**CERTIFICATION**

**REGARDING ENVIRONMENTAL TOBACCO SMOKE**

SERVICE PROVIDER agrees to comply with Public Law 103-227, Section 1041-1044, 20 U.S.C. Sections 6081-6084, also known as the Pro-Children’s Act of 1994, which requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children’s services provided in private residences; portions of facilities used for inpatient hospital drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities (other than clinics) where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the SERVICE PROVIDER certifies that the submitted organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The submitting organization agrees that it will require that the language of this certification be included in any sub-awards, which contain provisions for children’s services and that all subcontractors shall certify accordingly.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

Type Name and Title:

# **CERTIFICATION**

# **REGARDING DRUG-FREE WORKPLACE REQUIREMENTS**

Service Provider, in accordance with 45 CFR Part 76 certifies that it shall provide a drug-free workplace by:

1. Establishing a drug-free awareness program to inform employees about:

a. the dangers of drug abuses in the workplace; and

1. service provider’s policy of maintaining a drug-free workplace; and
2. any available drug counseling, rehabilitation and employee assistance programs; and
3. the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace.
4. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Service Provider’s workplace and specifying the actions that shall be taken against employees for violation of such prohibition.
5. Including in the published statement in #2 above, a requirement that each employee, as a condition of employment, shall:
6. abide by the terms of the statement; and
7. notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than 5 days after such conviction.
8. Notifying the County (and ODAP for services funded with PA Dept. of Health, Bureau of Drug and Alcohol funds) within 10 days after receiving notice under paragraph 3(b) above from an employee or otherwise receiving actual notice of such conviction.
9. Taking one of the following actions within 30 days of receiving notice under paragraph 3(b) with respect to any employee who is so convicted:
10. taking appropriate personnel action against such an employee, up to and including termination; or
11. requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a federal, state, or local health, law enforcement or other appropriate agency.
12. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1-5 above.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_

Type Name and Title:

**SERVICE PROVIDER RESPONSIBILITY PROVISIONS**

1. Service Provider certifies that it is not currently under suspension or debarment by the Commonwealth, any other state, or the Federal government, and if the Service Provider cannot so certify, then it agrees to submit along with the bid/proposal (agreement) a written explanation of why such certification cannot be made.

2. If Service Provider enters into subcontracts or employs under this contract any subcontractors/individuals who are currently suspended or debarred by the Commonwealth or Federal government or who become suspended or debarred by the Commonwealth or Federal government during the term of this contract or any extension or renewals thereof, the Commonwealth shall have the right to require the Service Provider to terminate such subcontracts or employment.

3. The Service Provider agrees to reimburse the Commonwealth for the reasonable costs of investigation incurred by the Office of the Inspector General for investigation of the Service Provider’s compliance with terms of this or any other agreement between Service Provider and the Commonwealth/County which result in the suspension or debarment of the Service Provider. Such costs shall include, but are not limited to, salaries of investigators, including overtime; travel and lodging expenses; and expert witness and documentary fees. The Service Provider shall not be responsible for investigative costs for investigations which do not result in the Service Provider’s suspension or debarment.

4. The Service Provider may obtain the current list of suspended and debarred Service Providers by contacting the:

 Department of General Services

 Office of Chief Counsel

 603 North Office Building

 Harrisburg PA 17125

 Telephone: 717-783-6472

 Fax 717-787-9138

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Type Name and Title:

**TAX CERTIFICATION**

Pursuant to the terms of the AGREEMENT between SERVICE PROVIDER and ALLEGHENY COUNTY DEPARTMENT OF HUMAN SERVICES, an authorized representative of SERVICE PROVIDER shall complete the following:

|  |  |  |  |
| --- | --- | --- | --- |
| I |       | as the |       |
|  (name) (title) |
| of  |       |
|  | (name of organization) |
| do hereby certify that the above-named organization has complied with the requirements of the law and the prime funding sources’ regulations regarding the obtaining of employer identification/account numbers and the Collection Payment Depositing, and Reporting of Federal, State and Local Taxes, and The provision of W-2 forms to employees. |
| Signature |  |
| Date |  |  |

