**Amendment #3 to RFQ 20211210: RFQ Appendices D, E, F, G, and H in Word Format – Issued January 21, 2022**

Provided herein are Microsoft Word versions of the following Appendices included with RFQ 20211210:

* APPENDIX D: Certifications
* APPENDIX E: Innovation and Commitment
* APPENDIX F: Corporate Background and Experience
* APPENDIX G: Ownership and Financial Disclosure Information
* APPENDIX H: Organization and Staffing

Additionally, the following typographical errors were corrected in the following documents included in this Amendment:

**Appendix E**

Text in 4.2.3.6: Health Literacy Campaigns has been altered in the following manner, with removed text stricken through and replacement text added in **RED**:

Use the Health Literacy Campaign: Summary Chart on the following page for each ~~PIP~~ Campaign the Offeror is including in its response to this section. The Offeror must include four (4) Health Literacy Campaigns in its response.

**Appendix F**

Text in the header for 4.3.1.2: Corporate Experience has been altered in the following manner, with removed text stricken through and replacement text added in **RED**:

4.3.1.~~1~~2:Corporate Experience

**Appendix H**

The form included 4.3.3.5 Subcontractors entitled **Prior Experiences with Subcontractor** has been updated to remove one of the fields requesting Geographic and population coverage requirements. Duplication of this field was an error.

**Receipt of Amendment Acknowledged:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Title)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Company)

# APPENDIX D: Certifications

The forms in this Appendix must be used by the Offeror to provide the following Certifications. The Offeror must also include a statement in its Transmittal Letter stating that each have been executed. These Certifications should be included after the last page of the Offeror’s Transmittal Letter.

* Certifications and Assurances Regarding Contingent Fees and Gratuities
	+ Representation Regarding Contingent Fees
	+ Representation Regarding Gratuities
	+ Prospective Contractor’s Representation Regarding Contingent Fees
* DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals
* DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters

[REST OF PAGE INTENTIONALLY LEFT BLANK]

**Certifications and Assurances Regarding Contingency Fees and Gratuities**

**Instructions:** Mark the applicable word for each certification provided below. Failure to mark the applicable word or words and/or to sign the qualification form may result in the qualification being rejected as nonresponsive. Modifications or additions to any portion of this qualification document may be cause for rejection of the qualification.

**Certifications:**

I/We make the following certifications and assurances as a required element of the qualification to which it is attached, of the understanding that the truthfulness of the facts affirmed here and the continued compliance with these requirements are conditions precedent to the award or continuation of the related contract(s) by circling the applicable word or words in each paragraph below:

**1. Representation Regarding Contingent Fees**

The Offeror represents that it [ ] **has [ ] has not** retained a person to solicit or secure a state contract upon an agreement or understanding for a commission, percentage, brokerage, or contingent fee, except as disclosed in Contractor’s qualification.

**2. Representation Regarding Gratuities**

The Offeror represents that it [ ] **has [ ] has not** violated, is not violating, and promises that it will not violate the prohibition against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Public Procurement Review Board Rules and Regulations.

**3. Prospective Contractor’s Representation Regarding Contingent Fees**

The prospective Contractor (Offeror) represents as a part of such Contractor’s qualification that such Contractor [ ] **has [ ] has not** retained any person or agency on a percentage, commission, or other contingent arrangement to secure this contract.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed name of person attesting for Offeror Title of person attesting for Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person attesting for Offeror Date**

[END OF RESPONSE]

**DHHS Certification Regarding Drug-Free Workplace Requirements: Grantees Other than Individuals**

Instructions for Certification: By signing and/or submitting this application or grant agreement, the grantee is providing the certification set out below.

1. This certification is required by regulations implementing the Drug-Free Act of 1988, 45 C.F.R. Part 76, Subpart F. The regulations, published in the May 25, 1990, Federal Register, require certification by grantees that they will maintain a drug-free workplace. The certification set out below is a material representation of fact upon which reliance will be placed when the Department of Health and Human Services (HHS) determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, HHS, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.
2. Workplaces under grants, for grantees other than individuals, need not be identified on the certification. If known, they may be identified in the grant application. If the grantee does not identify the workplaces at the time of application, or upon award, if there is no application, the grantee must keep the identity of the workplace(s) on file in its office and make the information available for Federal inspection. Failure to identify all known workplaces constitutes a violation of the grantee's drug-free workplace requirements.
3. Workplace identifications must include the actual address of buildings (or parts of buildings) or other sites where work under the grant takes place. Categorical descriptions may be used (e.g., all vehicles of a mass transit authority or State highway department while in operation, State employees in each local unemployment office, performsers in concert halls or radio studios).
4. If the workplace identified to the Division changes during the performance of the grant, the grantee shall inform the Division of the change(s), if it previously identified the workplaces in question (see above).
5. Definitions of terms in the Nonprocurement Suspension and Debarment common rule and Drug-Free Workplace common rule apply to this certification. Grantees' attention is called, in particular, to the following definitions from these rules:
	1. "Controlled substance" means a controlled substance in Schedules I through V of the Controlled Substances Act (21 U.S.C. 812) and as further defined by regulation (21 C.F.R. § 1308.11 through § 1308.15);
	2. "Conviction" means a finding of guilt (including a plea of nolo contendere) or imposition of sentence, or both, by any judicial body charged with the responsibility to determine violations of the Federal or State criminal drug statutes;
	3. “Criminal drug statute" means a Federal or non-Federal criminal statute involving the manufacture, distribution, dispensing, use, or possession of any controlled substance;
	4. "Employee" means the employee of a grantee directly engaged in the performance of work under a grant, including (i) all direct charge employees; (ii) all indirect charge employees unless their impact or involvement is insignificant to the performance of the grant; and (iii) temporary personnel and consultants who are directly engaged in the performance of work under the grant and who are on the grantee's payroll. This definition does not include workers not on the payroll of the grantee (e.g., volunteers, even if used to meet a matching requirement; consultants or independent contractors not on the grantee's payroll; or employees of subrecipients or subcontractors in covered workplaces).

