BID RESPONSE PACKET
710-19-1033RR

BID SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION					
Company:	DR. SUZI WALLACE, PHD CLINICAL PSYCHOLOGIST				
Address:	4711 OAK HOLLOW LANE				
City:	FORT SMITH,	State:	AR	Zip Code:	72903
Business Designation:	☑ Individual ☑ Sole Proprietorship ☐ Public Service Corp ☐ Partnership ☐ Corporation ☐ Nonprofit				
Minority and Women-Owned Designation*:	☐ Not Applicable ☑ American Indian ☐ Asian American ☐ Service Disabled Veteran ☐ African American ☐ Hispanic American ☐ Pacific Islander American ☑ Women-Owned AR Certification #: 18-082 * See *Minority and Women-Owned Business Policy*				

PROSPECTIVE CONTRACTOR CONTACT INFORMATION *Provide contact information to be used for bid solicitation related matters.*			
Contact Person:	SUZI WALLACE	Title:	CLINICAL PSYCHOLOGIST
Phone:	479/651-7413	Alternate Phone:	—
Email:	SUZI.WALLACE@AOL.COM		

CONFIRMATION OF REDACTED COPY

☐ YES, a redacted copy of submission documents is enclosed.

☑ NO, a redacted copy of submission documents is not enclosed. I understand a full copy of non-redacted submission documents will be released if requested.

Note: If a redacted copy of the submission documents is not provided with Prospective Contractor's response packet, and neither box is checked, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA). See Bid Solicitation for additional information.

ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this *Bid Solicitation*, a Prospective Contractor agrees and certifies that they do not employ or contract with illegal immigrants. If selected, the Prospective Contractor certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract.

ISRAEL BOYCOTT RESTRICTION CONFIRMATION

By checking the box below, a Prospective Contractor agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.

☐ Prospective Contractor does not and will not boycott Israel.

An official authorized to bind the Prospective Contractor to a resultant contract must sign below.

The signature below signifies agreement that any exception that conflicts with a Requirement of this *Bid Solicitation* **will cause the Prospective Contractor's bid to be disqualified:**

Authorized Signature: _____ **Title:** CLINICAL PSYCHOLOGIST

Use Ink Only.

Printed/Typed Name: SUZI WALLACE **Date:** 043019

SECTION 1 - VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*
- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

NONE / N/A

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

Vendor Name:	NONE	**Date:**	043019
Signature:		**Title:**	CLINICAL ASSOCIATE
Printed Name:	SUZI WALLACE, PHD		

SECTION 2 - VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*
- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

NONE / N/A

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

Vendor Name:	NONE / NO REQUESTS	**Date:**	8/30/19
Signature:		**Title:**	CLINICAL PSYCHOLOGIST
Printed Name:	SUZ WALLACE, PHD		

SECTION 3 - VENDOR AGREEMENT AND COMPLIANCE

- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

NONE/N/A

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

Vendor Name:	NONE/NO REQUESTS	**Date:**	04-3019
Signature:		**Title:**	CLINICAL PSYCHOLOGIST
Printed Name:	SUZI WALLACE, PHD		

SECTION 4 - VENDOR AGREEMENT AND COMPLIANCE

- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

NONE / N/A

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

Vendor Name:	NO REQUESTS	**Date:**	04/30/19
Signature:		**Title:**	CLINICAL PSYCHOLOGIST
Printed Name:	SUE WALLACE, PHD		

PROPOSED SUBCONTRACTORS FORM

- ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

N/A

PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.

Type or Print the following information

Subcontractor's Company Name	Street Address	City, State, ZIP
NONE / N/A		

☑ **PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

By signature below, vendor agrees to and **shall** fully comply with all Requirements related to subcontractors as shown in the bid solicitation.

Vendor Name:	DR. SUZI WALLACE, PHD	**Date:**	04/30/19
Signature:		**Title:**	CLINICAL PSYCHOLOGIST
Printed Name:	SUZI WALLACE, PHD		

FIND

PAGE 8/8

SECURELY

~~SEALED~~

IN

ENVELOPE

ENCLOSED

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM

F-1

Failure to complete all the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

SUBCONTRACTOR: ☐ YES ☑ NO

SUBCONTRACTOR NAME: N/A

Contractor for which this is a subcontractor: N/A

Estimated dollar amount of subcontract: N/A

TAXPAYER ID NAME: SUSAN WALLACE "SUZ"

IS THIS FOR: ☐ Goods? ☑ Services ☐ Both?