**LOBBYING CERTIFICATION FORM**

Certification for Contracts, Grants, Loans, and Cooperative Agreements

The undersigned certifies, to the best of his/her knowledge and belief, that:

1. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities,” in accordance with its instructions.
3. The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a pre-requisite for making or entering into this transaction imposed under Section 1352, Title 31, US Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for such failure.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

Type Name and Title:

**ALLEGHENY COUNTY**

**DEPARTMENT OF HUMAN SERVICES**

**ANTI-TERRORISM CERTIFICATION FORM**

In compliance with the intent of the USA Patriot Act and other counter-terrorism laws, all organizations or individuals receiving funds through an agreement with the Allegheny County Department of Human Services, must certify:

1. The organization/individual is not on any federal terrorism watch lists, including the list in Executive Order 13224, the master list of specially designated nationals and blocked persons maintained by the Treasury Department, and the list of Foreign Terrorist Organizations maintained by the US State Department.
2. The organization/individual does not, will not and has not knowingly
	* + provided financial, technical, in-kind or other material support or resources to any individual or entity that is a terrorist or terrorist organization, or that supports or funds terrorism.
		+ provided or collected funds or provided material support or resources with the intention that such funds or material support or resources be used to carry out acts of terrorism.
		+ provided financial or material support or resources to any entity that has knowingly concealed the source of funds used to carry out terrorism or to support Foreign Terrorist Organizations.
		+ regrant to organizations, individuals, programs and/or projects outside of the United States of America without compliance with IRS guidelines.

(Material support and resources means currency or monetary instruments or financial securities, financial services, lodging, training, expert advise or assistance, safe houses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, personnel, transportation and other physical assets, except medicine or religious materials.)

1. The organization/individual
	* + takes reasonable affirmative steps to ensure that any funds or resources distributed or processed do not fund terrorism or terrorist organizations.
		+ takes reasonable steps to certify against fraud with respect to the provision of financial, technical, in-kind or other materials support or resources to terrorist and terrorist organizations.

This certification is a material representation of fact upon which reliance was placed when this transaction as made and entered into.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date |  |
| Please print/type Name & Title |       |
| Please print/type Organization Name |       |

**SERVICE PROVIDER’S BOARD MEMBERSHIP LISTING**

In column 1, identify all board members and note which member(s) is/are officers (i.e., Chairperson, Vice Chairperson, etc.)

|  |  |  |
| --- | --- | --- |
| Board Members | Term of MembershipFrom and To | Place of Employment and Title |
|       |       |       |
|       |       |       |
|       |       |       |
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**LISTING OF SUBCONTRACTORS**

It is required that Service Provider submit to COUNTY a listing of all provider’s subcontractors subject to this agreement that provider has entered into a formal agreement with for the performance of services exceeding $10,000. The information required may be expanded at the discretion of the Director (or Director’s designee) of the Department of Human Services.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name and Address | Contact Person | Telephone Number | Function/Description | Est. No. of Units | Dollar Amount |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
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|       |       |       |       |       |       |
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Submitted for approval with the understanding that prior written approval from the Department of Human Services will be obtained for any revision or addition to this listing.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |
| Print/Type: |       | Name |
|  |       | Title |

