

**Northwest Ohio Psychiatric Hospital  
930 South Detroit  
Toledo, OH 43614**

**Dental Service Invitation to Bid**

Dear Prospective Vendor:

Northwest Ohio Psychiatric Hospital (NOPH) located in Toledo Ohio is currently negotiating a personal service contract for Dental Services. The terms of this contract are from February 25, 2013 thru June 30, 2013. Your proposals may be emailed to DMHBidOpportunity@mh.ohio.gov or received by mailed to the address listed below by 4:00 PM on Thursday, February 21, 2013:

Northcoast Behavioral Healthcare  
Attn: William Von Alt - **Bid #: DMH13048**  
P.O. Box 305  
1756 Sagamore Road  
Northfield, OH 44067

**The bid opening will occur on Friday, February 22, 2013 at Northcoast Behavioral Healthcare at 9:00 AM.**

**DENTAL SERVICES BID 2013**

- The Dental Service Vendor shall provide high quality Dental Services to patients of the Facility. Dental Services shall include annual dental examinations, prophylactic dental care, and other additional dental care services as appropriate. Approval for these additional services will be based upon the acute and immediate nature of the dental needs and the physical and mental condition of the patient. A consent must be obtained prior to or at the time of such oral examination.
- Dental treatment as outlined below will be provided only when authorized by the patient /guardian and Chief Clinical Officer and is within the staff dentist's abilities and capabilities when using portable equipment. Such treatment shall be limited to the following:
  - (a.) routine examinations
  - (b.) X-rays
  - (c.) Prophylaxis (cleanings)
  - (d.) Amalgam and composite restorations (fillings)
  - (e.) Simple extractions
  - (f.) Complete dentures
  - (g.) Complete dentures and partial denture repairs and relines
  - (h.) Acrylic partial dentures with wrought iron clasps
  - (i.) Other services may be available at the discretion of the Dental staff according to availability and ability of its staff dentists.
- Emergency Services will not be provided. Patient's needing emergency dental services will be sent to the local Emergency Room for dental consultation.
- Medication orders will be processed through the facility's computerized physician order entry (COPE). Documentation will be processed by way of a computerized medical record.
- The Vendor certifies that it has and shall maintain during the term of this Agreement a staff, all of whom are duly licensed dentists or dental hygienists with the Ohio State Dental Board. The Vendor agrees to present the Facility with medical licenses, verification of 2-Step Mantoux Testing, Hepatitis B, and MMR testing of employees from the Center who will be performing said services. The Facility will review all related documentation for credentialing and privileges to the Medical Staff at the Facility.

- The Vendor certifies that all Dental services will be provided in accordance with any and all standards, ruling, and regulations of the applicable State Department of Health and Human Services, Medicare/Medicaid, and any other State or Federal agency responsible for administering or regulating said services.
- The Vendor shall establish with the Facility mutually agreeable routine days each month to provide service in the amount of 16 hours per month. Additional hours may be approved based on acute need.
- The Vendor shall provide the necessary dental equipment, instruments and supplies for each visit. The Facility shall provide the Center with adequate, cleared and sanitary space to set up dental equipment in order to provide treatment by 9:00 a.m. on each treatment day. Adequate space shall include access to water, electricity and **no** carpet.
- The Vendor shall conduct and continuously monitor the quality of service and outcome of services provided. Such finding will be reported are communicated to the facility on an established basis.
- The Vendor agrees to accept reimbursements from facility at rates not to exceed the 2012 Medicare/Medicaid fee schedule for all members. All invoices will be submitted on a UB04 or a HCFA1500.
- The Vendor and its staff shall each acquire, maintain and provide proof to the Facility of such policies of professional liability insurance. Such coverage shall include professional liability insurance with a minimum of no less than \$1,000,000/3,000,000 aggregate and as shall be necessary to insure the Vendor, its professional staff and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of the Dental Services rendered by the Vendor pursuant to this Agreement. The Facility may, in its sole discretion, annually verify professional liability insurance coverage of the Vendor. Similarly, the Facility shall establish to its satisfaction that the Vendor has in effect all insurances requires by the State of Ohio and which the Vendor may find necessary.
- The Facility shall provide the Dental Vendor a staff person on days scheduled for treatment to transport patients to and from the treatment area and help manage and reassure the patients during dental treatment.
- The Facility shall designate a Clinic Nurse Manager or other professional involved in direct patient care to serve as a dental coordinator who will assist in and obtain necessary patient information, nursing care plans, medical clearance and post-treatment care.