**The grantee certifies that it will or will continue to provide a drug-free workplace by:**

1. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
2. Establishing an ongoing drug-free awareness program to inform employees about:
	1. The dangers of drug abuse in the workplace;
	2. the grantee's policy of maintaining a drug-free workplace;
	3. any available drug counseling, rehabilitation, and employee assistance programs; and
	4. the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
3. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);
4. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will:
	1. Abide by the terms of the statement; and
	2. notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
5. Notifying the Division in writing, within ten calendar days after receiving notice under paragraph D(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
6. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph D(2), with respect to any employee who is so convicted:
	1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
	2. requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

The grantee may insert in the space provided below the site(s) for the performance of work done in connection with the specific grant (use attachments if needed. If attachments are needed, use the table provided below):

|  |
| --- |
| **Place of Performance** |
| Name of Location: |
| Line 1 (Street Name and Number): |
| Address Line 2 (Suite, Room, etc.): |
| City: | State: | Zip Code: | County: |
| Mailing Address (P.O. Box): | City: | State: | Zip Code: | County: |

[ ] Check if there are workplaces on file that are not identified here.

---->NOTE: Sections 76.630(c) and (d)(2) and 76.635(a)(1) and (b) provide that a Federal agency may designate a central receipt point for STATE-WIDE AND STATE AGENCY-WIDE certifications, and for notification of criminal drug convictions. For HHS, the central receipt point is Division of Grants Management and Oversight, Office of Management and Acquisition, HHS, Room 517-D, 200 Independence Ave, S.W., Washington, D.C. 20201

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed name of person attesting for Offeror Title of person attesting for Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person attesting for Offeror Date**

[END OF RESPONSE]

**DHHS Certification Regarding Debarment, Suspension, and Other Responsibility Matters**

Primary Covered Transactions

45 CFR Part 76,

* + 1. The prospective primary participant certifies to the best of its knowledge and belief that it and its principals:
	1. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;
	2. Have not within a three-year period preceding this qualification been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
	3. Are not presently indicted for or otherwise criminally or civilly charged by a government entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and
	4. Have not within a three-year period preceding this qualification had one or more public transactions (Federal, State or local) terminated for cause or default.
		1. Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this qualification.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed name of person attesting for Offeror Title of person attesting for Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person attesting for Offeror Date**

[END OF RESPONSE]

# APPENDIX E: Innovation and Commitment

The forms in this Appendix must be used by the Offeror to respond (either in whole or in part, depending on the instructions in the RFQ) to the following:

* 4.2.3.3: Social Determinants of Health (SDOH) (Unmarked): 20 points available
* 4.2.3.4: Value Added Benefits (Value-Adds) (Unmarked): 10 points available
* 4.2.3.5: Performance Improvement Projects (Unmarked): 10 points available
* 4.2.3.6: Health Literacy Campaigns (Unmarked): 10 points available
* 4.3.2.9: Potential Partnerships (Unmarked): 10 points available

The Offeror must respond to all other portions of the Innovation and Commitment section of the RFQ in the manner and format stated therein. Answers should be presented in the Offeror’s qualification in the order and format indicated within the RFQ.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

**4.2.3.3: Social Determinants of Health (SDOH) (Unmarked): 20 points available**

If additional and/or dedicated staff will be required to execute the Offeror’s SDOH proposal, use the chart on the following page to provide that information.

If no additional/dedicated staff will be required to execute the Offeror’s SDOH proposal, indicate that by marking the below and submitting this page at the end of the Offeror’s SDOH proposal. **This page will not count against the Offeror’s SDOH proposal page limit.**

[ ] The Offeror does not expect to require additional and/or dedicated staff to execute its SDOH proposal.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

|  |
| --- |
| **Social Determinants of Health: Staffing** |
| **Title of Position:** |
| **SDOH Component to which Position will be Linked:** |
| **Description of Position:**  |
| **Number of Staff Expected to Fill this Position/Staffing Need:** |
| **Employee(s) filling this position would be:****[ ] Hourly [ ] Salaried** | **Employee(s) filling this position would be:****[ ] Full-Time [ ] Part-Time** |
| **Expected Wage of Position (Hourly rate or salary):** | **Expected Location of Employee:** **[ ] Mississippi [ ] Out-of-State** |
|  |
| **Title of Position:** |
| **SDOH Component to which Position will be Linked:** |
| **Description of Position:**  |
| **Number of Staff Expected to Fill this Position/Staffing Need:** |
| **Employee(s) filling this position would be:****[ ] Hourly [ ] Salaried** | **Employee(s) filling this position would be:****[ ] Full-Time [ ] Part-Time** |
| **Expected Wage of Position (Hourly rate or salary):** | **Expected Location of Employee:** **[ ] Mississippi [ ] Out-of-State** |
|  |
| **Title of Position:** |
| **SDOH Component to which Position will be Linked:** |
| **Description of Position:**  |
| **Number of Staff Expected to Fill this Position/Staffing Need:** |
| **Employee(s) filling this position would be:****[ ] Hourly [ ] Salaried** | **Employee(s) filling this position would be:****[ ] Full-Time [ ] Part-Time** |
| **Expected Wage of Position (Hourly rate or salary):** | **Expected Location of Employee:** **[ ] Mississippi [ ] Out-of-State** |
|  |

**4.2.3.4: Value-Added Benefits (Value-Adds) (Unmarked): 10 points available**

The Division has provided on the following page a curated set of Value-Added Benefits in which it is interested for the Offeror to review. The Offeror may choose to use any of these Value-Adds as part of its proposal or choose to use none.