|  |  |
| --- | --- |
|  **Allegheny County****Vendor Creation Form** | Controller’s use only:Supplier No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1099 Eligibility: [ ]  Yes [ ]  No |
|  |
| [ ]  Add [ ]  Change Supplier No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Company Information:** | **Federal Tax ID (TIN)** |
|       |  |       |
| **Company Name** (Please type or print) | **Original** W-9 must be attached |
|  |
| **Type of Service Provided** | **Type of Commodity Provided**(please describe) |
| [ ]  Independent Contractor | [ ]  Rent |       |
| [ ]  Maintenance/Service Agreement | [ ]  Care Giver |  |
| [ ]  Insurance | [ ]  Legal |  |
| [ ]  Personal Reimbursement | [ ]  Medical |  |
| [ ]  Other (please list) |       |
| **Minority Owned** | [ ]  Yes [ ]  No |
|  | If yes [ ]  MBE [ ]  DBE [ ]  WBE [ ]  Veteran-Owned |
| Certified By: |       | (attach copy of certification) |
| **Industry Classification by NAICS Code** |
| Primary Industry       |
| Secondary Industry (if applicable)       |
| \*If code is not known, go to http://www.census.gov/epcd/naics/naics3dx.htm#N54 and select the correct code. |
| **Supplier Information (Search Type “P”)** – (Where PO should be sent to place order.) |
| Company Name |  | Telephone Number |  |
| Address Line 1 |  | Fax Number |  |
| Address Line 2 |  |  |  |
| Address Line 3 |  |  |  |
| City |  | State |  |
| ZIP Code |  |  |  |

**CONTINUED ON REVERSE**

**DHS Providers complete “V” section (next page) in lieu of “P”**

|  |
| --- |
| **Supplier/Remit To Information (Search Type “V”)** – (Where check will be mailed for payment. Check **must** be made payable to exact name listed under TIN provided or check cannot be processed.) |
| Supllier/Payee Name |       | Telephone Number |       |
| Address Line 1 |       | Fax Number |       |
| Address Line 2 |       |  |  |
| Address Line 3 |       |  |  |
| Email Address (required) |       |  |  |
| City |       | State |       |
| ZIP Code |       |  |  |
| \*If the “remit to” information provided on form does not match invoices submitted for payment, the Controller’s Office MUST contact supplier to verify address information before payments are processed. Thank you for your cooperation. |
|  |
| **Allegheny County Departmental Contact** |  | **Supplier/Payee Contact Name** |
| Name |  |  | Name |       |
| Telephone No. |  |  | Telephone No. |       |
| Fax No. |  |  | Fax No. |       |
| EMail Address: |  |  | Email Address: |       |
|  |

**SERVICE PROVIDER**

**CORPORATE NAME CHANGE**

|  |
| --- |
| Please prepare and send the following notice to DHS when your organization’s corporate name changes OR when you have decided to “do business as”, under another name. |
|  | **PREVIOUS** | **NEW / CHANGE TO** |
| Organization’s Name: |       |       |
| Doing Business As: |       |       |
| Address: |       |       |
| EIN: |       |       |
| Telephone Number: |       |       |
| Fax Number: |       |       |
| Email Address: |       |       |
| Date Name Changes Officially: |       |
| Voted/Approved by Organization’s Board: | [ ]  Yes [ ]  No |
| Date of Vote: |       |
|  |  |
| Reason for Change: |       |

As an authorized signatory for the above-identified organization, I hereby certify the above information regarding the entity’s name change is true and accurate.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |
| Print/Type: |       | Name |
|  |       | Title |

**SERVICE PROVIDER**

**ADDRESS CHANGE**

|  |
| --- |
| Please prepare and send the following notice to DHS when any of your organization’s addresses change. |
|  |  |  |
| Organization’s Name: |       |
| Doing Business As: |       |
| EIN: |       |
| The address will change for (check all that apply) | **[ ]** Billing [ ]  Local Office [ ]  Facility [ ]  Headquarters |
|  | **PREVIOUS** | **NEW / CHANGE TO** |
| Address: |       |       |
|  |       |       |
| Telephone Number: |       |       |
| Fax Number: |       |       |
| Email Address: |       |       |
| Date Address Changes Officially: |  |

As an authorized signatory for the above-identified organization, I hereby certify the above information regarding the entity’s address change is true and accurate.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |
| Print/Type: |       | Name |
|  |       | Title |