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Bid Fax: (250) 363-3344

Revision to a Request for a Standing Offer

Révision à une demande d'offre à commandes

Regional Individual Standing Offer (RISO)

Offre à commandes individuelle régionale (OCIR)

The referenced document is hereby revised; unless otherwise indicated, all other terms and conditions of the Offer remain the same.

Ce document est par la présente révisé; sauf indication contraire, les modalités de l'offre demeurent les mêmes.

Comments - Commentaires

Vendor/Firm Name and Address
Raison sociale et adresse du fournisseur/de l'entrepreneur

Issuing Office - Bureau de distribution

Public Works and Government Services Canada - Pacific Region
401 - 1230 Government Street
Victoria, B. C.
V8W 3X4

Title - Sujet RISO-Vocational Rehab		
Solicitation No. - N° de l'invitation G5799-110020/A		**Date** 2012-07-19
Client Reference No. - N° de référence du client G5799-110020		**Amendment No. - N° modif.** 001
File No. - N° de dossier VIC-1-34286 (250)	**CCC No./N° CCC - FMS No./N° VME**	
GETS Reference No. - N° de référence de SEAG PW-$VIC-250-5974		
Date of Original Request for Standing Offer **Date de la demande de l'offre à commandes originale**		2012-07-17
Solicitation Closes - L'invitation prend fin **at - à 02:00 PM** **on - le 2012-08-27**		**Time Zone** **Fuseau horaire** Pacific Daylight Saving Time PDT
Address Enquiries to: - Adresser toutes questions à: Sole, Mike		**Buyer Id - Id de l'acheteur** vic250
Telephone No. - N° de téléphone (250) 363-8444 ( )	**FAX No. - N° de FAX** (250) 363-3344	
Delivery Required - Livraison exigée		
Destination - of Goods, Services, and Construction: **Destination - des biens, services et construction:**		
Security - Sécurité This revision does not change the security requirements of the Offer. Cette révision ne change pas les besoins en matière de sécurité de la présente offre.		

Instructions: See Herein

Instructions: Voir aux présentes

Acknowledgement copy required **Accusé de réception requis**	**Yes - Oui** ☐	**No - Non** ☐

The Offeror hereby acknowledges this revision to its Offer.
Le proposant constate, par la présente, cette révision à son offre.

Signature **Date**

Name and title of person authorized to sign on behalf of offeror. (type or print)
Nom et titre de la personne autorisée à signer au nom du proposant.
(taper ou écrire en caractères d'imprimerie)

For the Minister - Pour le Ministre

Canada

This amendment is issued to include Appendices A-K that were not attached to original solicitation.

ALL OTHER TERMS AND CONDITIONS REMAIN THE SAME.

Appendices: Required content for reports, and templates

APPENDIX A

HYPOTHETICAL CASE STUDY

Referral Source: 1-800 call

Self referral

Age: 53

Sex: Male

Family Status: Separated

Education: Completed grade 12.

1976 completed Pipefitter/Steamfitter ticket

1974 completed Plumber/gasfitter ticket

Living accommodation: Home owner in medium urban suburban community

Occupational History: **1998/2001:** Facilities Manager of a Non Profit organization for First Nations Housing

1992/1997: Facilities Manager for the City

1974/1992: Journeyman Pipefitter/Plumber/Gasfitter Self-employed

Volunteer work: **2009/2011:** Elizabeth Fry Society – chairperson

Financial History:

Client has been in receipt of CPP-D since 2002. Is receiving $1097.00 per month in CPP-D benefits.

Medical History:

Medical report dated 2002 diagnosed with Schizoaffective disorder, depression /anxiety. Treated by family physician and psychiatrist. Rx: Respirdal, Celexa, Clonazepam. Tx: Group therapy for depression and anxiety, psych every 6 weeks.

Medical report dated 2008 - psychiatrist wrote that the most persistent and durable diagnosis is social phobia with panic attacks. There was a history of a brief psychotic disorder precipitated in the past by extreme stress. His psychotic experiences are under control. His anxiety level has improved. Future treatment will involve regular follow up for support. Current medication: Risperidone. Psychiatrist did not support return to work on a full time basis at the time.