Use the Proposed Value-Added Benefit: Summary Chart for each Value-Add the Offeror is including in its response to this section.

If additional and/or dedicated staff will be required to execute a Value-Add, use the Value-Added Benefit: Staffing Chart to provide that information.

If no additional/dedicated staff will be required to execute any of the Offeror’s Value-Adds, indicate that by marking the below and submitting this page at the end of the Offeror’s Value-Adds proposal.

[ ] The Offeror does not expect to require additional and/or dedicated staff to execute any of its proposed Value-Adds.

If the Offeror has chosen not to offer any Value-Adds in its qualification, indicate that below, and submit this page as the Offeror’s response to this request.

[ ] The Offeror is not including Value-Adds as part of its qualification response.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

**Division-Curated Value-Adds for CCO Contract**

The Division has compiled a list of desired Value-Adds for this procurement. If an Offeror chooses to include value-added services in its qualification, the Offeror may choose from this list, propose their own original value-added services, or include a combination of both. To the extent that some or all of the desired value-added services may be covered through the offeror’s Care Management strategy, that should be made evident in the Offeror’s Care Management answers in its qualification.

**Perinatal**

1. Full sponsorship, including any materials, fees, transportation, and childcare for Members, and support for providers, of the Centering Pregnancy Model and/or prenatal classes for pregnant members.
2. CPR and Parenting classes for parents/caregivers
3. Dental preventative care during pregnancy and postpartum
4. Wound care management or home health nursing in postpartum for cesarean sections and slow-healing vaginal lacerations

**Expanded Services**

1. Hearing aids for members over 21
2. Vision benefits for members over 21
3. In-home respite services
4. Home modifications and/or environmental adaptations
5. Over-the-counter (OTC) monthly allowance for non-prescription/commonly used OTC and hygiene items
6. Enhanced dental services

**Social Determinants of Health**

1. Nutrition Assistance, including but not limited to additional nutrition resources for Members (even those who receive SNAP and/or WIC benefits) and education and training for Members regarding nutritious foods and food preparation
2. Utility payment assistance
3. Pest Control/Bed Bug home treatment
4. Education and employment supports, including but not limited to paying for GED classes, supporting pregnant minors in pursuit of high school diploma, paying for skills training, and supplying Members with a computer and internet in the home

**Children**

1. A monthly supply of diapers and baby wipes for children until they are potty trained
2. Car seats and booster seats for children, including ensuring that parents/caregivers receive proper installation training
3. Childcare of a Member’s sibling(s) during a Well Child or EPSDT visit

[REST OF PAGE INTENTIONALLY LEFT BLANK]

|  |
| --- |
| **Proposed Value-Added Benefit: Summary Chart** |
| **Benefit Name:** |
| **Target Beneficiary Population(s):** |
| **Benefit description, including any limitations and prior authorization requirements:** |
| **Projected utilization in year one (total units):** | **Price per unit:**  |
| **Gross value:** | **Offsetting costs (provide amount and basis for estimate):** |
| **Net Value (gross value minus offsetting costs):**  | **Will a staffing investment be made for this Value-Add? [ ] Yes [ ]****If yes, use the Proposed Value-Added Benefit: Staffing Chart to provide details.** |
|  |

|  |
| --- |
| **Proposed Value-Added Benefit: Staffing** |
| **Title of Position:** |
| **Value-Add to which Position will be Linked:** |
| **Description of Position:**  |
| **Number of Staff Expected to Fill this Position/Staffing Need:** |
| **Employee(s) filling this position would be:****[ ] Hourly [ ] Salaried** | **Employee(s) filling this position would be:****[ ] Full-Time [ ] Part-Time** |
| **Expected Wage of Position (Hourly rate or salary):** | **Expected Location of Employee:** **[ ] Mississippi [ ] Out-of-State** |
|  |

**4.2.3.5: Performance Improvement Projects (Unmarked): 10 points available**

Use the Performance Improvement Project (PIP): Summary Chart on the following page for each PIP the Offeror is including in its response to this section. The Offeror must include four (4) PIP proposals in its response.

If additional and/or dedicated staff will be required to execute a PIP, use the Performance Improvement Project (PIP): Staffing Chart to provide that information.

If no additional/dedicated staff will be required to execute any of the Offeror’s PIPs, indicate that by marking the below and submitting this page at the end of the Offeror’s PIP proposal.

[ ] The Offeror does not expect to require additional and/or dedicated staff to execute any of its proposed PIPs.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

|  |
| --- |
| **Performance Improvement Project (PIP): Summary Chart** |
| **PIP Title:** |
| **Target Beneficiary Population(s):** |
| **Overview of PIP Strategy and Goals:** |
| **Reason for choosing this PIP:**  |
| **Tools for measuring impact:** |
| **Will a staffing investment be made for this PIP? [ ] Yes [ ] No****If yes, use the Performance Improvement Project (PIP): Staffing Chart to provide details.** |
|  |

|  |
| --- |
| **Performance Improvement Project: Staffing** |
| **Title of Position:** |
| **PIP to which Position will be Linked:** |
| **Description of Position:**  |
| **Number of Staff Expected to Fill this Position/Staffing Need:** |
| **Employee(s) filling this position would be:****[ ] Hourly [ ] Salaried** | **Employee(s) filling this position would be:****[ ] Full-Time [ ] Part-Time** |
| **Expected Wage of Position (Hourly rate or salary):** | **Expected Location of Employee:** **[ ] Mississippi [ ] Out-of-State** |
|  |

**4.2.3.6: Health Literacy Campaigns (Unmarked): 10 points available**

Use the Health Literacy Campaign: Summary Chart on the following page for each Campaign the Offeror is including in its response to this section. The Offeror must include four (4) Health Literacy Campaigns in its response.

