BID RESPONSE PACKET

710-22-0007

PROPOSAL SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION					
Company:	CONWAY BEHAVIORAL HEALTH				
Address:	2255 STURGIS ROAD				
City:	CONWAY	State:	AR	Zip Code:	72034
Business Designation:	☒ Individual ☐ Partnership ☐ Sole Proprietorship ☑ Corporation ☐ Public Service Corp ☐ Nonprofit				
Minority and Women-Owned Designation*:	☑ Not Applicable ☐ African American ☐ Asian American ☐ American Indian ☐ Hispanic 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 RFP solicitation related matters.*			
Contact Person:	VAN HOANG	Title:	CHIEF FINANCIAL OFFICER
Phone:	501-205-0011, Ext 221	Alternate Phone:	
Email:	van.hoang@conwaybh.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 RFP Solicitation for additional information.

ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this *RFP Solicitation*, Prospective Contractor agrees and certifies that they do not employ or contract with illegal immigrants and **shall not** employ or contract with illegal immigrants during the term of a contract awarded as a result of this RFP.

ISRAEL BOYCOTT RESTRICTION CONFIRMATION

By checking the box below, Prospective Contractor agrees and certifies that they do not boycott Israel and **shall not** boycott Israel during the term of a contract awarded as a result of this RFP.

☑ Prospective Contractor does not and **shall not** boycott Israel.

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 RFP *Solicitation* **may cause the Prospective Contractor's proposal to be rejected.**

Authorized Signature: _____ **Title:** CHIEF FINANCIAL OFFICER

Use Ink Only.

Printed/Typed Name: VAN HOANG **Date:** 03/09/2022

SECTION 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 vendor's proposal to be disqualified.*

None requested exception.

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

Vendor Name:	CONWAY BEHAVIORAL HEALTH	**Date:**	03/09/2022
Authorized Signature:		**Title:**	CFO
Print/Type Name:	VAN HOANG		

MINIMUM QUALIFICATIONS

Please select one of the following:

☑ Currently providing CRT and/or SRP services. Contract Number: 46000050026

If the Respondent currently provides Acute, Subacute, or Sexual Rehabilitative services for Arkansas Department of Human Services, the Respondent may check the box above and provide contract number(s) in lieu of submitting each item detailed in 2.2 Minimum Qualifications A-G.

☐ Not currently providing CRT and/or SRP services. Submit the following information:

If the Respondent does not currently provide Acute, Subacute, or Sexual Rehabilitative services for Arkansas Department of Human Services, the Respondent shall:

A. Contractors providing acute care **must** be licensed by the Arkansas Department of Health (ADH). For verification purposes, prospective contractor must submit copy of licensure.

B. Contractors providing sub-acute care must be licensed by the Arkansas Department of Health (ADH) or by the Division of Child Care and Early Childhood Education (DCCECE). For verification purposes, prospective contractors must submit copy of licensure.

C. Contractors providing sexual rehabilitation services **must** be licensed under Arkansas law for the independent practice of social work or counseling to provide all diagnosis, evaluation, and therapy. Personnel providing direct client service **shall** have a current Arkansas license and degree in one or more of the following: psychology, psychological examiner, licensed associate counselor under appropriate supervision, licensed professional counselor, licensed master social worker under appropriate supervision, licensed certified social worker, licensed psychologist, or psychiatrist. For verification purposes, prospective contractor **must** submit copy of licensure, with bid submission, for all personnel providing sexual rehabilitation services.

D. All facilities must be certified by Joint Commission on Accreditation of Healthcare Organization (JCAHO), or Commission on Accreditation of Rehabilitation Facilities (CARF), now known as Rehabilitation Accreditation Commission, or the Council on Accreditation (COA). For verification purposes, Prospective Contractor **must** submit copy of certification.

E. Contractors must be currently enrolled as a Medicaid Provider. For verification purposes, Prospective Contractor **must** submit current Medicaid Provider ID number: _____

F. The Contractor **shall** be registered to do business in the State of Arkansas. For verification purposes, Contractor must submit official documentation of their active registration from the Arkansas Secretary of State's Office.

G. The Contractor **shall** maintain a copy of the current Arkansas license/certification of staff who are required by state laws, rules, or regulations to be licensed. These licenses **shall** remain current throughout the duration of the contract.

OFFICIAL BID PRICE SHEET

710-22-0007 Comprehensive Residential Treatment/Sexual Rehabilitative Services

Bidder may only include pricing for each category of service that bidder can currently provide. In the event that Medicaid rates are applied, contractor must invoice the Arkansas Medicaid rates based on the date of service according to the current fee schedule.

Category 1: Acute Care - CRT

Please insert a dollar amount for Option A or check the box for Option B. Option A is a set daily rate at which services may be invoiced throught the duration of the contract. Option B is the Arkansas Medicaid rate that fluctuates based on the date of service.

