**Terms Of Reference**

**1. Introduction**

CARE South Sudan is implementing, together with UNIDOR (Implementing Partner), a Joint Response project in Rubkona and Pibor funded by the Netherlands Ministry of Foreign Affairs. CARE is seeking the services of a competent and registered audit firm to carry out a project audit for the period **1 January 2024 to 31 December 2024**. The value of the project is approximately **€ 970,498.**

**2. Audit objective and scope**

The auditor must establish that the transactions as accounted for in the financial statement comply with the framework mentioned under paragraph 1.2 of the attached Audit Protocol. The audit must be carried out in accordance with the requirements laid down in this Audit Protocol and with the relevant auditing standards.

The audit subject is the consortium partners’ financial statement for the year under review including processes and administrations relevant for the Joint Response.

Kindly see the attached Audit Protocol for details of the audit process and activities. The activities described in section 2.3 of the Audit Protocol result in an audit opinion on the financial statement, drawn up in accordance with auditing ISA 800/805 and a report in accordance with the text of annex A of this protocol.

**3. Audit Timeline**

The audit will commence on **10th of February 2025** with a draft report due on **24th February 2025.** The audit will take place at CARE South Sudan offices in Juba. The final report should be submitted to CARE South Juba Office on **10th March 2025.**

All proposals should be received no later than **4:00pm** on **Monday 3rd January 2025** by email addressed to [ssd.procurement@care.org](mailto:ssd.procurement@care.org).

Proposals will be scored on the criteria below:

|  |  |  |
| --- | --- | --- |
| **S/N** | **Evaluation Criteria** | **Marks** |
| 1 | **Number of Partners in the firm and number of professionally qualified staff.**  {Audit firm to submit a profile of the organization detailing how many partners and professionally qualified staff it has.} | 10 |
| 2 | **CVs of audit lead and audit team.**  {The Audit firm must provide a CV of the lead auditor/Audit Manager and team members to be assigned for this audit. The auditors must be registered with a recognized Accountancy Board and must be in good standing. Each member will be evaluated on their training, length of experience and experience auditing organizations in the NGO sector} | 15 |
| 3 | **Audit Approach**  {The Audit firm should detail their audit approach based on the Audit Protocol} | 20 |
| 4 | **Number of Audits and similar assignments undertaken in the last 3 years** {Provide a list of four (4) references for audits and similar assignments carried out in the last 3 years} | 25 |
| 5 | **Audit Fees** {The audit contract will be awarded based on the most economically advantageous offer} | 30 |
|  | **TOTAL** | 100 |

**Qualifications if contracting an individual or assessing audit team CVS**

* Bachelor’s degree in Accounting, Finance, or related field. CPA, ACCA or other recognized professional qualifications preferred.
* 3-6 years’ experience in financial accounting, auditing, or a combination thereof
* Experience in auditing NGOs required and Reference contacts for their previous similar work.
* Strong understanding of accounting, banking laws, regulations, and internal controls
* Sound understanding of audit theories, principles, and practices.
* Familiarity with general accounting practices and techniques
* Proficient verbal and written communication skills

**Payment terms**

There will be a once-off payment after completion of the work and reports submitted verified and accepted by CARE. Consultancies are subject to 20% withholding tax.

The matrix of liability between the Auditor/Audit firm and CARE for Travel expenses, Medical & travel insurance, accommodation in case of travel, per-diem, visa cost, COVID-19 test cost (if applicable) lies with the auditor/audit firm.