If additional and/or dedicated staff will be required to execute a Health Literacy Campaign, use the Health Literacy Campaign: Staffing Chart to provide that information.

If no additional/dedicated staff will be required to execute any of the Offeror’s proposed Health Literacy Campaigns, indicate that by marking the below and submitting this page at the end of the Offeror’s Health Literacy Campaign proposal.

[ ] The Offeror does not expect to require additional and/or dedicated staff to execute any of its proposed Health Literacy Campaigns.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

|  |
| --- |
| **Health Literacy Campaign: Summary Chart** |
| **Campaign Title:** |
| **Target Beneficiary Population(s):** |
| **Overview of Campaign Strategy and Goals:** |
| **Reason for choosing this Campaign:**  |
| **Information Delivery Channel(s) (mailings, social media, traditional media, email, etc.):** |
| **Tools for measuring engagement:** |
| **Tools for measuring impact:** |
| **Will a staffing investment be made for this Campaign? [ ] Yes [ ] No****If yes, use the Health Literacy Campaign: Staffing Chart to provide details.** |
|  |

|  |
| --- |
| **Health Literacy Campaign: Staffing** |
| **Title of Position:** |
| **Campaign to which Position will be Linked:** |
| **Description of Position:**  |
| **Number of Staff Expected to Fill this Position/Staffing Need:** |
| **Employee(s) filling this position would be:****[ ] Hourly [ ] Salaried** | **Employee(s) filling this position would be:****[ ] Full-Time [ ] Part-Time** |
| **Expected Wage of Position (Hourly rate or salary):** | **Expected Location of Employee:** **[ ] Mississippi [ ] Out-of-State** |
|  |

**4.2.3.9: Potential Partnerships (Unmarked): 10 points available**

Use the Potential Partnerships: Summary Chart on the following page for each Potential Partnership the Offeror is including in its response to this section. The Offeror must include four (4) potential partnerships its response.

Additionally, use the Care Management Potential Partnership: Summary Chart for each Care Management Potential Partnership the Offeror is including in its response to this section. The Offeror must include four (4) potential partnerships its response.

The Offeror may not duplicate potential partners in answering either part of the section.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

|  |
| --- |
| **Potential Partnership: Summary Chart** |
| **Name of Organization:** | **Type of Organization (community-based organization or government):** |
| **Goal of partnership:** |
| **Expected financial commitment to project/partnership:** |
| **Scale of project (local, statewide):** | **Population(s) targeted by the partnership:** |
|  |

|  |
| --- |
| **Care Management Potential Partnerships: Summary Chart** |
| **Name of Organization:** | **Type of Organization (community-based organization or government):** |
| **Type of Referral(s) to be sent to this partner:** |
| **Population target(s) for referral to this partner:** |
|  |

# APPENDIX F: Corporate Background and Experience

The forms in this Appendix must be used by the Offeror to respond (either in whole or in part, depending on the instructions in the RFQ) to the following:

* 4.3.1.1 Corporate Background
* 4.3.1.2 Corporate Experience

[REST OF PAGE INTENTIONALLY LEFT BLANK]

**4.3.1.1: Corporate Background**

The Offeror must use the form provided on the next page to detail its corporate background, as required by 4.3.1.2.2, Corporate Background.

Responses to 4.3.1.1.2, Corporate Resources must be provided as described in the RFQ.

[REST OF PAGE INTENTNIONALLY LEFT BLANK]

|  |
| --- |
| **Biographical Information** |
| **General Background Information** |
| **Date Business was Established:** |
| **Legal Business Name as Reported to the Internal Revenue Service:** |
| **Doing Business As Name (if applicable):** | **Tax Identification Number (required):** |
| **Ownership Type (public company, partnership, subsidiary, etc.):** |
| **Number of Personnel Currently Engaged in Operations:** |  **Total Number of Employees:** |
|  **Professional accreditations pertinent to the services provided by this RFQ:** |
| **Location of the Principal Place of Business** |
| **Address Line 1 (Street Name and Number):** |
| **Address Line 2 (Suite, Room, etc.):** |
| **City:** | **State:** | **Zip Code:** | **County:** |
| **Mailing Address (P.O. Box):** | **City:** | **State:** | **Zip Code:** | **County:** |
| **Location of place of performance of the proposed Contract** |
| **Address Line 1:** |
| **Address Line 2:** |
| **City:** | **State:** | **Zip Code:** | **County:** |
| **Contractual Termination** |
| **Has the Offeror been a party to any contractual termination within the past five (5) years? [ ] Yes [ ] No****If yes, attach a narrative explanation for each termination including date, market, population covered, circumstances of termination, and contact information for the state entity that was party to the contract.** |

[REST OF PAGE INTENTIONALLY LEFT BLANK]

**4.3.1.2: Corporate Experience**

Use the following form to provide information for any states that the Offeror is currently or has been under contract with to provide managed care services since January 1, 2018, for any market of beneficiaries totaling or exceeding 400,000.