YOUR LAST NAME: WALLACE **FIRST NAME:** SUSAN **MI:**

ADDRESS: 4711 OAK HOLLOW LANE

CITY: FORT SMITH **STATE:** AR **ZIP CODE:** 72903 **COUNTRY:** UNITED STATES OF AMERICA

AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:

FOR INDIVIDUALS*

Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse is a current or former: Member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:

Position Held	Mark (✓)		Name of Position of Job Held [senator, representative, name of board/commission, data entry, etc.]	For How Long?		What is the person(s) name and how are they related to you? (i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.)	
	Current	Former		From MM/YY	To MM/YY	Person's name(s)	Relation
General Assembly	☐	☐					
Constitutional Officer	☐	☐					
State Board or Commission Member	☐	☐					
State Employee	☑	☐	CLINICAL/EXTRA HELP	01/17	CURRENT	SUSAN WALLACE (HIGHFILL)	SELF

☐ **None of the above applies**

FOR A VENDOR (BUSINESS)*

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

Position Held	Mark (✓)		Name of Position of Job Held (senator, representative, name of board/commission, data entry, etc.	For How Long?		What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control?		
	Current	Former		From MM/YY	To MM/YY	Person's name(s)	Ownership Interest (%)	Position of Control
General Assembly	☐	☐						
Constitutional Officer	☐	☐						
State Board or Commission Member	☐	☐						
State Employee	☐	☐						

☐ **None of the above applies**

* NOTE: PLEASE LIST ADDITIONAL DISCLOSURES ON SEPARATE SHEET OF PAPER IF MORE SPACE IS NEEDED

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM F-2

Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.

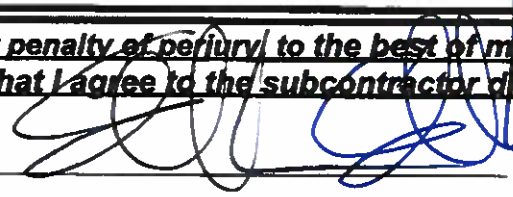
As an additional condition of obtaining, extending, amending, or renewing a contract with a state agency I agree as follows:

1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete a **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM.** Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.
2. I will include the following language as a part of any agreement with a subcontractor:

   Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.

3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM** completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

I certify under penalty of perjury to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.

Signature  **Title** CLINICAL PSYCHOLOGIST **Date** 04/30/19

Vendor Contact Person SUZI WALLACE **Title** CLINICAL PSYCHOLOGIST **Phone No.** 479/651-7413

AGENCY USE ONLY

Agency Number	Agency Name	Agency Contact Person	Contact Phone No.	Contract or Grant No.
0710	Department of Human Services			

* *NOTE: PLEASE LIST ADDITIONAL DISCLOSURES ON SEPARATE SHEET OF PAPER IF MORE SPACE IS NEEDED*

Attachment C

BUSINESS ASSOCIATE AGREEMENT

Between

ARKANSAS DEPARTMENT OF HUMAN SERVICES

And

DR. SUZI WALLACE, PHD CLINICAL PSYCHOLOGIST

(Business Name)

430-43-7395

(Business Taxpayer Identification Number)

This Business Associate Agreement ("Agreement") is made effective on _____, (the "Effective Date") by and between the Arkansas Department of Human Services ("Covered Entity") and SUZI WALLACE, PHD, ("Business Associate,") (collectively, the "Parties").

Background

a) Covered Entity has been designated as a hybrid entity for the purposes of the HIPAA Privacy Rule, and it has designated several of its component agencies as health care components.

b) In accordance with the laws of Arkansas, Business Associate provides services for Covered Entity unrelated to treatment, payment, or healthcare operations and therefore the Parties believe a Business Associate Agreement is required. The provision of such services may involve the disclosure of individually identifiable health information from Covered Entity to Business Associate.

c) The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule.

d) The Parties enter into the Agreement with the intention of complying with the HIPAA Privacy and Security Rule provisions and the Health Information Technology for Economic and Clinical Health (HITECH) Act, that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

Definitions

Catch-all definition:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care

Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information (PHI), Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) "Breach" shall have the meaning set out in its definition at 45 C.F.R. 164.402, as such provision is currently drafted and as it is subsequently updated, amended, or revised.

(b) "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean [Insert Name of Business Associate].

(c) "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Arkansas Department of Human Services.

(d) "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(e) "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

(f) "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.103.

(g) "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his/her designee.

(h) "Unsecured Protected Health Information" shall have the meaning set out in its definition at 45 C.F.R. 164.402; protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the U.S. Secretary of DHHS in the guidance issued under section 13402(h)(2) of Pub. L. 111-5; as such provision is currently drafted and as it is subsequently updated, amended, or revised.

Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the HIPAA Privacy Rule.

Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

(c) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;

(d) Business Associate agrees to report to Covered Entity any unauthorized acquisition, access, use, or disclosure of unsecured PHI the Business Associate holds on behalf of the covered entity, including the identity of each individual who is the subject of the unsecured PHI of which it becomes aware, no case later than ten calendar days after the discovery of the breach;

(e) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;

(f) Make available protected health information in a designated record set to the covered entity as necessary to satisfy covered entity's obligations under 45 CFR 164.524;

(g) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR 164.526;

(h) Maintain and make available the information required to provide an accounting of disclosures to the Covered Entity as necessary to satisfy covered entity's obligations under 45 CFR 164.528;

(i) To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

(j) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

Permitted Uses and Disclosures by Business Associate

(a) Business Associate may only use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in:

Contract #_____, dated _____,

(known as "the Contract") between the parties, provided that such use or disclosure does not violate the policies and procedures of all HIPAA rules.

(b) Business Associate may use or disclose protected health information as required by law.

(c) Business Associate agrees to make uses and disclosures and requests for protected health information consistent with covered entity's Privacy and Security policies and procedures.

(d) Business Associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity, except for the specific uses and disclosures set forth below.

(e) Business Associate may disclose protected health information for the proper management and administration of business associate or to carry out the legal responsibilities of the business associate, provided the disclosures are required by law, or business associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies business associate of any instances of which it is aware in which the confidentiality of the information has been breached. The Business Associate will notify Covered Entity within 10 calendar days of such a disclosure.

(f) Business Associate may provide data aggregation services relating to the health care operations of the covered entity.

Discovery and Notification of Breach or Incident

(a) Business Associate shall implement reasonable systems, policies, and procedures for discovery of possible HIPAA violations and breaches (as defined by HIPAA rules), and shall ensure that its workplace members and other agents are adequately trained and aware of the importance of timely reporting of possible breaches.

(b) Upon the discovery of any HIPAA violation by the Business Associate or any member of its workforce, (which includes, without limitation, employees, subcontractors and agents), with respect to PHI, the Business Associate shall promptly perform a risk assessment to determine whether a breach of unsecured PHI has occurred and whether or not the breach has resulted in any harm to the owner of the PHI as required by HITECH Act.

(c) The Business Associate shall take immediate steps to mitigate any HIPAA violation with respect to the Covered Entity's PHI that is discovered and shall provide the Covered Entity with written documentation of such steps.

(d) If the Business Associate determines that a breach of unsecured PHI may have occurred, the Business Associate shall notify the Covered Entity of such breach or incident within ten calendar days. The Business Associate will specifically notify the DHS Privacy Officer in writing via posted mail as well as email and will confirm receipt of the email immediately by phone.

Such notice shall include:

(i) A brief description of the occurrence, including the date of the breach and the date of discovery, if known;

(ii) To the extent possible, the identity of each individual whose unsecured PHI has been, or is reasonably believed to have been, breached;

(iii) A description of the types of unsecured PHI involved;

(iv) A brief description of what the owners of the PHI can do to protect themselves;

(v) A brief description of what the Business Associate is doing to investigate the breach, mitigate harm to affected individuals, and protect against further breaches; and,

(vi) Any other information that the Covered Entity reasonably believes necessary to enable it to comply with its obligations under HIPAA.

(e) The Business Associate shall continue to provide the Covered Entity with any additional information related to the required disclosures that becomes available following initial notice of the breach. The Business Associate will fully cooperate with the Covered Entity's investigation.

1) For a breach involving unsecured PHI of more than 500 individuals of a state or jurisdiction, the Business Associate shall promptly provide notice of such breach to the Covered Entity, the U.S. Secretary of Health and Human Services and any other federal authorities as required by HIPAA.

2) The Business Associate agrees to maintain documentation of all breaches of unsecured PHI for a minimum of six years after the creation of the documentation, and shall make such documentation available to the U.S. Secretary of Health and Human Services upon request.

(f) The Business Associate hereby agrees to indemnify and hold the Covered Entity harmless from and against liability and costs, including attorney's fees that are created by any breach resulting from the acts of its employees, agents or workforce members.

Permissible Requests by Covered Entity

Covered entity shall not request business associate to use or disclose protected health information in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by covered entity.

Term and Termination

(a) Term. This Agreement shall be effective as of the effective date stated above and shall terminate when all of the protected health information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to the Covered Entity, or if it infeasible to return or destroy the protected health information protections acceptable to Covered Entity are extended to such information in accordance with the termination provisions below, or on the date covered entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. Business associate authorizes termination of this Agreement by covered entity, if covered entity determines business associate has violated a material term of the Agreement and Business Associate has not cured the breach or ended the violation within the time specified by covered entity.

