BID SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION						
Company:	Annette's Nursing Service					
Address:	1814 N. Reynolds Rd					
City:	Bryant,		State:	AR	Zip Code:	72022
Business Designation:	☐ Individual ☐ Partnership	☐ Sole Proprietorship ☑ Corporation		☐ Public Service Corp ☐ Nonprofit		
Minority and Women-Owned Designation*:	☐ Not Applicable ☐ African American	☐ American Indian ☐ Hispanic American	☐ Asian American ☐ Pacific Islander American	☐ Service Disabled Veteran ☑ Women-Owned		
	AR Certification #: _____		* See *Minority and Women-Owned Business Policy*			

PROSPECTIVE CONTRACTOR CONTACT INFORMATION *Provide contact information to be used for bid solicitation related matters.*			
Contact Person:	Annette Ward	Title:	President
Phone:	501-847-8116	Alternate Phone:	501-626-9003
Email:	jennifer.m.barnett@sbcglobal.net		

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: Annette Ward **Title:** President
Use Ink Only.

Printed/Typed Name: Annette Ward **Date:** 4/29/20

BID RESPONSE PACKET

710-20-2029

(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.

DFA Illegal Immigrant Contractor Disclosure Certification

DFA Illegal Immigrant Contractor Disclosure Certification View Submission Details

Disclosure forms are valid for one year.

Vendor:	Annette's Nursing Service
Tax ID:	7183
Disclosure Statement:	I certify that I **DO NOT** employ or contract with an illegal immigrant.
Contact E-mail:	tina.l.robbins@sbcglobal.net
Submitted on:	04-29-20
Valid through:	04-28-21

(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: Annetter Nursing Service Inc

By: Annette Ward

Title: President

Date: 7-1-20

(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.

(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 wa 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 w 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 discover 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 PHI, the Business Associate shall promptly perform a risk assessment to determine whether a brea of unsecured PHI has occurred and whether or not the breach has resulted in any harm to the owne of the PHI as required by HITECH Act.

(c) The Business Associate shall take immediate steps to mitigate any HIPAA violation with respec 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,

OFFICIAL BID PRICE SHEET

Check nursing discipline for which you are bidding.

☐ LPN/LPTN only

☐ CNA only

☑ LPN/LPTN and CNA

Respondent proposes to do the work described in the "Scope of Work: of this IFB at the following proposed rate during the anticipated contract period:

Nursing Discipline	Estimated Monthly Hours	Hourly Rate	Total (Est. Annual Hours X's Hourly rate)
Licensed Practical Nurse (LPN) or (LPTN)	3,601	$	$
Certified Nurse Assistant (CNA)	3,967	$	$
GRAND TOTAL			$

AUTHORIZATION SIGNATURE

By my signature below, I certify that the aforementioned statements are true and correct and that I accept the Terms and Conditions as presented in this bid, and that I am authorized by the respondent to submit this bid on his/her behalf.

Vendor Name: Annettes Nursing Service Inc	**Date:** 4/29/20
Signature: Annette Ward	**Title:** President
Printed Name: Annette Ward	

SECTION 4 - VENDOR AGREEMENT AND COMPLIANCE

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

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

Vendor Name:	Annettes Nursing Service	**Date:**	4/29/20
Signature:	Annette Ward	**Title:**	President
Printed Name:	Annette Ward		

Attachment B
710-20-2029 Nursing Services
Written Questions

Instructions

This Response Template must be used for submission of written questions. All questions should provide the requested information. Those that do not, may not be answered by DHS. The Vendor may add as many lines as needed. DHS would strongly prefer the Vendor to ask multi-part questions as individual questions on seperate lines.

Instructions: Complete all cells of each question asked in the Table below. Clearly identify the referenced section or text.