**This form MUST be completed by the applicant**

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| **Supplier/Payee Set-Up and Change Form (INTERNAL USE ONLY)** | | | | | |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Vendor ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  |  |
|  |  |  |  | *Page 1 of 2* |  |
|  |  |  |  |  |
| Vendor/Payee Type | New | Change | Discontinue | Approval Responsibility |
| Procurement Vendor |  |  |  | Procurement Committee |
| Consultant |  |  |  | Procurement Committee |  |
| Discontinue Vendor |  |  |  | Procurement Committee |  |
| National Employee |  |  |  | Human Resources |  |
| International Employee |  |  |  | Human Resources |  |
| Sub-Grantee |  |  |  | Program |  |
| Donor |  |  |  | Program |  |
| Utility |  |  |  | Administration |  |
| Landlord |  |  |  | Administration |  |
| Bank |  |  |  | Finance |  |
|  |  |  |  |  |  |
| Vendor/Payee Details (note some information may not be applicable) | | | | |  |
| Vendor/Payee Name |  |  |  |  |  |
| Vendor/Payee Physical Address |  |  |  |  |  |
| Vendor/Payee e-mail Address |  |  |  |  |  |
| Vendor/Payee website |  |  |  |  |  |
| Vendor/Payee Phone/Fax |  |  |  |  |  |
| Vendor Short Name |  |  |  |  |  |
| Owner Name if Different |  |  |  |  |  |
| Trade Class (see list) |  |  |  |  |  |
| Vendor Nationality |  |  |  |  |  |
| Persistence | Regular |  |  |  |  |
| Vendor Status | Approved | | Inactive | |  |
| Currency of Payment |  | | | |  |
| Payment Method |  | | | |  |
| Payment Terms |  | | | |  |
| Vendor/Payee Bank Name |  | | | |  |
| Vendor/Payee Bank Address |  | | | |  |
| Bank Account Number |  | | | |  |
| International Bank Account Number |  | | | |  |
| Bank Code |  | | | |  |
| Branch Name & Address |  | | | |  |
| Swift Code |  | | | |  |
| Tax ID Number, Sales Tax or VAT |  | | | |  |
| Business Registration Number |  | | | |  |
|  |  |  |  |  |  |
| **Sub-Recipient Information** | | | | |  |
| Employer Identification Number (EIN) |  |  |  |  |  |
| DUNS Number |  |  |  |  |  |
| PADOR Number |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  | page 2 of 2 |  |
|  |  |  |  |  |  |
| **Vendor/Payee Selection Criteria** |  |  |  |  | **Yes** |
| Vendor/Payee Anti-Terror Check Completed (note this is done through the Vendor Set-Up in PeopleSoft) OFFLINE ONLY | | | | |  |
| Vendor/Payee has the Necessary Goods and/or Services | | |  |  |  |
| Vendor/Payee Credit and Payment Terms | |  |  |  |  |
| Vendor/Payee costs and prices are reasonable and competitive | | |  |  |  |
|  |  |  |  |  |  |
| **Procurement Committee Approval (Procurement Vendors and Consultants Only)** | | | | | |
| Name | Title |  | Signature |  | Date |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Name | Title |  | Signature |  | Date |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
| Name | Title |  | Signature |  | Date |
|  |  |  |  |  |  |
| **Human Resources, Program, Administration or Finance Approval (As Appropriate)** | | | | | |
|  |  |  |  |  |  |
| Name | Title |  | Signature |  | Date |
|  |  |  |  |  |  |
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|  |  |  |  |  |  |
| Revised 1 July, 2015 |  |  |  |  |  |

**This form MUST be completed by the applicant**

**Instructions for Completing CARE Vendor Questionnaire**

**NOTE:**

*The grey boxes on the CARE Vendor Questionnaire form allow you to type in the information directly into the document on your computer.*

1. Please complete all sections of the form completely. If a piece of information is not applicable (n/a), please indicate this on the form.
2. If you are a US company or individual subject to US Federal Tax regulations, you are required to provide a completed tax form [W-9](https://www.irs.gov/pub/irs-pdf/fw9.pdf). If non-US company or individual, it is a tax form [W-8](https://www.irs.gov/pub/irs-pdf/fw8bene.pdf). CARE uses this information for documentation of compliance with US regulations.
3. Please provide the following list of documents attached to this Questionnaire:

* Legal Business Registration Form
* Business Owner Information
* Supplier Activity Category
* Registration Tax Identification Number

1. Also, in compliance with US tax codes, use the following definitions for determining your status as a “Qualified Business Concern”

*Definitions of “qualified business concern” as set forth in FAR 52.219-8*

**“HUBZone business concern”** means a business concern that appears on the List of Qualified HUBZone Business Concerns maintained by the Business Administration.

