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**ATTACHMENT D: RFQ CLIENT REFERENCE FORM/ RELEVANT PROJECT EXPERIENCE**

**Help Me Grow San Mateo County:**

**Child Health Care Provider Liaison**

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| **RFQ Respondent Name:**       |
| **Relevant Experience/Project Name:**       |
| **Client Organization Name (if applicable):**       |
| **Location (City, State) :**       |
| **Project Dates:**       |
| **Project Cost:**       |
| **Lead Contact Name, Title:**       |
| **Email Address**       |
| **Phone #:**       |
| **Project Description:**       |
| **Scope of Services Provided:**       |
| **Completion Date:**      **Project Completed on Time:** [ ] **Yes** [ ] **No** **Project Completed within Budget:** [ ] **Yes** [ ] **No If no, please explain:**        |
| **List each member of your proposed team who worked on this project and their respective roles (if relevant):**                   |