If the Offeror has no current or recent clients, the Offeror must provide an explanation. Offerors must submit appropriate documentation to support information provided. Acceptance of the explanation provided is at the discretion of the Division.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

|  |
| --- |
| **Corporate Experience: Current and/or Recent Client** |
| **Client’s Name:** |
| **Client Location** |
| **Address Line 1:**  |
| **Address Line 2:**  |
| **City:**  | **State:** | **Zip Code:** | **County:** |
| **Mailing Address (P.O. Box):** | **City:** | **State:** | **Zip Code:**  | **County:** |
| **Direct Contact for Client** |
| **Name:** |
| **Title:** |
| **Phone Number:** | **Email Address:** |
| **Work Details** |
| **Number of covered lives:** |
| **Time period of contract:** |
| **Total number of staff hours expended during time period of contract:** |
| **Personnel requirements:** |
| **Geographic and population coverage requirements:** |
| **Geographic and population coverage requirements:** |
| **Publicly funded contract cost:** |
| **Description of work performed under this contract** |
|  |

# APPENDIX G: Ownership and Financial Disclosure Information

The forms in this Appendix must be used by the Offeror to respond to the listed RFQ sections:

* 4.3.2.1 Information to Be Disclosed
* 4.3.2.2 When and to Whom Information Will Be Disclosed
* 4.3.2.3 Information Related to Business Transactions
* 4.3.2.4 Change of Ownership
* 4.3.2.5 Disclosure of Identity of Any Person Convicted of a Criminal Offense

For 4.3.2.6 Audited Financial Statements and Pro Forma Financial Template:

* The Offeror must respond in the manner and format stated within that section of the RFQ.
* The pro forma financial template may be found at the Division’s dedicated Coordinated Care Procurement website: <https://medicaid.ms.gov/coordinated-care-procurement/>. The Offeror must complete the designated fields of the Excel workbook and submit as attachment to the Offeror’s Qualification.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

**Response to 4.3.2.1 Information to Be Disclosed (Marked) – Pass/Fail**

In accordance with 42 C.F.R. § 455.104(b), the Offeror shall disclose the following:

1. The name and address of any individual or corporation with an ownership or control interest in the Offeror. The address for corporate entities shall include as applicable primary business, every business location, and P.O. Box address;
2. Date of birth and Social Security Number (in the case of an individual);
3. Other tax identification number (in the case of a corporation) with an ownership or control interest in the Offeror or in any subcontractor in which the Offeror has a five percent (5%) or more interest;
4. Whether the individual or corporation with an ownership or control interest in the Offeror is related to another person with ownership or control interest in the Offeror as a spouse, parent, child, or sibling; or whether the individual or corporation with an ownership or control interest in any subcontractor in which the Offeror has a five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling;
5. The name of any other managed care entity in which an owner of the Offeror has an ownership or control interest; and,
6. The name, address, date of birth, and Social Security Number of any managing employee of the Offeror.

Full disclosure through use of the following forms meets the requirements of completion of this section.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

**Section 1: Ownership Interest and/or Managing Control Identification Information**

|  |
| --- |
| **Section 1(a): Legal Entities with Ownership Interest and/or Managing Control Identification Information** |
| This response applies to an entity with:[ ] Managing Control [ ] 5% or More Ownership Interest (percentage owned: \_\_\_\_\_\_% ) |
| Effective Date of Ownership: |
| Legal Business Name as Reported to the Internal Revenue Service: |
| Doing Business As Name (if applicable): | Tax Identification Number (required): |
| **Primary Business Address** |
| Line 1 (Street Name and Number): |
| Address Line 2 (Suite, Room, etc.): |
| City: | State: | Zip Code: | County: |
| Mailing Address (P.O. Box): | City: | State: | Zip Code: | County: |
| **Business Location** |
| Address Line 1: |
| Address Line 2: |
| City: | State: | Zip Code: | County: |
| **Business Location** |
| Address Line 1: |
| Address Line 2: |
| City: | State: | Zip Code: | County: |
| **Business Location** |
| Address Line 1: |
| Address Line 2: |
| City: | State: | Zip Code: | County: |
| **Business Location** |
| Address Line 1: |
| Address Line 2: |
| City: | State: | Zip Code: | County: |

|  |
| --- |
| **Section 1(b): Individuals with Ownership Interest and/or Agents/Managing Control** |
| **The following individuals must be reported on this form:*** **All individual owners with 5% or more direct/indirect ownership**
* **All officers and directors of the disclosing Offeror**
* **All managing employees of the disclosing Offeror**
* **All authorized and delegated officials**

If there is more than one individual with ownership/control interest that should be reported, copy and complete this page for each individual. |
| Last Name | First Name | MI | Suffix |
| Title  | Social Security Number (required) | Date of Birth (MM/DD/YYYY) | Gender (M/F) |
| Home Address Line 1 |
| Address Line 2 |
| City | State | Zip Code | County |
| **If the above noted individual is an owner, please select one of the following options and give the effective date:** |
| [ ] Direct/Indirect Owner \_\_\_\_\_ | [ ] Partner  |
| Effective Date (MM/DD/YYYY): |
| Ownership Percentage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_% |
| **If the above noted individual is a managing employee, please select all that apply and give the effective date:** |
| Title | Effective Date (MM/DD/YYYY) |  | Effective Date (MM/DD/YYYY) |
| [ ] Director/Officer |  | [ | ] Managing Employee (W‐2) |  |
| [ ] Contracted Managing Employee |  | [ | ] Agent |  |
| **If the above noted individual is an authorized or delegated official, please select one of the following options and give the effective date:** |
| [ ] Authorized Official | [ ] Delegated Official |
| Effective Date (MM/DD/YYYY): |

