

***RESPONSE PACKET***  
***710-24-037***

# RESPONSE SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION				
Company:				
Address:				
City:		State:		Zip Code:
Business Designation:	<input type="checkbox"/> Individual <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Public Service Corp <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Nonprofit			
Minority and Women Owned Designation*:	<input type="checkbox"/> Not Applicable <input type="checkbox"/> American Indian <input type="checkbox"/> Service Disabled Veteran <input type="checkbox"/> African American <input type="checkbox"/> Hispanic American <input type="checkbox"/> Women-Owned			
	<input type="checkbox"/> Asian American <input type="checkbox"/> Pacific Islander American			
	AR Certification #: _____ * See <i>Minority and Women-Owned Business Policy</i>			
PROSPECTIVE CONTRACTOR CONTACT INFORMATION				
<i>Provide contact information to be used for solicitation related matters.</i>				
Contact Person:		Title:		
Phone:		Alternate Phone:		
Email:				
CONFIRMATION OF REDACTED COPY				
<input type="checkbox"/> YES, a redacted copy of submission documents is enclosed. <input type="checkbox"/> NO, a redacted copy of submission documents is <u>not</u> enclosed. I understand a full copy of non-redacted submission documents will be released if requested.  <i>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 Solicitation Terms and Conditions for additional information.</i>				
COMBINED CERTIFICATIONS FORM				
Bidder has included in the Bid Response Packet the signed Attachment H: Combined Certifications for Contracting with the State of Arkansas.				

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

The signature below signifies agreement that any exception that conflicts with a Requirement of this *Solicitation* **may cause the Prospective Contractor's response to be rejected.**

Authorized Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Printed/Typed Name: \_\_\_\_\_ Date: \_\_\_\_\_

## 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.**

## **SECTIONS 1 - 4 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 bid to be disqualified.

By signature below, vendor agrees to and **shall** fully comply with all requirements as shown in the RFQ.

<b>Vendor Name:</b>		<b>Date:</b>	
<b>Signature:</b>		<b>Title:</b>	
<b>Printed Name:</b>			

## ADDITIONAL INFORMATION

### VENDOR CONTACT INFORMATION

Provide primary and secondary contact information to be used by DHS during their maintenance and administration of the resulting Qualified Vendor Listing.

	Primary Contact	Secondary Contact
Name		
Title		
Phone		
Email		

### AREA(S) OF EXPERTISE

Select the area(s) of expertise in which your company can provide Medicaid-related consulting services to DHS.

- ☐ State Administration and Reporting for the Medicaid Program
- ☐ Federal Cost Allocation Plans
- ☐ Medicaid, National Health and Federal Child Welfare Law, Policy Development and Program Implementation

# Client History Form

## Medicaid Related Consultants

*Instructions:* This form is intended to help the State gain a more complete understanding of each Respondent's experience. This form **must** be completed completely and accurately.

The State reserves the right to verify the accuracy of these answers by contacting any of the listed clients, and all applicable clients **must** be listed. Omission of a client will constitute a failure to complete this form.

For purposes of this form, the "client" is not an individual but the entity which held the contract. By way of explanation, in the resulting QVL, Arkansas DHS will be the client. For each listed client, Respondents may (but are not required) provide the contact information for a person at the client entity who is knowledgeable of the named project. If the State contacts clients listed on this form, the State reserves the right to contact the listed individual or another person at the listed client.

The boxes below each prompt will expand if necessary. The form **must** be signed (please see the final page) by the same signatory who signed the Response Signature Page.

1. Provide a detailed background including, without limitation, the following:
  - Date established
  - Ownership (whether public, partnership, subsidiary, or specified other)
  - Total number of employees
  - An organizational chart displaying the overall business structure (this can be a separate attachment if necessary)

2. The Prospective Contractor shall list three (3) key personnel and their direct relevant functional experience over the last five (5) years per selected area of expertise or give an explanation as to why three (3) are not submitted. Direct relevant experience can include both contract and direct employment. The Prospective Contractor should provide:

- Evidence of the qualifications and credentials of the respondent's key personnel.

3. The Prospective Contractor shall provide at least three (3) past performance examples of similar functional services performed within the past three (3) years per selected area. Services performed can include both contract and direct employment. For each referenced project, the Prospective Contractor shall provide:

- A description of the work performed;
- The time period of the project or contract;
- The staff months required; and
- Project amount.

4. Please list at least three (3) clients where you (the prime contractor only) **served as the prime contractor** for State Administration and Reporting for the Medicaid Program in the past three (3) years. For each client, please specify the organization/agency/division. Please briefly describe the scope of the contract and duration of service including dates. If there are no contracts which meet this definition, please state “none.” Note: Complete this section only if this service area is selected.



5. Please list at least three (3) clients where you (the prime contractor only) **served as the prime contractor** for Federal Cost Allocation Plans in the past three (3) years. For each client, please specify the organization/agency/division. Please briefly describe the scope of the contract and duration of service including dates. If there are no contracts which meet this definition, please state “none.” Note: Complete this section only if this service area is selected.

6. Please list at least three (3) clients where you (the prime contractor only) **served as the prime contractor** for Medicaid, National Health and Federal Child Welfare Law, Policy Development and Program Implementation in the past three (3) years. For each client, please specify the organization/agency/division. Please briefly describe the scope of the contract and duration of service including dates. If there are no contracts which meet this definition, please state “none.” Note: Complete this section only if this service area is selected.

**Authorized Signature:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Printed/Typed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_