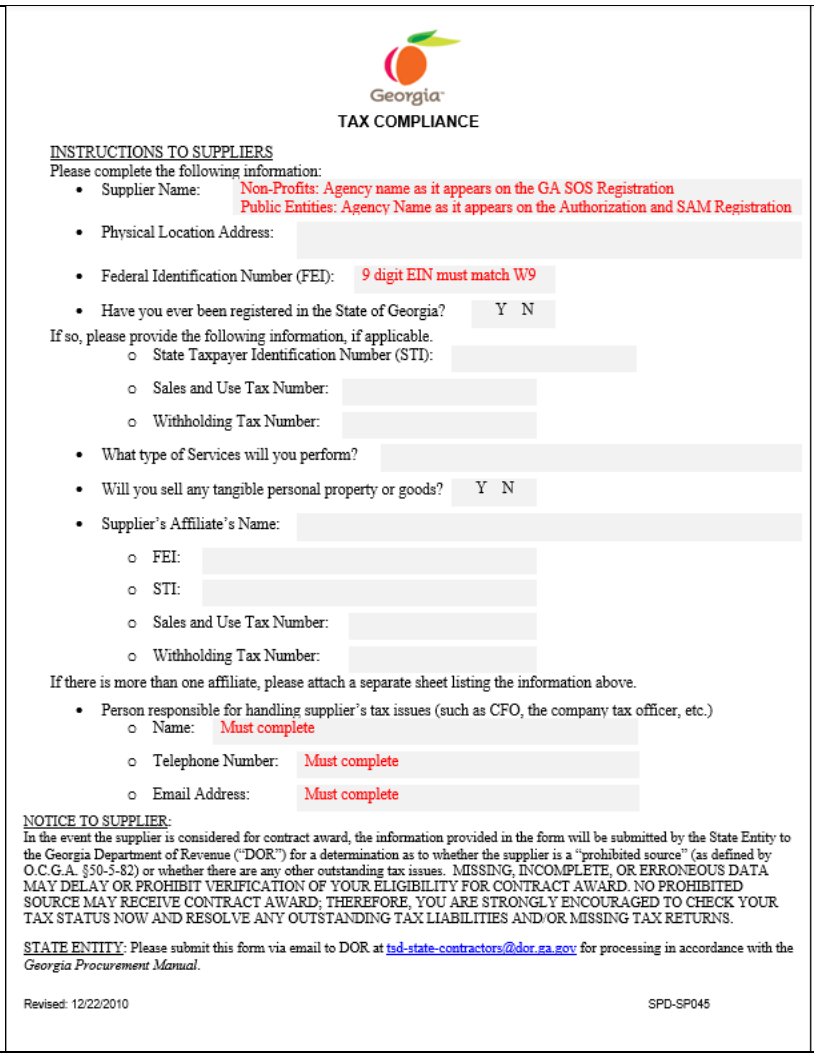
Certification that applicant conducts criminal history investigations on all staff and volunteers as outlined.

- Download form and complete as directed.
- Record ORI or OAC# verifying agency registration with Georgia Applicant Processing Service (GAPS). Note: Also transfer this number to the corresponding space on the Application Cover.
- Form must be signed by an officer authorized by the Corporate Resolution (or Authorization for public entities).
- Title of officer must match designation indicated on Georgia Secretary of State website screenshot or Authorization.
- Form must be notarized and contain notary signature, commission expiration date, and notary seal.
- Scan, save as a pdf, and upload as indicated on the application checklist.

A scanned copy of notarized form is required to be submitted with the proposal. Keep original on file as it will be required to prepare contract, if proposal is selected for funding.

Tax Compliance Form

- Download as a word document, complete as directed below and save as a PDF.
- If Agency is submitting multiple program proposals, complete only one Tax Compliance form and upload with each proposal.
- "Supplier Name" should match GA Secretary of State Registration (NP) or Authorization(PE)
- "Federal Identification number" (EIN or FEIN) should be 9 digits and match W-9
- Supplier's Affiliate section should be completed if you have subcontractors.
- Must include a contact person and contact information.
- Save as PDF and upload as identified on the application checklist.



Georgia

TAX COMPLIANCE

INSTRUCTIONS TO SUPPLIERS

Please complete the following information:

- Supplier Name: Non-Profits: Agency name as it appears on the GA SOS Registration
  Public Entities: Agency Name as it appears on the Authorization and SAM Registration
- Physical Location Address:
- Federal Identification Number (FEI): 9 digit EIN must match W9
- Have you ever been registered in the State of Georgia? Y N

If so, please provide the following information, if applicable.

  - State Taxpayer Identification Number (STI):
  - Sales and Use Tax Number:
  - Withholding Tax Number:

- What type of Services will you perform?
- Will you sell any tangible personal property or goods? Y N
- Supplier's Affiliate's Name:
  - FEI:
  - STI:
  - Sales and Use Tax Number:
  - Withholding Tax Number:

If there is more than one affiliate, please attach a separate sheet listing the information above.

- Person responsible for handling supplier's tax issues (such as CFO, the company tax officer, etc.)
  - Name: Must complete
  - Telephone Number: Must complete
  - Email Address: Must complete

NOTICE TO SUPPLIER:

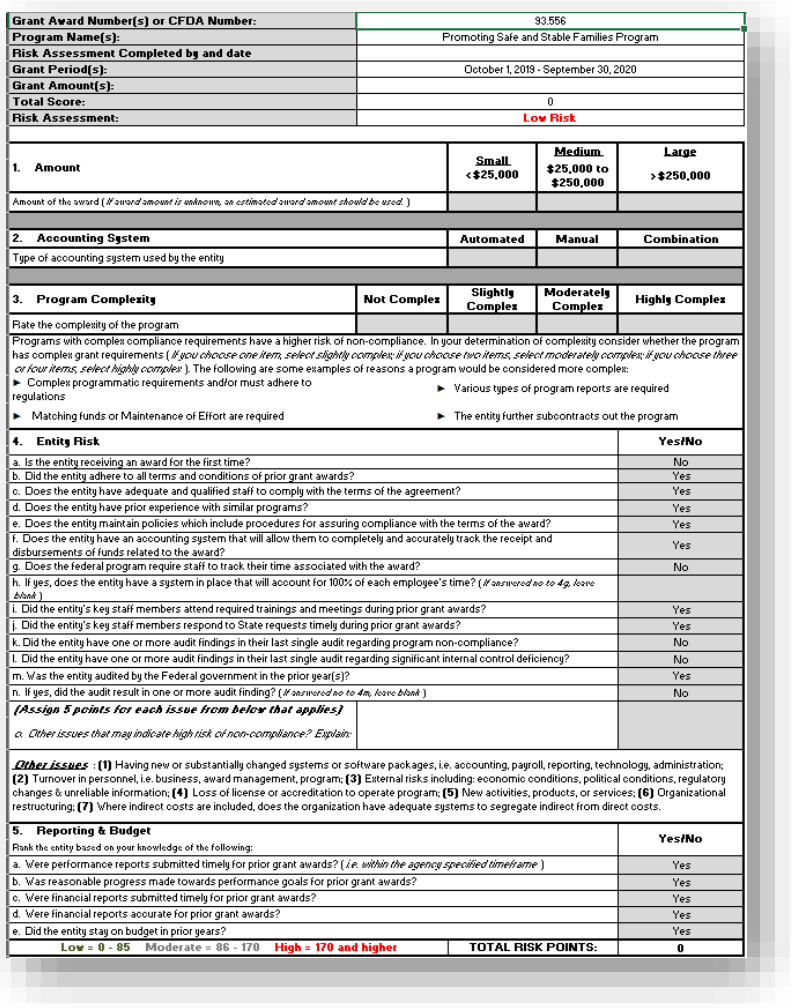
In the event the supplier is considered for contract award, the information provided in the form will be submitted by the State Entity to the Georgia Department of Revenue ("DOR") for a determination as to whether the supplier is a "prohibited source" (as defined by O.C.G.A. §50-5-82) or whether there are any other outstanding tax issues. MISSING, INCOMPLETE, OR ERRONEOUS DATA MAY DELAY OR PROHIBIT VERIFICATION OF YOUR ELIGIBILITY FOR CONTRACT AWARD. NO PROHIBITED SOURCE MAY RECEIVE CONTRACT AWARD; THEREFORE, YOU ARE STRONGLY ENCOURAGED TO CHECK YOUR TAX STATUS NOW AND RESOLVE ANY OUTSTANDING TAX LIABILITIES AND/OR MISSING TAX RETURNS.