[REST OF PAGE INTENTIONALLY LEFT BLANK]

|  |
| --- |
| **Section 1(c): Familial Relationships** |
| **Are any individuals listed in Section 1 related to each other as a spouse, parent, child, or sibling?** **[ ] Yes [ ] No**If yes, provide additional information below. Duplicate this page as necessary to provide a complete disclosure. |
| **Names of related individuals:**  |  |  |
| **Relationship (e.g., sibling):** |
|  |
| **Names of related individuals:**  |  |  |
| **Relationship (e.g., sibling):** |
|  |
| **Names of related individuals:**  |  |  |
| **Relationship (e.g., sibling):** |
|  |
| **Names of related individuals:**  |  |  |
| **Relationship (e.g., sibling):** |
|  |
| **Names of related individuals:**  |  |  |
| **Relationship (e.g., sibling):** |
|  |
| **Names of related individuals:**  |  |  |
| **Relationship (e.g., sibling):** |
|  |
| **Names of related individuals:**  |  |  |
| **Relationship (e.g., sibling):** |
|  |

**Section 2: Disclosure of Subcontractor Information**

|  |
| --- |
| **Disclosure of Subcontractor Information** |
| Include information about subcontractors of the Offeror in which the Offeror or owner of the Offeror has a more than 5% ownership interest and/or a management control interest. Use a new form for each subcontractor and/or ownership interest. Use a copy of this page for each subcontractor subject to disclosure. |
| This response applies to: [ ] The Offeror [ ] An Owner of the Offeror |
| If this applies to an owner of the offeror, name that owner (as already disclosed in Section 1, above):  |
| The person or entity named as an: [ ] Ownership Interest [ ] Management Control Interest |
| If there is an ownership interest, what is the ownership percentage? \_\_\_\_\_\_\_\_\_% |
| If there is a management control interest, describe that interest: |
| **Effective Date of Ownership and/or Management Control:** |
| Legal Business Name of Subcontractor as Reported to the Internal Revenue Service: |
| Doing Business As Name (if applicable): | Tax Identification Number (required): |
| **Primary Business Address** |
| Line 1 (Street Name and Number): |
| Address Line 2 (Suite, Room, etc.): |
| City: | State: | Zip Code: | County: |
| Mailing Address (P.O. Box): | City: | State: | Zip Code: | County: |
| **Additional Business Location(s): Duplicate this page to provide all locations if necessary.** |
| Address Line 1: |
| Address Line 2: |
| City: | State: | Zip Code: | County: |
| **Business Location** |
| Address Line 1: |
| Address Line 2: |
| City: | State: | Zip Code: | County: |
| **Business Location** |
| Address Line 1: |
| Address Line 2: |
| City: | State: | Zip Code: | County: |

|  |
| --- |
| **Disclosure of Subcontractor Information (cont.)** |
| **Are any individuals disclosed in Section 1 or 2 related to the subcontractor or an owner of the subcontractor as a spouse, parent, child, or sibling? [ ] Yes [ ] No****If yes, provide the following information for each.** |
| **Name of Subcontractor/ Subcontractor’s Owner** | **Name of Offeror’s Owner** | **Relationship** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Section 3:** **Other Disclosing Entities**

|  |
| --- |
| **Ownership Interests in the Division’s Fiscal Agent, Another Managed Care Entity, or other Disclosing Entity under 42 C.F.R § 104(b)** |
| Do any of the entities or individuals named in Sections 1.a or 1.b have an ownership and/or management control interest in the Division’s Fiscal Agent? [ ] Yes [ ] NoDo any of the entities or individuals named in Sections 1.a or 1.b have an ownership and/or management control interest in Another Managed Care Entity? [ ] Yes [ ] NoDo any of the entities or individuals named in Section 1.a or 1.b have an ownership and/or management control interest in any other Disclosing Entity under 42 C.F.R § 104(b)? [ ] Yes [ ] NoIf yes to any question above, provide additional information below: |
| **Name of entity/individual named in Section 1.a or 1.b** | **Name of Entity in which the entity/individual has an interest** | **Describe the entity/individual’s interest (Ownership or Management)** | **If the entity/individual is an owner, give the ownership percentage.** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Response to** **4.3.2.2 When and to Whom Information Will Be Disclosed (Marked) – Pass/Fail**

**The Offeror attests to and affirms the following:**

In accordance with 42 C.F.R. § 455.104(c), disclosures from the Offeror/winning Contractor are due at any of the following times:

1. Upon the Contractor submitting a qualification in accordance with the State’s procurement process;
2. Annually, including upon the execution, renewal, and extension of the contract with the State; and,
3. Within thirty-five (35) days after any change in ownership of the Contractor.

In accordance with 42 C.F.R. § 455.104(d), all disclosures shall be provided to the Division, the State’s designated Medicaid agency.

The Offeror attests that the disclosures made as part of this application are true and correct, and the Offeror will make required disclosures as necessary for this RFQ. If the Offeror is chosen as a Contractor, the Offeror will comply with all disclosure requirements.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed name of person attesting for Offeror Title of person attesting for Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person attesting for Offeror Date**

[END OF RESPONSE]

**Response to 4.3.2.3 Information Related to Business Transactions (Marked) – Pass/Fail**

In accordance with 42 C.F.R. § 455.105, the Offeror shall fully disclose all information related to business transactions. The Contractor shall submit full and complete information about:

1. The ownership of any subcontractor with whom the Offeror has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request and,

2. Any significant business transactions between the Offeror and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5)-year period ending on the date of the request.

The date of the request is the issue date of the RFQ.

If the Offeror has information responsive to this request, use the forms in the following pages of this Attachment to respond to this request.

If the Offeror does not have information responsive to one or both of these requests, attest to that by signing below and submitting this page as the response to this request. If the Offeror has information responsive to one of these requests and not the other, use the following attestation as applicable as well as the applicable form to respond.

The Offeror does not have:

[ ] The ownership of any subcontractor with whom the Offeror has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request.