Current Status:

Appendices: Required content for reports, and templates

Client has challenged himself to become more socially active and take on unpaid work activities. He occasionally uses Clonazepam .5 mg as needed for anxiety. The client is asking for assistance with his job search. He feels he has transferable work skills and has been getting interviews but no success in getting a job.

Client's doctor is supporting the client to return to work on a near/full time basis with a recommendation to avoid jobs where interpersonal confrontation is the norm.

Note: Client had requested assistance from CPP voc rehab a few years ago. At that time, the case manager determined that client was not ready for voc rehab due to his medical situation. However, suggestions were made regarding engaging in pre-vocational activity which the client has followed through on over the past year.

APPENDIX B

REQUIRED CONTENT

CPP DISABILITY VOCATIONAL REHABILITATION

INITIAL ASSESSMENT REPORT

Client Name: **Date of Referral:**
Client address and tel. #: **Consultant name and direct telephone #:**
Date(s) of interview(s) with the client: **Date of interview with the physician**
Date of interview with Employer (if appropriate):
Service Canada Case Manager:

Diagnosis:

Specific reasons for referral:

Please ensure that your report addresses the areas identified below:

1. Psychosocial Profile

Subjective:
- General impression of the client
- General attitude of the client
- Motivation: what are the incentives, disincentives to return to work (RTW)
- Cognition status
- Emotional status

Objective:
- Client personal and vocational goals
- Client perceived level of disability/capacity
- Support available
- Family situation and obligations

2. Description of client's home environment
Note: If the client is not met in his/her own home, provide the client's reason(s) for not meeting there.

3. Medical and Rehabilitative Interventions (May be contained in physician report)
- Main and secondary diagnosis(es)
- Recent medical interventions including client's compliance
- Past and current rehabilitation including client's compliance
- Change in medical status since granted
- Prognosis: Potential for "medical instability"
- Signed letter by client's physician, or summary of consultant's meeting and/or telephone conversation with clients physician.
- Special considerations, restrictions to RTW
- Medications including when they were last altered/changed
- Need/use of assistive devices

Appendices: Required content for reports, and templates

4. Education/Vocational Profile

- Previous testing (aptitude, interest, vocational, etc.)
- Formal and informal education, course, certificate
- All previous work experience (occupations, duration, job descriptions)
- Transferable skills
- Client vocational goals, expectations of a return to work program
- Employer's willingness to accommodate the client, provide alternative work, proposed schedule and salary (if applicable)
- Employability profile: academic skills, personal management skills, teamwork skills
- Interests and hobbies
- Volunteer work

5. Financial situation

- Revenues and expenses from other sources
- Coverage under, and/or eligibility for other programs (student loan, EI program, WCB, insurers etc.)

6. Functional Status

- Give a description of the client's past and current functional level based on the client, physician and employer interviews (report of each interview to be attached) clarifying the type of impairment affecting the client and how it affects current activities: self-care, work and leisure activities, transportation, child care, etc.
- List actual and potential barriers to employment and identify those that can be decreased/minimized *(e.g. child care/elder care, transportation, education/skills, legal concerns, health-related concerns, demographic, language, substance dependency etc.)*
- Identify whether or not the client's goals are realistic and within the CPP program mandate

7. Recommendations

Accurately choose one of the following recommendations:

a) the client has rehabilitation potential and is likely to succeed. Clarify if the client can return to work now without assistance

b) the client has some rehabilitation potential but may be at risk of failure;specify risk factors

c) the client's potential is not clear, needs further exploration; specify steps/actions required

d) the client has no rehabilitation potential and should not participate in the program

Explain your recommendation and justify the need for CPP investment in a Vocational Rehabilitation Program.

Give your opinion regarding whether or not the claimant remains totally disabled from performing any substantially gainful occupation and your impression of their abilities

_____ _____

Consultant Signature Date

APPENDIX C

REQUIRED CONTENT

CPP DISABILITY VOCATIONAL REHABILITATION

LABOUR MARKET ANALYSIS REPORT

Client Name:
Client address and tel. #:
telephone #:

Date of Report:
Consultant name and direct

A Labour Market Survey for ___*(list type of occupation)*____ was completed by *(service provider's name)*. All labour market research was conducted *on* _____ *(or) between* _____ *and* _____.