## **Additions to Dental Contract**

### **Medical Equipment on Grounds**

No outside contractor is permitted to bring medical equipment onto NOPH grounds without prior approval and written consent from the chairman of the Environment of Care Committee.

### **Medical Equipment Inspection, Testing and Maintenance Program:**

1. All medical equipment will meet the requirements for all Joint Commission and CMS Hospital Accreditation Standards
2. All Radiology equipment, operators and facilities will meet the standards and licensure as prescribed by the Ohio Department of Health.
3. A licensed biomedical equipment technician or testing firm will inspect and test all Medical Equipment before it is placed in service on NOPH grounds and thereafter on a semi-annual basis in April and October of each year.

4. The Biomedical equipment testing technician or firm will attach a label to each piece of equipment they test indicating the test date.
5. Copies of all equipment Inspection, Testing and Preventive Maintenance will be forwarded to the Chief Operating Officer.
6. Any deficiencies will be reported to the Operation department; the equipment will be immediately taken out of service and remain out of service until repaired, inspected and passed by the biomedical equipment technician or testing firm.
7. Outside contractors will provide product manuals and manufacturer recommended maintenance schedules for all equipment including any prior maintenance performed to date on the equipment for review before going before the EOC medical equipment evaluation subcommittee.

**Other language**

1. The Dentist will be required to prescribe medications through ODMH/NOPH Computerized Physician Order System (CPOE).
2. The Dentist will use the Electronic Medical Record (EMR) approved by ODMH for patient data entry
3. The PI department will monitor the clinical performance of the quality of dental services provided on a quarterly basis and collaborate with the Office of the Chief Clinical Officer.

**Quality Inspection Procedure:**

1. All reusable dental instruments brought into NOPH will have accompanying sterilization cycle and spore testing documentation that shows successful sterilization.
2. Spore testing will be done weekly at minimum.
3. No instruments processed in a failed sterilization cycle or spore test will be used at NOPH until successfully reprocessed.
4. Infection Control Nurse or designee will inspect records upon delivery.
5. Dental service provider will inspect integrity of packaging of pouched sterilized instruments prior to their use.
6. Reports of sterilization cycle and spore test results will be maintained by the Infection Preventionist.

Please include the following information in your proposal:

- Corporate name and billing address
- Tax identification number
- Brief summary of other contracts with the State of Ohio Department of Mental Health
- Name and telephone number of primary contact
- Provide proof of Worker's Compensation coverage
- Complete and return all attached documents by filing deadline
- Total number of employees in Ohio and Nationwide
- Percentage of Female employees
- Percentage of Minority employees

Sincerely,

William Von Alt  
Chief Financial Officer

## REQUIRED CERTIFICATION FOR BIDDING

Those bidders claiming preference for Domestic Source End Products and/or the Ohio preference, pursuant to Revised Code Sections 125.09 and 125.11 and Administrative Code Section 123:5-1-06 must complete the following information. Bidders who qualify as an "Ohio" bidder (offer an Ohio product or who have significant Ohio economic presence) or who qualify as a Border State bidder are eligible to receive a five percent (5%) preference over non-Ohio/Border state bidders. The state reserves the right to clarify any information during the evaluation process. **BIDDERS MUST COMPLETE THIS CERTIFICATION TO RECEIVE THE PREFERENCE.**

**A. DOMESTIC PREFERENCE (BUY AMERICA):** [Not applicable to "Excepted Products"]

1. Where is each product/services being offered mined, raised, grown, produced or manufactured?

United States: \_\_\_\_\_(State)     Canada     Mexico    (Go to B-1)

Other: (Specify Country)\_\_\_\_\_ (Go to A-2)

2. End product is manufactured outside the United States and at least 50% of the cost of its components are produced, mined, raised, grown or manufactured within the United States. The cost of components may include transportation costs to the place of manufacture and, in the case of components of foreign origin, duty whether or not a duty free entry certificate is issued.

