

REQUEST FOR SEALED PROPOSAL

PHYSICIAN ON CALL SERVICES
FOR THE PERIOD
JULY 1, 2013 THROUGH JUNE 30, 2014
AND
JULY 1, 2014 THROUGH JUNE 30, 2015

GALLIPOLIS DEVELOPMENTAL CENTER
2500 OHIO AVENUE
GALLIPOLIS, OHIO 45631
PHONE: 740-446-1642
FAX: 740-446-1341

1.0 INTRODUCTION

- 1.1 Gallipolis Developmental Center intends to select an offeror through this Request for Proposal (RFP) process to provide physician on call services for individuals who reside at Gallipolis Developmental Center.
- 1.2 This developmental center is a Medicaid-certified Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), operated by the Ohio Department of Developmental disabilities (DODD), serving persons with intellectual disabilities and a wide range of other disabilities.

2.0 SERVICES REQUIRED

- 2.1 The services consist of all items listed herein for DODD, Gallipolis Developmental Center, including all required labor, materials and equipment (including items not specifically noted or shown as required for complete service, subject to any exclusions listed below). It is the intent of this document that vendors provide a single proposal covering all categories of work for this service.
- 2.2 Vendor providing services under this RFP will:
 - 2.2.1 Provide during Fiscal Years 2014 (FY14) and 2015 (FY15) on-call primary physician services for approximately 125 individuals with developmental disabilities who reside at the Center, not to exceed 3,000 hours of services in each fiscal year.
 - 2.2.2 Adhere to a written monthly work schedule provided by GDC; all subsequent changes must be approved by GDC at least one (1) week in advance of the change. The exact on-call schedule will be developed with the Medical Director and it can be flexible. The total number of days will depend on the Medical Director's personal schedule but will not exceed 52 onsite days per year with maximum billing hours of 3000 hours of services each fiscal year. The on-call physician will generally know well in advance when the Medical Director will be away.
 - 2.2.3 Perform the following under the direction of the Medical Director or the Superintendent when the Medical Director is unavailable.
 - 2.2.4 Contact staff physician for review of individuals' condition prior to beginning on-call time;
 - 2.2.5 MUST COMPLETE detailed rounds with all primary care physicians prior to taking any on-call so as to familiarize themselves with all GDC individuals;
 - 2.2.6 Provide medical direction and administrative services in conjunction with the administrative needs of GDC.
 - 2.2.7 Coordinate the exchange of information with nursing staff to disseminate all necessary individual medical information.
 - 2.2.8 Render proper medical judgment for treatment based on evaluation by Center nursing staff and medical assessment of individual needs.

- 2.2.9 Performs examinations on the individuals that may be admitted, provides admission note and orders for care.
- 2.2.10 Attend all meetings deemed necessary.
- 2.2.11 Perform all services as stipulated herein and other related duties as determined necessary by GDC.
- 2.2.12 Provide written service delivery documentation for each unit of service rendered in accordance with established facility procedures and documentation systems.
- 2.2.13 Any modifications, variations or addendums to the above specified duties or services shall result in the immediate disqualification of that bid.**

3.0 SPECIAL CONSIDERATIONS

- 3.1 The offeror shall identify the person(s) providing services under the RFP. Said person(s) must:
 - 3.1.1 Present prior to initiating services and maintain throughout the contracting period, a current State of Ohio license to practice medicine or other applicable licenses, certifications, and registrations.
 - 3.1.2 Be Board Certified.
 - 3.1.3 Neither the contractor nor any of its employees, shall not have been found guilty of, or pleaded guilty to, any offense set forth in Section 5123.081(1), (2), or (3) of the Ohio Revised Code; nor employ any person to provide services under this RFP who has been found guilty of, or pleaded guilty to any offense set forth in Section 5123.081(1), (2), or (3) of the Ohio Revised Code. *The person(s) providing services under this RFP shall be subject to a criminal background check prior to performing any services at Gallipolis Developmental Center.*
- 3.2 Contractor shall perform all services rendered in accordance with all applicable State of Ohio, Ohio Department of Developmental Disabilities (DODD) regulations/licensure requirements, federal and state Medicaid (ICF/IID) regulations, Gallipolis Developmental Center (GDC) policies and procedures, and any and all other regulatory statutes and/or procedures GDC desires to institute at any time during the contract period.
- 3.3 Contractor shall perform all services rendered in accordance with the service provider's licensure/certification requirements and the Code of Ethics established by the discipline/profession and/or State of Ohio licensing board.
- 3.4 Contractor shall certify that all of its employees, while working at GDC, will not purchase, transfer, use, be under the influence of, or possess illegal drugs or alcohol, or abuse prescription drugs in any way.
- 3.5 Contractor shall comply with all applicable provisions of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), both in the provision of specified services and in its employment practices.
- 3.6 By submitting a signed proposal for this service, the vendor affirms that, as applicable to the vendor, no party listed in Division (I) and (J) of Section 3517.13 of the Revised Code or spouse of such party has made, as an individual, within the two previous calendar