[ ] Any significant business transactions between the Offeror and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5)-year period ending on the date of the request.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed name of person attesting for Offeror Title of person attesting for Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person attesting for Offeror Date**

|  |
| --- |
| **Business Transactions with Subcontractors** |
| Disclose The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than twenty-five thousand dollars and zero cents ($25,000.00) during the twelve (12)-month period ending on the date of the request. Use additional pages as necessary. |
| **Name of Subcontractor:**  | **TIN/SSN (as applicable):**  |
| **Address of Subcontractor:**  |
| **Date of Transaction:**  | **Amount of Transaction:**  |
|  |
| **Name of Subcontractor:**  | **TIN/SSN (as applicable):**  |
| **Address of Subcontractor:**  |
| **Date of Transaction:**  | **Amount of Transaction:**  |
|  |
| **Name of Subcontractor:**  | **TIN/SSN (as applicable):**  |
| **Address of Subcontractor:**  |
| **Date of Transaction:**  | **Amount of Transaction:**  |
|  |
| **Name of Subcontractor:**  | **TIN/SSN (as applicable):**  |
| **Address of Subcontractor:**  |
| **Date of Transaction:**  | **Amount of Transaction:**  |
|  |
| **Name of Subcontractor:**  | **TIN/SSN (as applicable):**  |
| **Address of Subcontractor:**  |
| **Date of Transaction:**  | **Amount of Transaction:**  |
|  |

|  |
| --- |
| **Significant Business Transactions** |
| Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.  |
| **Name of Entity with Whom the Transaction Took Place:**  |
| **TIN/SSN (as applicable):** | **The entity is a:** **[ ] Subcontractor****[ ] Wholly-Owned Subsidiary**  |
| **Address of Subcontractor:**  |
| **Date of Transaction:**  | **Amount of Transaction:**  |
|  |
| **Name of Entity with Whom the Transaction Took Place:**  |
| **TIN/SSN (as applicable):** | **The entity is a:** **[ ] Subcontractor****[ ] Wholly-Owned Subsidiary**  |
| **Address of Subcontractor:**  |
| **Date of Transaction:**  | **Amount of Transaction:**  |
|  |
| **Name of Entity with Whom the Transaction Took Place:**  |
| **TIN/SSN (as applicable):** | **The entity is a:** **[ ] Subcontractor****[ ] Wholly-Owned Subsidiary**  |
| **Address of Subcontractor:**  |
| **Date of Transaction:**  | **Amount of Transaction:**  |
|  |
| **Name of Entity with Whom the Transaction Took Place:**  |
| **TIN/SSN (as applicable):** | **The entity is a:** **[ ] Subcontractor****[ ] Wholly-Owned Subsidiary**  |
| **Address of Subcontractor:**  |
| **Date of Transaction:**  | **Amount of Transaction:**  |
|  |

**Response to 4.3.2.4 Change of Ownership (Marked) – Pass/Fail**

If the Offeror has a disclosure to make that is responsive to this section, the Offeror must include an explanation of the circumstances surrounding the Change of Ownership. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose any Change(s) of Ownership during the life of the Contract.

If the Offeror does not have a disclosure to make that is responsive to this request, the offeror must sign below, attesting to the following:

* The Offeror does not have a disclosure that is responsive to this request.
* Should the Offeror be chosen as a winning Contractor, the Offeror will comply with the requirement to disclose any and all changes of ownership in the time and manner required by the C.F.R. and the Division.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed name of person attesting for Offeror Title of person attesting for Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person attesting for Offeror Date**

[END OF RESPONSE]

**Response to 4.3.2.5 Disclosure of Identity of Any Person Convicted of a Criminal Offense (Marked) – Pass/Fail**

If the Offeror has information responsive to this request, provide that information using the form on the following page. The Offeror must also include in its response an attestation that, should the Offeror be a winning Contractor, it will comply with the duty to disclose make disclosures regarding this issue during the life of the Contract.

If the Offeror does not have a disclosure to make that is responsive to this request, the offeror must sign below, attesting to the following:

* The Offeror does not have a disclosure that is responsive to this request.
* Should the Offeror be chosen as a winning Contractor, the Offeror will comply with the requirement to make disclosures regarding this issue in the time and manner required by the C.F.R. and the Division.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed name of person attesting for Offeror Title of person attesting for Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person attesting for Offeror Date**

|  |
| --- |
| **Criminal Convictions and Other Sanctions** |
| Provide the requested information in this section for any person who:1. Has an ownership or control interest in the Offeror OR is an agent or managing employee of the Offeror

AND1. Has been convicted of a criminal offense related to any program under Medicare, Medicaid, or Titles XIX or XXI services since the inception of those programs,

OR1. Has been convicted of a crime referenced in Miss. Code Ann. § 43‐13‐121(7)(c) – (h),
2. Has been convicted of a felony under state or federal law that is not otherwise referenced in Miss. Code Ann. § 43‐13‐121(7)(c‐h),
3. Has been subject to a previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program,
4. Has been sanctioned for violation of federal or state laws or rules relative to the Medicaid program, any other state’s Medicaid program, Medicare or any other public health care or health insurance program,
5. Has had his/her/its license or certification revoked, or
6. Has failed to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.
 |
| **Identify the person and each conviction/sanction, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any. Provide a copy of any documentation. Include additional copies of this page as necessary.** |
| Name | Criminal/Sanction Information | Date |
| Agency/Court/Administrative Body | Resolution |
| Name | Criminal/Sanction Information | Date |
| Agency/Court/Administrative Body | Resolution |
| Name | Criminal/Sanction Information | Date |
| Agency/Court/Administrative Body | Resolution |
| Name | Criminal/Sanction Information | Date |
| Agency/Court/Administrative Body | Resolution |
| Name | Criminal/Sanction Information | Date |
| Agency/Court/Administrative Body | Resolution |