STATE ENTITY: Please submit this form via email to DOR at tsd-state-contractors@dor.ga.gov for processing in accordance with the *Georgia Procurement Manual*.

Revised: 12/22/2010 SPD-SP045

Pre-Award Risk Assessment

- Download as Excel document.
  - Grantee Name: Applicant legal entity name
  - Grant Award Number or CFDA Number: 93.556
  - Program Name(s): CAPTA Plan of Safe Care
  - Risk Assessment completed by and date: Enter name and date of individual completing Risk Assessment questionnaire
  - Grant Period: July 1, 2025-June 30, 2026
  - Grant Amount: provide total amount of funding requested
  - Total Score: This field will update automatically as you complete Risk Assessment questionnaire
  - Risk Assessment: This field will update automatically as you complete Risk Assessment questionnaire
- Complete questions 1-5 using drop down boxes and by answering yes/no
- The score will calculate automatically.
- **This does not require a signature by your agency. Leave signature blank.**
- Save Excel document, upload Excel document (PDFs will not be accepted)
- Save as EXCEL file and upload as identified on application checklist.



Grant Award Number(s) or CFDA Number:	93.556
Program Name(s):	Promoting Safe and Stable Families Program
Risk Assessment Completed by and date	
Grant Period(s):	October 1, 2019 - September 30, 2020
Grant Amount(s):	
Total Score:	0
Risk Assessment:	**Low Risk**

1. Amount	**Small** <$25,000	**Medium** $25,000 to $250,000	**Large** >$250,000
Amount of the award (*If award amount is unknown, an estimated award amount should be used.*)			

2. Accounting System	**Automated**	**Manual**	**Combination**
Type of accounting system used by the entity			

3. Program Complexity	**Not Complex**	**Slightly Complex**	**Moderately Complex**	**Highly Complex**
Rate the complexity of the program				

Programs with complex compliance requirements have a higher risk of non-compliance. In your determination of complexity consider whether the program has complex grant requirements (*If you choose one item, select slightly complex; if you choose two items, select moderately complex; if you choose three or four items, select highly complex*). The following are some examples of reasons a program would be considered more complex:

- Complex programmatic requirements and/or must adhere to regulations
- Various types of program reports are required
- Matching funds or Maintenance of Effort are required
- The entity further subcontracts out the program

4. Entity Risk	**Yes/No**
a. Is the entity receiving an award for the first time?	No
b. Did the entity adhere to all terms and conditions of prior grant awards?	Yes
c. Does the entity have adequate and qualified staff to comply with the terms of the agreement?	Yes
d. Does the entity have prior experience with similar programs?	Yes
e. Does the entity maintain policies which include procedures for assuring compliance with the terms of the award?	Yes
f. Does the entity have an accounting system that will allow them to completely and accurately track the receipt and disbursements of funds related to the award?	Yes
g. Does the federal program require staff to track their time associated with the award?	No
h. If yes, does the entity have a system in place that will account for 100% of each employee's time? (*If answered no to 4g, leave blank*)	
i. Did the entity's key staff members attend required trainings and meetings during prior grant awards?	Yes
j. Did the entity's key staff members respond to State requests timely during prior grant awards?	Yes
k. Did the entity have one or more audit findings in their last single audit regarding program non-compliance?	No
l. Did the entity have one or more audit findings in their last single audit regarding significant internal control deficiency?	No
m. Was the entity audited by the Federal government in the prior year(s)?	Yes
n. If yes, did the audit result in one or more audit finding? (*If answered no to 4m, leave blank*)	No
(Assign 5 points for each issue from below that applies)	
o. Other issues that may indicate high risk of non-compliance? Explain:	

Other issues **: (1)** Having new or substantially changed systems or software packages, i.e. accounting, payroll, reporting, technology, administration; **(2)** Turnover in personnel, i.e. business, award management, program; **(3)** External risks including: economic conditions, political conditions, regulatory changes & unreliable information; **(4)** Loss of license or accreditation to operate program; **(5)** New activities, products, or services; **(6)** Organizational restructuring; **(7)** Where indirect costs are included, does the organization have adequate systems to segregate indirect from direct costs.

5. Reporting & Budget	**Yes/No**
Rank the entity based on your knowledge of the following:	
a. Were performance reports submitted timely for prior grant awards? (*i.e. within the agency specified timeframe*)	Yes
b. Was reasonable progress made towards performance goals for prior grant awards?	Yes
c. Were financial reports submitted timely for prior grant awards?	Yes
d. Were financial reports accurate for prior grant awards?	Yes
e. Did the entity stay on budget in prior years?	Yes

Low = 0 - 85 Moderate = 86 - 170 High = 170 and higher	**TOTAL RISK POINTS:**	**0**

Supplier Change Management Form

- Download form and complete as directed. Instructions are provided.
- Use applicant legal entity name.

APPLICANT AUDIT (or BALANCE SHEET & CERTIFIED STATEMENT OF FINANCIAL ACTIVITIES)

All Applicants must include a copy of most recent audit with application. If Applicant is not required to conduct an audit, then application must include a balance sheet and a certified statement of financial activities form a qualified professional, with their application.

- Only a single pdf can be uploaded.
- If submitting balance sheet and certified statement of financial activities, document MUST be combined as a single document and saved or scanned as a pdf.
- Save document as a pdf and upload as identified on the application checklist.

Audit Alternative: In the event that the audit for the Applicant is so large that uploading may be hindered, Applicant may upload a word document with a link accessing the file. Provide the URL and link to access the full Audit.

Required Compliance Documents
Non-Profits Only

CORPORATE RESOLUTION	Non-Profits ONLY

Non-Profit applicants must provide a scanned copy of the corporate resolution passed by the board of directors authorizing an officer(s) of the non-profit organization to enter into an agreement with DFCS to provide services in accordance with the terms of the contract, if awarded.

- Using the template provided, complete on agency letterhead.
- Only the titles Secretary, CEO, and/or CFO will be acceptable as authorized. Individual name must correspond with the correct designation on GA Secretary of State registration.
    - Note: The "Registered Agent" of the corporation (listed on the SOS Registration) is NOT considered an officer and cannot be designated as the signatory for any proposal or contract documents.
- Resolution can be signed by the CEO, CFO, or Secretary as identified on the Secretary of State Registration **(note the individual signing the Corporate Resolution cannot also be the individual who signs the contract documents, if awarded).**
- Resolution must include a corporate seal or notary attestation. Affix seal to document and seal must be visible.
- If notarized form must contain notary signature, commission expiration date, and notary seal.
- Scan and upload pdf as identified on the application checklist.

Only a scanned copy of notarized or sealed form is required with the proposal. Keep original on file as it will be required to prepare contract, if proposal is funded.

GA SECRETARY OF STATE REGISTRATION — Non-Profits ONLY

Applicants must submit a copy of their Georgia Secretary of State registration with the following information:

- **Business Name:** legal name of the entity must match "Agency Name" or "applicant name" in all applicable fields throughout proposal.
- **Business Type:** must be identified as "nonprofit corporation"
- **Business Status**: must be "Active/compliant"
    - "Owes current year" is not acceptable and does not satisfy requirement
    - Note the *annual registration filing does not include this information,* do not a submit a copy of your annual filing. Only the pdf format in the example below is acceptable because it contains complete information needed to ensure compliance.
- **Last Annual Registration Year:** Must be current year (2024/2025).
    - Screenshots or PDFs from previous years are not acceptable.
- **Officer Information:** Must be current and contain individuals identified as CEO, CFO, and Secretary. **Only these titles will be recognized as acceptable throughout the proposal. Any individuals signing on behalf of these titles must match the corresponding names printed on the SOS registration.**
    - Note: The "Registered Agent" of the corporation (listed on the SOS Registration) is NOT considered an "Officer" and cannot be designated as the signatory for any proposal or contract documents.

Note: There may be a delay in the site being updated to reflect paid registration; complete your current filing promptly to allow time to obtain the required screenshot. Proof of payment submission does not satisfy the proposal requirement.

Instructions for completing a Business Search on SOS website:

- Georgia Secretary of State website: https://ecorp.sos.ga.gov/BusinessSearch.
- Select "Business Search"
- Enter legal name of agency submitting proposal and select search.
- Select correct agency name to display registration status.
- Select "Print" from your drop-down menu and save as a PDF file.
- Upload as identified on the application checklist.

Example Registration on next page

GEORGIA
CORPORATIONS DIVISION

GEORGIA SECRETARY OF STATE
BRAD RAFFENSPERGER

HOME (/)

BUSINESS SEARCH

BUSINESS INFORMATION

Business Name:	[redacted] INC.	Control Number:	[redacted]
Business Type:	**Domestic Nonprofit Corporation**	Business Status:	**Active/Compliance**
Business Purpose:	**NONE**		
Principal Office Address:	[redacted] **USA**	Date of Formation / Registration Date:	**11/30/1987**
State of Formation:	**Georgia**	Last Annual Registration Year:	**2024**

REGISTERED AGENT INFORMATION

Registered Agent Name:	[redacted]
Physical Address:	
County:	

OFFICER INFORMATION

Name	Title	Business Address
[redacted]	CFO	[redacted]
	CEO	
	Secretary	

Back

Filing History Name History

Return to Business Search

Office of the Georgia Secretary of State Attn: 2 MLK, Jr. Dr. Suite 313, Floyd West Tower Atlanta, GA 30334-1530,
Phone: (404) 656-2817 Toll-free: (844) 753-7825, WEBSITE: https://sos.ga.gov/
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Report a Problem?

CERTIFICATE OF LIABILITY INSURANCE — Non-Profits ONLY

- ALL non-profit applicants must submit a Certificate of Insurance (COI) describing current liability coverage in effect.
- COI can be obtained through your insurance agent or carrier identifying Applicant as insured and describing general liability, professional liability, automobile liability, and workers compensation coverage in effect. Facsimile of required certificate is posted at the bottom of this section. No other document will be accepted.
- DHS/DFCS MUST be identified as the certificate holder.
- In the event that coverage expires prior to the commencement of the contract year, proof of renewal will be required.
- Applicants who receive an award, whose coverage is insufficient will be required to obtain additional coverage and provide an updated certificate to demonstrate full coverage prior to receiving a contract.
- Applicant is responsible for ensuring that any approved Subcontractor (s) also maintain required liability coverage.
- Scan or save file and upload as identified on the application checklist.

Minimum Insurance Coverage: Contractor will be required to maintain the following limits and types of insurance coverage for the duration of the DHS/DFCS Contract:

- Workers Compensation Insurance (Occurrence) in the amounts of the statutory limits established by the General Assembly of the State of Georgia in Title 34, Chapter 9 of the O.C.G.A. (A self-insurer must submit a certificate from the Georgia Board of Workers Compensation stating that Contractor qualifies to pay its own workers compensation claims). Contractor shall require all subcontractors that are required by statute to hold workers compensation insurance and that occupy the premises or perform work under this Contract to obtain an insurance certificate showing proof of Workers Compensation Coverage.
- Commercial General Liability Policy (Occurrence) to include contractual liability. $1 million per occurrence/$3 million aggregate policy limits.
- Business Auto Policy (Occurrence) to include but not be limited to liability coverage on any owned, non-owned and hired vehicle used by Contractor or Contractor's personnel in the performance of this Contract. $1 million per occurrence.
- Malpractice/Professional Liability Policy (Claims Based) with Errors and Omissions Coverage. $1 million per occurrence/$3 million aggregate policy limits. (Directors and Officers coverage does not satisfy this requirement.)
- Commercial Umbrella Policy (Occurrence). An umbrella policy may cover the aggregate policy limits required herein. There must be no gap between the $1 million and $3 million policy limits and the umbrella policy must follow the form of the underlying $1 million primary policy. Additional umbrella coverage is not required if all other limits are satisfied.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/01/2024

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: Christine Account
Dawson-Taylor & Company P. O. Box 14729 3510 Roundabout Rd. Augusta GA 30919	PHONE (A/C, No, Ext): (706) 733-6111 FAX (A/C, No): (706) 738-4063 E-MAIL ADDRESS: emailagent@insurance.com

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A : American States Ins Co	
INSURER B : Wesco Insurance Co	2XXX1
INSURER C : General Insurance Co of Americ	
INSURER D :	
INSURER E :	
INSURER F :	

INSURED: Legal entity name, Inc.
PO Box 76000
Atlanta GA 30338

COVERAGES **CERTIFICATE NUMBER:** 19-20 **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC			BKW2060158715	10/20/202X	10/20/202X	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$ 1,000,000 $ 1,000,000 $ 20,000 $ 1,000,000 $ 3,000,000 $ 3,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY HIRED AUTOS ONLY SCHEDULED AUTOS NON-OWNED AUTOS ONLY			BKW2060158715	10/20/202X	10/20/202X	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$ 1,000,000 $ $ $
	UMBRELLA LIAB OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION $						EACH OCCURRENCE AGGREGATE	$ $
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) Y / N N / A If yes, describe under DESCRIPTION OF OPERATIONS below			WWC3441091	10/18/202X	10/18/202X	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	$ 100,000 $ 100,000 $ 500,000
C	Professional Liability			LP7740074C	10/20/202X	10/20/202X	Each Occurance General Aggregate	$1,000,000 $3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

Georgia DHS/DFCS
47 Trinity Ave SW
2nd Floor
Atlanta GA 30334

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

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Required Compliance Documents
Public Entities Only

AUTHORIZATION *(Template provided)* Public Entities Only

Public entities (state agencies, public school/school districts or educational institutions) must provide a scanned copy of the authorization passed by the governing body of public entity authorizing designated representative to enter into an agreement with DHS/DFCS, if an award is approved.

- Prepare authorization using template provided on official letterhead.
- If authorization stipulates any amount, the amount must **exactly** match amounts on Application Cover (total funding request).
- Document must identify a representative who is authorized to act on behalf of the public entity and must be signed by a public entity official and notarized. Expiration date of notary's commission must be included.
- Scan and upload file as identified on application checklist.

Only a scanned copy of notarized or sealed form is required with the proposal. Keep original on file as it will be required to prepare contract, if proposal is funded.

Required Compliance Documents
Only required if fiscal agent is used

Both of the following documents are REQUIRED only if Applicant is using a Fiscal Agent.

FISCAL AGENT AUDIT only if using a Fiscal Agent

- Only a single document can be uploaded.
- Save audit document as a pdf (or scan as a pdf) and upload as identified on the application checklist.

Audit Alternative: In the event that the audit for the Applicant is so large that uploading may be hindered, Applicant may upload a word document with a link accessing the file. Provide the URL and link to access the full Audit.

MOU or AGREEMENT W/ FISCAL AGENT only if using a Fiscal Agent

- Applicant and Fiscal Agent identified on MOU or Agreement MUST be consistent with the Applicant and Fiscal Agent identified on the Application Cover.
- Scan signed MOU or Agreement, and save pdf and upload as identified on application checklist.

Georgia Department of Human Services, Division of Family and Children Services

FY2026 CAPTA Plan of Safe Care Program

Application Cover

Complete as directed.