Question ID	RFP Reference (page number, section number, paragraph)	Specific IFB Language	Question	Answer
Example	*Page 20, Desk Reviews*	Desk Review	*Where are the Desk Review Specifications?*	
1	*General*	*General*	*Why is the contract out for bid?*	*The current contract will expire on June 30, 2020*
2	*General*	*General*	*Is the contract required to be put out for bid?*	*yes*
3	*General*	*General*	*Who are your current incumbent vendors for these services?*	*For FY 2020 Arkansas Healthcare Personnel. Annette's Nursing Services*
4	*General*	*General*	*Are you satisfied with your current vendors?*	*yes*
5	*General*	*General*	*Are your needs being met?*	We have unfilled needs and are having to work some in excess of 40 hours a week to meet our needs.
6	*General*	*General*	*Can you provide last year's usage for these services in either number of hours filled and/or total cost in dollar amount used for these services broken down by the positions solicited in this Invitation for Bid?*	FY 2019 Total C.N.A Hours 63,234 Total LPN hours 48,224
7	*General*	*General*	*What are your current hourly bill rates by classification?*	*(AHP) LPN $32.90 Cna $19.90* *(ANS) LPN $32.88 Cna $20.38*
8	*General*	*General*	*Are we able to take exceptions and propose language to any of the terms and/or requirements?*	*See IFB Section 1.5.*

PROPOSED SUBCONTRACTORS FORM

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

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

☑ **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:	Annettes Nursing Service	**Date:**	4/29/20
Signature:	Annette Ward	**Title:**	President
Printed Name:	Annette Ward		

Attachment F

BUSINESS ASSOCIATE AGREEMENT

Between

ARKANSAS DEPARTMENT OF HUMAN SERVICES

And

Annettes Nursing Service Inc

(Business Name)

71-0767183

(Business Taxpayer Identification Number)

This Business Associate Agreement ("Agreement") is made effective on 7-1-20, (the "Effective Date") by and between the Arkansas Department of Human Services ("Covered Entity") and Annettes Nursing Service Inc, ("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

Attachment F

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;

ANNETTE'S NURSING SERVICE

SINCE 1992

"Where People Count"

Listed below are two (2) current accounts held by Annette's Nursing Service:

1. Arkansas Health Center
   6701 US 67
   Benton, AR 72015
   Contact: Dorena Kitchens
   Email: Dorena.Kitchens@arkansas.gov
   Phone: (501) 860-0500
   Fax: (501) 860-0795

2. Elders Choice
   Human Services Department
   115 Stover St.
   Hot Springs, AR 71913
   Contact: Linda Higgs
   Email: Linda.Higgs@arkansas.gov
   Phone: (501) 623-2583 ext. 221
   Fax: (501) 623-2645

DO NOT STAPLE

33333	a Control number 22222	For Official Use Only ▶ OMB No. 1545-0008	

b Kind of Payer (Check one): 941 [X] | Military [ ] | 943 [ ] | 944 [ ] | CT-1 [ ] | Hshld. emp. [ ] | Medicare govt. emp. [ ]

Kind of Employer (Check one): None apply [X] | 501c non-govt. [ ] | State/local non-501c [ ] | State/local 501c [ ] | Federal govt. [ ]

Third-party sick pay (Check if applicable) [ ]

c Total number of Forms W-2: 28	d Establishment number:
e Employer identification number (EIN): 71-0767183	
f Employer's name: ANNETTE'S NURSING SERVICE	
ANNETTE'S NURSING SERVICE IN 1814 N.REYNOLDS RD BRYANT AR 72022-270 g Employer's address and ZIP code	
h Other EIN used this year	
15 State: AR — Employer's state ID number: 71-0767183 'WHW'	
16 State wages, tips, etc.: 320416.49	17 State income tax: 8990.43
Employer's contact person	
Employer's tax number: (501) 653-2115	

1 Wages, tips, other compensation: 320416.49	2 Federal income tax withheld: 17048.03
3 Social security wages: 320416.49	4 Social security tax withheld: 19865.83
5 Medicare wages and tips: 320416.49	6 Medicare tax withheld: 4646.05
7 Social security tips	8 Allocated tips
9	10 Dependent care benefits
11 Nonqualified plans	12a Deferred compensation
13 For third-party sick pay use only	12b
14 Income tax withheld by payer of third-party sick pay	
18 Local wages, tips, etc.	19 Local income tax
Employer's telephone number: (501) 847-8116	For Official Use Only: 0000/ 1030D
Employer's email address: jennifer.m.barnett@sbcglobal	

Under penalties of perjury, I declare that I have examined this return and accompanying documents and, to the best of my knowledge and belief, they are true, correct, and complete.

Signature ▶ Title ▶ Date ▶

Form **W-3** Transmittal of Wage and Tax Statements 2018 Department of the Treasury Internal Revenue Service

Send this entire page with the entire Copy A page of Form(s) W-2 to the Social Security Administration (SSA). Photocopies are not acceptable. Do not send Form W-3 if you filed electronically with the SSA.