**“Service-disabled veteran-owned business concern”**

1. Means a business concern -
2. *Not less than 51 percent of which is owned by one or more service-disabled veterans or, in the case of any publicly owned business, not less than 51 percent of the stock of which is owned by one or more service-disabled veterans; and*
3. The management and daily business operations of which are controlled by one or more service-disabled veterans or, in the case of a veteran with permanent and severe disability, the spouse or permanent caregiver of such veteran.
4. Service-disabled veteran means a veteran, as defined in 38 U.S.C. 101(2), with a disability that is service connected, as defined in 38 U.S.C. 101(16).

**“Small business concern”** means a small business as defined pursuant to Section 3 of the Small Business Act and relevant regulations promulgated pursuant thereto. Refer to <https://www.sba.gov/federal-contracting/contracting-guide/size-standards> to determine the appropriate size standard for your business.

**“Small disadvantaged business concern,”** (8 (a)) means a small business concern that represents, as part of its offer that— (1) It has received certification as a small disadvantaged business concern consistent with 13 CFR part 124, Subpart B; (2) No material change in disadvantaged ownership and control has occurred since its certification;

1. Where the concern is owned by one or more individuals, the net worth of each individual upon whom the certification is based does not exceed $750,000 after taking into account the applicable exclusions set forth at 13 CFR 124.104(c)(2); and
2. It is identified, on the date of its representation, as a certified small disadvantaged business in the database maintained by the Small Business Administration (PRO-Net).

**“Veteran-owned business concern”** means a business concern -

1. Not less than 51 percent of which is owned by one or more veterans (as defined at 38 U.S.C. 101(2)) or, in the case of an y publicly owned business, not less than 51 percent of the stock of which is owned by one or more veterans; and
2. The management and daily business operations of which are controlled by one or more veterans.

**“Women-owned business concern”** means a business concern -

1. That is at least 51 percent owned by one or more women, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more women; and
2. Whose management and daily business operations are controlled by one or more women.

**“Minority-owned business concern”** means a business concern -

1. That is at least 51 percent owned by one or more Minority, or, in the case of any publicly owned business, at least 51 percent of the stock of which is owned by one or more Minority; and
2. Whose management and daily business operations are controlled by one or more Minority.

**“Native American business concern”** means a business concern -

1. That is majority owned by one or more qualifying native Americans, or, for any publicly owned business, the majority of the voting stock is owned by one or more qualifying native Americans; and
2. Whose management and daily business operations are controlled by one or more native Americans.
3. References **MUST** be business clients who have received your products or services during the past three (3) years.
4. The form **MUST** be electronically-signed (e-signed) utilizing the built in [Adobe](https://get.adobe.com/reader/otherversions/) signature feature and returned to your CARE representative.
5. Virtual Pay OPTION for US Bank (US based suppliers only): CARE has partnered with US Bank to provide an easy and expedient means of accepting payment. If you would like to participate in the Virtual Pay option, please choose this option on the Electronic Banking From (last page of the VQ). The standard processing fee administered by a supplier’s merchant acquiring bank will apply. We encourage suppliers to review their merchant account agreement. US Bank will contact your organization through the person you list below on the Vendor Questionnaire (see “Your company’s Contact” line on following page) . Benefits your organization may experience when you accept payment through Virtual Pay:

* Accelerated payment
* Reduced paperwork and streamlined accounts receivables process
* Real-time notifications for each card payment
* Complete remittance detail to support efficient receivables posting
* No changes or modifications to your existing card acceptance procedures
* CARE will be provided an End of Year rebate to further our operational Mission & Vision of saving lives around the world, defeating poverty and achieving social justice.