Check one.	☐ New FY2026 applicant or new program	☐ Continuation of project funded in FY2025	☐ Expansion or modified project in FY2025

Section 1: APPLICANT AGENCY/INSTITUTION *(for contracting purposes)*						
Applicant Agency: (legal name)				Check one:	☐ Public Entity ☐ Non-Profit Agency	
Street Address: *Must be physical address, not PO*				Mailing Address: *If different from street address*		
City:		State:	Zip:	City:	State:	Zip:
County:		Telephone				
Executive Officer (name):				Title		Email:

Unique Entity ID# (from SAM screenshot):		SAM Expiry Date (from SAM screenshot):	
GAPS ORI/OAC# (as reported on Criminal History Certification):		Federal Employer ID#:	Year End (month):
Federal Authorization User ID# (as reported on SECIM form):		***NON-PROFITS ONLY*** - Date 501c3 issued:	

AUTHORIZED AUTHORITY *(individual authorized to sign contract and identified on Non-Profit Corporate Resolution or Public Entity Authorization)*			
Authorized Officer #1 (name):		Authorized Officer #2 if required (name):	
Title:		Title:	
Telephone	Email:	Telephone:	Email:

SAMPLE

PROJECT INFORMATION						
Project Name:				Project Contact:		
Street Address:				Title:	State:	Zip:
City:	State:		Zip:	Telephone:	Email:	

Section 2: FISCAL AGENT & CONTACT *Complete only if Applicant contracts with another entity to manage financial matters for this projectl. Copy of executed agreement between Applicant and Fiscal Agent must be included with proposal submission.*					
Applicant Fiscal Agent: (legal name)				Check one:	☐ Public Entity ☐ Non-Profit Agency
Fiscal Contact (name):				Street Address:	
Title:				City:	State: Zip:
Telephone:	Email:				
Federal Employer ID#:		DUNS#:		Year End (month):	

Section 3: PROJECT AMOUNT REQUESTED	Amount:	$

Section 4: AUTHORIZED SIGNATURES

I(We), the undersigned, an authorized officer/authority of the applicant, have read, understand, and agree to all relative conditions specified in the DFCS – POSC Funding Opportunity Announcement and having read all attachments thereto do submit this application on behalf of the applicant agency. If awarded a contract to implement the provision herein, I do certify that all applicable federal and state laws, rules, and regulations thereto will be followed.

Applicant Signature

Authorized Authority/Officer: *(signature)* _____

Name: _____

Title: _____ Date: _____

Second signature only if Resolution or Authorization requires two.

Authorized Authority/Officer: *(signature)* _____

Name: _____

Title: _____ Date: _____

FY26 Plan of Safe Care - Narrative

Proposal ID	**POSCXXXXX**

Agency Name:	
Program Name:	

PROPOSAL OVERVIEW
Project Summary/Abstract Concise but comprehensive overview of the project's goals and significance.
The project aims to provide support to families affected by prenatal substance exposure, addressing the identified needs of this target population. This includes infants experiencing symptoms of withdrawal or harmful effects due to prenatal substance exposure, infants testing positive for substances, and mothers with substance use problems during pregnancy. The project will serve families with specific demographic characteristics and geographic locations, focusing on closing existing gaps in services.
Target Population and Assessment of Need
1. Describe the target population in detail, including demographic characteristics and geographic locations. 2. Emphasize the specific needs of families affected by prenatal substance exposure, drawing on existing research data and your organization's prior work. 3. Identify any gaps in existing services that your project will address.
Assessment of Individual/Family Need
1. Be more detailed in explaining how services are determined to address needs identified in target population. 2. Provide concrete data sources that support the identified needs. 3. Explain the criteria and rationale for determining the elements of an effective service plan including services, frequency, and duration. Include rationale for additional services, frequency, duration, etc. used in the development of an individual service plan. 4. Specify the expected average length of time for family/individual enrollment. 5. Define the criteria for service plan completion.

SAMPLE

Assessment of Community Need

1. Offer a comprehensive profile of the proposed service area, including demographic data.
2. Elaborate on the collaboration and feedback with stakeholders and community partners, emphasizing local county DFCS offices' input.
3. Provide the data that demonstrates the need for the proposed model (or project) in the service area.
4. Detail any existing providers offering similar services and justify the need for additional resources.

Project Description

1. Explain how your project will address the identified needs of the target population. This includes detailing specific deliverables and outcomes to be achieved by the end of the grant period.
2. Clarify whether your agency will complete full POSC or Partial POSC activities.
3. Estimate the total number of families, or cases, that this program will serve during the year, along with the estimated monthly caseload. Highlight how this was determined based on staff and agency capacity.
4. Identify key individuals responsible for project activities and their roles.
5. Mention if any subcontractors will be utilized and their roles.

SAMPLE

Alignment with Best Practices

1. Clearly state whether your project is based on best practices or evidence-based model or practice.
2. If the project aligns with existing best practices, explain how it builds upon similar project or initiatives in Georgia or nationwide.
3. If the project is not based on best practices, explain how it builds upon similar projects or initiatives in Georgia or nationwide.

Goals and Objectives

1. List measurable goals and objectives related to the development, implementation and monitoring of POSC.
2. Ensure that the goals and objectives are specific, realistic, and quantifiable.
3. Emphasize how these changes will relate to child safety, permanency, and well-being.

Project Activities and Implementation Timeline

1. Outline the sequential activities that will lead to the achievement of deliverables and outcomes described in the Project Description
2. Provide anticipated completion dates for each activity to include activities and preparation for launch off at contract start date.
3. Include detail on number of anticipated referrals and cases served for each quarter, along with detail on anticipated service delivery
4. Elaborate on any pre and/or post assessment dates and tools used to measure client progress.
5. Include activities related to monthly or quarterly reporting as related to CAPTA/POSC project.

Launch-off activities and prep for contract start date include:

SAMPLE

Quarter 1 anticipated referrals, caseload, service deliverables (including assessments)

Quarter 2 anticipated referrals, caseload, service deliverables (including assessments)

Quarter 3 anticipated referrals, caseload, service deliverables (including assessments)

Quarter 4 anticipated referrals, caseload, service deliverables (including assessments)

ORGANIZATIONAL INFORMATION

Agency History

1. Expand on the agency's history, mission, and experience in serving children and families.
2. Describe the qualifications, capacity, track record of the agency to reassure the ability to achieve desired results.

Administrative Oversight and Fiscal Management

1. Provide more information about the agency's organizational structure.
2. Highlight the qualifications of the individual responsible for fiscal oversight for CAPTA/POSC activities.

Supervision

1. Highlight the qualifications responsible for supervision of staff, volunteers and/or contractors.
2. Highlight the qualifications of the individuals responsible for direct service provision, including any relevant required training.
3. Explain the ongoing supervision process for staff, volunteers, contractors, and subcontractors.

Subcontractors

If applicable, describe any paid agencies or public entities who provide any services on your agency's behalf.

SAMPLE

Non-Profit Agencies ONLY: Financial Information (as reported in last fiscal year-end financial report or audit). .

Complete as directed.

1. Highlight any capital in reserves and any restricted funds

Period (FY) covered by Report or Audit:		Total Operating Expenses:		Total Revenue (from all Sources):	$

1.

Funding Request

1. Clearly state the amount of funding being requested
2. Provide a simple budget outlining how the funding will be used.

********SEE BUDGET WORKBOOK*********

Total funding request $_____

Grants, Awards, and Contracts

1. Detail any previous community, state, or federal funding, including the source, amount, and contracted activities.
2. Indicate any funding expected during the period covered by this proposal
3. Describe how your agency will maintain the separation of clients served, services and expenses to ensure integrity of the program and prevent duplication of services.

REFERRALS, COORDINATION & RESOURCES

Referral Sources

1. Address the process of generating and handling referrals, making it clear how agency will ensure responsiveness, appropriateness, and sufficiency.
2. How it was determined that these sources would generate sufficient referrals to sustain average monthly caseload needed.

Coordination of Services

1. For families with DFCS or non DFCS involvement describe the process for collecting and sharing information on family prior to, during, and when CAPTA/POSC services conclude.
2. For families receiving services from multiple sources, describe a plan for coordinating services to maximize community resources and prevent duplication of services.

SAMPLE

Community Resources

1. Identify the community resources that your agency collaborates with to ensure that families have services that are not available through your agency. Emphasize your organizations ability to collaborate with community partners to reduce barriers to entry.

PROGRAM MONITORING & EVALUATION

Program Activities

1. Elaborate on the methods used to monitor service quality, consistency, and fidelity to evidence-based practices.
2. Detail the staff training process on service delivery standards, documentation, and reporting.

Service Effectiveness

1. Specify how the agency will evaluate the responsiveness of services to target population needs. **2.** Describe the criteria and methods for evaluating the effectiveness of individual service plans.
Program Evaluation
1. Lay out the agency's plan for evaluating the program's overall effectiveness. 2. Explain the data and information collected for reporting results. 3. Describe methods for soliciting feedback from families, referral sources, and stakeholders to improve program quality and responsiveness.

SAMPLE

Georgia Department of Human Services, Division of Family and Children Services

FY2026 CAPTA Plan of SafeCare

Project Timeline

Identify milestones and key project elements to be completed each quarter and describe associated tasks. Bullet points are acceptable.
Please note: This form will serve as the Scope of Services for the contract so include all deliverables for which you will be requesting payment upon completion.

Applicant:		**Project:**	

Month	Milestone/Key Element	Tasks
October 2025		
November 2025		
December 2025		
January 2026		
February 2026		
March 2026		
April 2026		
May 2026		
June 2026		
July 2026		
August 2026		
September 2026		

SAMPLE

FY2026 CAPTA Plan of Safe Care Application
Proposal Deadline: March 31, 2025

Proposal ID#:

Assurance - DFCS Acknowledgement of Intent to Submit Proposal

Complete as directed. Please do not exceed 1 page.

Georgia DFCS is soliciting proposals for Plan of Safe Care (POSC) services to support substance affected infants and their caregivers. Applicants are required to notify county/regional DFCS of their intent to submit a proposal to serve families in the community.

Section A

Section A is completed by applicant. After DFCS has completed Section B, form must be scanned and uploaded with POSC proposal.

Agency:		Proposed POSC Service:	CAPTA/POSC
Program:			
Address:		Telephone:	
Contact Name:		Email:	
Counties Served:			

The project aims to provide direct services and support for Plans of Safe Care. A Plan of Safe Care (POSC) is a document that directs services and supports to provide for the safety and well-being of an infant affected by substance use, withdrawal symptoms resulting from prenatal drug exposure, or a fetal alcohol spectrum disorder, including services for the infant and their family/caregiver.

SAMPLE

Section B

Section B is completed by County/Regional DFCS representative and returned to applicant identified in Section A.

The county representative acknowledges that the services described would be beneficial in expanding or enhancing service array and accessibility for families in this community. This does not constitute an unconditional endorsement of the applicant's proposal or commitment to automatically refer families but acknowledges an awareness of the need for proposed services and that sharing of information will improve coordination of services.

DFCS Representative Signature:	County/Region:
Print Name:	Email:
Title:	Date:
Feedback or Comments:	

For additional information on the FY2026 CAPTA Plan of Safe Care Funding Opportunity Announcement, contact DFCS CAPTA Contracts Specialist, Estelline Beamon at Estelline.Beamon@dhs.ga.gov

APPLICANT:

FY 26: Proposal Budget Summary

PERSONNEL SERVICES: Enter monthly cost per position. Enter %FTE (full time equivalent applied contract) then enter number of months. Worksheet will auto calculate "Total Budget" based on FTE and number of months.

	List Position	Name of Current Employee	ENTER: Hourly or Salary	ENTER: Hours Per Week Program Work	MONTHLY COST: Total Wages Earned	MONTHLY COST: Taxes & Benefits	MONTHLY COST: % FTE (Enter as decimal)	ENTER X Number of Months	Federal Request: Total	Total: Total
1.			0						0.00	0.00
2.			0						0.00	0.00
3.			0						0.00	0.00
4.			0						0.00	0.00
5.			0						0.00	0.00
6.			0						0.00	0.00
7.									0.00	0.00
8.									0.00	0.00
9									0.00	0.00
10.									0.00	0.00
								Sub-Total	**0.00**	**0.00**

REGULAR OPERATING: General office supplies, repairs/maintenance, rents other than real estate, insurance & bonding, registration, membership, educational materials, freight, office equipment & furniture not on inventory. List how items contribute to program's objectives/goals.

	Description	Federal Request: Total	Total: Total
1.		0.00	0.00
2.		0.00	0.00
3.		0.00	0.00
4.		0.00	0.00
5.		0.00	0.00
6.		0.00	0.00
7.		0.00	0.00
8.		0.00	0.00
9.		0.00	0.00
10.		0.00	0.00
	Sub-Total	**0.00**	**0.00**

TRAVEL: List separately local and long distance travel. List staff person traveling, mileage rate, # of miles, common carrier, reason for travel. List travel expenses associated with meetings, trainings, workshops. http://sao.georgia.gov/state-travel-policy. **Federal/State mileage rate as of 1/2025 is $0.70**

	Description	Federal Request: Total	Total: Total
1.		0.00	0.00
2.		0.00	0.00
3.		0.00	0.00
4.		0.00	0.00
5.		0.00	0.00
	Sub-Total	**0.00**	**0.00**

SAMPLE

EQUIPMENT: Equipment, furniture, IT equipment cost >$4,999 or requi to be inventory **NON ALLOW BUDGET CATEGO**

	Who will use Equipment?	Description	Federal Request: Total	Total: Total
1.			0.00	0.00
		Sub-Total	**0.00**	**0.00**

FACILITY COST: Real estate rental, water, sewage, electric. Cost should be pro-rated between all programs of applicant. Facility cost is a cost-shared item.

	Vendor/Provider Name	List Type of Facility Cost	Provide description. How was cost determined? What is monthly cost x pro-rated share = $ amount charged to contract.	Federal Request: Total	Total: Total
1.				0.00	0.00
2.				0.00	0.00
3.				0.00	0.00
			Sub-Total	**0.00**	**0.00**

PER DIEM/FEES/CONTRACTS: Consultants, contracts, professional services, per diem payments. Enter name of consultant/contractor. Under description enter summary of service to be provided and the rate of pay. State how service contributes to program's objectives/goals.

	Vendor/Provider Name	List Type of PD/F/C	Summarize service. How was cost determined? What is monthly cost x pro-rated share = $ amount charged to contract.	Federal Request: Total	Total: Total
1.				0.00	0.00
2.				0.00	0.00
3.				0.00	0.00
4.				0.00	0.00
5.				0.00	0.00
			Sub-Total	**0.00**	**0.00**

TELECOMMUNICATIONS: **Voice/data communications. Under purpose include title of position using voice / data communications.**

	Vendor/Provider Name	List Type of Telecomm	Name Employee Using Telec.	What is monthly cost x pro-rated share = $ amount charged to contract.	Federal Request: Total	Total: Total
1.						
2.					0.00	0.00
3.					0.00	0.00
				Sub-Total	**0.00**	**0.00**

OTHER: Per Diem and Fees

	Vendor/Provider Name	List Type of Other	List Purpose of Cost	Provide summary of cost; rate of pay; pro-rated share of cost.	Federal Request: Total	Total: Total
1.					0.00	0.00
2.					0.00	0.00
				Sub-Total	**0.00**	**0.00**

	Federal Request	Total
	0.00	**0.00**
TOTAL: ALL BUDGET CATEGORIES	**Federal Request**	**Total**

TAX COMPLIANCE

INSTRUCTIONS TO SUPPLIERS
Please complete the following information:

- Supplier's Name:
- Physical Location Address:
- Federal Identification Number (FEI):
- Have you ever been registered with Georgia Department of Revenue?
- If so, please provide the following information, if applicable:
    - State Taxpayer Identification Number (STI):
    - Sales and Use Tax Number:
    - Withholding Tax Number:
- What type of service will you perform?
- Will you sell any tangible personal property or goods?
- Supplier's Affiliate's Name:
    - FEI:
    - STI:
    - Sales and Use Tax Number:
    - Withholding Tax Number:

  If there is more than one affiliate, please attach a separate sheet listing the information above.
- Person responsible for handling supplier's tax issues (such as the CFO, the company tax officer, etc.):
    - Name:
    - Telephone Number:
    - E-mail Address:

SAMPLE

NOTICE TO SUPPLIER:
In the event the supplier is considered for contract award, the information provided in the form will be submitted by the State Entity to the Georgia Department of Revenue ("DOR") for a determination as to whether the supplier is a "prohibited source" (as defined by O.C.G.A. §50-5-82) or whether there are any other outstanding tax issues. MISSING, INCOMPLETE, OR ERRONEOUS DATA MAY DELAY OR PROHIBIT VERIFICATION OF YOUR ELIGIBILITY FOR CONTRACT AWARD. NO PROHIBITED SOURCE MAY RECEIVE CONTRACT AWARD; THEREFORE, YOU ARE STRONGLY ENCOURAGED TO CHECK YOUR TAX STATUS NOW AND RESOLVE ANY OUTSTANDING TAX LIABILITIES AND/OR MISSING TAX RETURNS.

STATE ENTITY: Please submit this form via email to DOR at compliance-state-con@dor.ga.gov for processing in accordance with the *Georgia Procurement Manual*.

SUPPLIER CHANGE REQUEST FORM

Agency Supplier Liaisons MUST complete the Agency Liaison Use Only sections AND ensure the supplier has completed sections 1 - 3, the Supplier Use Only sections prior to submitting this form to SAO.