Do not send any payment (cash, checks, money orders, etc.) with Forms W-2 and W-3.

Reminder

Separate instructions. See the 2018 General Instructions for Forms W-2 and W-3 for information on completing this form. Do not file Form W-3 for Form(s) W-2 that were submitted electronically to the SSA.

Purpose of Form

Complete a Form W-3 Transmittal only when filing paper Copy A of Form(s) W-2, Wage and Tax Statement. Don't file Form W-3 alone. All paper forms **must** comply with IRS standards and be machine readable. Photocopies are **not** acceptable. Use a Form W-3 even if only one paper Form W-2 is being filed. Make sure both the Form W-3 and Form(s) W-2 show the correct tax year and Employer Identification Number (EIN). Make a copy of this form and keep it with Copy D (For Employer) of Form(s) W-2 for your records. The IRS recommends retaining copies of these forms for four years.

E-Filing

The SSA strongly suggests employers report Form W-3 and Forms W-2 Copy A electronically instead of on paper. The SSA provides two free e-filing options on its Business Services Online (BSO) website:

- **W-2 Online.** Use fill-in forms to create, save, print, and submit up to 50 Forms W-2 at a time to the SSA.
- **File Upload.** Upload wage files to the SSA you have created using payroll or tax software that formats the files according to the SSA's *Specifications for Filing Forms W-2 Electronically (EFW2).*

W-2 Online fill-in forms or file uploads will be on time if submitted by **January 31, 2019.** For more information, go to *www.SSA.gov/bso*. First time filers, select "*Register*"; returning filers select "*Log In.*"

When To File Paper Forms

Mail Form W-3 with Copy A of Form(s) W-2 by **January 31, 2019.**

Where To File Paper Forms

Send this entire page with the entire Copy A page of Form(s) W-2 to:

Social Security Administration
Direct Operations Center
Wilkes-Barre, PA 18769-0001

Note: If you use "Certified Mail" to file, change the ZIP code to "18769-0002." If you use an IRS-approved private delivery service, add "ATTN: W-2 Process, 1150 E. Mountain Dr." to the address and change the ZIP code to "18702-7997." See Publication 15 (Circular E), Employer's Tax Guide, for a list of IRS-approved private delivery services.

REV 01/14/19 QB

For Privacy Act and Paperwork Reduction Act Notice, see the separate instructions.

Bryant Police Dept.
Code Enforcement Div.
312 Roya Lane
Bryant, AR 72022
Phone: 501-943-0943
Fax:501-943-0978

City of Bryant

2020 Business License 2020

License is Granted to: ANNETTE'S NURSING SERVICE INC.

License Address: 1814 N. REYNOLDS RD. BRYANT, AR 72022

License #: 76

Issue Date: April 29, 2020

# Employees	Description of Business	Fee Assessment
10	Nursing Service	$100.00

In the City of Bryant, County of Saline, State of Arkansas

TOTAL $725.00

Effective for 12 months from the 1st of January 2020

Sue Ashcraft, City Clerk

By: Ramsey Wooten

INFORMATION OF IMPORTANCE TO HOLDER OF THIS ORIGINAL LICENSE:

This License:

1. Does not authorize a business to operate in conflict with the laws of the City of Bryant (inclusive of zoning regulations) or the State of Arkansas.
2. Must be posted in a conspicuous place at the business location being licensed.
3. Is NOT transferable with respect to location, business classification, or ownership. Change in location, classification or ownership will necessitate a new license.

Warning!

This license constitutes a privilege granted to the individual, partnership, or corporation named to engage only in the business described. Improper use is forbidden under penalty of law. License is due January 1 of each year unless otherwise provided.

Equal Opportunity Employer Policy

Annette's Nursing Service provides equal employment opportunities (EEO) to all employees and applicants for employment without regard to race, color, religion, gender, sexual orientation, gender identity or expression, national origin, age, disability, genetic information, marital status, amnesty, or status as a covered veteran in accordance with applicable state and local laws. Annette's Nursing Service complies with applicable state and local laws governing non-discrimination in employment in every location in which the company has facilities. This policy applies to all terms and conditions of employment including, but not limited to, hiring placement, promotion, termination, layoff, recall, transfer, leaves of absence, compensation, and training.