(c) Obligations of Business Associate Upon Termination.

Upon termination of this Agreement for any reason, business associate shall return to covered entity or, if agreed to by covered entity, destroy all protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, that the business associate still maintains in any form. Business associate shall retain no copies of the protected health information.

(d) Survival. The obligations of business associate under this Section shall survive the termination of this Agreement.

Miscellaneous

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

(c) Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be executed in its name and on its behalf effective as of the Effective Date at the top of this document.

Business Associate: SUZI WALLACE, PHD

By: _____

Title: CLINICAL PSYCHOLOGIST

Date: 04/30/19

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Developmental Disabilities Services
Booneville Human Development Center
87 Reed Road • Booneville, AR 72927
Telephone (479) 675-2121 • Fax: (479) 675-2518

To: Arkansas DHS
ATTN: Office of Procurement

Re: Bid Number 710-19-1033R
Professional Reference for Suzi Wallace, Clinical Psychologist

To whom it may concern:

As the superintendent at Booneville Human Development Center (BHDC), I am writing as a professional reference for Suzi Wallace, PhD, for the contract bid noted above.

Suzi and I have collaborated in client care at BHDC since her years as an intern beginning in 2012. In my experience working with her, she has demonstrated a concern for the clients that goes above and beyond her job description as an Extra Help mental health professional. She has shown the ability to successfully navigate complicated issues concerning client diagnoses and crises, family inquiries, psychiatric clinical rounds, court hearings for various client needs, and other duties, all of which remained client-centered while also meeting the high standards expected of those employed here at BHDC. In addition, Suzi has served an integral role as virtual chief psychologist for our Psychology Department since the position was vacated in 2017. Because of this, I have been privy to observe the excellent quality of work that Suzi is capable of performing in the position as a Clinical Psychologist.

Please don't hesitate to contact me with any questions you might have about Suzi's qualifications for the Clinical Psychology position at BHDC.

Respectfully,

Jeff Gonyea, Superintendent
Booneville Human Development Center

FROM THE DESK OF

FAYZ HUDEFI, MD
PSYCHIATRIST
MEDICAL DIRECTOR
VALLEY BEHAVIORAL HEALTH SYSTEM
479/ 353-0901
FAYZHUDEFI@GMAIL.COM

To: Arkansas DHS
ATTN: Office of Procurement

Re: Bid Number 710-19-1033R
Professional Reference for Suzi Wallace, Clinical Psychologist

To whom it may concern:
As the principal psychiatrist at Booneville Human Development Center (BHDC), I am writing to recommend Suzi Wallace, PhD, for the contract position of Clinical Psychologist.
Suzi and I have collaborated in the comprehensive mental health care for the clients at BHDC over a number of years. There is no question about the incredible aptitude, creativity, and compassion that Suzi demonstrates when considering the psychological treatment that is most needed to benefit clients, their families, and BHDC staff. Although officially in an "Extra Help" position at present, Suzi has virtually functioned as the chief psychologist of the BHDC Psychology Department since the position became vacant in 2017. The opportunity to do so has allowed her to experience and address the myriad issues that arise in such an ICF, whether in relation to clients, families, or staff, whether regulatory or professional, in a way that highly qualifies Suzi for the contract position as Clinical Psychologist at BHDC.
Please don't hesitate to contact me with any questions you might have about Suzi's qualifications or the stellar work that she does with clients at BHDC.
Respectfully,

4.2.19.

FAYZ HUDEFI, MD
PSYCHIATRIST
MEDICAL DIRECTOR
VALLEY BEHAVIORAL HEALTH SYSTEM

10301 Mayo Drive, Barling AR 72923
Phone: 479-494-5700 Fax: 479-494-5777

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Developmental Disabilities Services

Booneville Human Development Center

87 Reed Road, Hwy 116 South ■ Booneville, AR 72927 ■ 479-675-2121 ■ Fax: 479-675-2518

2 April 2019

Stacy Weinbrenner, RN, Nurse Manager
87 Reed Road
Booneville, AR 72927

It is my absolute pleasure to recommend Suzanna Highfill for a psychology position with the Booneville Human Development Center. I have known Ms. Highfill for 11 years first in a long- term care setting as a physical therapist and as a core member of the psychology department at BHDC. I have worked the past 2 years with her as a core member of BHDC's psychology team.

She has brought a tremendous knowledge base to BHDC with her expertise in both physical therapy and psychology to provide a holistic approach to client-based care.

