BID RESPONSE PACKET

710-22-0039

BID SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION					
Company:	Samaritan Integrative Services				
Address:	5501 Medical Parkway Drive				
City:	Texarkana	State: TX		Zip Code:	75503
Business Designation:	☐ Individual ☐ Sole Proprietorship ☐ Public Service Corp ☐ Partnership ☒ Corporation ☐ Nonprofit				
Minority and Women-Owned Designation*:	☒ Not Applicable ☐ American Indian ☐ Service Disabled Veteran ~~☒~~ BS African American ☐ Hispanic American ☐ Women-Owned ☐ Asian American ☐ Pacific Islander American				
	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:	Shalunda Sasser	Title:	Psychiatric Mental Health - NP
Phone:	903-244-8944	Alternate Phone:	903-794-1636
Email:	Shalunda.sasser@samaritanintegrative.org		

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: Shalunda Sasser **Title:** APRN, PMHNP-BC

Printed/Typed Name: Shalunda Sasser **Date:** 5/23/2022

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 vendor's proposal to be disqualified.*

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

Vendor Name:	Shalunda Sasser	**Date:**	5/23/2022
Signature:	Shalunda Sasser	**Title:**	APRN, PMHNP-BC
Printed Name:	Shalunda Sasser		

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.**

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: SUBCONTRACTOR NAME:

☐ Yes ☑ No

TAXPAYER ID NAME: Shalunda Sasser

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

YOUR LAST NAME: Sasser FIRST NAME Shalunda M.I.: R.

ADDRESS: 5501 Medical Parkway Drive

CITY: Texarkana STATE: TX ZIP CODE: 75503 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

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 Shalunda Sass Title PMHNP Date 5/23/2022

Vendor Contact Person Shalunda Sasser Title PMHNP Phone No. 903-244-8944

Agency use only

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

ILLEGAL IMMIGRANT CERTIFICATION

Pursuant to Arkansas Code Annotated § 19-11-105, Contractor(s) **shall** certify with OSP that they do not employ or contract with illegal immigrants.

By signing below, the Contractor agrees and certifies that they do not employ illegal immigrants and will not employ illegal immigrants during the remaining aggregate term of the contract.

Contract Number	
AASIS Number	
Description	
Contractor	

Contractor Signature: _____ Date: 5/22/2022

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: May 20, 2022
SUBJECT: 710-22-0039 Psychiatric Services

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

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

OTHER

Page 10, Section 2.3.D, Minimum Qualifications – Replace with the following:

The Contractor must have a minimum of three (3) years of experience providing Psychiatric Services which must include treating individuals who are developmentally disabled with behavioral health issues. For verification purposes, the bidder **must** provide, with bid submission, three (3) references from the past seven (7) years that attest to the bidder's required years of experience providing the psychiatric services described in this solicitation. DHS reserves the right to contact the references submitted as well as any other references which may attest to the respondent's work experience. Submissions may be disqualified from respondents whose references do not respond within five (5) business days of the request for verification. References must include a current phone number, mailing address, email address, title, and printed name. References provided must not be from current DHS employees.

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.

Shaluda Sasser
Vendor Signature

5/23/2022
Date

Samaritan Integrative Services
Company

Transmission Log

Samaritan Monday, 05-23-2022 13:11 1

Date	Time	Type	Job #	Length	Speed	Fax Name/Number	Pages	Status
05-23-2022	13:10	SCAN	11196	0:26	31200	501 682 3500	1	OK -- V.34 AM31

Arkansas Secretary of State

John Thurston

1401 W. Capitol, Suite 250, Little Rock, AR 72201
501-682-3409 • www.sos.arkansas.gov

Records Request Form

(Please type or print)

Requestor's Name: Shalunda Sasser Name of Firm/Organization (If applicable): _____

Address: 5501 Medical Parkway Drive City: Texarkana State: TX Zip Code: 75503

Daytime telephone number: 903-244-8944 Email address: Mzlunda82@sbcglobal.net

Entity Information:

Name of Entity: Samaritan Integrative Services LLC Filing Number: 803754181

Name of Entity: _____ Filing Number: _____

Name of Entity: _____ Filing Number: _____

Type of Record Requested (at least ONE option below MUST be checked)

- [x] Plain Copies: (these come with a "file stamp" at top of document. Plain copies can be mailed, faxed, emailed or picked up)
- [ ] Certified Copies: (these comes with attached certificate. Certified copies can only be returned via mail or pickup)

Copy of Records Being Requested:

- [ ] Articles of Incorporation/Qualification / Certificate of Organization
- [ ] Articles / Certificate **PLUS** Amendments Showing a Name Change
- [ ] Complete Corporate File
- [ ] Franchise Tax Records (Redacted)
- [x] Certificate of Good Standing
- [x] Other Documentation of active registration

Form of Payment Enclosed or Authorized:

Note: A 4% convenience fee will be added to all credit/debit card transactions.

- [ ] **Check drawn on U.S. bank** *(Checks/Money Orders must be payable to Arkansas Secretary of State.)*
- [ ] **Money Order from a U.S. bank**
- [x] **Credit/Debit Card:** [x] Visa [ ] MasterCard [ ] American Express [ ] Discover

Name as it appears on Card: Shalunda Renee Sasser

Billing Address: 304 Hilltop Dr City: Atlanta State: TX Zip Code: 75551

Card Number: 4342 5801 7750 3240 CVV#: 283 Expiration: 03/25

Payment Authorization; I authorize the Arkansas Secretary of State to charge my credit/debit card for the amount due for the records provided by the Secretary.

Cardholder's Signature: Shalunda Sasser Date: 5/22/2022

If the name on the credit card or debit card is in the name of a corporation or other business entity, please print the signer's name: _____

Return Information:

- [ ] Return by Mail (Plain Copies, Certified Copies, Certificates)

Name: _____ Street Address or P.O. Box: _____

City: _____ State: _____ ZIP Code: _____

- [ ] Return by Fax (Plain Copies Only) Fax Number: _____
- [x] Return by Email (Plain Copies Only) Email Address: Mzlunda82@sbcglobal.net
- [ ] Customer will come to the Secretary of State's Office to pick up the Records (Plain Copies, Certified Copies, Certificates)

1401 West Capitol Avenue, Suite 250
Little Rock, AR 72201

Arkansas Secretary of State

John Thurston

1401 W. Capitol, Suite 250, Little Rock, AR 72201
501-682-3409 • www.sos.arkansas.gov

Records Request Form

(Please type or print)

Requestor's Name: Shalunda Sasser Name of Firm/Organization (If applicable): _____

Address: 5501 Medical Parkway Drive City: Texarkana State: TX Zip Code: 75503

Daytime telephone number: 903-244-8944 Email address: Mzlunda82@sbcglobal.net

Entity Information:

Name of Entity: Samaritan Integrative Services LLC Filing Number: 803754181

Name of Entity: _____ Filing Number: _____

Name of Entity: _____ Filing Number: _____

Type of Record Requested (at least ONE option below MUST be checked)

- [x] Plain Copies: (these come with a "file stamp" at top of document. Plain copies can be mailed, faxed, emailed or picked up)
- [ ] Certified Copies: (these comes with attached certificate. Certified copies can only be returned via mail or pickup)

Copy of Records Being Requested:

- [ ] Articles of Incorporation/Qualification / Certificate of Organization
- [ ] Articles / Certificate **PLUS** Amendments Showing a Name Change
- [ ] Complete Corporate File
- [ ] Franchise Tax Records (Redacted)
- [x] Certificate of Good Standing
- [x] Other Documentation of active registration

Form of Payment Enclosed or Authorized:

Note: A 4% convenience fee will be added to all credit/ debit card transactions.

- [ ] **Check drawn on U.S. bank** *(Checks/Money Orders must be payable to Arkansas Secretary of State.)*
- [ ] **Money Order from a U.S. bank**
- [x] **Credit/Debit Card:** [x] Visa [ ] MasterCard [ ] American Express [ ] Discover

Name as it appears on Card: Shalunda Renee Sasser

Billing Address: 304 Hilltop Dr City: Atlanta State: TX Zip Code: 75551

Card Number: 4342 5801 7750 3240 CVV#: 283 Expiration: 03/25

Payment Authorization; I authorize the Arkansas Secretary of State to charge my credit/debit card for the amount due for the records provided by the Secretary.

Cardholder's Signature: Shalunda Sasser Date: 5/22/2022

If the name on the credit card or debit card is in the name of a corporation or other business entity, please print the signer's name: _____

Return Information:

- [ ] Return by Mail (Plain Copies, Certified Copies, Certificates)

Name: _____ Street Address or P.O. Box: _____

City: _____ State: _____ ZIP Code: _____

- [ ] Return by Fax (Plain Copies Only) Fax Number: _____
- [x] Return by Email (Plain Copies Only) Email Address: Mzlunda82@sbcglobal.net
- [ ] Customer will come to the Secretary of State's Office to pick up the Records (Plain Copies, Certified Copies, Certificates)

1401 West Capitol Avenue, Suite 250
Little Rock, AR 72201

Arkansas State Board of Nursing

Primary Source
License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

SHALUNDA SASSER

Saturday, May 21 2022 11:53:37 AM

For a more accurate search, select Search by License Number or Search by NCSBN ID above.Partial name searches are accepted

This online verification system is a free service provided to the public for primary source verification for Registered Nurse Practitioner (RNP), Licensed Psychiatric Technician Nurse (LPTN), and Medication Assistant- Certified (MA-C) license/certification issued in the state of Arkansas. The information contained within the verification is true and complete to the best of the Board's knowledge.
For nurses (RNs and LPNs) this report is not sufficient as primary license verification when applying to another board of nursing for licensure. For primary verification to transfer/endorse to another state, use the Nurse License Verification service to request the required verification of licensure.

Temporary and Permanent (Post Exam) License(s)/Certificate(s)

Name on License	License/Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
SASSER, SHALUNDA RENEE	APRN-CNP	A003935	Active	08/07/2013	04/30/2024	N/A	NO

Advanced Practice license/recognition information

- Population Focus/Specialty:
  - Focus/Specialty: Psychiatric/mental Health
  - Certification expiration date: 06/28/2023
- Prescriptive Authority:
  - Prescriptive Authority Status: Active
  - Prescriptive Authority Number: 003733

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home state provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance

Texas Board of Nursing
Primary Source License Verification

View Report

Primary Source Board of Nursing Report Summary for

SHALUNDA SASSER

Saturday, May 21 2022 11:50:44 AM

For a more accurate search, select Search by License Number or Search by NCSBN ID above. Partial name searches are accepted.

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification service to request the required verification of licensure.

Contact the board of nursing for details about the Nurse Practice Act.

Board of Nursing - Temporary and Permanent (Post Exam) Licenses

Name on License	Board of Nursing - License Type	License Number	License Status	Original Issue Date	Current Expiration Date	Compact Status
SASSER, SHALUNDA RENEE RICHARDSON	RN	700988	Current	10/14/2003	04/30/2024	Multistate

Name on License	Board of Nursing - License Type	License Number	License Status	Original Issue Date	Current Expiration Date	Compact Status
SASSER, SHALUNDA RENEE RICHARDSON	APRN-CNP	AP124027	Current-APRN TXRN	07/12/2013	04/30/2024	N/A

Advanced Practice license/recognition information

- Population Focus/Specialty:
  - Focus/Specialty: Psychiatric/Mental health
  - Expiration Date: 04/30/2024
  - Original Issuance Date: 07/12/2013
  - Status: Active
- Prescriptive Authority:
  - Prescriptive Authority: YES
  - Prescriptive Authority Status: Active
  - Prescriptive Authority Number: 14402
  - Expiration Date: 04/30/2024
  - Original Issuance Date: 07/12/2013

License type information

- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home state provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC)

Collaborative Practice Agreement

This agreement is for the management of the collaborative practice between:

Shalunda Sasser, APRN, and Robert Strayhan, MD/DO.

The physician hereby agrees to be available to the Advanced Practice Registered Nurse (APRN), either in person or via electronic or telephonic communication, for consultation and referral. Mutually agreed upon protocols for Prescriptive Authority will be utilized by the APRN as a guide for general categories of health states. The APRN shall limit prescribing to the area of educational preparation and certification as noted below.

The above named APRN is authorized to prescribe drugs from each of the categories of controlled substances below which are initialed by the collaborating physician and APRN.

SS RS **a. Drugs listed in Schedule III-V of the Controlled Substance Act (CSA), 17-87-210 (b)(1)**

____ ____ **b. Hydrocodone combination products from Schedule II of the CSA, 17-87-210 (b)(2)(A)**

____ ____ **c. Schedule II opioids and /or stimulants, 17-87-310 (b)(2)(B)(i-ii)**

____ ____ **d. Not requesting ability to prescribe controlled substances**

Should an emergency arise, necessitating the absence of the APRN or the collaborating physician from patient care responsibilities, provision for comparable coverage shall be arranged at the first possible opportunity.

Until that time, Howard Memorial Hospital with which the collaborating providers are associated, provides emergency services 24-hours daily for the clients of Compass Behavioral Geriatric Center

There is a written provision for quality assurance (attach the Quality Assurance Plan).

This agreement of professional collaboration is by no means intended as a business contract but rather as a document that fulfills the requirements for Prescriptive Authority as set forth in the Arkansas *Nurse Practice Act*. The signatures below signify agreement to the terms of the collaborative practice.

_____, APRN

Print Name Shalunda Sasser

APRN AR License # A003935

Certification/Specialty ~~Select~~ SS Psychiatric / Mental Health

Additional Certification ~~Not Applicable~~ SS ANCC

Practice Site Compass Behavioral Geriatric Center

Practice Address (Street, City, County, Zip):

130 Medical Cir
Nashville, AR 71852

Date Signed 3/3/2022

Practice Phone # 870-845-6066

_____, MD/DO

Print Name Robert Strayhan

MD/DO AR License # E-5611

Certification/Specialty Psychiatry

☐ Practice Site Same as APRN

Practice Address (Street, City, County, Zip):

4100 Summerhill Rd
Texarkana, TX 75503

Date Signed 3/3/2022

Quality Assurance Plan

The purpose of this document is to outline guidelines for the Quality Assurance Plan for Shalunda Sasser, APRN while practicing at Compass Behavioral Geriatric Center. The APRN's specialty area is Psychiatric/Mental Health.

Quality Assurance Plan of Action:

- Once per quarter, a minimum of 5 of the APRN's charts will be randomly selected by the collaborating physician(s) for review. Some charts may be selected based on specific medical conditions and treatments
- Periodic face-to-face meetings between the advanced practice registered nurse and the physician will take place at least monthly
- Patient interviews may be included to demonstrate patient satisfaction
- Review of all practice issues regarding patient problems or complaints
- Feedback from the chart review will be documented and reviewed with the APRN by the collaborating physician(s)
- Any recommendation for improvement will be addressed and documented in a timely manner
- Any recommendations that are not satisfactorily met by the APRN will be referred for further review with the medical staff for administrative action
- The collaborative practice physician(s) will provide consultation to the APRN on an ongoing basis

This Quality Assurance Plan will be reviewed, signed, and dated on an annual basis. Documentation and evidence of compliance of the Quality Assurance Plan will be maintained.

Shalunda Sasser
(Signature of APRN)

3/3/2022
(Date signed)

(Signature of collaborating physician)

3/3/2022
(Date signed)

Arkansas State Board of Nursing

CERTIFICATE OF PRESCRIPTIVE AUTHORITY

This is to Certify That Shalunda Renee Sasser

has complied with requirements as set forth by the Arkansas State Board of Nursing and is hereby granted this Certificate of Prescriptive Authority.

In Witness Whereof *we, the undersigned, have hereunto set our hands and caused the Seal of said Board of Nursing to be affixed this Twentieth day of August, 2013.*

Executive Director

ASBN Program Coordinator

Certificate Number: 3733

Bid No. 710-22-0033

Vendor: Shalunda Sasser, APRN, PMHNP-BC

References

Robert Strayhan, MD

4501 Summerhill Rd, Apt 177

Texarkana, TX 75503

903-280-6666

sakanouetamuramauro@gmail.com

Delisa Brooks, APRN, FNP-C, PMHNP-BC

108 King Kent Ct

Scroggins, TX 75480

903-269-6466

Delisa320@msn.com

Jody Barham, APRN, PMHNP-BC

P.O. Box 228

Fouke, AR 71837

870-703-7764

txkps2116@gmail.com

Bid No. 710-22-0033

Vendor: Shalunda Sasser, APRN, PMHNP-BC

Equal Employment Opportunity Policy

In order to provide employment and development opportunities to all individuals, employment decisions at Samaritan Integrative Services will be based on merit qualifications and skills. Samaritan Integrative Services does not discriminate in employment opportunities or practices on the basis of race, color, religion, sex, national origin, age, disability, or any other characteristics protected by the law.

Samaritan Integrative Services will make reasonable accommodations for qualified individuals with known disabilities unless doing so would result in an undue hardship. This policy governs all aspects of employment, including selection, job assignment, compensation, discipline, termination, and access to benefits and training.

Any employees with questions or concerns about any type of discrimination in the workplace are encouraged to bring these issues to the attention of their immediate supervisor. Employees can raise concerns and make reports without fear of retaliation. Anyone found to be engaging in any type of unlawful discrimination will be subject to disciplinary action, up to and including termination of employment.

Corporations Section
P.O.Box 13697
Austin, Texas 78711-3697

Ruth R. Hughs
Secretary of State

Office of the Secretary of State

September 10, 2020

Attn: Legalzoom.com, Inc.

Legalzoom.com, Inc.
101 N. Brand Blvd, 10th Floor
Glendale, CA 91203 USA

RE: Samaritan Integrative Services LLC
File Number: 803754181

It has been our pleasure to file the certificate of formation and issue the enclosed certificate of filing evidencing the existence of the newly created domestic limited liability company (llc).

Unless exempted, the entity formed is subject to state tax laws, including franchise tax laws. Shortly, the Comptroller of Public Accounts will be contacting the entity at its registered office for information that will assist the Comptroller in setting up the franchise tax account for the entity. Information about franchise tax, and contact information for the Comptroller's office, is available on their web site at https://window.state.tx.us/taxinfo/franchise/index.html.

The entity formed does not file annual reports with the Secretary of State. Documents will be filed with the Secretary of State if the entity needs to amend one of the provisions in its certificate of formation. It is important for the entity to continuously maintain a registered agent and office in Texas. Failure to maintain an agent or office or file a change to the information in Texas may result in the involuntary termination of the entity.

If we can be of further service at any time, please let us know.

Sincerely,

Corporations Section
Business & Public Filings Division
(512) 463-5555

Enclosure

Corporations Section
P.O.Box 13697
Austin, Texas 78711-3697

Ruth R. Hughs
Secretary of State

Office of the Secretary of State

CERTIFICATE OF FILING
OF

Samaritan Integrative Services LLC
File Number: 803754181

The undersigned, as Secretary of State of Texas, hereby certifies that a Certificate of Formation for the above named Domestic Limited Liability Company (LLC) has been received in this office and has been found to conform to the applicable provisions of law.

ACCORDINGLY, the undersigned, as Secretary of State, and by virtue of the authority vested in the secretary by law, hereby issues this certificate evidencing filing effective on the date shown below.

The issuance of this certificate does not authorize the use of a name in this state in violation of the rights of another under the federal Trademark Act of 1946, the Texas trademark law, the Assumed Business or Professional Name Act, or the common law.

Dated: 09/09/2020

Effective: 09/09/2020

Ruth R. Hughs
Secretary of State

Shalunda Sasser

304 Hilltop Drive

Atlanta, TX 75551

(903) 244-8944

Mzlunda82@sbcglobal.net

Job Objective

To acquire a position as a Family Psychiatric Mental Health Nurse Practitioner that allows me to use my abilities to enhance and grow with the company.

Board Certification

June 29, 2013

American Nurses Credentialing Center's (ANCC) PMHNP-BC

Certification Number: 2013010078

Education

May 2013

Masters Degree of Science in Nursing (MNSc)

UAMS College of Nursing, Little Rock, AR

May 2008

Bachelors Degree of Science in Nursing (BSN)

UAMS College of Nursing, Little Rock, AR

December 2002

Associate in Applied Science Degree in Nursing (RN)

Central Texas College, Killeen, TX

May 2000

High School Diploma

Queen City High School, Queen City, TX

Nurse Practitioner Licensure (Psychiatric/Mental Health)

Texas- APN: AP124027 RN: 700988

Arkansas- A003935

National Provider Identifier: 1710312285

Work Experience

APRN

Samaritan Integrative Services, Texarkana, TX

10/2020- current

Provide holistic psychiatric mental health treatment to clients across the lifespan in a private practice setting.

APRN

Community Healthcore, Atlanta, TX

12/2019- current

Provide psychiatric mental health care to adults via telemedicine.

APRN

Compass Behavioral Health, Nashville, AR

6/2017- Current

Provide intensive outpatient treatment weekly along with a multidisciplinary team.

APRN

Serendipity Wellness Center, Texarkana, TX

2/16/2016- 10/2020 (closed)

Provide holistic psychiatric mental health treatment to clients across the lifespan in a private practice setting.

APRN

Riverview Behavioral Health Hospital, Texarkana, AR (OP School Base Program)

8/2016- 12/2017 (closed)

APRN

Community Healthcore, Atlanta, TX

4/2014- 10/2017

Provide psychiatric mental health care to adults face-to-face and telemedicine.

APRN

South Arkansas Youth Services, Texarkana, AR

11/2013- 7/2017 (closed)

Provide weekly medication management to youth (OP School Base Program).

RN

Riverview Behavioral Health Hospital, Texarkana, AR

8/2013 – 11/2013

Worked as a scribe for the attending psychiatrist. Documenting assessments and evaluations in progress notes awaiting a position as an APRN.

RN

Christus St. Michael Hospital, Texarkana, TX

4/2012 – 7/2013

Worked and performed bedside care, treatment, and clinical documentation on medical-surgical/telemetry floors prn throughout hospital. Handled medication administration, dressing changes, IVs and all other aspects of nursing care. Facilitated admissions, discharges and transfers; prepared chart notes and other documentation; and participated on interdisciplinary team.

RN

Atlanta Memorial Hospital- Senior Care Unit, Atlanta, TX

9/2010 – 3/12/2012

Served as a RN at hospital on an eight bed locked Geri-psych unit until closure of unit. Played a key role on interdisciplinary team of psychiatrists, RNs, a social worker, and activity coordinator. Actively participated in development and implementation of individual treatment plans for patients with broad range of mental health issues. Ensured that doctors' orders were effectively carried out, including testing, medical procedures, and consultations.

RN

Atlanta Memorial Home Health, Atlanta, TX

2/2008 – 9/2010

Worked as a Case Manager for six months initially, and then took on the Director position 8/2008. Directed the Home Health agency until a position came available in Psych unit at the hospital.

RN

Millennium Home Care of NE Texas, Atlanta, TX

01/2004 – 01/2008

Provided bedside care, treatment and documentation in the home. Handled dressing changes, IVs, and all other aspects of nursing care. Facilitated admissions, discharges, resumption of cares, and transfers; participated on interdisciplinary team.

RN

Christus St. Michael Hospital, Texarkana, TX

10/2003 – 01/2004

Worked and provided bedside care, treatment, and clinical documentation on medical-surgical floor. Handled medication administration, dressing changes, IVs, and all other aspects of nursing care. Facilitated admissions, discharges and transfers; prepared chart notes and other documentation; and participated on interdisciplinary team.

Skills

- Crisis intervention
- Leadership and management skills
- Computer skills
- Self motivator
- Patient advocate

Affiliation

American Psychiatric Nurses Association (APNA)- since 2012

ANCC

AMERICAN NURSES CREDENTIALING CENTER

CERTIFICATION

The Commission on Certification grants

Shalunda Renee Sasser

the credential of

PSYCHIATRIC-MENTAL HEALTH NURSE PRACTITIONER PMHNP-BC

valid from June 29, 2018 to June 28, 2023

Certification Number: 2013010078

Mayola L. Villarruel

Mayola L. Villarruel, DNP, ANP-BC, NEA-BC
Chair, Commission on Certification

Patricia Reid Ponte, RN, DNSC, NEA-BC, FAAN

Patricia Reid Ponte, RN, DNSC, NEA-BC, FAAN
President, American Nurses Credentialing Center

NCCA ABSNC Accreditation Board for Specialty Nursing Certification

Formerly the ABNS Accreditation Council

This ANCC certification is accredited by the National Commission for Certifying Agencies and the Accreditation Board for Specialty Nursing Certification.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 07/21/2021

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME: CM&F Group	
CM&F Group Inc. 110 West 40th Street 10th Floor, Suite 1000/1001 New York, NY 10018	PHONE (A/C, No, Ext): 1-800-221-4904	FAX (A/C, No):
	E-MAIL ADDRESS: info@cmfgroup.com	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : MEDICAL PROTECTIVE COMPANY- MPC	
INSURED	INSURER B :	
Shalunda R. Sasser 4100 SUMMERHILL RD TEXARKANA, TX75503-2732	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N/A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$
A	Professional Liability			F71091	08/14/2021	08/14/2022	Per Incident	1,000,000
							Aggregate	3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Occurrence Coverage
Nurse Practitioner

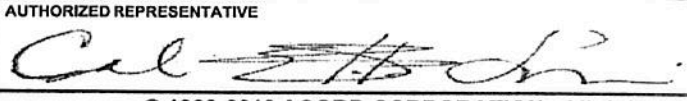
CERTIFICATE HOLDER

Shalunda R. Sasser
4100 SUMMERHILL RD
TEXARKANA,TX75503-2732

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



BUSINESS ASSOCIATE AGREEMENT

Arkansas Department of Human Services, Choose Division or Office ("**Covered Entity**")

and

("**Business Associate**") enter into this Business Associate Agreement ("**BAA**") as of ("**Effective Date**").

Covered Entity and Business Associate agree that under entered into by Covered Entity and Business Associate (the "**Agreement**"), Business Associate provides services for or on behalf of Covered Entity that may involve access to PHI (as defined below) and that, as such, the parties agree as follows:

I. DEFINITIONS

Unless otherwise specified in this BAA, all capitalized terms used in this BAA not otherwise defined have the meanings ascribed by HIPAA and ARRA, as each may be amended from time to time.

A. "**ARRA**" means the Health Information Technology for Economic and Clinical Health Act provisions of the American Recovery and Reinvestment Act of 2009, Pub. Law No.111-5 and its implementing regulations.
B. "**Breach**" means the actual or reasonably suspected acquisition, access, Use or Disclosure of PHI in a manner not permitted by the Privacy Rule that compromises the security or privacy of the PHI.
C. "**Breach Notice Rule**" means the federal breach notification regulations issued pursuant to ARRA, as amended from time to time, 45 C.F.R. Parts 160 and 164.
D. "**Compliance Date**" means, in each case, the date by which compliance is required under the referenced provision of ARRA's or HIPAA's implementing regulations, as applicable.
E. "**Discovery**" means the first day on which Business Associate, or any workforce member, agent, or Subcontractor of Business Associate, knows, or, by exercising reasonable diligence would have known, of a Breach.
F. "**Encrypt**" means to use an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key, which process conforms to NIST Special Publications 800–111, 800–52, 800–77, or 800–113, as appropriate, or that is otherwise validated against the Federal Information Processing Standards (FIPS) 140–2.
G. "**ePHI**" means PHI as defined below, which is transmitted or maintained in electronic media.
H. "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.
I. "**PHI**" means Protected Health Information, as defined in 45 C.F.R. § 160.103, limited to the Protected Health Information received from, or received, created, or accessed on behalf of, Covered Entity.
J. "**Privacy Rule**" means the federal privacy regulations issued pursuant to HIPAA, as amended from time to time, 45 C.F.R. Parts 160 and 164.
K. "**Security Incident**" means the successful unauthorized access, Use, Disclosure, modification or destruction of ePHI or interference with system operations in an information system. Unsuccessful attempts to breach security, including pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as such incidents do not result in unauthorized access, use or disclosure of PHI, shall not be deemed Security Incidents. However, more than 20 unsuccessful attempts or other patterns of successive attempts, that are not individual deemed Security Incidents in themselves shall be considered Security Incidents due to the number or pattern of such events.

L. "**Security Rule**" means the federal security regulations issued pursuant to HIPAA, as amended from time to time, 45 C.F.R. Parts 160 and 164.
M. "**Subcontractor**" means Business Associate's subcontractors and agents that create, receive, maintain or transmit PHI for the purpose of performing any of Business Associate's obligations under the Agreement.

II. RESPONSIBILITIES OF BUSINESS ASSOCIATE.

A. Business Associate shall provide relevant training on HIPAA and the requirements of this agreement to all persons accessing PHI or ePHI. The training materials and records shall be provided to the covered entity upon request.
B. Business Associate shall implement and use appropriate Technical, Physical and Administrative Safeguards to reasonably and appropriately protect the Confidentiality, Integrity and Availability of PHI and to prevent Use or Disclosure of PHI, other than as permitted by this BAA.
C. Business Associate shall, within the earlier of the Compliance Date or 90-days from the Effective Date, comply with all applicable provisions of the Security Rule. The Business Associate shall conduct a risk assessment to evaluate compliance with the Security Rule and shall, at the request of the Covered Entity, provide a written attestation acknowledging completion and communicating the results of the risk assessment.
D. Business Associate shall Encrypt all transmissions of ePHI and all portable media or storage devices on which ePHI may be stored, including laptops, back-up media, CDs, or USB drives.
E. Within 30-days after receiving a written request from Covered Entity, make available information necessary for Covered Entity to make an accounting of disclosures of PHI about an Individual, as provided in 45 C.F.R. § 164.528; and in accordance with 42 U.S.C. § 17935(c) and its implementing regulations as of the Compliance Date, make that accounting directly to the Individual if directed to do so by Covered Entity.
F. At the request of Covered Entity and in the time, manner, and form designated by Covered Entity, not to exceed 15-days, provide access to PHI in a Designated Record Set to Covered Entity or, if directed by Covered Entity, to an Individual or to a recipient designated by the Individual, in accordance with the requirements of 45 C.F.R. § 164.524. Business Associate shall not charge Covered Entity or any Individual any fee associated with the production of PHI in accordance with this section that exceeds fees described at 45 C.F.R. § 164.524.
G. Make available PHI in a Designated Record Set, no more than 30-days following receipt of a written request by Covered Entity, PHI for amendment and incorporate any amendments to the PHI as directed by Covered Entity, all in accordance with 45 C.F.R. § 164.526.
H. Business Associate shall notify Covered Entity, in writing, no more than 3-days following Business Associate's receipt directly from an Individual of any request for an accounting of disclosures or access to or amendment of PHI as contemplated in Sections II (D) (E) or (F), above.
I. Business Associate shall require each Subcontractor to agree, in writing, to the same restrictions and conditions that apply to Business Associate. Furthermore, to the extent that Business Associate provides ePHI to Subcontractor, Business Associate shall require Subcontractor to comply with all applicable provisions of the Security Rule upon the earlier of the Compliance Date or 90-days from the Effective Date. If Subcontractor is not subject to the jurisdiction or laws of the United States, or if any use or disclosure of PHI in performing the obligations under this BAA or the Agreement will be outside of the jurisdiction of the United States, Business Associate must require Subcontractor to agree by written contract with Business Associate to be subject to the jurisdiction of the Secretary, the laws, and the courts of the United States, and waive any available jurisdictional defenses that pertain to the parties' obligations under this BAA, HIPAA, or ARRA.

J. Business Associate shall not Use or Disclose PHI except as necessary to perform its obligations under the Agreement or as otherwise required by this BAA, provided that such Use or Disclosure is permitted by applicable law and complies with each applicable requirement of 45 C.F.R. § 164.504(e).
   1. In compliance with 45 C.F.R. § 164.502(b)(1), as of its Compliance Date or no more than 90-days following the Effective Date, whichever is earlier, Business Associate shall request, Use, and Disclose only the minimum amount of PHI necessary to accomplish the purpose of the request, Use, or Disclosure.
   2. Business Associate shall not use PHI to make or cause to be made any communication that would constitute Marketing.

K. Without unreasonable delay, and in any event, no more than 24-hours after Discovery, Business Associate shall notify Covered Entity of any Breach, Use or Disclosure of PHI not permitted under this BAA, or any Security Incident. Business Associate shall deliver the initial notification of such Breach, in writing, which must include a reasonably detailed description of the Breach and the steps Business Associate is taking and would propose to mitigate or terminate the Breach. Furthermore, Business Associate shall supplement the initial notification, no more than 5 calendar-days following Discovery, with information including the identification of each individual whose PHI was or is believed to have been involved; a reasonably detailed description of the types of PHI involved, and written updates every 5 calendar-days until the event has been concluded; all other information reasonably requested by Covered Entity, including all information necessary to enable Covered Entity to perform and document a risk assessment in accordance with 45 C.F.R. Part 164 subpart D; and all other information necessary for Covered Entity to provide notice to individuals, the U.S. Department of Health & Human Services ("**HHS**"), or the media, if required. Despite anything to the contrary in the preceding provisions, in Covered Entity's sole and absolute discretion and in accordance with its directions, Business Associate shall conduct, or pay the costs of conducting, an investigation of any Breach and shall provide or pay the costs of providing any notices required by the Breach Notice Rule or other applicable law.

L. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a Use or Disclosure of PHI by Business Associate that is not permitted by this BAA.

M. Business Associate shall make available to HHS its internal practices, books, and records, relating to the Use and Disclosure of PHI pursuant to the Agreement for purposes of determining Business Associate's and Covered Entity's compliance with the Privacy Rule.

N. Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI.

O. To the extent Business Associate is to carry out one or more of Covered Entity's obligations under the Privacy Rule, the Business Associate shall comply with the requirements of the Privacy Rule that apply to Covered Entity in the performance of such obligations.

P. Business Associate shall provide contact information for one primary person and one secondary person in Appendix A. Any changes in the contact information shall be forwarded to the Covered Entity.

Q. The Business Associate shall respond in writing within 10 business days to the Covered Entity's request(s) to attest to the Business Associate's compliance with the Privacy Rule, the Security Rule, and the Responsibilities of the Business Associate as specified in this BAA. The Business Associate shall make available to the Covered Entity its internal practices, books, and records, relating to the Use and Disclosure of PHI as necessary to substantiate the attestation of compliance.

III. RESPONSIBILITIES OF COVERED ENTITY

Covered Entity shall notify Business Associate, in writing, of an Individual's request to restrict the Use or Disclosure of such Individual's PHI, any limitations in Covered Entity's Privacy Notice relevant to Business Associate's performance of its obligations under this BAA or the Agreement, or any revocation by an Individual of authorization to Use or Disclose PHI.

IV. TERM, TERMINATION AND DAMAGES

A. This BAA is effective as of the Effective Date and terminates when Business Associate and its Subcontractors no longer have access to PHI, and when all of the PHI in Business Associate's possession, inclusive of PHI in the possession of Business Associate's Subcontractors, has been returned or destroyed, unless earlier terminated in accordance with Sections IV(B) through (C) of this BAA.

B. Upon Covered Entity's determination of a breach of a material term of this BAA by Business Associate, Covered Entity may terminate this BAA. As of the Compliance Date of 45 C.F.R. § 164.504(e)(1)(iii), if either party knows of a pattern of activity or practice of the other party that constitutes a material breach or violation of this BAA, the non-breaching party will provide notice thereof to the other party. Such notice must clearly specify the nature of the breach or violation. Each party must take reasonable steps to cure the breach or end the violation. If after 30-days or such longer time specified in writing by the non-breaching party, the non-breaching party reasonably determines that such steps are unsuccessful in curing the breach or ending the violation, the non-breaching party may terminate this BAA and the Agreement, if feasible. In the event that termination is not feasible, the non-breaching party shall report the problem to HHS.

C. Except as provided below, Business Associate shall return or destroy all PHI, including all PHI in possession of its Subcontractors, immediately following the termination or expiration of this BAA. However, in the event that Business Associate is legally obligated to retain such PHI, Business Associate may do so provided that:
   1. Business Associate notifies Covered Entity of such legal obligation, in writing, immediately upon Business Associate's notice of such legal obligation, which such writing must describe in detail the legal obligation;
   2. Business Associate extends all protections, limitations, and restrictions contained in this BAA to Business Associate's Use or Disclosures of any PHI retained after termination or expiration of this BAA;
   3. Business Associate limits any further Use or Disclosures solely to satisfying such legal obligation for which it has provided Covered Entity with written notice in accordance with Section IV(C)(1), above.
   4. Business Associate returns or destroys all PHI when such legal obligation has been fulfilled or has concluded.

D. In addition to any damages recoverable under this BAA, the parties acknowledge that certain breaches or violations of this BAA may result in litigation or investigations pursued by federal or state governmental authorities of the United States resulting in civil liability or criminal penalties. Each party shall cooperate in good faith in all respects with the other party in connection with any request by a federal or state governmental authority for additional information and documents or any governmental investigation, complaint, action, or other inquiry.

V. INDEMNIFICATION

Business Associate shall indemnify Covered Entity, its owners, employees and representatives in the event Business Associate's performance or failure to perform under this BAA has given rise to liabilities, costs, damages, and losses (including attorneys' fees) reasonably and properly incurred by Covered Entity in connection with any actual, threatened, or pending, civil, criminal, or administrative cause of action, claim, inquiry, investigation, lawsuit, or other proceeding (collectively a "Claim"). Upon demand by Covered Entity, Business Associate shall defend any Claim brought or threatened against Covered Entity, at Business Associate's expense, by counsel acceptable to Covered Entity. Business Associate shall not authorize or enter into any settlement without Covered Entity's written consent.

VI. GENERAL TERMS

A. This BAA amends and is made a part of the Agreement. Any changes or modification to this BAA must be in writing and signed by both parties.
B. To the extent not clear, the terms of this BAA are to be construed to allow for compliance by the parties with HIPAA or ARRA. If any provision of the BAA is in conflict with any provision of the Agreement, the conflicting provision of this BAA prevails to the extent necessary for the parties to comply with HIPAA and ARRA.
C. Nothing in this BAA confers upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities, whatsoever.
D. Sections II(G)(H)(J)(M) and Sections IV, V, VI(E)(F) survive the termination for any reason or expiration of this BAA.
E. In the event Business Associate receives a notification from or on behalf of HHS regarding a compliance review, an audit, or an investigation or inquiry of any kind pertaining to the services provided under the Agreement or Covered Entity, it will notify Covered Entity no more than 3-days following its receipt of that notice.
F. The law of the State of Arkansas without regard to its internal law on the conflict of laws, controls this BAA. The Business Associate consents and submits to the jurisdiction of the federal and/or state courts of Arkansas, and hereby waives any defense based upon venue, inconvenience of forum, or lack of personal jurisdiction in any action or suit brought in connection with or relating to this BAA or related matters. The Business Associate will bring any action or suit concerning this Agreement or related matters in federal or state court or the Arkansas Claims Commission with appropriate subject matter jurisdiction in Little Rock, Arkansas. **The Business Associate acknowledges that it has read and understands this clause and agrees willingly to these terms.**
G. The parties may execute this BAA in a number of counterparts and each counterpart signature, when taken with the other counterpart signatures, is treated as if executed upon one original of this BAA. A facsimile or pdf signature, or a scanned image of an original signature, of any party to this BAA is binding upon that party as if it were an original.

Signed: Shalonda Sasser

BUSINESS ASSOCIATE:

Signed: Shalonda Sasser

Title: APRN, PMHNP-BC

Date: 5/22/2022

COVERED ENTITY Choose Division or Office

Signed:

Title:

Date:

Appendix A: Business Associate Contact Information

Business Associate Primary Contact:		Business Associate Secondary Contact:
Name: Shalunda Sasser	Name:	
Title: APRN, PMHNP-BC	Title:	
Address: 5501 Medical Parkway Dr.	Address:	
City: Texarkana	City:	
State: TX	State:	
Phone: 903-244-8944	Phone:	
Fax: 903-793-1746	Fax:	
Email: Mzlunda82@sbcglobal.net	Email:	