JOB DESCRIPTION

Job title:

NOC #:

Duties:

Skills, interests, values:

Environment/Physical Demands of the job:

Qualifications/Educational Requirements:

RESEARCHED POSITIONS *(It is expected that three companies will be contacted by the service provider and five by the client.)*

Position:

Company:

Contact:

Location:

Qualifications and Responsibilities:

Physical requirements:

Tools and equipment utilized:

Travel requirements:

Security Clearance Required: *(yes or no)*

Salary range:

Company Benefits:

Hours:

Available positions (past, current and predicted):

Accessibility:

Repeat above group of headings for each company contacted.

Appendices: Required content for reports, and templates

Summary: *(Address whether the job market in the client's area of residence, as per the information gathered above, supports his/her career choice)*

Enclosures: Client's labour market research and job postings.

_____*(signature)*_____

Consultant's Name

Appendices: Required content for reports, and templates

APPENDIX D

REQUIRED CONTENT

CPP DISABILITY VOCATIONAL REHABILITATION

INDIVIDUAL WRITTEN REHABILITATION PLAN (IWRP)

Original (Y/N) ____ Revised (Y/N) ____ If yes, revision # ____ Date: _____

Client Name:	**CPPD Case Manager:**
Client Address: **Phone**	**Rehabilitation Consultant:** **Address:** **Phone:**
Previous Occupation:	
Education:	
Future Job Expectations:	

EMPLOYMENT GOAL

Return to Work (Same Employer)	**Return to Work (New Employer)**	**Self-Employment**
Same Occupation	**Same Occupation**	**Same Occupation**
Alternate Job	**Alternate Job**	**Alternate Job**
Modified Work	**Modified Work**	**Modified Work**

Appendices: Required content for reports, and templates

REHABILITATION GOALS

Short Term:

Long Term:

Client Name:	
Assessment Phase: 6.1.1 Initial Assessment 6.1.2 Vocational Confirmation/Exploration 6.1.3 Specialized Assessments **Planning Phase:** 6.2.1 Development of IWRP 6.2.2 Revised IWRP	**Intervention Phase:** 6.3.1 Client Dev. & Skills Training Activity 6.3.2 Job Search Activity 6.3.3 Follow-Up and On-The-Job Evaluation Activity (Work Trial) 9.5 Reports 10.3 Disbursements and Travel Expenses

Phase:	**Objective:**	**Services/Goods/Strategies Required**	**Service/Goods Provider**	**Cost/ Funding Source**	**Start Date**	**End Date**

Appendices: Required content for reports, and templates

CPPD/Contractor Costs: _____

Partner/Client Costs: _____

Total IWRP Cost: _____

I agree to comply and take responsibility for my own rehabilitation plan, including *maintaining contact as determined with the service provider and informing the service provider of any change(s) in my medical condition and/or life situation that will affect the progression of the rehabilitation plan.* ***I understand the plan may change as required throughout the rehabilitation process and will be subject to further review and signatures.***

Client Signature:	**Date:**
Consultant Signature:	**Date:**
Partnering Agency - Name: _____ **Representative Signature:**	**Date:**
SERVICE CANADA Case Manager Signature:	**Date:**

I agree with the rehabilitation plan as outlined. There are no medical concerns re: the client's active participation in this rehabilitation plan.

Physician Signature:	**Date:**

I do not accept this plan ☐

Client Signature:	**Date:**
Physician Signature:	**Date:**

COMMENTS:

Appendices: Required content for reports, and templates

APPENDIX E

REQUIRED CONTENT

CPP DISABILITY VOCATIONAL REHABILITATION

PROGRESS REPORT #___

Date:
Client Name: **Date of Last Progress Report:**
Client address and tel. #: **Consultant name and direct telephone #:**
Date(s) of contact(s) with the client: **Service Canada Case Manager:**
Rehab Phase Client Currently in; *(e.g. 6.3.2 Job Search Activity)*

Note: Please do not repeat information contained in previous reports or in the referral information

SUMMARY OF ACTIVITY

List of all activities performed since the last progress report and date for each activity (the date for billable activities should match the date on the invoice)

SUMMARY OF CONTACTS

Client/Employer/Physician/Educational Institution/Others

JOB DEVELOPMENT/PLACEMENT ACTIVITIES *(if in phase 6.3.2)*

-list specific employers contacted; job and salary information; employer response/outcome