Annette's Nursing Service expressly prohibits any form of unlawful employee harassment based on race, color, religion, gender, sexual orientation, gender identity or expression, national origin, age, genetic information, disability, or veteran status. Improper interface with the ability of Annette's Nursing Service employees to perform their expected job duties is absolutely not tolerated.

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 Annette Ward **Title** President **Date** 4-29-20

Vendor Contact Person Jennifer Barnett **Title** Office Manager **Phone No.** 501-847-8116

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

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:

Contractor for which this is a subcontractor:

Estimated dollar amount of subcontract:

TAXPAYER ID NAME: Annettes Nursing Service

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

YOUR LAST NAME: Ward **FIRST NAME:** Annette **MI:** S

ADDRESS: 1814 N. Reynolds Rd

CITY: Bryant **STATE:** AR **ZIP CODE:** 72022 **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	☐	☐	N/A				
Constitutional Officer	☐	☐					
State Board or Commission Member	☐	☐					
State Employee	☐	☐					

☐ **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	☐	☐	N/A					
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

SECTION 3 - VENDOR AGREEMENT AND COMPLIANCE

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

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

Vendor Name:	Annette's Nursing Service	**Date:**	4/29/20
Signature:	Annette Ward	**Title:**	President
Printed Name:	Annette Ward		

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.*

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

Vendor Name:	Annette's Nursing Service	**Date:**	4/29/20
Signature:	Annette Ward	**Title:**	President
Printed Name:	Annette Ward		

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.*

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

Vendor Name:	Annette's Nursing Service	**Date:**	4/29/20
Signature:	Annette Ward	**Title:**	President
Printed Name:	Annette Ward		

DO NOT STAPLE

33333	a Control number 33333	For Official Use Only ▶ OMB No. 1545-0008

b Kind of Payer (Check one): 941 ☒ | Military ☐ | 943 ☐ | 944 ☐ | CT-1 ☐ | Hshld. emp. ☐ | Medicare govt. emp. ☐

Kind of Employer (Check one): None apply ☒ | 501c non-govt. ☐ | State/local non-501c ☐ | State/local 501c ☐ | Federal govt. ☐ | Third-party sick pay (Check if applicable) ☐

c Total number of Forms W-2: 28	d Establishment number
e Employer identification number (EIN): 71-0767183	
f Employer's name: ANNETTE'S NURSING SERVICE	
ANNETTE'S NURSING SERVICE IN 1814 N.REYNOLDS RD BRYANT AR 72022-270 g Employer's address and ZIP code	
h Other EIN used this year	
15 State: AR — Employer's state ID number: 71-0767183 'WHW'	
16 State wages, tips, etc.: 324159.58	17 State income tax: 8400.47
Employer's contact person	
Employer's fax number: (501) 653-2115	

1 Wages, tips, other compensation: 324159.58	2 Federal income tax withheld: 14352.00
3 Social security wages: 324159.58	4 Social security tax withheld: 20096.33
5 Medicare wages and tips: 324159.58	6 Medicare tax withheld: 4699.03
7 Social security tips	8 Allocated tips
9	10 Dependent care benefits
11 Nonqualified plans	12a Deferred compensation
13 For third-party sick pay use only	12b
14 Income tax withheld by payer of third-party sick pay	
18 Local wages, tips, etc.	19 Local income tax
Employer's telephone number: (501) 847-8116	For Official Use Only
Employer's email address: jennifer.m.barnett@sbcglobal	

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and, to the best of my knowledge and belief, they are true, correct, and complete.

Signature ▶ Title ▶ Date ▶

Form W-3 Transmittal of Wage and Tax Statements 2019

Department of the Treasury
Internal Revenue Service

Send this entire page with the entire Copy A page of Form(s) W-2 to the Social Security Administration (SSA).
Photocopies are not acceptable. Do not send Form W-3 if you filed electronically with the SSA.
Do not send any payment (cash, checks, money orders, etc.) with Forms W-2 and W-3.

Reminder

Separate instructions. See the 2019 General Instructions for Forms W-2 and W-3 for information on completing this form. Do not file Form W-3 for Form(s) W-2 that were submitted electronically to the SSA.