Yes (Go to Section B-1)     No (Go to Section A-3)

3. The Bidder hereby certifies that each end product, except the products listed below, is a domestic source end product as defined in the Buy America Act and that components of unknown origin have been considered to have been mined, produced, grown or manufactured outside the United States.

\_\_\_\_\_ (Item)    \_\_\_\_\_ (Country of Origin)

\_\_\_\_\_ (Item)    \_\_\_\_\_ (Country of Origin)

A domestic end source product is deemed to be excessively priced if it exceeds the cost of the foreign product by more than 6%. Pursuant to FAR, Part 25, the state of Ohio does not acquire supplies or services that cannot be imported lawfully into the United States. The contractor, their subcontractor(s) and any agent of the contractor or subcontractor must not acquire any supplies or services originating from sources within, or that were located in or transported from or through Cuba, Iran, Iraq, Libya, North Korea, Sudan Territory of Afghanistan controlled by the Taliban, or Serbia (excluding the territory of Kosovo).

**B. OHIO PREFERENCE (BUY OHIO):**

1. The products/services being offered are raised, grown, produced, mined or manufactured in Ohio.

Yes (Go to C)     No (Go to B-2)



2. Bidder has significant economic presence within the state of Ohio.     Yes (Answer a, b, c, d below)     No (Go to B-3)

a) Bidder has paid the required taxes due the state of Ohio     Yes     No

b) Bidder is registered with the Ohio Secretary of State

Yes (Charter/Registration No.: \_\_\_\_\_)     No

Questions regarding registration should be directed to (614) 466-3910 or visit their web site at:

<http://www.sos.state.oh.us/>

c) Bidder has ten or more employees based in Ohio or border state.     Yes     No (Go to B-2d)

d) Bidder has seventy-five percent or more employees based in Ohio or border state.     Yes     No (Go to B-3)

3. Border state bidder:

Yes (Specify which state then go to B-2c):  KY     MI     NY     PA     IN     No (Go to B-4)

4. Border state bidder: mined products mined in respective border state     Yes     No     Not Applicable

**C. E.D.G.E. DESIGNATION**

Bidder is certified E.D.G.E. business     Yes     No

For information on E.D.G.E. designation, please visit the DAS Equal Opportunity Division website at:

<http://das.ohio.gov/Eod/Edge/Index.htm>



# VENDOR INFORMATION FORM

All parts of the form must be completed by the vendor and returned to Ohio Shared Services. The information must be legible.

## SECTION 1 – PLEASE SPECIFY TYPE OF ACTION

- NEW (W-9 OR W-8ECI FORM ATTACHED)     CHANGE OF CONTACT PERSON/INFORMATON  
 ADDITIONAL ADDRESS (PLEASE PROVIDE COPY OF INVOICE OR LETTER OF EXPLANATION)  
 CHANGE OF ADDRESS – ENTER OLD ADDRESS   
 CHANGE OF TIN (NEW W-9 AND LETTER OF EXPLANATION OF CHANGE, WHICH INCLUDES OLD TIN, IS REQUIRED)  
 CHANGE OF NAME (NEW W-9 AND LETTER OF EXPLANATION OF CHANGE IS REQUIRED)  
 CHANGE OF PAY TERMS     CHANGE OF PO DISPATCH METHOD     OTHER \_\_\_\_\_

## SECTION 2 – PLEASE PROVIDE VENDOR INFORMATION

LEGAL BUSINESS OR INDIVIDUAL NAME: (MUST MATCH W-9 OR W-8ECI FORM)

BUSINESS NAME, TRADE NAME, DOING BUSINESS AS: (IF DIFFERENT THAN ABOVE)

FEDERAL TAX ID (TIN), EMPLOYER ID (EIN) OR SOCIAL SECURITY NUMBER (REQUIRED):

BUSINESS ENTITY: (IF A SOLE PROPRIETOR, THE INDIVIDUAL'S NAME MUST APPEAR IN LEGAL BUSINESS NAME) **CHECK ONE:**  
 INDIVIDUAL/SOLE PROPRIETOR     CORPORATION     S CORPORATION     PARTNERSHIP     TRUST/ESTATE  
 LIMITED LIABILITY COMPANY    **CIRCLE THE TAX CLASSIFICATION (C=CORPORATION, S= S CORPORATION, P=PARTNERSHIP)** \_\_\_\_\_  
 OTHER (PLEASE EXPLAIN)