Note that even if you select the Virtual Pay option, we ask that you still complete the banking information on the Vendor Electronic Funds Transfer (EFT) Form on p. 6.

For question for specific to Virtual Pay, please contact Catherine Newbill ([Catherine.Newbill@care.org](mailto:Catherine.Newbill@care.org)).

1. For questions regarding the completion of this form, please contact Joanne Rivera, CARE Procurement, [Joanne.Rivera@care.org](mailto:Joanne.Rivera@care.org).

**VENDOR QUESTIONNAIRE** (**Confidential**)



(Please utilize electronic signature feature. If for any reason you are unable to electronically sign this form, please contact your CARE representative so that we may send you an alternate document).

Please review the attached instructions prior to completing this form. All information must be completed.

***Note: CARE Standard Payment Terms are Net 30 days from receipt of a CARE approved invoice.***

**REQUIRED INFORMATION (Please Print Clearly)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| CARE Contact Name: | | | | | | | | | | | | | | | | | | | |
| Company/Individual Name (Match contract, bank, invoice & W9/8? DBA name?): | | | | | | | | | | | | | |  | | | | | |
| Your company’s Contact name & title: | | | | | | |  | | | | | | | | | If legally incorporated, in what State or district: | | |  |
| If an individual, are you a U.S. citizen? | | | | | | | Yes: | |  | | No: |  | | | | If not, Country of Citizenship or licensing (required): | | |  |
| Federal Income Tax ID# (or Social Security #, if an individual [or green card holder]): | | | | | | | | | | | | | | |  | | | | |
| Primary and Secondary NAICS Codes: | | | | | | | |  | | | | | | | | | | | |
|  | | | | | | | | | | | (Refer to 13 C.F.R. Part 121 or [www.SBA.gov](http://www.SBA.gov) website. If unknown, please indicate description of primary service.) | | | | | | | | |
| Contact’s Email: | | |  | | | | | | | | | | | | | Website: |  | | |
| Street Address: | | |  | | | | | | | | | | | | | Phone Number: |  | | |
|  | | | Number, Street, Floor, Suite # | | | | | | | | | | | | |  | | |  |
|  |  |  | | |  |  | | | |  |  | |  | | |  | | | |
|  |  | City | | |  | State | | | |  | Zip | |  | | |  | | | |
| Remit Address: | | |  | | | | | | | | | | | | | Phone Number: |  | | |
|  | | | | Number, Street, Floor, Suite # | | | | | | | | | | | |  |  | | |
|  |  |  | | |  |  | | | |  |  | |  | | | Email for Payment Notification: |  | | |
|  |  | City | | |  | State | | | |  | Zip | |  | | |  | |  | |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Check or Fill in All That Apply** | | | | | | | | | | | |  |  | | |  | | |  |  |  | |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please note that CARE procures products and services under government contract. If indicating your company qualifies as one of the following designations, refer to FAR 52.219.8 for definitions and to <https://www.sba.gov/federal-contracting/contracting-guide/size-standards> for size standards. | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | |  |  | | |  | |  |  |  |  | | |  | | |  |  |  | |  | | |
| Cert. Small Disadv.Bus.8(a) Certified: | | | | | | |  |  | | Small-Bus. Enterprise: | | | |  | Certified HUBZone Bus. Enterprise: | | | | | | | | | |  |
|  |  | | |  |  | | |  | |  |  |  |  | | |  | | |  |  |  | |  | | |
| It is important to note that to qualify as one of the following businesses, a qualifying individual who has a controlling interest in the company must operate it. | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | |  |  | | |  | |  |  |  |  | | |  | | |  |  |  | |  | | |
| Native American Owned: | | | |  | Veteran Owned: | | | |  | | | Minority Owned: | | | | | |  | Women Owned: | | | | |  | |
|  |  | | |  |  | | |  | |  |  |  |  | | |  | | |  |  |  | |  | | |
| **Additional Classifications:** | | | | | | | | | | | |  |  | | |  | | |  |  |  | |  | | |
|  |  | | |  |  | | |  | |  |  |  |  | | |  | | |  |  |  | |  | | |
| Private Company: | |  | | | Public Company: | | | | |  |  | Non-Profit: | | | | |  | | Consultant | | |  | | | |
| Sole Proprietorship: | | |  | | | Partnership: | | | |  |  |  |  | | |  | | |  |  |  | |  | | |