Purpose of Form

Complete a Form W-3 Transmittal only when filing paper Copy A of Form(s) W-2, Wage and Tax Statement. Don't file Form W-3 alone. All paper forms **must** comply with IRS standards and be machine readable. Photocopies are **not** acceptable. Use a Form W-3 even if only one paper Form W-2 is being filed. Make sure both the Form W-3 and Form(s) W-2 show the correct tax year and Employer Identification Number (EIN). Make a copy of this form and keep it with Copy D (For Employer) of Form(s) W-2 for your records. The IRS recommends retaining copies of these forms for four years.

E-Filing

The SSA strongly suggests employers report Form W-3 and Forms W-2 Copy A electronically instead of on paper. The SSA provides two free e-filing options on its Business Services Online (BSO) website.

- **W-2 Online.** Use fill-in forms to create, save, print, and submit up to 50 Forms W-2 at a time to the SSA.
- **File Upload.** Upload wage files to the SSA you have created using payroll or tax software that formats the files according to the SSA's *Specifications for Filing Forms W-2 Electronically (EFW2).*

W-2 Online fill-in forms or file uploads will be on time if submitted by **January 31, 2020**. For more information, go to *www.SSA.gov/bso*. First time filers, select "*Register*"; returning filers select "*Log In*."

When To File Paper Forms

Mail Form W-3 with Copy A of Form(s) W-2 by **January 31, 2020.**

Where To File Paper Forms

Send this entire page with the entire Copy A page of Form(s) W-2 to:

Social Security Administration
Direct Operations Center
Wilkes-Barre, PA 18769-0001

Note: If you use "Certified Mail" to file, change the ZIP code to "18769-0002." If you use an IRS-approved private delivery service, add "ATTN: W-2 Process, 1150 E. Mountain Dr." to the address and change the ZIP code to "18702-7997." See Pub. 15 (Circular E), Employer's Tax Guide, for a list of IRS-approved private delivery services.

ANNETTE'S NURSING SERVICE

SINCE 1992

"Where People Count"

The following roaster consists of ANS employees that are currently working at Arkansas Health Center. Their licenses and qualifications are on file and up to date:

Licensed Practical Nurse
Jennifer Smith, LPN
Jennifer Vail, LPN
Tiffany Kelley, LPN
Katherine Fagan, LPN
Jean Smock, LPN
Shonda Bogard, LPN
Nancy Sheard, LPN
Callie Griffis, LPN
Keri Balance, LPN
Karyne Farrell, LPN

Certified Nursing Assistant
Lovelle Dulaney Anderson, CNA
Aquira Bell, CNA
Abby Jordan, CNA
Emily Sutterfield, CNA
Shelby Bray, CNA
Brittney Cole, CNA
Sandra Douglass, CNA
Elisha House, CNA
Stacy Knox, CNA
Dana Ramsey, CNA

Annette's Nursing Service and its employees are governed by and adhere to any and all policies and procedures set forth by Arkansas health Center.

1814 N. Reynolds Rd., Bryant, Arkansas 72022 ~ ph: 501-847-8116 ~ fax: 501-847-1418

ANNETTE'S NURSING SERVICE

SINCE 1992

"Where People Count"

Please use this statement as certification that all personnel provided by Annette's Nursing Service have obtained current/valid items listed below.

- Drug/Alcohol Screening
- TB Skin Test
- Flu Immunization
- Hepatitis B Record
- OLTC Background Check
- Arkansas State Police Background Check
- CPR-American Heart Association- Health Provider Basic Life Saver
- Registry screening checks as follows:
    - Child Maltreatment Registry
    - Adult Maltreatment Registry
    - OLTC Employment Clearance Registry
    - Registry records for LPNs

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ANNETTE'S NURSING SERVICE

SINCE 1992

"Where People Count"

All personnel provided by Annette's Nursing Service are able to demonstrate the following:

a. the ability to observe and evaluate psychiatric conditions
b. the ability to use good judgment and to maintain confidentiality related to patient and information
c. the ability to perform in a high level stimulated environment
d. the ability to react calmly and effectively in emergency situations
e. the ability to work as a team player
f. the ability demonstrate tact, resourcefulness, patience, and dedication
g. the ability to adhere to and to apply skills to policy and procedures
h. the ability to work different shift times/flexible staffing times
i. effective oral and written communications skills
j. organizational skills
k. a basic knowledge of computers
l. provide written documentation that the employee has completed HIPPAA training
m. the ability to adhere to HIPAA standards (provide written documentation that the employee has completed HIPAA training)
n. The ability to perform nursing duties commensurable to level of nursing qualifications

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