COMMUNITY RESOURCES USED *(during the reporting period)*

DEGREE OF CLIENT FOLLOW THROUGH/COOPERATION

- comment on the interest, motivation, and specific efforts initiated by the client

DESCRIPTION OF PROBLEMS/ISSUES

- barriers emerging which may delay the rehabilitation process and actions taken/recommendations

Appendices: Required content for reports, and templates

EVIDENCE OF CAPACITY/INCAPACITY TO WORK

NEXT SIGNIFICANT MILESTONES FOR CLIENT

TOTAL COST TO DATE:

PROJECTED COSTS TO COMPLETE CASE (if different from IWRP)Phase:
Provider/Service: Cost: *eg. 6.3.1 Monitoring client's program - __hours @ $__ = $____*

RATIONALE FOR CHANGE IN REHABILITATION COST/PLAN

SPECIFIC RECOMMENDATIONS

PROGNOSIS ON OUTCOME (SUCCESS vs. FAILURE)

Service Canada Vocational Rehabilitation Case Manager action requested

*(signature)*_____

Consultant's Name _____

Appendices: Required content for reports, and templates

APPENDIX F

REQUIRED CONTENT

CPP DISABILITY VOCATIONAL REHABILITATION

JOB SEARCH AGREEMENT

Original ____ Revised ____ If yes, revision # ____ Date: _____

Client Name:	**CPPD Case Manager:**
Client Address	**Rehabilitation Consultant:**
Client Phone:	**Consultant Direct Phone:**

As a component of (*clients name*) active participation in Canada Pension Plan's (CPP) Disability Vocational Rehabilitation Program, CPP has agreed to sponsor (*client name*) in a **_____ month job search** facilitated by (contractor name) from (*date*) to (*date*).

(*Client name*) will be provided Employer Contact Sheets by (*contractor name*) in order to document job search efforts on a bi-weekly basis. (*Client name*) is expected to contact a **minimum of ____ employers per day (___ employers per week)** and to submit these to (*contractor name)* every one/two (*circle one*) weeks. *(Client name*) agrees to access Job Finding Clubs, job banks and other community resources to submit these to (*contractor name*) every two weeks. *(CONTRACTOR name)* agrees to independently assist *him/her* in *his/her* job search.

(*Client name*) agrees to focus job search efforts in the following occupations: (*list occupation(s) here).*

(*Contractor name)* agrees to ongoing regular weekly communication with (*client name*) to assist with the Job Search process. This assistance may include the provision of additional copies of resumes and cover letters when required, the identification of potential employers and job opportunities (and/or sources where these can be obtained) as well as ongoing job search support throughout the job search period.

Should (*client name*) be successful in his/her efforts to secure paid substantially gainful employment within the ___ month job search period his/ her disability benefits will be extended during a work trial for a minimum of three months. (*Client name*) agrees to inform *(contractor*

name) of all employment and employment related earnings obtained during the job search and work trial period.

I agree to comply with the conditions outlined above and to take responsibility for carrying out my own job search to the best of my ability.

Client Signature:	**Date:**
Consultant Signature:	**Date:**

APPENDIX G

REQUIRED CONTENT

CPP DISABILITY VOCATIONAL REHABILITATION

EMPLOYER CONTACT SHEET

Client Name: _____

Date	Contact type Phone	In-person	Company	Contact Person	Call Back	Apply In Person	Submit Resume or application	Job Intervie
			Name: Address:	Name: Phone #:	Date: Time:	Date:	Date:	Date: Time: Contact:
			Name: Address:	Name: Phone #:	Date: Time:	Date:	Date:	Date: Time: Contact:
			Name: Address:	Name: Phone #:	Date: Time:	Date:	Date:	Date: Time: Contact:
			Name:	Name:	Date:	Date:	Date:	Date:

Appendices: Required content for reports, and templates

			Address: Phone #:	Time:			Time: Contact:
			Name: Name: Address: Phone #:	Date: Time:	Date:	Date:	Date: Time: Contact:

APPENDIX H

REQUIRED CONTENT

CPP DISABILITY VOCATIONAL REHABILITATION

RTW FOLLOW-UP REPORT

Date:
Client Name: **Date of Last Progress Report:**
Client address and tel. #: **Consultant name and direct telephone #:**
Date(s) of contact(s) with the client: **Service Canada Case Manager:**
Date(s) of contact(s) with the employer:

1. General information on employment

- Date of Return to Work:
- Employer's name:
- Employer's address:
- Job Title:
- Type of work:
- Hours of work per: day/week
- Rate of pay per: hour/week/month
- Total earnings by month:
- Date/Reason work ceased (if applicable):

Type of work: Please provide details

- continuing/permanent?; temporary ? (end date); seasonal? (end date)
- self-employment?

