Clear Form

THE SCHOOL BOARD OF MIAMI-DADE COUNTY, FLORIDA
SCHOOL BOARD ADMINISTRATION BUILDING
Procurement Management Services
1450 N.E. 2nd Avenue, Room 650
Miami, FL 33132

Direct All Inquiries To
Procurement Management Services
Buyer's Name: Charisma Montfort
PHONE: (305) 995- 2364
Email: cmontfort@dadeschools.net
TDD PHONE: (305) 995-2400

BID/RFP ADDENDUM

Date: 7/31/2019

Addendum No. 1

BID/RFP No. RFP-18-068-CM BID/RFP TITLE: Sign Language and Transliteration Services

This addendum modifies the conditions of the above-referenced BID/RFP as follows:

Please see attached attachments for the RFP. All other terms and conditions of the RFP remain the same.

All information, specifications terms, and conditions for the above-referenced BID/RFP, are included on the document posted on the Procurement Management website at http://procurement.dadeschools.net

The attached pages containing clarifications, additional information and requirements constitute an integral part of the referenced bid. If your bid/proposal has not been submitted, substitute the pages marked REVISED and mail your entire bid/proposal package.

I acknowledge receipt of Addendum Number _____

PLEASE NOTE: If your firm has forwarded a copy of this bid/proposal to another vendor, it is your responsibility to forward him/her a copy of this addendum.

(PLEASE TYPE OR PRINT BELOW)

LEGAL NAME OF BIDDER: _____

MAILING ADDRESS: _____

CITY, STATE ZIP CODE: _____

TELEPHONE NUMBER: _____ E-MAIL I.D. _____ FAX # _____

BY: SIGNATURE (Manual): _____
OF AUTHORIZED REPRESENTATIVE

NAME (Typed): _____ TITLE: _____
OF AUTHORIZED REPRESENTATIVE

ATTACHMENT A

MIAMI-DADE COUNTY PUBLIC SCHOOLS
DEAF AND HARD OF HEARING PROGRAMS K-12

School / Department Requesting Services	Date Requested *(MMDDYY)*

SIGN LANGUAGE INTERPRETER SERVICES REQUEST FOR K-12 STUDENTS

Language: ☐ ASL Only ☐ ASL/Spanish ☐ Other: _____

Start Date: _____ **End Date:** _____

Start Time: _____ am/pm **End Time:** _____ am/pm

Event: _____

Location of Event: _____ **Phone:** _____

Address: _____ **Room:** _____

City, State, Zip: _____

☐ **Staff Interpreter Substitute Coverage Request** **Staff Interpreter Name** _____

Requestor Information:

Name: _____ **Title:** _____

Phone: _____ **Cell:** _____

E-Mail: _____

Contact Person Information: *(if different from above)*

Name: _____ **Phone:** _____

Student Information:

Name: _____ **Student ID:** _____ **Grade:** _____

*Due to the shortage of qualified sign language interpreters and their sometimes limited availability, requests made with less lead time and without the required information may result in the District's inability to provide an interpreter. Minimum **TWO WEEKS** notice is required for services. Confirmation will be e-mailed to requestor's e-mail address. Cancellations must be made 48-hours in advance.*

Please return completed form to:
Deaf and Hard of Hearing Programs K-12
Mail Code: #9729
FAX # (305) 995-2049

For questions, please call (305) 995-1531.

FOR OFFICE USE ONLY: **Request Received:** _____ ☐ **Timely** ☐ **Untimely**

Request No.: _____

Assigned Agency: _____

Assigned Interpreter(s): _____ **Level(s):** _____

Comments: _____

_____

Cancellation Date: _____ **Reason:** _____

DEPARTMENT OF EXCEPTIONAL STUDENT EDUCATION

Weekly Contact Verification Log

Sign Language Interpretation/Transliteration Services

Pick One Below
Nationally Certified
(circle one): Yes / No
EIPA/QA:

Name of Sign Language Interpreter:					Week of :						
Name of school site:					Time			Total			
	Student Initials / Task (Attach List)	Services	Date	Day of the Week	From	To	Location of Service	Hours	Minutes	Total	Request Number
1											
2											
3											
4											
5											
6											
7											
8											
9											
10											
11											
12											
13											
14											
15											
16											
17											
									Total Hours		

CL – Classroom Interpreting

MTG – IEP/Staffing

EC – Extracurricular Activity

PC – Parent Consultation

Sign Language Interpreter (Signature) Date

Company/Vendor Name

Region Center/School Administrator or Designee Date

ATTACHMENT B

ATTACHMENT C

PROVIDER APPLICATION FORM

PROVIDE AMERICAN SIGN LANGUAGE INTERPRETATION / TRANSLITERATION, CAPTION AND/OR COMPUTER-ASSISTED TRANSCRIPTION SERVICES

Provider's Name _____

Type of Credential _____ Number_____

Number of years providing Interpreter Services _____

Bi-Lingual _____ If yes, Indicate Languages_____

Professional specialization skills_____

If yes, please provide explanation for each of the following:

Educational/Classroom setting _____

Tutoring _____

Professional Development Workshops _____

Extracurricular Activities _____

Cued Speech Interpreting _____

Oral Interpreting _____

Tactile (Deaf-Blind Interpeting)_____

Other _____

Required Attachments:

1 page resume to include documentation of experience

2 letters of reference

Copy of credentials