Contracts subject to appropriation availability and approval of DODD and, if applicable, the Controlling Board, State of Ohio.

years, one or more contributions totaling in excess of \$1,000.00 to the Governor or to his campaign committees.

- 3.7 All services provided under this RFP shall meet the appropriate standards of the Federal Medicaid program for Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID).
- 3.8 The provisions of the **Ohio Department of Developmental Disabilities Personal Service Contract** will become part of the final agreement between the successful offeror and the Center. Therefore, the evaluation process resulting in the final award of a contract rests with the Center and the Ohio Department of Developmental Disabilities. The Center and the Ohio Department of Developmental Disabilities reserve the right to determine that the award of a contract would not be in the best interest of the Center, the Ohio Department of Developmental Disabilities, or the State of Ohio. The Center and the Ohio Department of Developmental Disabilities reserve the right to accept or reject any and all bids, in whole or in part, and may determine that any irregularities or deviations from the specifications do not result in the bid being non-responsive, provided this does not affect the amount of the bid or result in a competitive advantage to the bidder.

4.0 PROPOSALS

- 4.1 All proposals shall be in accordance with information provided in this document as well as an interview on site, if requested.
- 4.2 All proposals shall be in writing and signed by the person providing services (or in the case of companies by an authorized representative on company letterhead).
- 4.3 All proposals shall be submitted on the basis of a per hour charge. Travel expenses and travel time will not be paid. **A separate quotation shall be submitted for each fiscal year period.**
- 4.4 All proposals shall be guaranteed.
- 4.5 Proposals shall be submitted via mail or courier to: Gallipolis Developmental Center Attn: Business Office, 2500 Ohio Avenue, Gallipolis, Ohio 45631, with **"ON-CALL PHYSICIAN SERVICES"** clearly marked on the outside of the envelope.
- 4.6 Deadline for Proposal:

Proposals will be received at the above address **until 2:00 p.m. on August 30, 2013** and opened immediately thereafter. Proposals not received at Gallipolis Developmental Center by the deadline will be returned to sender unopened.

5.0 SITE INTERVIEW

- 5.1 As a representative of State Operated Services and Supports/DODD, Gallipolis Developmental Center reserves the right to interview all persons providing services under the provisions of this RFP to determine the best responsive vendor. Interviews will be after the proposal deadline and conducted on the premises of Gallipolis Developmental Center.

6.0 SUBMISSIONS REQUIRED

- 6.1 Complete and submit with your proposal a "Contractor Information" form (attached),

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- 6.2 Complete and submit with your proposal a "Price/Compensation" form (attached),
- 6.3 Complete and submit with your proposal a IRS W-9 form (attached),
- 6.4 Complete and submit with your proposal a DMA form (attached),
- 6.5 Complete and submit with your proposal a statement of the ability to meet the minimum requirement qualifications,
- 6.6 Complete and submit with your proposal a statement of ability to perform the responsibilities listed above,
- 6.7 A copy of all pertinent current licenses,
- 6.8 List of previous services performed to include facility name, complete address, telephone number, contact person, and dates service was performed.
- 6.9 Any accommodation or special needs of any person providing services under the provisions of this RFP.

7.0 **SCHEDULE**

- 7.1 July 1, 2013 – June 30, 2014 (Fiscal Year 2014)
- 7.2 July 1, 2014 – June 30, 2015 (Fiscal Year 2015)

8.0 **PAYMENTS**

- 8.1 Payments for services are made thirty (30) days from the receipt of a proper invoice. A **proper itemized invoice** must be provided in accordance with the [ORC section 125.01\(B\)](#), which defines a proper invoice as being free from defects, errors, discrepancies, or other improprieties. It must include but may not be limited to:
 - 8.1.1 Delivery of the commodity or performance of the service described in the order.
 - 8.1.2 Date of the purchase or rendering of the service.
 - 8.1.3 Itemization of the things done, material supplied, or labor furnished.
 - 8.1.4 Sum due pursuant to the contract or obligation.
 - 8.1.5 Vendor/provider name and address.
 - 8.1.6 Buying agency name.
 - 8.1.7 Proper invoice signed by the vendor.