OPTION A		OPTION B	
Per Diem Rate	$ 850.00	Medicaid Per Diem with W3 Specialty Default Rate	☐

Category 2: Sub-Acute/Psychiatric Residential Care - CRT

Please insert a dollar amount for Option A or check the box for Option B. Option A is a set daily rate at which services may be invoiced throught the duration of the contract. Option B is the Arkansas Medicaid rate that fluctuates based on the date of service.

OPTION A		OPTION B	
Per Diem Rate	$	Medicaid Per Diem with W3 Specialty Residential RTU Rate	☐

Category 3: One-to-One Attendance - CRT

Please insert pricing for one-to-one therapy. Category 3 will not be considered in low price determination. Rate must not exceed the Arkansas Medicaid Rate for Outpatient Qualified Behavioral Health Professional.

Hourly Rate	$ 25.00

Category 4: Sexual Rehabilitation Services

Please insert a dollar amount for Option A or check the box for Option B. . Option A is a set daily rate at which services may be invoiced throught the duration of the contract. Option B is the Arkansas Medicaid rate that fluctuates based on the date of service.

OPTION A		OPTION B	
Per Diem Rate	$	Medicaid Rate	☐

Contract Number _____

Attachment Number _____

Action Number _____

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM

Failure to complete all of 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:

TAXPAYER ID NAME: CONWAY BEHAVIORAL HEALTH, LLC

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

YOUR LAST NAME: HOANG FIRST NAME VAN M.I.:

ADDRESS: 2255 STURGIS ROAD

CITY: CONWAY STATE: AR ZIP CODE: 72034 COUNTRY: USA

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							

☐ **None of the above applies**

FOR AN ENTITY (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, 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**

Contract Number _____

Attachment Number _____

Action Number _____

Contract and Grant Disclosure and Certification Form

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 CHIEF FINANCIAL OFFICER Date 03/16/22

Vendor Contact Person VAN HOANG Title CHIEF FINANCIAL OFFICER Phone No. (501) 205-0011, ext 221

Agency use only

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

ACADIA
HEALTHCARE

Policy Title: **Equal Employment Opportunity**

Policy Number: **HR - 030**

Effective Date: **September 1, 2015**

Policy:

It is the policy of Acadia to provide equal employment opportunity to all employees and applicants for employment regardless of any individual's race, creed, color, religion, national origin, sex, age, physical or mental disability, and genetic information unrelated to the individual's ability to perform essential functions of a particular job; status as a military veteran or qualified disabled veteran; or any other characteristic protected under applicable state, federal and local laws.

Additionally, it is the company's policy to provide promotion and advancement or transfer opportunities, compensation, participation in training or educational activities or programs, discipline and termination in a nondiscriminatory fashion.

Approval:

Administrative: Kim Pharr Date: 09/01/15

State of Arkansas
DEPARTMENT OF HUMAN SERVICES
700 South Main Street
P.O. Box 1437 / Slot W345
Little Rock, AR 72203

ADDENDUM 1

TO: All Addressed Vendors
FROM: **Office of Procurement**
DATE: February 14, 2022
SUBJECT: 710-22-0007 Comprehensive Residential Treatment/Sexual Rehabilitative Program

The following change(s) to the above referenced IFB have been made as designated below:

__X__ Change of specification(s)
__X__ Additional specification(s)
_____ Change of bid opening date and time
_____ Cancellation of bid
_____ Other

CHANGE OF SPECIFICATIONS

- IFB, page 12, Section 2.4.5.F, delete and replace with the following:

Requirements in IFB Section 2.4.6 (F-W) apply to both acute and sub-acute care.

- IFB, page 14, Section 2.4.6.U, delete and replace with the following:

The Contractor shall provide for discharge of youth from the program. The Contractor shall produce a letter of recommendation for the mental health treatment team to review. Discharge summaries may be provided at the date and time of discharge to the DCFS family service worker.

- IFB, page 14, Section 2.4.6.W, delete and replace with the following:

In rare circumstances, a client may need one-to-one treatment. Contractor shall submit a written request to DCFS for authorization prior to providing services along with a copy of physician orders. DCFS reserves the right to deny or approve requests for one-to-one treatment. If one-to-one treatment is provided, the Contractor shall not bill more than the hourly rate of non-licensed direct care staff for one-to-one treatment.

ADDITIONAL SPECIFICATIONS

- **ATTACHMENT J**, add Certification of Compliance to the list of attachments.

The specifications by virtue of this addendum become a permanent addition to the above referenced IFB. Failure to return this signed addendum may result in rejection of your proposal.

If you have any questions, please contact: Buyer's name, Buyer's email address and phone number.

Vendor Signature VAN HOANG, CFO

03/17/2022
Date

CONWAY BEHAVIORAL HEALTH
Company