# APPENDIX H: Organization and Staffing

The forms in this Appendix must be used by the Offeror to respond (either in whole or in part, depending on the instructions in the RFQ) to the following:

* 4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked) – 20 points
* 4.3.3.3 Administrative Requirements (Marked) – 10 points
* 4.3.3.5 Subcontractors – 20 points
* 4.3.3.6 Economic Impact – 20 points

The Offeror must respond to all other portions of the Organization and Staffing portion of the RFQ in the manner and format stated therein. Answers should be presented in the Offeror’s qualification in the order and format indicated within the RFQ.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

**4.3.3.2 Job Descriptions and Responsibilities of Key Positions (Marked) – 20 points**

Use the following form to provide job descriptions and responsibilities for each position included in Section 1.13, Administration Management, Facilities, and Resources, Appendix A, Draft Contract.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

|  |
| --- |
| **Key Position: Job Description** |
| **Title of Position:** |
| **Description of Position:** |
| **Description of Responsibilities of Position:**  |
| **Minimum Experience Required:**  |
| **Skills Required:** |
| **Are there any educational requirements for this position?****[ ] Yes [ ] No****If yes, list below:** |
| **Are any professional licenses or certifications required for this position?****[ ] Yes [ ] No****If yes, list below:** |
| **Are there any continuing education requirements for this position?****[ ] Yes [ ] No****If yes, list below:** |
| **Any additional information relevant to this position:**  |

**4.3.3.3 Administrative Requirements (Marked) – 10 points**

Offeror attests to the following:

1. The Offeror will have an Administrative Office within fifteen (15) miles of the Mississippi Division of Medicaid’s Central Office at the Walter Sillers Building, Jackson, Mississippi 39201-1399, as required by the RFQ.
2. The Offeror will Describe how and where administrative records and data will be maintained and the process and time frame for retrieving records requested by the Division or other State or external review representatives.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed name of person attesting for Offeror Title of person attesting for Offeror**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of person attesting for Offeror Date**

**4.3.3.5 Subcontractors – 20 points**

Use the first provided form entitled “Subcontractor” to describe the any subcontractor the Offeror plans to use if chosen as a winning Contractor through this RFQ.

If the Offeror has worked with the subcontractor in the past three (3) years on a managed care contract, use the second form, “Prior Experience with Subcontractor” to give details about that experience.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

|  |
| --- |
| **Subcontractor** |
| **Name of Subcontractor:**  |
| **TIN/SSN (as applicable):** | **The entity is a:** **[ ] Subcontractor****[ ] Wholly-Owned Subsidiary**  |
| **Address Line 1:**  |
| **Address Line 2:**  |
| **City:**  | **State:** | **Zip Code:** | **County:** |
| **Mailing Address (P.O. Box):** | **City:** | **State:** | **Zip Code:**  | **County:** |
| **Description of Services to be Rendered by Subcontractor for this Contract:** |
| **How will the Offeror monitor and manage this Subcontractor?** |
| **Has the Offeror worked with the subcontractor on a managed care contract in the past three (3) years? [ ] Yes [ ] No****If yes, fill out Prior Experience with Subcontractor for each applicable instance.** |
| **Prior Experiences with Subcontractor** |
| **Client’s Name:** |
| **Client Location** |
| **Address Line 1:**  |
| **Address Line 2:**  |
| **City:**  | **State:** | **Zip Code:** | **County:** |
| **Mailing Address (P.O. Box):** | **City:** | **State:** | **Zip Code:**  | **County:** |
| **Direct Contact for Client** |
| **Name:** |
| **Title:** |
| **Phone Number:** | **Email Address:** |
| **Work Details** |
| **Number of covered lives:** |
| **Time period of contract:** |
| **Total number of staff hours expended during time period of contract:** |
| **Personnel requirements:** |
| **Geographic and population coverage requirements:** |
| **Publicly funded contract cost:** |
| **Description of work performed under this contract** |
|  |

**4.3.3.6 Economic Impact – 20 points**

There are numerous positions listed in Appendix A: Draft Contract that require that the individual filling the position be located in Mississippi. Please provide the Offeror’s expected wages for each of those positions.

Additionally, include a list of any other positions the Offeror will locate in Mississippi and include expected wages for each of those positions, as well as any other investment that the Offeror plans to make inside the state.

[REST OF PAGE INTENTIONALLY LEFT BLANK]

|  |
| --- |
| **Economic Impact: Wage Chart** |
| **Title of Position:** |
| **If Position is not a Key Position, provide description:** |
| **Number of Staff Expected to Fill this Position/Staffing Need:** | **Expected Wage of Position (Hourly rate or salary):** |
| **Employee(s) filling this position would be:****[ ] Hourly [ ] Salaried** | **Employee(s) filling this position would be:****[ ] Full-Time [ ] Part-Time** |
|  |
| **Title of Position:** |
| **If Position is not a Key Position, provide description:** |
| **Number of Staff Expected to Fill this Position/Staffing Need:** | **Expected Wage of Position (Hourly rate or salary):** |
| **Employee(s) filling this position would be:****[ ] Hourly [ ] Salaried** | **Employee(s) filling this position would be:****[ ] Full-Time [ ] Part-Time** |
|  |
| **Title of Position:** |
| **If Position is not a Key Position, provide description:** |
| **Number of Staff Expected to Fill this Position/Staffing Need:** | **Expected Wage of Position (Hourly rate or salary):** |
| **Employee(s) filling this position would be:****[ ] Hourly [ ] Salaried** | **Employee(s) filling this position would be:****[ ] Full-Time [ ] Part-Time** |
|  |