



Arizona State Set-Aside

Certification Application for Certified Non-Profit Agencies that Serve Individuals with Disabilities (CNAID)

Under A.R.S. §41-2636(G), a non-profit business/organization may request written approval from the Arizona State Set-Aside Committee to become a Certified Non-Profit Agency that Serve Individuals with Disabilities (CNAID). Moreover, once a non-profit business/organization becomes a CNAID, Governmental Units and Local Public Procurements may purchase or contract for any products, materials, services directly from certified Non-Profits that serve and employ individuals with disabilities and without competitive bidding if the delivery and quality of products, materials or services meet the Governmental Unit's reasonable requirements.

Please fill out the following questionnaire and submit all documents specified in the checklist below. Questions that do not apply to your organization should be marked "NA" in the spaces provided. Failure to follow these instructions will delay the processing of the application.

Please visit the Arizona Set Aside Website to determine where your completed / notarized document should be sent.

<https://spo.az.gov/procurement-services/set-aside>

General Business Information:		
Please select one of the following: New Certification <input type="checkbox"/> Re-Certification <input type="checkbox"/>		
Legal Business/Organization Name:		
Federal Tax ID:		
Other Names Used by Business / Doing Business As (DBAs):		
List Affiliated Organization or Agencies:		
Non-Profit Organization 501(c) 3:	Yes <input type="checkbox"/> No <input type="checkbox"/> If No – Explain:	
Physical Address of Main Facility:		
City:	State:	Zip Code:
If there is more than one physical location, list all offices and/or work sites on a separate sheet and attach it to this application. If services will be offered off-site, submit general description such as: Highways and Streets, Client Offices		
Mailing Address:		
City:	State:	Zip Code:
President/Chief of Operations/Executive Director:		
Phone:	Cell:	Email:
Website:		
Business Description:		
Date Business/Organization Started or was Acquired:		
Current Years of Business/Organization Operation:		
If a New Business/Organization, Estimate First-Year Start-Up Costs: (Please break-down rent, transportation, salaries, supplies, permits, etc. & attach additional sheets as necessary)		
Describe Business/Organization Mission Statement:		
List Business/Organization Goals:		
Does business/organization adhere to the laws of this state or another state, is operated in the interest of individuals with disabilities and the next income does not inure in whole or in part to the benefit of any shareholder or individual? Yes <input type="checkbox"/> No <input type="checkbox"/> If No – Explain:		
Does business/organization comply with any applicable occupational health and safety standard required by the laws of the United States and this state? Yes <input type="checkbox"/> No <input type="checkbox"/> If No – Explain:		
Number of Current Employees (Part-Time & Full-Time):		
Number of Current Full-Time-Equivalent (FTEs) employees (Assuming an FTE is 40 HRs/Week, 2,080 hours annually):		
Number of Individuals with Disabilities Employed by the Business/Organization (Part-Time & Full-Time):		
Number of Current Individuals with Disabilities Full-		

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Time-Equivalent (FTEs) employees (Assuming an FTE is 40 HRs/Week, 2,080 hours annually):	
Primary Types of Disabilities the Business/Organization can Serve:	
<p>Does business/organization have required and readily accessible documentation on file of disabilities, consistent with the definition of a disability from Arizona Revised Statute, Title 41, Chapter 2636, and Section G.2.</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/> If No – Explain:</p>	
Current Number of <i>Direct-Labor</i> Able-Bodied FTEs Employed by Business/Organization:	
Current Ratio of <i>Direct-Labor</i> FTEs with Disabilities Vs. Able Bodied FTEs Employed to Work <i>Just on</i> State Programs/Contracts:	
<p>*Note: This Ratio should be calculated with Full-Time Employees.</p>	
<p>Is % of Organization’s Current <i>Direct-Labor</i> ≥ 60% Employees with Disabilities:</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/> If No – Explain:</p>	

State Contracts & Services:	
Describe Current Customer-Base:	
Specify what Agencies you intend on engaging with:	
<p>Does business/organization intend on requesting an Arizona Statewide Set-Aside Contract?</p> <p style="text-align: center;">Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
Describe All Services and Products to Be Offered and the Work Locations:	
Services:	Locations:
Products:	Locations:

Please list the **names** and **titles** of each individual responsible for the following functions:

Functions:	Name (Last, First)	Title:	Phone:	Email:
Negotiate & Sign Contracts:				
Compile & Submit Reports to ADOA:				
Products:				
Services:				
Other:				

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REQUIRED DOCUMENTATION

To obtain CNAID certification, the following documents are required for consideration:

- A copy of the IRS non-profit determination – Sec. 501(c) or other, if required by law
- If required by law, a copy of the Articles of Incorporation granted by the Secretary of State. The Articles of Incorporation should state the purpose of the company is to provide employment for people with disabilities. If the Articles of Incorporation do not specifically state the appropriate purpose, a copy of the Bylaws stating the purpose may also be included
- A list of the board of directors, including names, addresses, and telephone numbers
- A copy of the organizational chart with job titles and names
- Insurance:
 - 1.) A copy of current Certificate of Liability Insurance
 - 2.) If applicable, a copy of current Automobile Liability Insurance policy
 - 3.) If applicable, a copy of current Worker’s Compensation Insurance
- A copy of current fire inspection certificate dated within the last year for each location where clients will be served or where persons with disabilities will be employed (or a statement of unavailability from the appropriate city, county, or state entity)
- A copy of building inspection certificate or occupancy certificate for each location where clients will be served or where persons with disabilities will be employed (or a statement of unavailability from the appropriate city, county, or state entity)
- A copy of wage exemption certificate if sub-minimum wages will be paid to clients and a statement of the circumstances requiring sub-minimum wages. Please include a copy of your approved 14C sub-minimum wage certificate.

AFFIRMATION AND EXECUTION

I certify, by signature below, that no real or apparent conflict of interest exists between the applicant organization, and the Arizona State Set-Aside Committee. Moreover, if a real or apparent conflict of interest exists, the Arizona State Set-Aside Committee will be contacted and made aware of said conflict prior to submission of this application.

I certify, by signature below, that after being awarded CNAID status, real or apparent conflicts of interest may occur if a CNAID employee, Arizona State Set-Aside Committee member or immediate family member has a financial or other interest in the business relationship involving a CNAID and that interest might reasonably be expected to influence the outcome of an official action. If it is found that such conflict of interest occurs and is not disclosed and remedied, the CNAID may be barred from receiving future grants or contracts, and existing grants or contracts may be canceled.

I certify, by signature below, that I have read the Arizona Revised Statute, Title 41, Chapter 2636 and the Arizona Procurement Code, Chapter 23, and agree to abide by the criteria for CNAIDs, and I am making application, on behalf of the applicant CNAID named above, to become an approved CNAID with the Arizona State Set-Aside Committee.

If certification is approved, the CNAID agrees to maintain compliance with the requirement that 60% of direct labor necessary to perform services and to produce products must be by persons with documented disabilities. The CNAID also agrees to maintain proper and timely reporting required by ADOA, failure to report in a timely manner may result in the loss of your State Set-Aside certified non-profit organization status.

I certify, by signature below, that if our organization is granted CNAID status, we will provide Annual Contract-Spend Reporting.

I certify, by signature below, that if our organization is granted CNAID status, certification will be for three (3) calendar years, starting from the date of Arizona State Set-Aside Signature, and that to maintain CNAID status, our organization will have to re-certify every three (3) years.

I certify that all statements and information in this application are true and correct and that I have the authority to execute and submit this application for certification.

Printed Name and Title of Applicant Representative:

Signature of Applicant Representative:

State of Arizona)
)
County of _____)

Subscribed and sworn (or affirmed) before me this _____ day of _____, year _____ by
_____ of _____

Printed Name of Applicant Representative: Name of Applicant Entity/Corporation on behalf of said Entity/Corporation:

Notary Public Signature

My Commission Expires

(Notary Seal/Stamp)

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<i>For Arizona State Set-Aside Use Only:</i>	
On-Site Visit Date:	
On-Site Visit was Completed By?	
Is the CNAID Application Completed in its Entirety?	
Did the CNAID Applicant Submit All Necessary Documentation and Supporting Materials?	
Is the Applicant Business/Organization Approved for CNAID Organization?	Yes <input type="checkbox"/> No <input type="checkbox"/> If No – Explain:
Arizona State Set-Aside Committee Approval Date:	
Set-Aside Committee Chair Signature/Date:	