☐ NEW ☐ EXISTING **SUPPLIER ID NUMBER:** Agency Use Only | 0 | 0 | 0 | 0 | | | | | | |

SECTION 1: SUPPLIER IDENTIFICATION

FEI/SSN/TIN

Supplier Name:

Doing Business As (dba): if applicable

SUPPLIER ADDRESS

Address 1:

Address 2:

City:

State: **Postal Code:**

Contact Email:

Primary Phone #: **Ext:** **Secondary Phone #:** **Ext:**

☐ Landline ☐ Cell Used for Identity Verification ☐ Landline ☐ Cell Used for Identity Verification

Driver's License #: For individuals only **DL State:**

SAMPLE

SECTION 2: BANK ACCOUNT INFORMATION

Required for New and Reactivating suppliers to add/change bank information to receive payments via ACH.

☐ I do not wish to provide banking information and understand all payments made to me will be via check.

☐ Replace Remittance Address at Loc # **With Addr ID #**

☐ Replace Invoicing Address at Loc # **With Addr ID #**

☐ Add New Bank Account ☐ Change Bank Account **Enter Loc #** Agency Liaisons are required to complete items on this line for bank changes

ROUTING # **NEW ACCOUNT #**

Last Four Digits of Previous Bank Account # For changes only

☐ Check here if General Bank Account can be used by ALL State of Georgia agencies making payments.

☐ Check here if this account can only be used for a SPECIFIC PURPOSE

DESCRIBE SPECIFIC PURPOSE

ACCOUNTS RECEIVABLE NOTIFICATION

PAYMENT REMIT EMAIL ADDRESS 1:

PAYMENT REMIT EMAIL ADDRESS 2:

I authorize the State of Georgia to deposit payment for goods and/or services received into the provided bank account by the Automated Clearing House (ACH). I further acknowledge that this agreement is to remain in full effect until such time as changes to the bank account information are submitted in writing by the vendor or individual named below. It is the sole responsibility of the vendor or individual to notify the State of Georgia of any changes to the bank account information. The State of Georgia independently authenticates bank account ownership.

Printed Name of Company Officer **Signature of Company Officer**

SECTION 3: DIVERSITY IDENTIFICATION (Check ALL That Apply)

BUSINESS CERTIFICATIONS

- ☐ GA Small Business*
- ☐ GA Resident Business**
- ☐ Not Applicable
- ☐ Women Owned
- ☐ Minority Business Certified
- ☐ Prefer Not to Disclose

MINORITY BUSINESS ENTERPRISE (51% ownership)

- ☐ Hispanic – Latino
- ☐ Native American
- ☐ Pacific Islander
- ☐ Prefer Not to Disclose
- ☐ African American
- ☐ Asian American
- ☐ Not Applicable

*Based on Georgia law (OCGA 50-5-21) (3) **"Small Business** " means any business which is independently owned and operated. Additionally, such business must either have 300 or less employees OR $30 million or less in gross receipts per year.

****Georgia resident business** is defined as any business that regularly maintains a place from which business is physically conducted in Georgia for at least one year prior to any bid or proposal to the state or a new business that is domiciled in Georgia and which regularly maintains a place from which business is physically conducted in Georgia; provided, however, that a place from which business is conducted shall not include a post office box, a leased private mailbox, site trailer, or temporary structure.

VETERAN-OWNED SMALL BUSINESS (Check ALL That Apply)

☐ Nonveteran-owned Small Business ☐ Veteran-owned Small Business ☐ Service Disabled VOSB ☐ Prefer Not to Disclose

SECTION 4: REQUESTED CHANGE(S) – (Check ALL That Apply)

- ☐ **FEI/TIN Change** (Cannot change if supplier is 1099 applicable)
- ☐ **Business Name Change**
- ☐ **1099 Eligible** Cannot change to non-eligible if supplier is already 1099 eligible
  - **1099 Addr ID #** Agency Liaisons are REQUIRED to enter the AddrID # where to mail 1099 ☐
  - ☐ **1099 – M Enter Code (Required for Form 1099 – M)** ☐
  - ☐ **1099 – N** Code 01 (01 is the only code available for the 1099 – NEC)
- ☐ **Reactivate Supplier Profile**
- ☐ **Deactivate Supplier Profile** (Agency Liaison MUST attach written justification from supplier with the SCR.)
- ☐ **Add Additional Business Address** (Enter additional address in section
- ☐ **Change Existing Business Address** **Enter Addr ID # to change:** ☐ (Agency Liaisons are required to enter Addr ID # to change)

SAMPLE

- ☐ **Change/Add Payment Alt Name to an existing address** (if payable to a different name).
  - **Payment Alt Name:**
- ☐ **Classification Change:** (Agency Liaisons are required to check one for Classification Changes.)
  - ☐ Attorney ☐ HCM ☐ Student ☐ Supplier Non-minority
  - ☐ Gov Non-State of GA ☐ Non-Supplier ☐ Supplier Minority
- ☐ **Statewide Contract** (DOAS Use Only)
- ☐ **HCM Vendor**
- ☐ **Other** (Provided details in the Comments section below)
- ☐ **Comments**

AGENCY USE ONLY SECTION 5: AGENCY LIAISON CERTIFICATION (REQUIRED)

By my signature below, I certify that all reasonable effort has been made to submit information that is complete, accurate, true, and is associated with the supplier's name and Tax ID listed above.

AGENCY LIAISON NAME	AGENCY LIAISON SIGNATURE	DATE	

PRINT CLEAR

Form **W-9**
(Rev. March 2024)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give form to the requester. Do not send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See ***Specific Instructions*** on page 3.

1 Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)

2 Business name/disregarded entity name, if different from above.

3a Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor ☐ C corporation ☐ S corporation ☐ Partnership ☐ Trust/estate

☐ LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) . . . . .

Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner.

☐ Other (see instructions)

3b If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions . . . . . ☐

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any)

Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any)

(Applies to accounts maintained outside the United States.)

5 Address (number, street, and apt. or suite no.). See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

___ – ___ – ____

or

Employer identification number

__ – _____

SAMPLE

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person**	**Date**

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9*.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they

Criminal Records Certification

Complete as directed. Scan signed document and save pdf as

Applicant Agency*:		Proposal Username

**Legal name of agency/organization/institution.*

Georgia Applicant Processing Services (GAPS) ORI or OAC #:

By signing below, I attest that by signing a contract with the Georgia Department of Human Services (referred herein as the Department or DHS), I will comply with the contract provision entitled*: CRIMINAL HISTORY INVESTIGATIONS* of the contract. I understand registration with the Office of Inspector General as outlined in the Criminal History be completed no later than July 1, 2025. I further understand all backgrounds checks for staff who work within the DHS funded program must be completed monthly for new staff/contractor (or before direct services can be provided to the family and youth participants of the DFCS funded program).

Documentation verifying all background checks have been completed for program staff who will work within the DHS funded program will be submitted to the identified DFCS/Support Services Unit Staff representative monthly for new staff/contractor (or before direct services can be provided to the family and youth participants of the DHS funded program). If receiving a contract with the Department, DHS/DFCS has the right to contact the Office of Inspector General to confirm my organization has registered and completed criminal history investigation (background) checks for staff who work under the DHS/DFCS contract. Any false information provided by my agency/organization on this form may result in the exclusion, disqualification or termination of my application and contract for the fiscal year.

CRIMINAL HISTORY INVESTIGATIONS: (135C) 03/07/18

A. The Contractor agrees that, for the filling of positions or classes of positions having direct care/treatment/custodial responsibilities for services rendered under this Contract, applicants selected for such positions shall undergo a criminal history investigation which shall include a fingerprint record check pursuant to the provisions of § 49-2-14 of the Official Code of Georgia, Annotated (O.C.G.A.). New staff/sub-contractors must have a successful criminal history fingerprint background check prior to service provision. Existing staff must have a successful criminal history fingerprint background check every five (5) years from the initial criminal background check. Fingerprint record checks shall be submitted via Live Scan electronic fingerprint technology. Contractor must register with the Georgia Applicant Processing Services (GAPS) at www.ga.cogentid.com and follow the instructions provided at that website.