If part-time work, is it:

- due to client's choice?; only available work? all the client can do?

2. Evaluation of performance as perceived by the supervisor *(If no employer contact, please provide reason)*

- Client tolerance regarding job demands
- Special arrangement made by the employer to accommodate
- Any time lost due to illness? If YES, provide explanation(s):

3. Evaluation of performance as perceived by the client

- Client tolerance regarding job demands
- Special arrangements made by the employer to accommodate
- Any time lost due to illness? If YES, provide explanation(s):

4. Major problems/issues identified

5. Recommendations

_____
Consultant Signature Date

APPENDIX I

REQUIRED CONTENT

CPP DISABILITY VOCATIONAL REHABILITATION

CLOSURE REPORT

Date:
Client Name:
Client address and tel. #:
Consultant name and direct telephone #:
Service Canada Case Manager:

1. **Overview of complete IWRP activities and outcome(s).**

2. **Evidence of client's capacity or incapacity to return to substantially gainful occupation:**

3. **Recommendations**
    - *If client is unable to obtain substantially gainful employment, provide recommendations where applicable.*
    - *If the client has obtained substantially gainful employment and is working, provide recommendations to maintain employment where applicable*

4. **Total invoiced costs on this case:**
    - **Supplier services total: $_____**
    - **Disbursements / Travel $_____**
    - **Total $_____**

Confirmation / declaration of return of all data related to this file (Y) (N)

_____ _____
Consultant Signature Date

APPENDIX J

REQUIRED CONTENT

CPP DISABILITY VOCATIONAL REHABILITATION

INVOICE TEMPLATE

CANADA PENSION PLAN DISABILITY VOCATIONAL REHABILITATION

INVOICE TEMPLATE

Date	
Offeror Name	
Offeror Branch/Address *(where payment is to be sent)*	
Offeror File Number	
Offeror Invoice Number	
Rehab Consultant Name	

Client *(Surname and first name)*	
Procurement or Requisition Number	
Service Canada VRCM	

SERVICES FEES

Phase 6.1.1	**Initial Assessment** *(including report)***:** $___/Hr. X __ hrs =	**$**
6.1.2	**Vocational Confirmation/Exploration Activity** *(including report)*: $___/Hr. X __ hrs =	**$**
6.1.3	**Specialized Assessment(s) Admin Fee only** $___/Hr. X __ hrs =	**$**
6.2.1	**IWRP**: $___/Hr. X __ hrs=	**$**
6.2.2	**Revised IWRP:** $___/Hr. X __ hrs =	**$**
6.3.1	**Client Development and Skills Training Activity**: $___/Hr. X __ hrs =	**$**
6.3.2	**Job Search Activity:**	
	a) Job Search Preparation: $___/Hr. X __ hrs =	**$**
	b) Job Search Assistance: ___mos $__/Hr. X __ hrs/per mo. =	**$**

	c) Job Development and Placement: $___/Hr. X __ hrs =	**$**
6.3.3	**Follow-up and On-the-job evaluation activity:** $___/Hr. X __ hrs =	**$**
9.4	**Reports**: a) Progress Reports: ___ reports $__/Hr. X __ hrs/rprt =	**$**
	b) Return to Work follow-up report: $__/Hr. X __ hrs =	**$**
	c) Closure Report: $__/Hr. X __ hrs =	**$**
	Travel - Consultant Travel Time only: *Charged at* 50% *of the hourly rate in which the travel occurred* $_____Rate of rehab phase in which travel occurred x (50%) x __hrs	**$**
6.0	Financial services (disbursement payments) $_____Rate of rehab phase for which payment issued x 0.5 hrs X # of payments	**$**
	SERVICES FEE SUBTOTAL	**$ Box A**
	GST (Alta, Sask, Man) (5% of Box A above); **HST** (BC only) (12% of Box A)	**$ Box B**

