



**Diocese of Cleveland  
Facilities Services Corporation**

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1404 E. 9<sup>th</sup> Street, Cleveland, Ohio 44114 (tel): 216.696.6525 (fax): 216.902.1314

## **Contractor Qualification Questionnaire**

**Welcome, new subcontractors and vendors!**

To better serve our clients, the Diocese of Cleveland Facilities Services Corporation (DCFS) maintains a pre-qualified subcontractor/vendor list that is continuously reviewed and updated. DCFS requires that all subcontractors and vendors submit a response to our "Contractor Qualification Questionnaire." All submitted information is held in strict confidence.

- Print out this document
- Fill out the form completely
- Mail the completed form along with a copy of your Certificate of Premium Payment – Ohio Bureau of Worker's Compensation, Certificate of Liability Insurance, current financial statement (if specifically requested) and other required documents to the following address:

Diocese of Cleveland Facilities Services Corporation  
Attn: Director of Property Services  
1404 E. 9<sup>th</sup> Street  
Cleveland, Ohio 44114

Be sure to provide all requested details to prevent any delay in the pre-qualification process. If you have any questions or require assistance, please contact DCFS at 216.696.6525.



## Contractor Qualification Questionnaire

1. Date: \_\_\_\_\_

2. Company: \_\_\_\_\_

3. Address: \_\_\_\_\_

\_\_\_\_\_

4. Website: \_\_\_\_\_

5. Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

6. Contact Person(s): \_\_\_\_\_

7. E-mail Address: \_\_\_\_\_

8. How many years has your firm been in business as a contractor:  
How many years has your firm been in business under its present name?  
Under what other or former names has your organization operated? \_\_\_\_\_

\_\_\_\_\_

9. Tax ID Number: \_\_\_\_\_

10. Type of Organization (please check one):

Corporation

Partnership

Individually

Other (describe) \_\_\_\_\_

Date of incorporation or organization: \_\_\_\_\_

Please provide names, titles of principals (e.g., CEO, president, partners, owner), and parish affiliation if any:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Is your company union or non-union? \_\_\_\_\_

If union, please list all locals that you are signatory to:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



12. Please list jurisdictions and trade categories in which your organization is legally qualified to do business, and indicate registration or license numbers, if applicable.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list jurisdictions in which your organization’s partnership or trade name is filed.

\_\_\_\_\_  
\_\_\_\_\_

13. Is your company bondable?  Yes  No

If yes, please complete the following:

Bonding Capacity: \_\_\_\_\_ (single project)  
\_\_\_\_\_ (aggregate)

Bonding Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Agent Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Provide a letter from your bonding company indicating your company’s ability to bond and your bonding capacity:**

Single Project \$ \_\_\_\_\_ and Aggregate \$ \_\_\_\_\_

14. Annual volume of work (past 5 years):

Year 5 \_\_\_\_\_  
Year 4 \_\_\_\_\_  
Year 3 \_\_\_\_\_  
Year 2 \_\_\_\_\_  
Year 1 \_\_\_\_\_

15. Preferred Market(s): (Please check all that apply)

- Healthcare/Hospital
- Educational
- Industrial
- Commercial
- Church
- Design-build
- Waste Water Treatment
- Multi-unit Housing



16. Trades / Division(s) of Work: (Please check all that best describe your company's function)

- |  |  |
|--|--|
| <input type="checkbox"/> Asbestos Mitigation   | <input type="checkbox"/> Mechanical                |
| <input type="checkbox"/> Concrete              | <input type="checkbox"/> Painting                  |
| <input type="checkbox"/> Doors                 | <input type="checkbox"/> Paving                    |
| <input type="checkbox"/> Electrical            | <input type="checkbox"/> Plumbing                  |
| <input type="checkbox"/> Excavation/Demolition | <input type="checkbox"/> Restoration               |
| <input type="checkbox"/> Flooring              | <input type="checkbox"/> Roofing                   |
| <input type="checkbox"/> General Contractor    | <input type="checkbox"/> Security                  |
| <input type="checkbox"/> Gutters/Siding        | <input type="checkbox"/> Specialty Finishes        |
| <input type="checkbox"/> Landscaping           | <input type="checkbox"/> Windows                   |
| <input type="checkbox"/> Life Safety           | <input type="checkbox"/> Other (please list) _____ |
| <input type="checkbox"/> Masonry               |  |