B. Pursuant to O.C.G.A § 49-2-14, after receiving and reviewing the criminal history report generated through the Cogent-GAPS process, the Department will advise the Contractor if the applicant is eligible or not eligible to provide services to the Department. Said advisement will be accomplished through a fitness determination letter issued by the Department's Office of Inspector General Background Investigations Unit (OIG BIU) within fifteen (15) days of receiving the criminal history record. Circumstances may extend said fifteen (15) days if OIG BIU determines that the applicant's criminal history record needs further review. If it is determined that the applicant is not eligible to provide services to the Department, said applicant will not be eligible to provide services to the Department under any circumstances.

SAMPLE

C. Contractor further agrees to complete a criminal history fingerprint National Crime Information Center (NCIC) background report for foster parents, residential and group home staff. Contractor must obtain satisfactory results of criminal history prior to the placement of a child in Contractor's foster parent fail to successfully pass the criminal history fingerprint check, such individual will not be qualified to perform any services under this Contract. Further, Contractor agrees that if a child is placed in a foster home with foster parents for whom Contractor has not received a satisfactory criminal history report, Contractor will repay all amounts paid to Contractor for the Room, Board and Watchful Oversight of the child during any such period when Contractor had not received a satisfactory criminal history report for the foster parents and the Department may, in its discretion, withhold payments owed to Contractor under this or any other Contract to recoup the amount paid to the contractor during such period.

D. Any adult (age 18 and over) residing permanently or temporarily in the home and having access to children must inform the approving agency of any criminal indictments or convictions. A criminal history check including GCIC and NCIC finger printing must be performed and the outcomes documented. Repeat criminal history check, including fingerprinting, is required at least every (5) years at the time of the Annual Re-evaluation for all current foster parents and adults (age 18 and over) residing in the home.

Provisions of this paragraph of the Contract shall not apply to persons employed in day-care centers, group day-care homes, family day-care homes, or childcare learning centers which are required to be licensed, registered, or commissioned by the Department or by the Georgia Department of Early Care and Learning, or to personal care homes required to be licensed, permitted, or registered by the Department of Community Health

If awarded a contract with the Department, failure to comply with the criminal history investigation requirements as outlined in *the paragraph entitled CRIMINAL HISTORY INVESTIGATIONS* of the contract may be cause for contract termination. By signing this Criminal History Investigations Attestation Form, I understand this is not a guarantee or commitment for any award or funding from the Georgia Department of Human Services.

Signature of **AUTHORIZED** Officer	Notary Signature
Printed Name of Officer	Date Commission Expires
Title of Officer	*Affix notary seal or stamp below.*
Date	

Brian P. Kemp
Governor

Candice L. Broce
Commissioner

Georgia Department of Human Services

Aging Services | Child Support Services | Family & Children Services

Contractor Name: _____

RE: Security and Immigration Compliance – Purchase of Services $2,499.99 or More

Dear Sir or Madam:

The Department of Human Services (DHS), among other public employers in Georgia, is required to ensure that its Contractors comply with the provisions of Title 13, Chapter 10, Article 3 titled Security and Immigration Compliance. See Senate Bill 160 at http://www.legis.ga.gov/Legislation/en-US/display/20132014/SB/160.

Accordingly, DHS is required to obtain the sworn affidavit herein provided for purchases of services which exceed $2,499.99. The Contractor's representative must complete the information in the spaces provided on the form titled "Contractor Affidavit under O.C.G.A. § 13-10-91(b)(1)" and sign on behalf of the Contractor in the presence of a notary public.

Return the Contractor Affidavit to my attention by e-mail at _____. The Subcontractor and Sub-subcontractor Affidavits should not be returned. They are to be used by you as the Contractor. If additional copies of the forms are needed, they can be found at http://www.audits.ga.gov/NALGAD/section_3_affidavits.html. Again, do not return the Subcontractor and
Sub-subcontractor Affidavits.

If you are an individual (non-entity) claiming an exemption under Option 1 or Option 2 below, check the appropriate option, sign, date and return this letter to my attention with a copy of your driver's license (Option 1 only).

Please return the required documentation immediately to permit DHS to report compliance in a timely manner. Questions concerning compliance with or exemption from Title 13, Chapter 10, Article 3 must be directed to your legal advisor. We appreciate your prompt consideration of this matter.

Respectfully,

_____

SAMPLE

Claim of Exemption ***(check only one (1) option, if applicable)***

____ **Option 1: Applies only to licensed professionals (individuals only – not entities) such as Attorneys, Pharmacists, Certified Public Accountants, etc.**
As an individual (non-entity) Contractor who is licensed pursuant to the Official Code of Georgia, Annotated (O.C.G.A.) Title 26 or Title 43 or by the State Bar of Georgia (Attorneys), in good standing, and who has contracted with DHS to render such licensed professional services, I am exempt from providing the affidavit required by O.C.G.A. Title 13, Chapter 10, Article 3.

____ **Option 2: Applies only to Contractors with Zero (0) Employees**
As a Contractor who has zero (0) employees and has no intent to hire employees during the project period, in lieu of the affidavit required by O.C.G.A. 13-10-91(b), I am submitting a copy of my state issued driver's license or identification card. The driver's license or identification card is issued by a state that verifies lawful immigration status prior to issuance.

____ **Copy of Driver's License or Identification Card is Attached for Option 2** ***(not required for Option1)***.

_____ _____ _____
Individual's Printed Name Individual's Signature Date Signed

Attachments: Contractor, Subcontractor and Sub-Subcontractor Affidavit Forms

Contractor Affidavit under O.C.G.A. § 13-10-91(b)(l)

The undersigned contractor ("Contractor") executes this Affidavit to comply with O.C.G.A § 13-10-91 related to any contract to which Contractor is a party that is subject to O.C.G.A. § 13-10-91 and hereby verifies its compliance with O.C.G.A. § 13-10-91, attesting as follows:

a) The Contractor has registered with, is authorized to use and uses the federal work authorization program commonly known as E-Verify, or any subsequent replacement program;

b) The Contractor will continue to use the federal work authorization program throughout the contract period, including any renewal or extension thereof;

c) The Contractor will notify the public employer in the event the Contractor ceases to utilize the federal work authorization program during the contract period, including renewals or extensions thereof;

d) The Contractor understands that ceasing to utilize the federal work authorization program constitutes a material breach of Contract;

e) The Contractor will contract for the performance of services in satisfaction of such contract only with subcontractors who present an affidavit to the Contractor with the information required by O.C.G.A. § 13-10-91(a), (b), and (c);

f) The Contractor acknowledges and agrees that this Affidavit shall be incorporated into any contract(s) subject to the provisions of O.C.G.A. § 13-10- 91 for the project listed below to which Contractor is a party after the date hereof without further action or consent by Contractor; and

g) Contractor acknowledges its responsibility to submit copies of any affidavits, driver's licenses, and identification cards required pursuant to O.C.G.A. § 13-10-91 to the public employer within five business days of receipt.

SAMPLE

_____ _____
Federal Work Authorization User Identification Number Date of Authorization

_____ _____
Name of Contractor Name of Project

_____
Name of Public Employer

I hereby declare under penalty of perjury that the foregoing is true and correct.

Executed on _____, _____, 20_____ in _____ (city), _____ (state).

_____
Signature of Authorized Officer or Agent

_____
Printed Name and Title of Authorized Officer or Agent

SUBSCRIBED AND SWORN BEFORE ME
ON THIS THE _____ DAY OF _____, 20_____.