9.0 **EVALUATION CRITERIA**

- 9.1 Scores will be given for each of the following items. The highest possible score is noted with each line item. The award will be given to the vendor with the highest score.
 - 9.1.1 Person(s) to provide services are have a doctors of medicine and are licensed in State of Ohio, (Yes = continue to next criteria; No = proposal is rejected).
 - 9.1.2 Experience serving person with intellectual disabilities (<6 years = 0; 6-9 years = 5 points; 10+ years = 10 points).

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- 9.1.3 Experience providing service under ICF/IID standards (<3 years = 0; 3-5 years = 2; 6-9 years = 5; 10 + years = 10 points)
- 9.1.4 Experience serving Developmental Center residents
 - 9.1.4.1 (Yes = 20, No = 0)
- 9.1.5 Price. Rank highest to lowest order when compared to all proposals and multiplied: (1=5, 2=10, 3=15, 4=20, 5=25, etc.).
- 9.1.6 In the event of a tie, the award will be determined through the vendor interview process

10.0 ATTACHMENTS

- 10.1 Contractor Information form
- 10.2 Pricing/Compensation form
- 10.3 IRS Form W-9
- 10.4 HIPAA Compliance Provisions
- 10.5 DMA Direct Material Assistance form
- 10.6 Personal Services Contract form (*provided as information*)

CONTRACTOR INFORMATION

**THIS FORM MUST BE SUBMITTED WITH YOUR PROPOSAL
(The pricing/Compensation form must be in a separately sealed envelope)**

Vendor Name: _____
Street Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Phone Number: _____ **Fax Number:** _____

1. Number of contracts with the State of Ohio (including DODD). Specifically,
State Agency: _____
Contracted Services: _____
Duration of Contract: _____
Amount/Rate: _____

(Attach additional sheets if necessary.)

2. Provide the following current information on both a corporate-wide basis (including Ohio) and, if a multi-state corporation, the corporation's Ohio-based operations:

	Ohio Offices	Nationwide (incl. Ohio Offices)
Total Employees:	_____	_____
% Women:	_____	_____
% Minorities:	_____	_____

3. What is your **TAX IDENTIFICATION** number? _____

4. If your billing address is different from your mailing address please list below:

Vendor Name: _____
Street Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Phone Number: _____ **Fax Number:** _____

Authorized Signature

Date

PRICING/COMPENSATION

Vendor Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Service Provided: _____

Please complete Hourly Rate or Fee Schedule, as applicable:

FY 2014 \$ _____ X _____ hours = \$ _____ **(Total FY 2014)**
 (Hourly Rate)

FY 2015 \$ _____ X _____ hours = \$ _____ **(Total FY 2015)**
 (Hourly Rate)

TOTAL FY'S 2014 & 2015: \$ _____

OR

Fee Schedule:

Procedure:	FY' 14 Fee	FY' 15 Fee
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

Please use an attachment if additional lines are necessary.

 Authorized Signature

 Date

Form W-9 (Rev. November 2005) Department of the Treasury Internal Revenue Service	Request for Taxpayer Identification Number and Certification	Give form to the requester. Do not send to the IRS.
Print or type See Specific Instructions on page 2.	Name (as shown on your income tax return)	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶ <input type="checkbox"/> Exempt from backup withholding	
	Address (number, street, and apt. or suite no.)	Requester's name and address (optional)
	City, state, and ZIP code	
List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
or Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here	Signature of U.S. person ▶	Date ▶
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Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

HIPAA Compliance Provisions

Ohio Department of Mental Retardation and Developmental Disabilities

Personal Service Contract

Provisions for Compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A. Definition

Protected Health Information (hereinafter "PHI") is information received from or on behalf of the Department that meets the definition of PHI as defined by the Health Insurance Portability and Accountability Act (HIPAA) and the regulations promulgated by the United States Department of Health and Human Services, specifically 45 C.F.R. 164.501, and any amendments thereto.

B. Permitted Uses and Disclosures

Contractor shall not use or disclose PHI except as provided within this contract solely to fulfill the specific contract activities specified herein or as otherwise required under the HIPAA regulations or other applicable law. Contractor and all subcontractors and agents of Contractor are limited to the uses or disclosures that the Department is permitted by HIPAA to conduct.