**ADDITIONAL INFORMATION** (fill in all that apply)

|  |  |
| --- | --- |
| Parent Company: |  |
|  | (If Applicable) |

|  |  |
| --- | --- |
| Dun & Bradstreet Number: |  |
|  | (If Applicable) |

**Business References**

**Provide 3 current business references, listing business, phone number, contact person, contact’s e-mail and a description of**

**the product or service provided to the client (If you need additional space please use a separate page.)**

|  |  |
| --- | --- |
| 1.) |  |
| 2.) |  |
| 3.) |  |

**Protection from Sexual Exploitation and Abuse**

**CARE does not tolerate any activity that may constitute or result in the sexual exploitation or abuse of the vulnerable adults**

**or children CARE supports through its work. CARE expects that any incidents of sexual exploitation or abuse will be promptly**

**reported to CARE.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. | Will your work under this engagement involve interaction with vulnerable adults or children?  (If YES, please also complete Questions 2-6. If NO, please proceed to Section VI.) | | Yes | No |
| 2. | Do you have a policy addressing sexual exploitation or abuse? | | Yes | No |
| 3. | Do you engage in staff training on the issue? | | Yes | No |
| 4. | Do you conduct reference checks pre-hiring that includes investigation of complaints of sexual exploitation or abuse of program participants? | | Yes | No |
| 5. | In the past two years, has your organization been accused of sexual exploitation or abuse of vulnerable adults or children? (Your answer of YES does not automatically disqualify you from this engagement, but CARE will be requesting additional information.) | | Yes | No |
| 6. | If YES, please provide the name of a staff member whom we can contact for additional information and his/her contact information. |  | | |

**Indicate below the products or services sold or provided by you (if applicable)**

|  |  |  |  |
| --- | --- | --- | --- |
| [a] |  | [b] |  |
| [c] |  | [d] |  |

**Indicate languages spoken:**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | French | |  | English |  | Spanish | |  | Portuguese | |
|  | Other |  | | |  | |  |  | |  |