17. Preferred Region(s) of Work: (Please check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Ashland County | <input type="checkbox"/> Cuyahoga County      |
| <input type="checkbox"/> Medina County  | <input type="checkbox"/> Lake / Geauga County |
| <input type="checkbox"/> Wayne County   | <input type="checkbox"/> Summit County        |
| <input type="checkbox"/> Lorain County  |   |

18. What is your firm's project size capacity? (Please state minimum and maximum project values.)

Minimum: \$ \_\_\_\_\_ Maximum: \_\_\_\_\_

19. Preferred Project Size: (Please check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Under \$50,000        | <input type="checkbox"/> \$200,000 - \$500,000       |
| <input type="checkbox"/> \$50,000 - \$100,000  | <input type="checkbox"/> \$500,000 - \$1,000,000     |
| <input type="checkbox"/> \$100,000 - \$200,000 | <input type="checkbox"/> \$1,000,000 - \$3,000,000 + |

20. Safety (for companies with more than 5 employees)

Do you have a written Safety Package?  Yes  No



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Current Incident Rating: \_\_\_\_\_

To calculate: 
$$\frac{[\# \text{ (Recordable Injuries or Lost Work Day Injuries)} \times 200,000]}{\text{Exposure Hours}} = \text{Incident Rate}$$
 (RIR or LWIR)

Please provide your company's Experience Modification Rate (EMR) for the past three years, and *attach proof of current EMR from your insurance agent.*

Year (current): \_\_\_\_\_ EMR Rating: \_\_\_\_\_  
 Year: \_\_\_\_\_ EMR Rating: \_\_\_\_\_  
 Year: \_\_\_\_\_ EMR Rating: \_\_\_\_\_

Has OSHA cited you in the past three years?  Yes  No  
 If yes, explain in detail and attach to this form.

21. Quality

Does your firm have a written quality plan?  Yes  No

Does your firm have a quality officer?  Yes  No

If yes, please provide the following information:

Name: \_\_\_\_\_ Title: \_\_\_\_\_  
 Phone: \_\_\_\_\_

22. Does your firm have AutoCAD capability?  Yes  No

Software version: \_\_\_\_\_

23. Does your firm have design/build capability?  Yes  No

If yes, please provide the following information:

Typical amount of work self-performed: \_\_\_\_\_%

Total number of employees: \_\_\_\_\_

List design/build projects completed within the past two years:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



24. References

OWNERS / GENERAL CONTRACTORS

Company Name: \_\_\_\_\_

Contact Person/Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Company Name: \_\_\_\_\_

Contact Person/Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Company Name: \_\_\_\_\_

Contact Person/Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

ARCHITECTS

Company Name: \_\_\_\_\_

Contact Person/Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Company Name: \_\_\_\_\_

Contact Person/Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Company Name: \_\_\_\_\_

Contact Person/Title: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_



SUPPLIERS

Company Name: \_\_\_\_\_  
Contact Person/Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Company Name: \_\_\_\_\_  
Contact Person/Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Company Name: \_\_\_\_\_  
Contact Person/Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

BANK

Company Name: \_\_\_\_\_  
Contact Person/Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

25. Please list your professional liability insurance carrier and limits and **provide a copy of your Certificate of Liability Insurance:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## 26. Experience

Please list projects currently in progress

<b>Owner/Project</b>	<b>Architect</b>	<b>Contract Amount</b>	<b>Percent Complete</b>	<b>Type</b>

Please list projects completed within the past two years

<b>Owner/Project</b>	<b>Architect</b>	<b>Contract Amount</b>





27. Claims & Suits (If the answer to any of the questions below is yes, please attach details.)

Has your organization ever failed to complete any work awarded to it?  Yes  No

Are there any judgments, claims, arbitration proceedings or suits pending or outstanding against your organization or its officers?  Yes  No

Has your organization filed any law suits or requested arbitration with regard to construction contracts with the last five years?  Yes  No

Within the last five years, has any officer or principal or your organization ever been an officer or principal of another organization when it failed to complete a construction contract?  Yes  No

28. **IF SPECIFICALLY REQUESTED**, for all major projects contractor may be required to submit a CURRENT financial statement, preferably audited, including your organization's latest balance sheet and income statement, showing current assets, net fixed assets, other assets, current liabilities, and other liabilities. All information will be kept in strict confidence.

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The Contractor Qualification Questionnaire **must** be filled out completely. For confidential purposes, please send all completed forms and attachments in a sealed envelope to:

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