C. Safeguards

Contractor shall use appropriate safeguards to protect against use or disclosure not provided for by this contract.

D. Reporting of Disclosure

Contractor shall promptly report to the Department any knowledge of uses or disclosures of PHI that are not in accordance with this contract or applicable law. In addition, Contractor shall mitigate any adverse effects of such a breach to the extent possible.

E. Agents and Subcontractors

Contractor shall ensure that all of its agents and subcontractors that receive PHI from or on behalf of Contractor or the Department or create PHI on behalf of Contractor or the Department agree to the same restrictions and conditions that apply to Contractor with respect to the use or disclosure of PHI.

F. Accessibility of Information

Contractor shall make available to the Department such information as the Department may require to fulfill the Department's obligations to provide access to, provide a copy of, and account for disclosures with respect to PHI pursuant to HIPAA and regulations promulgated by the United States Department of Health and Human Services, including, but not limited to, 45 C.F.R. Sections 164.524 and 164.528 and any amendments thereto.

G. Amendments of Information

Contractor shall make PHI available to the Department in order for the Department to fulfill its obligations pursuant to HIPAA to amend the information and shall, as directed by the Department, incorporate any amendments into the information held by Contractor and ensure incorporation of any such amendments into information held by Contractor's agents or subcontractors.

HIPAA Compliance Provisions (Continued)

H. Disclosure

Contractor shall make available its internal practices, books and records relating to the use and disclosure of PHI received from the Department, or created or received by Contractor on behalf of the Department, to the Department and to the Secretary of the United States Department of Health and Human Services for the purpose of determining the Department's compliance with HIPAA and the regulations promulgated by the United States Department of Health and Human Services and any amendments thereto.

I. Material Breach

In the event of a material breach of Contractor's obligations under this section, the Department may at its option terminate this contract. Termination of this contract shall not affect any provision of this contract that, by its wording or nature, is intended to remain effective and to continue to operate in the event of termination.

J. Return or Destruction of Information

Upon termination of this contract, Contractor, at the Department's option, shall return to the Department, or destroy, all PHI in its possession, and keep no copies of the information except as requested by the Department or required by law. If Contractor or its agents or subcontractors destroy any PHI then Contractor will provide the Department documentation evidencing such destruction. Any PHI maintained by the Contractor shall continue to be extended the same protections set forth in this contract for as long as it is maintained.



Ohio Department of Public Safety
Division of Homeland Security
<http://www.homelandsecurity.ohio.gov>

REQUEST FOR A REVIEW OF THE DENIAL OF GOVERNMENT FUNDING OR BUSINESS CONTRACT DUE TO THE PROVISION OF MATERIAL ASSISTANCE TO A TERRORIST ORGANIZATION

In accordance with section 2909.33 of the Ohio Revised Code

This form serves as an official request for a review of the denial of a government funding or business contract due to the provision of material assistance to an organization on the U.S. Department of State Terrorist Exclusion List.

The Ohio Department of Public Safety, upon the request of any person, company or organization who has been denied a government funding or business contract due to the provision of material assistance to an organization on the U.S. Department of State Terrorist Exclusion List, shall review the request within thirty days to determine if the denial should be voided.

This form must be sent via certified mail to the Ohio Department of Public Safety's Division of Homeland Security.

Ohio Department of Public Safety
 Division of Homeland Security
 1970 West Broad Street Rm.422
 Columbus, Ohio
 43218-2081

LAST NAME		FIRST NAME		MIDDLE INITIAL
HOME ADDRESS				
CITY	STATE	ZIP	COUNTY	
HOME PHONE		WORK PHONE		

COMPLETE THIS SECTION ONLY IF YOU ARE A COMPANY, BUSINESS OR ORGANIZATION

BUSINESS/ORGANIZATION NAME				
BUSINESS ADDRESS				
CITY	STATE	ZIP	COUNTY	
PHONE NUMBER ()				

COMPLETE ALL APPLICABLE SECTIONS BELOW

1. On what date (day, month and year) was material assistance provided?
2. To which organization on the Terrorist Exclusion List was material assistance provided?
3. Describe the material assistance that was provided.

HLS 0040 2/06

GOVERNMENT FUNDING OR BUSINESS CONTRACT – CONTINUED

4. For what reason was material assistance provided?
5. Did you know of the organization's terrorism-related activities at the time material assistance was provided?
6. Why do you feel the denial of government funding or business contract due to the provision of material assistance is inappropriate or unjust?

X _____
Signature

Date