Her knowledge and expertise have been a tremendous asset to the psychology and medical department at BHDC. She has demonstrated an ability to be a core member of the team by fostering a positive reward system for the clients utilizing a certificate of merit.

It has been an absolute joy to work along with Suzanna as she is impressive with her dedication to the clients. She demonstrates an outstanding work ethic and a high degree of professionalism.

Please feel free to contact me by phone or email.

Sincerely,

Stacy Weinbrenner

Stacy Weinbrenner,

Telephone: 479-206-3863
Stacy.Weinbrenner@dhs.arkansas.gov

FROM THE DESK OF

SUZI WALLACE, PHD

CLINICAL PSYCHOLOGIST

479/ 651-7413

SUZI.WALLACE@AOL.COM

Re: Equal Employment Opportunity Policy

As a private contractor to provide services as a Clinical Psychologist to Booneville Human Development Center (BHDC), I am not required by law to have an EO Policy.

Respectfully,

SUZI WALLACE, PHD
CLINICAL PSYCHOLOGIST
ARKANSAS LIC # 18-087

CNA

HEALTHCARE PROVIDERS SERVICE ORGANIZATION PURCHASING GROUP

Certificate of Insurance

OCCURRENCE POLICY FORM

HPSO

Print Date: 6/28/2018

Producer	Branch	Prefix	Policy Number	Policy Period
018098	970	HPG	0665845792	from 07/11/18 to 07/11/19 at 12:01 AM Standard Time

Named Insured and Address:
Suzi Wallace
4711 Oak Hollow Ln
Fort Smith, AR 72903-6712

Program Administered by:
Healthcare Providers Service Organization
1100 Virginia Drive, Suite 250
Fort Washington, PA 19034
1-800-982-9491
www.hpso.com

Medical Specialty:	Code:
Psychologist/Psychotherapist	80723
Physical Therapist	80995
Excludes Cosmetic Procedures	

Insurance is provided by:
American Casualty Company of Reading, Pennsylvania
333 S. Wabash Avenue, Chicago, IL 60604

Professional Liability $1,000,000 each claim $ 3,000,000 aggregate

Your professional liability limits shown above include the following:
* Good Samaritan Liability * Malplacement Liability * Personal Injury Liability
* Sexual Misconduct Included in the PL limit shown above subject to $ 25,000 aggregate sublimit

Coverage Extensions

License Protection	$ 25,000	per proceeding	$ 25,000	aggregate
Defendant Expense Benefit	$ 1,000	per day limit	$ 25,000	aggregate
Deposition Representation	$ 10,000	per deposition	$ 10,000	aggregate
Assault	$ 25,000	per incident	$ 25,000	aggregate
Includes Workplace Violence Counseling				
Medical Payments	$ 25,000	per person	$ 100,000	aggregate
First Aid	$ 10,000	per incident	$ 10,000	aggregate
Damage to Property of Others	$ 10,000	per incident	$ 10,000	aggregate
Information Privacy (HIPAA) Fines and Penalties	$ 25,000	per incident	$ 25,000	aggregate
Media Expense	$ 25,000	per incident	$ 25,000	aggregate

Workplace Liability

Workplace Liability	Included in Professional Liability Limit shown above
Fire & Water Legal Liability	Included in the PL limit shown above subject to $150,000 aggregate sublimit
Personal Liability	$1,000,000 aggregate

Total: $ 451.00

Base Premium $451.00

Premium reflects Self Employed , Part Time , Member Discount

Policy Forms & Endorsements(Please see attached list for a general description of many common policy forms and endorsements.)

G-121500-D	G-121503-C	G-121501-C	G-145184-A	G-147292-A	GSL15563	GSL15564
GSL15565	GSL17101	GSL13424	CNA80051	CNA80052	G-123846-C03	CNA81753
CNA81758	CNA82011	CNA89027	CNA79575	CNA89026		

Chairman of the Board

Secretary

Keep this document in a safe place.It and proof of payment are your proof of coverage. There is no coverage in force unless the premium is paid in full.In order to activate your coverage, please remit premium in full by the effective date of this Certificate of Insurance.

Master Policy # 188711433

G-141241-B (03/2010)

Coverage Change Date:

Endorsement Change Date:

ARKANSAS PSYCHOLOGY BOARD

101 E. Capitol Ave., Ste. 415
Little Rock, AR 72201-3824
(501) 682-6167

THIS CERTIFIES THAT

IS DULY LICENSED BY THE STATE OF ARKANSAS AS A

Psychologist

License No: 18-08P

Expires: 6/30/2019

Issue Date: 4/20/2018

Signature: