LAKE CUMBERLAND AREA DEVELOPMENT DISTRICT
Occupational Therapy & Home Modification Coordination Services
RFP # LCADD-OAHMP-2026-OT

SECTION 1: Cover Sheet

Scoring: Not scored.

Complete all applicable items in this section.

This section and the remainder of the Response Packet may be completed electronically or by hand. Handwritten responses must be printed neatly and legibly. Illegible responses may not be evaluated.

A. Respondent Information

Occupational Therapist's Full Legal Name: _____

Business/Practice Name (if submitting through entity): _____

Physical Address: _____

City: _____ **State:** _____ **ZIP:** _____

Mailing Address (if different): _____

City: _____ **State:** _____ **ZIP:** _____

Cell Number: _____ **Email Address:** _____

Preferred Contact Method/Times: _____

LAKE CUMBERLAND AREA DEVELOPMENT DISTRICT
Occupational Therapy & Home Modification Coordination Services
RFP # LCADD-OAHMP-2026-OT

SECTION 2: Professional Qualifications

Scoring: Section A is evaluated Pass/Fail (no points).

Section B awards up to 10 points for relevant certifications, credentials, or specialized training.

Complete all items in this section. Brief, direct answers are encouraged.

A. Kentucky Occupational Therapy License

KY OT License Number: _____ **Exp. Date:** _____

☐ My Kentucky Occupational Therapy license is current, active, and unrestricted.

B. Other Certifications, Credentials, or Specialized Training

Please select all options that apply. Documentation for each item claimed must be attached.

☐ I am a Certified Aging-in-Place Specialist. (CAPS)

☐ I am a Certified Home Accessibility Therapist. (CHAT/HAT)

☐ Other Aging in Place and/or Home Modification certification, credential, or specialized training:

SECTION 3: Relevant Experience

Scoring: 25 Points.

Complete all applicable items. Responses should reflect services you personally performed. Do not include client names or other identifying information.

Prior OAHMP or LCADD experience is not required. Comparable experience in home health, rehabilitation, aging or disability services, housing, Medicaid waiver programs, or private home-modification work will receive equal consideration.

A. Relevant Experience Summary

1. How long have you provided occupational therapy services in clients' homes?

☐ None ☐ Less than 1 year ☐ 1–2 years ☐ 3–5 years
☐ 6–10 years ☐ 11+ years

2. How long have you provided aging-in-place, home safety, accessibility, and/or home modification services?

☐ None ☐ Less than 1 year ☐ 1–2 years ☐ 3–5 years
☐ 6–10 years ☐ 11+ years

3. Service Contexts — Check all that apply.

☐ Home health ☐ Hospital/rehabilitation/outpatient
☐ Long-term care ☐ Community aging/disability services
☐ Medicaid waiver/HCBS ☐ Housing/accessibility program
☐ Private home modification ☐ Other: _____

B. Experience Performing Relevant Services

For each activity, select the approximate number of cases in which you personally performed or directly participated in the service.

1. **Conducting in-home functional assessments, including ADLs/IADLs, mobility, balance, transfer, and fall risk.**

   ☐ None ☐ 1–5 cases ☐ 6–20 cases ☐ 21+ cases

2. **Using standardized functional, home-safety, fall-risk, or accessibility assessment tools.**

   ☐ None ☐ 1–5 cases ☐ 6–20 cases ☐ 21+ cases

3. **Considering cognition, vision, hearing, communication, and caregiver needs during assessment.**

   ☐ None ☐ 1–5 cases ☐ 6–20 cases ☐ 21+ cases

4. **Identifying fall risks, environmental hazards, and accessibility barriers within the home.**

   ☐ None ☐ 1–5 cases ☐ 6–20 cases ☐ 21+ cases

5. **Recommending adaptive equipment or durable medical equipment for use in the home.**

   ☐ None ☐ 1–5 cases ☐ 6–20 cases ☐ 21+ cases

6. **Recommending home modifications based on a client's functional needs, routines, and priorities.**

   ☐ None ☐ 1–5 cases ☐ 6–20 cases ☐ 21+ cases

7. **Preparing written modification recommendations, specifications, scopes, or work orders.**

   ☐ None ☐ 1–5 cases ☐ 6–20 cases ☐ 21+ cases

8. **Coordinating with contractors, Home Modifiers, or other home-repair professionals.**

   ☐ None ☐ 1–5 cases ☐ 6–20 cases ☐ 21+ cases

9. **Reviewing work in progress or completed equipment installations and home modifications.**

   ☐ None ☐ 1–5 cases ☐ 6–20 cases ☐ 21+ cases

C. Experience with Equipment and Modification Types

Check each type you have personally assessed, recommended, coordinated, or reviewed:

- ☐ Grab bars/handrails
- ☐ Bathing equipment
- ☐ Ramps, landings, or entries
- ☐ Flooring or trip-hazard correction
- ☐ Kitchen or bedroom accessibility
- ☐ Assistive technology
- ☐ Toilet or transfer equipment
- ☐ Tub cuts or accessible showers
- ☐ Thresholds, doors, or hardware
- ☐ Lighting/vision accommodations
- ☐ Stairs, porches, or egress
- ☐ Other

If you checked "Other," please specify below:

D. Comparable Case Examples

Provide two brief examples of work you personally performed. Comparable work may come from any program or practice setting. Do not identify the client, employer, or organization by name.

EXAMPLE ONE

Approximate Year(s): _____

Program or Service Context — Check all that apply:

- ☐ Home health
- ☐ Rehabilitation/therapy
- ☐ Community-based services
- ☐ Medicaid waiver/HCBS
- ☐ Housing/accessibility program
- ☐ Private home modification
- ☐ Other: _____

Briefly identify the client's functional needs and the home safety or accessibility barriers addressed:

Briefly identify the equipment or physical modifications recommended and why:

Services You Personally Performed — check all that apply:

☐ In-home assessment ☐ Written recommendation/work order ☐ Client education

☐ Contractor coordination ☐ Progress/completion review ☐ Requested corrections

☐ Estimate/invoice review ☐ Post-intervention follow-up ☐ Other: _____

Briefly identify the result or post-intervention outcome, if known:

EXAMPLE TWO

Approximate Year(s): _____

Program or Service Context — Check all that apply:

☐ Home health ☐ Rehabilitation/therapy ☐ Community-based services

☐ Medicaid waiver/HCBS ☐ Housing/accessibility program ☐ Private home modification

☐ Other: _____

Briefly identify the client's functional needs and the home safety or accessibility barriers addressed:

Briefly identify the equipment or physical modifications recommended and why:

Services You Personally Performed — Check all that apply:

☐ In-home assessment ☐ Written recommendation/work order ☐ Client education

☐ Contractor coordination ☐ Progress/completion review ☐ Requested corrections

☐ Estimate/invoice review ☐ Post-intervention follow-up ☐ Other: _____

Briefly identify the result or post-intervention outcome, if known:

E. Professional References

Please provide 2 professional references. Do not list a relative or personal reference.

Reference #1 ☐ *I authorize LCADD to contact this reference in regards to this RFP.*

Organization: _____

Contact Person: _____

Telephone: _____

Email Address: _____

Dates of Service: _____

Briefly describe the services you provided for this organization:

Reference #2 ☐ *I authorize LCADD to contact this reference in regards to this RFP.*

Organization: _____

Contact Person: _____

Telephone: _____

Email Address: _____

Dates of Service: _____

Briefly describe the services you provided for this organization:

LAKE CUMBERLAND AREA DEVELOPMENT DISTRICT
Occupational Therapy & Home Modification Coordination Services
RFP # LCADD-OAHMP-2026-OT

SECTION 4: Written Interview

Scoring: 30 Points.

Please answer each question based on how you would approach the situation described. Brief, direct answers are encouraged.

---

1. During an in-home assessment, you realize that a client has difficulty understanding your questions or communicating their needs. How would you adapt your approach while ensuring that the client remains meaningfully involved in the assessment?

2. An assessment identifies more needs than the program can reasonably address. Walk us through how you would decide which recommendations to include in the work order and what will be excluded.

3. A client strongly prefers a modification that differs from the approach you believe is safest or most appropriate. How would you handle that disagreement?

4. During a home visit, you observe a serious client welfare or household safety concern that extends beyond the scope of the OAHMP project. How would you respond?

5. How would you determine which of LCADD's contracted Home Modifiers to assign to a particular client? What factors do you take into consideration?

6. A Home Modifier contacts you after work has begun to report an unexpected condition that could affect whether or how the project can continue. Walk us through how you would handle the situation.

7. You begin to notice a pattern of performance or compliance problems involving a Home Modifier. How would you address the situation?

8. What draws you to this program? What do you believe you would bring to a team dedicated to helping older adults remain safely and independently in their homes?

LAKE CUMBERLAND AREA DEVELOPMENT DISTRICT
Occupational Therapy & Home Modification Coordination Services
RFP # LCADD-OAHMP-2026-OT

SECTION 5: Capacity, Availability, and Regional Coverage

Scoring: 15 Points. Minimum weekday availability and regional coverage requirements are Pass-Fail.

Provide realistic estimates based on your anticipated availability during the OAHMP project period, currently estimated by HUD as November 2, 2026 through November 1, 2029. The actual contract start date and term will depend upon funding, contract negotiations, and LCADD's written Notice to Proceed.

A. Availability and Time Commitment

Following LCADD's written Notice to Proceed, how soon could you begin accepting assignments?

☐ Immediately. ☐ Within one week. ☐ Within two weeks. ☐ Other: _____

How many hours per week (on average) would you be able/willing to commit to the OAHMP?

☐ 1-4. ☐ 5-10. ☐ 11-15. ☐ 16-20. ☐ 21+ (Approx. _____ hours.)

If selected, your schedule for performing OAHMP services will be very flexible. However, in order for your proposal to be considered responsive, you must be able to commit to the following:

Minimum Weekday Availability: During a typical week, the respondent must have a period of availability on at least one weekday to participate in scheduled, real-time communication with LCADD staff during LCADD's regular business hours. The specific day and time may vary from week to week, and reasonable exceptions for leave or temporary scheduling conflicts are permitted. Availability limited to evenings and weekends does not satisfy this requirement.

Can you commit to the minimum weekday availability requirement stated above? A "No" response will automatically fail the threshold for consideration.

☐ Yes ☐ No

When do you generally expect to conduct OAHMP duties? Please select all that apply.

- ☐ Weekday Mornings (Before 12PM)
- ☐ Weekday Afternoons (12PM – 4PM)
- ☐ Weekday Evenings (After 4PM)
- ☐ Weekends

Please list any current or anticipated professional commitments that may materially limit your availability during the contract period. If none, enter "None."

B. Caseload Capacity and Turnaround Times

The answers below are planning estimates, not binding guarantees. LCADD will consider whether the estimates appear to be reasonable and support timely program delivery.

Approximately how many new OAHMP client referrals could you generally accept each month while continuing to manage existing units through follow-up and closeout?

- ☐ 1–3 clients
- ☐ 4–6 clients
- ☐ 7–10 clients
- ☐ More than 10 clients

After receiving a referral from LCADD, how soon could you generally conduct the initial in-home assessment, subject to the client's availability?

- ☐ Within 1-2 business days
- ☐ Within 3-5 business days
- ☐ More than 5 business days

After completing the home assessment, how soon would you be able to prepare the work order and assign it to a Home Modifier?

- ☐ Within 1-2 business days
- ☐ Within 3-5 business days
- ☐ More than 5 business days

After a Home Modifier reports that work is complete, how soon would you generally be able to perform the required completion review?

- ☐ Within 1-2 business days
- ☐ Within 3-5 business days
- ☐ More than 5 business days

Could you generally accommodate occasional short-notice scheduling needs during normal business hours when client safety or the project schedule requires prompt attention?

- ☐ Yes
- ☐ No
- ☐ Possibly, depending on availability.

C. Regional Coverage, Communication, and Continuity

Are you able and willing to regularly travel throughout LCADD's 10-county service area? A "No" response will automatically fail the threshold for consideration.

- ☐ Yes, without material limitations.
- ☐ Yes, subject to the limitations outlined below that would not prevent full regional coverage.
- ☐ No.

Describe any geographic, travel, scheduling, or transportation limitations that could affect your ability to serve the full region. For example, being able to travel to a specific county only on certain days. If none, enter "None."

During normal business hours, how quickly would you generally be able to respond to messages from LCADD, clients, or Home Modifiers?

- ☐ By the end of the same business day.
- ☐ By the end of the next business day.
- ☐ Within two business days.
- ☐ More than two business days

Briefly explain how you would notify LCADD of planned or unexpected absences and manage pending assignments, deadlines, or client needs. Do not assume that another individual may perform the contracted services without LCADD's prior written approval.

Provide any additional information that would help LCADD understand your capacity to serve the region and complete assignments on schedule. If none, enter "None."

LAKE CUMBERLAND AREA DEVELOPMENT DISTRICT
Occupational Therapy & Home Modification Coordination Services
RFP # LCADD-OAHMP-2026-OT

SECTION 6: Cost Effectiveness

Scoring: 20 Points.

Enter one hourly rate and one mileage rate. LCADD will calculate the price score using the Evaluated Cost per Typical Client as stated in the RFP. An additional cost narrative is not required.

A. Proposed Rates

The proposed hourly rate must include all ordinary costs of providing the services except approved program mileage. Authorized travel time required to perform program duties may be billed as hours worked at the proposed hourly rate. No separate travel-time rate or fee may be charged.

Proposed Hourly Rate: $_____ per hour

Proposed Mileage Rate: $_____ per mile

B. Rate Confirmations

Check each box to confirm your acknowledgement and agreement.

- ☐ The proposed hourly rate applies to all authorized billable time, including authorized travel time, and includes all ordinary costs of performance, such as labor, administration, equipment, supplies, communications, insurance, overhead, and profit.
- ☐ Mileage will be billed only for authorized program travel at the proposed mileage rate.
- ☐ No separate fee, surcharge, minimum charge, or other cost is proposed beyond the hourly and mileage rates entered above.

- ☐ Monthly invoices will include an itemized timesheet and mileage report. Each mileage entry must identify the date, travel purpose, origin, destination, and miles claimed and must be supported by Google Maps or comparable route documentation acceptable to LCADD.
- ☐ The rates will remain valid for at least 120 days after the proposal due date.
- ☐ If selected for award, I agree that the proposed hourly and mileage rates will be incorporated into the resulting contract and will remain fixed and unchanged throughout the original three-year contract term. No automatic or annual adjustment will be made for inflation, fuel costs, changes in standard mileage-reimbursement rates, or other operating cost increases. Respondents should account for reasonably anticipated cost changes when establishing their proposed rates.
- ☐ I understand that LCADD does not guarantee any minimum number of referrals, hours, miles, or amount of compensation.

C. Exceptions or Conditions

List any exceptions or conditions that apply to the rates or confirmations above. If none, enter "None." LCADD may reject rates that are conditional, nominal, unbalanced, or inconsistent with the RFP.

LAKE CUMBERLAND AREA DEVELOPMENT DISTRICT
Occupational Therapy & Home Modification Coordination Services
RFP # LCADD-OAHMP-2026-OT

SECTION 7: Final Checklist, Acknowledgments, and Signature

Scoring: Not scored.

Complete all items in this section.
Use the checklist to confirm that your response packet is complete before submission.

A. Past Contract Performance Disclosure

During the past five years, have you failed to complete a material obligation under a contract for professional or client services, had such a contract terminated for performance-related reasons, or been subject to formal corrective action because of performance, billing, or compliance concerns?

☐ Yes. *Please provide an explanation below.*

☐ No.

If you responded "Yes," please briefly describe the circumstances, the contractual obligation or concern involved, and how the matter was resolved.

Responding "Yes" does not automatically disqualify the respondent. LCADD may consider the nature and circumstances of the matter, its relevance to the proposed services, and any corrective actions taken. Failure to disclose material information may be grounds for rejection.

B. Conflict of Interest Disclosure

Please disclose any known actual, potential, or perceived conflicts of interest, including any personal, professional, or financial relationship that could affect - or reasonably appear to affect - your impartial performance of the proposed services. If none, enter "None."

C. Final Submission Checklist

Response Packet:

- ☐ Section 1 – Cover Sheet is complete.
- ☐ Section 2 – Professional Qualifications is complete.
- ☐ Section 3 – Relevant Experience is complete.
- ☐ Section 4 – Written Interview is complete.
- ☐ Section 5 – Capacity, Availability, and Regional Coverage is complete.
- ☐ Section 6 – Cost Effectiveness is complete.
- ☐ Section 7 – Final Checklist, Acknowledgments, and Signature is complete and signed.

Required Attachments:

- ☐ Résumé relevant to the requested services (maximum of three pages).
- ☐ Kentucky Occupational Therapy license or license-verification record.
- ☐ Documentation of relevant certifications, credentials, or specialized training claimed in the response, if applicable.

D. Addenda Acknowledgment

LCADD will post written answers and any addenda at www.lcadd.org no later than August 17th, 2026 at 4:00PM Central. If you submit your proposal before that time, you remain responsible for checking LCADD's website through that deadline and promptly contacting LCADD if subsequently posted information requires you to withdraw or replace your response.

Please select one of the following acknowledgments:

☐ By checking this box, I acknowledge that I have checked LCADD's website before submitting this response and reviewed the posted written answers and all addenda to this RFP.

☐ By checking this box, I acknowledge that no written answers or addenda were posted as of the date of my submission.

E. Final Certifications and Acknowledgments

Check each box below. By signing this response, the respondent certifies and acknowledges each statement in this subsection. Failure to complete a required certification may render the proposal nonresponsive.

☐ If selected for contract negotiations, I agree to authorize and complete the background check required by LCADD. I understand that satisfactory review of the results, as determined by LCADD, will be a condition of contract award. LCADD may decline to award a contract based on violent offenses; financial offenses, fraud, or dishonesty; or other findings that LCADD reasonably determines would create an undue risk to program clients, program funds, or successful contract performance.

☐ I have reviewed the RFP and all acknowledged addenda, and this response has been prepared in accordance with their requirements. Any exceptions or conditions are clearly disclosed in the response packet.

☐ The rates proposed in Section 6 were independently developed without collusion, consultation, communication, or agreement with another respondent for the purpose of restricting competition.

☐ I have disclosed any actual, potential, or perceived conflict of interest related to this procurement or the proposed services. If none are disclosed, I certify that I am not aware of any such conflict.

☐ I am not suspended, debarred, or otherwise excluded from participating in federally funded work.

☐ I authorize LCADD to verify the information provided, including my licensure, qualifications, certifications, references, exclusions status, and past performance.

☐ I understand that selection does not guarantee a contract, referrals, hours, mileage, compensation, or authorization to begin work. Any engagement is contingent upon funding, required approvals and clearances, successful completion of LCADD's responsibility review, execution of a contract, and written authorization to proceed.

☐ If selected and contracted, I will comply with the final contract and all applicable LCADD, HUD, OAHMP, federal, state, and local requirements.

☐ This response, including proposed rates, will remain valid for at least 120 days after the due date.

F. Respondent Signature

By signing below, I certify that the information contained in this proposal and all accompanying materials is true, accurate, and complete to the best of my knowledge and belief. I understand that any material omission, false statement, or misrepresentation may result in rejection of the proposal, withdrawal of an award, termination of any resulting contract, or other action deemed appropriate by LCADD.

Respondent's Printed Name: _____

Signature: _____ **Date**: _____