_____
NOTARY PUBLIC
My Commission Expires: _____

Georgia Department of Human Services

Aging Services | Child Support Services | Family & Children Services

Pre-Award Risk Assessment Form

Contractor Name:	[enter applicant name]
CFDA/Contract/Grant Award Number(s) of Review:	93.556
Division/Program Name(s):	CAPTA Plan of Safe Care
Contract/Grant Period of Review:	**July 1, 2025 -June 30, 2026**
Contract/Grant Amount(s):	[enter total amount requested]
Risk Assessment Completed by:	
Risk Assessment Completed Date:	
Division Director or Program Manager Name	
Total Score:	0
Risk Level:	**Low Risk**

1. Amount	**Small <$25,000**	**Medium $25,000 to $250,000**	**Large >$250,000**
Amount of the award (contract) approved			

2. Accounting System	**Automated**	**Manual**	**Combination**
Type of accounting system used by the			

3. Program Complexity	**Slightly Complex**	**Moderately Complex**	**Highly Complex**
Rate the complexity of the program			

SAMPLE

Programs with complex compliance requirements have a higher risk of non-compliance. In your determination of complexity consider whether there are complex contract/grant requirements (*If you choose one item, select slightly complex; if you choose two items, select moderately complex; if you choose three or four items, select highly complex*). The following are some examples of reasons a program would be considered more complex:

- ► Complex programmatic requirements and/or must adhere to regulations
- ► Various types of program reports are required
- ► Matching funds or Maintenance of Effort are required
- ► The entity further subcontracts out the program

4. Entity Risk ***Rank the entity based on your knowledge of the following:***	**Yes/No**
a. Was this the first award (contract) the entity received?	
b. Did the entity follow all the terms and conditions of the prior contract and/or prior grant awards?	
c. Does the entity have adequate and qualified staff to comply with the terms of the contract/grant?	
d. Does the entity have previous experience with this or similar programs?	
e. Does the entity maintain policies which include procedures for assuring compliance with the terms of the contract/grant?	
f. Does the entity's accounting system accurately complete and track the receipt and disbursements of funds related to the contract/grant?	
g. Does the federal/state program require staff to track their time associated with the contract/grant?	
h. If yes, does the entity have a system that will account for 100% of each employee's time?	
i. Did the entity's key staff or program members attend required training and meetings during contract/grant awards?	
j. Did the entity's key staff or program members respond to State Office requests timely during contract/grant awards?	
k. Did the entity have one or more audit findings in their last and/or single audits regarding program non-compliance or internal controls?	
l. Did the entity correct, or is it currently correcting the findings mentioned in question 4k? (**If answered no to 4k, select N/A**)	
m. Was the entity audited by the DHS Internal Audit or State Auditors (DOAA) in the past 2 years?	
n. If yes to 4m, did the audit result in one or more audit findings? (***If answered No or N/A to 4m, select N/A***)	
o. Did the State Program Office perform a monitoring visit during or within the last 2 fiscal years?	
p. Did the entity have any findings from the program monitoring? (**If answered No or N/A to 4o, select N/A**)	

Georgia Department of Human Services
Aging Services | Child Support Services | Family & Children Services

Pre-Award Risk Assessment Form

(Assign 5 points for each issue below (1-8) that are applicable) *q. Other issues that may indicate high risk of non-compliance?*	Briefly explain which numbers were chosen and why. Add another page if necessary	0

Other issues : **(1)** Having new or substantially changed systems or software packages, i.e. accounting, payroll, technology; **(2)** Turnover in personnel, i.e. business, award management, program; **(3)** External risks including: economic conditions, political conditions, regulatory changes; **(4)** Loss of license or accreditation to operate program; **(5)** New activities, products, or services; **(6)** Organizational restructuring; **(7)** Where indirect costs are included, does the organization have adequate systems to segregate indirect from direct costs. **(8)** No issues

5. Reporting & Budget ***Rank the entity based on your knowledge of the following:***		**Yes/No**
a. Were performance reports submitted according to contract requirements? (*i.e. within the agency-specified timeframe*)		
b. Was reasonable progress made towards contract/grant awards performance goals?		
c. Were financial reports (i.e., expenditure, invoices, etc.) submitted timely?		
d. Were financial reports (i.e., expenditure) accurate?		
e. Did the entity stay within budget?		
Low = 0 - 85 Moderate = 86 - 170 High = 171 and higher	**TOTAL RISK POINTS:**	**0**

Common Attributes of Grantees with Low, Moderate and High Risk:	
Low Risk	**High Risk**
*Most of the following attributes should be present to be considered **low** risk*	*One or more of the following attributes may be present to be considered **high** risk*
► Entity has complied with the terms and conditions of prior grant awards	► History of unsatisfactory performance or failure to adhere to prior grant terms and conditions
► No known financial management problems or instability	► Financial management problems and/or instability; inadequate financial management system
► High quality programmatic performance	► Program has highly complex compliance requirements
► No, or very insignificant, audit or other monitoring findings	► Significant findings or questioned costs from prior audit
► Timely and accurate financial and performance reports	► Untimely, inadequate, inaccurate reports
► Program likely does not have complex compliance requirements	► Recurring/unresolved issues
► Entity has received some form of monitoring (e.g., single audit, on-site review, etc.)	► Lack of contact with entity or any prior monitoring
	► Large award amount
Moderate Risk ► *Entities that fall between low risk and high risk are considered **moderate** risk.*	

SAMPLE

Considerations/Justification/Notes specific to the Contractor/Grantee:

For any entity considered a moderate or high risk, the program must justify issuing the entity a current contract. Please provide the justification below and the Program Manger and/or Director should sign in the area indicated.

Justification:

PARA Completed by: _____ Title:_____ Date:_____

The contractor has been deemed a **moderate/high risk.** Therefore, the division and/or program manager is **required** to acknowledge the use of this contractor by signing the form below.

I acknowledge that the contractor has been deemed a moderate and/or high risk and agree with the justification provided.

Name:_____ Title:_____ Date:_____

Georgia Department of Human Services

Corporate Resolution Key Elements

Ensure the colorized elements below are included in all Corporate Resolution submissions.

Corporate Resolution Key Elements

At the ___(regular or called)___ meeting of ___(legal name of Contractor)___ on ___(date of board meeting)___, the following resolution was presented, seconded, and passed ___(unanimously or by majority vote)___:

WHEREAS: The ___(legal name of Contractor)___ desires to provide services, and

WHEREAS: Said Corporation desires to enter a contractual arrangement with the Georgia Department of Human Services for the provision of said services; be it therefore

RESOLVED, that ___(legal name of Contractor)___, agrees to enter a written contract with the Georgia Department of Human Services, for the provision of services for the period beginning ___(effective start date of contract)___ and ending ___(end date of contract)___.

AND THE ___(title(s) of authorized contract signers)___ is/are duly authorized to execute said contract on behalf of this entity.

SAMPLE

Witness my hand and seal of the corporation this ___ day of _____, 20__.

Signature	Title
The signer of the Corporate Resolution is prohibited from signing the contract.	**This title cannot be listed as an authorized contract signer if a sole individual is named**

(Corporate Seal)

Replicate on corporate letterhead

CORPORATE RESOLUTION
TO ENTER INTO CONTRACT

At the *[choose one: regular or called"]* meeting of *[insert legal name of non-profit as it appears on Secretary of State registration screenshot]* on [*insert date]*, the following resolution was presented, seconded, and passed: *[choose one: unanimously or by majority vote]*:

WHEREAS: The *[insert legal name of non-profit as it appears on Secretary of State registration screenshot]* desires to provide program services, and

WHEREAS: Said corporation desires to enter a contractual arrangement with the Georgia Department of Human Services, Division of Family and Children Services for the provision of said program services; be it therefore

RESOLVED, that *[insert legal name of non-profit as it appears on Secretary of State registration screenshot]* agrees to enter a written contract with the Georgia Department of Human Services, Division of Family and Children Services, to deliver services as described in the FY2026 CAPTA Plan of Safe Care proposal for the period beginning July 1, 2025, and ending June 30, 2026.

SAMPLE

AND THE *[insert title(s) of authorized contract signers, officer(s) as identified on the Secretary of State registration screenshot]* is/are duly authorized to execute said contract on behalf of this Corporation.

Witness my hand and seal of the Corporation

Signature
The signer of the Corporate Resolution is prohibited from signing the contract.

Title of Officer

This title cannot be listed as an authorized contract signer if the sole individual is named.

Name of Officer

Date

Imprint Seal of Corporation Here

If no Corporate Seal available, Resolution must be notarized in space below.

Replicate on agency letterhead

AUTHORIZATION
TO ENTER INTO CONTRACT

Date Authorized:

Program: CAPTA Plan of SafeCare

Contract Period: July 1, 2025 – June 30, 2026 Proposed

Cost:

Individual authorized to act on behalf of Public Entity:

Name:

Title:

SAMPLE

[insert Public Entity name as it appears on Application Cover] agrees to enter into a written contract with the Georgia Department of Human Services, Division of Family and Children Services, to deliver services as described in FFY2026 GA Children's Justice Act proposal.

Signature of AUTHORIZED Representative

Printed Name

Title

Date

Notary Signature

Date Commission Expires

Affix notary seal or stamp below.