**Indicate below the specific areas of expertise, unique characteristics etc.**

|  |  |  |  |
| --- | --- | --- | --- |
| [a] |  | [b] |  |
| [c] |  | [d] |  |

**Indicate below the rates\* associated with your products or services (if applicable)**

|  |  |
| --- | --- |
| [a] |  |
|  | \*Daily and hourly rates preferred in USD |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| A logo with orange and yellow hands  Description automatically generated | | **Vendor Electronic Funds Transfer (EFT) Form**   |  | | --- | | **Type of Request:**  New EFT Setup Authorization  Bank Change Authorization | | |
| **Section A** | **Vendor Information** | | |
| Vendor/Contract Name (Individual or Company): | | CARE Contact Name: |
| Trade or Business Name (e.g. Doing Business As, if applicable): | | If US Company, provide your [Tax ID Number](https://www.irs.gov/individuals/international-taxpayers/taxpayer-identification-numbers-tin): |
| **Section B** | **Payment into a Domestic / US Bank (Bank account located within the US)** | | |
| Bank Name: | | Branch Name (If Applicable): |
| Bank Address (Street Address, City, States, and Zip): | | |
| Account Name (account holder/Payee): | | 9-digit ABA Number for **ACH Payments** (for US banks only): |
| Account Number: | | Account Type:  Savings Account  Checking Account  Checking Account |
| **Automated Clearing House (ACH)** refers to the U.S. payment network used by financial institutions to electronically transfer funds between banks. ACH payments cost significantly less than Wires for the parties involved. | | Vendor Email Address (for Remittance Advice Alert/Notification): |
|  | **Virtual Pay Option:** refers to CARE USA’s partnership with US Bank to provide secure and expedited payments to our Approved Vendors with **US Banks.** Please see section 6 on p. 2 for more details. | | By checking this box, you are agreeing to participate in this Virtual Pay Option  ☐ |
|  | **Payment into an International Bank (Bank account located outside the US)** | | |
| Bank Name: | | Branch Name (If Applicable): |
| Bank Address (Street Address, City, States/Province, Zip (postal code), and Country): | | |
| Account Name (account holder/Payee): | | Branch Code (National Code/Local Clearing Code) (If Applicable): |
| Account Number: | | [SWIFT/BIC](https://www2.swift.com/bsl/) (8 or 11 alphanumeric code/not applicable to US banks): |
| [IBAN Code](https://www.iban.com/) (if applicable): | | Account Type:  Savings Account  Checking Account |
| Currency of Bank Account: | | Email Address (for Remittance Advice Notification): |
| **Section D** | **Acceptable Forms of Verification** | | | |
| Vendor **must** attach one of the following bank account verification documents with complete banking details along with this form: | | | |
| Voided pre-printed domestic check for US Bank Only (within the US). Voided check without printed name will not be accepted. Bank Statement is also acceptable for Savings Account in lieu of voided check with \*complete bank details (dated within the last 6 months)  Letter from Bank on bank letterhead with \*complete banking details to validate information (dated within the last 12 months)  Letter from Vendor on official company letterhead with \*complete banking detail to validate details (dated within the last 6 months) | | | |

CARE is not responsible for error, delays and other problems caused by or resulting from incorrect and/or incomplete banking instructions. Furthermore, CARE is not responsible for fees assessed by the intermediary/correspondent and/or beneficiary bank.

\*For **Domestic payments**, complete bank details refer to the Bank Name, Bank Address, Account Name, Type (checking or savings account), ABA Routing Number, and Account Number.

\*For **International payments**, complete bank details refer to the Bank Name, Bank Address, Branch Code (if applicable) Account Name, Type (checking or savings account), IBAN (if applicable), and SWIFT / BIC.

**Acknowledgement & Acceptance**

|  |  |
| --- | --- |
| I (the undersigned) certify that the information provided on this form is correct and complete and I hereby authorize CARE to electronically deposit payments to the bank account designated above. I understand that I must notify CARE in writing immediately of any changes in status or banking information and understand that this authorization will remain in full force and effect until CARE has received written notification by submitting a Bank Change Authorization.  I certify that the foregoing is true and complete to the best of my knowledge and belief and that no material changes have occurred to the business which would affect any of the above representations.  **CERTIFICATION REGARDING TERRORISM: Seller hereby certifies that it has not provided and will not provide material support or resources to any individual or organization that it knows, or has reason to know, is an individual or organization that advocates, plans, sponsors, engages in, or has engaged in an act of terrorism.**  Misrepresentation above may result in penalties and fines, including those as set forth in the Small Business Administration Act Section 16.d.2 and 18 U.S.C. § 1001. I have read the above statement and certify under oath that the information contained herein is true and accurate to the best of my knowledge and belief. | |
| Title of Authorized Signer: | Email Address of Authorized Signer: |
| Phone Number of Authorized (for call-back verification) (XXX) XXX-XXXX): | Date Signed (MM/DD/YYYY): |
| Name of Authorized Signer: | Electronic Signature of Authorized Signer: **ATTENTION: Once you electronically sign the form, all parts of this form will lock the document to prevent subsequent changes and ensure security**. |
| Additional signature line if provider policy requires a different signature format, such as certificate-based digital signature, inserting digital signature, draw signature, etc. | |