DISBURSEMENTS/TRAVEL EXPENSES (at cost, no mark-up)

6.1.3	**Specialized Assessment(s) -** Specify	**$**
6.3.2	**Job Search Activity** *(if sub-contracted)*	**$**
	Consultant travel expenses *(excluding consultant travel time)* as per submitted travel claim form.	**$**
	Other - *includes all other disbursements not noted above e.g.: tuition, books, disability related supports/adaptive equipment).* **Provide details and receipts**	**$**
	DISBURSEMENT FEE SUBTOTAL *(No additional GST/HST)*	**$ Box C**

TOTALS

	TOTAL SERVICES & DISBURSEMENT COSTS (excluding GST/HST) Total of Box **A** + Box **C**	**$**

	+ GST or HST (from Box **B** on previous page)	**$**
	= TOTAL ALL COSTS INCLUDING GST/HST *(Box A+B+C)*	**$**

NOTE:

- Hours in any given rehab phase in excess of the ***maximum hours indicated in the most current call-up*** shall not be paid.
- Service hour charges must be billed in maximums of ¼ hour allotments at the actual service hours, undertaken up to the pre-approved maximum. If actual service hours in any given phase are less than the maximum hours indicated in the call-up, **only actual time may be invoiced.**
- A detailed and **itemized** list is required for all service charges and expenses claimed.
- All travel costs must be pre-approved by the HRSDC Case Manager.
- For all travel expenses a completed travel expense claim invoice form signed by the consultant/client who undertook the travel is required.
- Original receipts are REQUIRED for travel expenses.
- Original receipts are preferred for reimbursements other than travel, and should be submitted with the appropriate invoice. **If a photocopy of the original receipt is submitted rather than the original, there must be a signed statement by the supplier on the receipt photocopy indicating the original receipt is being kept on their client file.**
- When submitting a revised invoice please notate **"REVISED"** beside the date at the top
- Contractor travel costs will be paid up to Treasury Board Travel Rates
  Current Treasury Board travel reimbursement rates are available from the following sites:
  http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/tbm_113/menu-travel-voyage-eng.asp :

    - GST/HST: - Invoice us only the exact amount paid out in disbursements. Do not add an additional 5% GST/12% HST (Whether or not the disbursement costs included GST/HST)
    - Exclude the 5% GST or 12% HST charged under "Service Fees" from all totals
    -

Invoice templates must be submitted on company letterhead.

APPENDIX K

REQUIRED CONTENT

CPP DISABILITY VOCATIONAL REHABILITATION

TRAVEL EXPENSE CLAIM

To Be Completed by the Traveller (Client / Contractor)

Organization _____ **Invoice #:** _____

Name: _____ **Telephone:** _____

Address: _____

City: _____ **Postal Code:** _____

Client: _____

PURPOSE OF TRAVEL: _____

START DATE OF TRAVEL: _____ **END DATE OF TRAVEL:** _____

STARTING LOCATION: _____

DESTINATION:_____

TIME OF DEPARTURE: _____ **TIME OF RETURN:** _____

TOTAL DAYS TRAVELED FOR THIS INVOICE: _____

TRANSPORTATION RECEIPTS REQUIRED	
Air fare as per ticket	$
Taxi, Bus, Train	$
Car: Rate/Km $_____x Km traveled _____ =	$
Other (specify)	$
Subtotal	$
MEALS AND INCIDENTALS **(AS PER T.B. RATES – NO RECEIPTS REQUIRED)**	

Breakfast (Leave residence before 6:30 a.m.)	$_____ X _____days	$
Lunch	$_____ X _____days	$
Dinner (Arrival at residence after 7:30 p.m.)	$_____ X _____days	$
Incidentals (For overnight stay only)	$_____ X _____days	$
	Subtotal	$
ACCOMMODATIONS RECEIPTS REQUIRED		
Hotel / Motel	$_____ X _____days	$
Other (specify)_	$_____ X _____days	$
	Subtotal	$
	TOTAL EXPENDITURES	$

Traveller's Signature:_____ Date:_____

This form must accompany the invoice and is subject to the Treasury Board Travel Policy.
Receipts and Itemized invoice required, if applicable.