## SECTION 3 – PLEASE PROVIDE COMPLETE ADDRESS 1 (IF MORE THAN 2 ADDRESSES, INCLUDE A SEPARATE SHEET)

ADDRESS: <input type="text"/>		COUNTY: <input type="text"/>
CITY: <input type="text"/>	STATE: <input type="text"/>	ZIP CODE: <input type="text"/>

## SECTION 4 – PLEASE PROVIDE COMPLETE ADDRESS 2

ADDRESS: <input type="text"/>		COUNTY: <input type="text"/>
CITY: <input type="text"/>	STATE: <input type="text"/>	ZIP CODE: <input type="text"/>

**SECTION 5 – CONTACT INFORMATION AND PERSON TO RECEIVE PURCHASE ORDER**

NAME:

WEBSITE:

PHONE:

FAX:

E-MAIL:

**SECTION 6 - STRATEGIC SOURCING CONTACT INFO (PERSON TO RECEIVE E-MAIL NOTICE OF BID EVENTS)  
THE USER ID & PASSWORD TO COMPLETE STRATEGIC SOURCING REGISTRATION WILL BE SENT TO E-MAIL ADDRESS BELOW.**

NAME:

E-MAIL:

PHONE NUMBER:

**SECTION 7 – IS YOUR BUSINESS CURRENTLY CERTIFIED AS? (PLEASE CHECK)**

MBE (MINORITY BUSINESS ENTERPRISE)     EDGE (ENCOURAGING DIVERSITY, GROWTH, & EQUITY)     N/A

**SECTION 8 – PAYMENT TERMS (PLEASE CHECK ONE, OTHERWISE NET 30 WILL BE APPLIED BY DEFAULT)**

2/10 NET 30     NET 30     NET 45     NET 60     NET 90

**SECTION 9 – PURCHASE ORDER DISTRIBUTION-OTHER THAN USPS MAIL (NOTE: APPLICABLE FOR VENDORS THAT RECEIVE PO ONLY (INPUT E-MAIL ADDRESS OR FAX NUMBER BELOW)**

E-MAIL OR FAX:

**SECTION 10 – PLEASE SIGN AND DATE**

PRINT NAME:

DATE:

SIGNATURE:

**SECTION 11 – STATE OF OHIO AGENCY CONTACT INFORMATION (AGENCY WHERE GOODS OR SERVICES ARE DELIVERED)**

AGENCY NAME: **OHIO DEPARTMENT OF MENTAL HEALTH**

E-MAIL: Lucille.Fuller@mh.ohio.gov

PHONE NUMBER: 614-466-7697

COMMENTS:

**Note: This document does contain sensitive information. Sending via non-secure channels, including e-mail and fax can be a potential security risk.**

**SUBMIT FORM TO:**

**Mail:** Ohio Shared Services  
P.O. Box 182880 Cols., OH 43218-2880  
**Fax:** (614) 485-1052  
**E-mail:** [vendor@ohio.gov](mailto:vendor@ohio.gov)

**QUESTIONS? PLEASE CONTACT:**

**Phone:** 1 (877) OHIO-SS1 (1-877-644-6771)  
1 (614) 338-4781  
**E-mail:** [vendor@ohio.gov](mailto:vendor@ohio.gov)

## Request for Taxpayer Identification Number and Certification

**Give Form to the  
 requester. Do not  
 send to the IRS.**

<b>Print or type See Specific Instructions on page 2.</b>	Name (as shown on your income tax return)	
	Business name/disregarded entity name, if different from above	
	Check appropriate box for federal tax classification (required): <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C Corporation <input type="checkbox"/> S Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate	
	<input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____	
	<input type="checkbox"/> Other (see instructions) ▶ _____	
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 the "Name" line 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									

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

Employer identification number									

### 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. citizen or other U.S. person (defined below).

**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.

<b>Sign Here</b>	Signature of U.S. person ▶	Date ▶
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### General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

#### 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.

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. 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.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**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.