# ATTACHMENT A

### BIDDER’S CERTIFIED STATEMENTS

**To be completed and included in the Administrative Proposal documents**

|  |
| --- |
| **RFP#17222 – Medicaid Transportation Management – Finger Lakes / Northern New York Region** |
| **1. Information with regard to the Bidder** |
| 1. **Provide the Bidder’s name, address, telephone number, and fax number.**
 |
| **Name:** Click here to enter text. |
| **Address:** Click here to enter text. |
| **City, State, ZIP Code:** Click here to enter text. |
| **Telephone Number (including area code):** Click here to enter text. |
| **Fax Number (including area code):** Click here to enter text. |
| 1. **Provide the name, address, telephone number, and email address of the Bidder’s Primary Contact with DOH with regard to this proposal.**
 |
| **Name:** Click here to enter text. |
| **Address:** Click here to enter text. |
| **City, State, ZIP Code:** Click here to enter text. |
| **Telephone Number (including area code):** Click here to enter text. |
| **Email Address:** Click here to enter text. |
| **2. By submitting the bid the Bidder acknowledges and agrees to all of the following:** **[Please note: alteration of any language contained in this section may render your proposal non-responsive.]** |
| **The Bidder certifies that it can and will provide and make available, at a minimum, all services as described in the RFP if selected for award.**  |
| **Bidder acknowledges that, should any alternative proposals or extraneous terms be submitted with the proposal, such alternate proposals or extraneous terms will not be evaluated by the DOH.** |
| **Bidder accepts, without any added conditions, qualifications or exceptions, the contract terms and conditions contained in this RFP including any exhibits and attachments.**  |
| **The bidder is either registered to do business in NYS, or if formed or incorporated in another jurisdiction than NYS, can provide a Certificate of Good Standing from the applicable jurisdiction or provide an explanation, subject to the sole satisfaction of the Department, if a Certificate of Good Standing is not available, and if selected, the vendor will register to do business in NYS.** |
| **The bidder cannot use subcontractors to perform Medicaid transportation management services, and cannot subcontract with transportation providers. For other services, bidder is/is not [circle one] proposing to utilize the services of a subcontractor (s). If a proposal is submitted which proposes to utilize the services of a subcontractor (s), the bidder provides, in an addendum to this BIDDER’S CERTIFIED STATEMENTS form, a subcontractor summary for each listed subcontractor and certifies that the information provided is complete and accurate.** **The summary document for each listed subcontractor should contain the following information:** * 1. **Complete name of the subcontractor, including DBA and the names of controlling interests for each entity;**
	2. **Complete address of the subcontractor;**
	3. **A general description of the scope of work to be performed by the subcontractor;**
	4. **Percentage of work the subcontractor will be providing;**
	5. **Evidence that the subcontractor is authorized to do business in the State of New York, and is authorized to provide the applicable goods or services in the State of New York; and**

**The subcontractor’s assertion that they do not discriminate in its employment practices with regards to race, color, religion, age, sex, marital status, political affiliation, national origin, or handicap.** |
| 1. **The Bidder is (check as applicable):**
 |
| **A New York State Certified Minority-Owned Business Enterprise****A New York State Certified Woman-Owned Business Enterprise****A New York State Certified Minority and Woman-Owned Business Enterprise (Dual Certified)****None of the above** |
| 1. **Provide the name, title, address, telephone number, and email address of the person authorized to receive Notices with regard to the contract entered into as a result of this procurement. See Appendix G of the DOH Agreement (Attachment E), NOTICES.**
 |
| **Name:** Click here to enter text. |
| **Title:** Click here to enter text. |
| **Address:** Click here to enter text. |
| **City, State, ZIP Code:** Click here to enter text. |
| **Telephone Number (including area code):** Click here to enter text. |
| **Email Address:** Click here to enter text. |
| 1. **Bidder’s Taxpayer Identification Number:**
 |
| Click here to enter text. |
| 1. **Bidder’s NYS Vendor Identification Number as discussed in Section 6.1.F, if enrolled:**
 |
| Click here to enter text. |
| **By my signature on this Attachment A, I certify to the statements made above in Section 2 and that I am authorized to bind the Bidder contractually. Furthermore, I certify that all information provided in connection with its proposal is true and accurate.** |
| **Typed or Printed Name of Authorized Representative of the Bidder** |
| **Title/Position of Authorized Representative of the Bidder** |
| **Signature of Authorized Representative of the Bidder** |
| **Date** |
|  |

# ATTACHMENT B

### PROPOSAL DOCUMENT CHECKLIST

**Please reference Section 7.0 for the appropriate format and quantities for each proposal submission.**

|  |
| --- |
| **RFP#17222 – Medicaid Transportation Management – Finger Lakes / Northern New York Region** |
| **FOR THE ADMINISTRATIVE PROPOSAL** |
| **RFP §** | **CRITERIA** | **INCLUDED** |
| **§ 6.1.A** | **M/WBE Participation Requirements:** | [ ]  |
|  | **Attachment F Form 1** | [ ]  |
|  | **Attachment F Form 2 (If Applicable)** |[ ]
| **§ 6.1.B** | **Attachment G – Disclosure of Prior Non-Responsibility Determinations, completed and signed.** |[ ]
| **§ 6.1.C** | **Attachment J- Vendor Responsibility Attestation** |[ ]
| **§ 6.1.D** | **Freedom of Information Law – Proposal Redactions (If Applicable)** |[ ]
| **§ 6.1.E** | **Attachment A - Bidder’s Certified Statements, completed & signed.** |[ ]
| **§ 6.1.F** | **Attachment H- Encouraging Use of New York Businesses in Contract Performance**  |[ ]
| **§ 6.1.G** | **Attachment D - (References)**  |[ ]
| **§ 6.1.H** | **Attachment L-Conflict of Interest or Detrimental Effect** |[ ]
| **FOR THE TECHNICAL PROPOSAL** |
| **RFP §** | **CRITERIA** | **INCLUDED** |
| **§ 6.2.A** | **Title Page**  |[ ]
| **§ 6.2.B** | **Table of Contents** |[ ]
| **§ 6.2.C** | **Documentation of Bidder’s Qualifications to Propose** |[ ]
| **§ 6.2.D** | **Executive Summary** |[ ]
| **§ 6.2.E** | **Technical Proposal Narrative** |[ ]
| **§ 6.2.F** | **Attachment K-Diversity Practices Questionnaire** |[ ]
| **FOR THE COST PROPOSAL****REQUIREMENT** |
| **RFP §** | **REQUIREMENT** | **INCLUDED** |
| **§ 6.3** | **Attachment C- Cost Proposal** |[ ]

#

# ATTACHMENT C

### COST PROPOSAL Bid Form

**NEW YORK STATE DEPARTMENT OF HEALTH**

**COST PROPOSAL BID FORM: Finger Lakes/Northern New York Region**

**Procurement Title: NYS Medicaid Transportation Management – Finger Lakes/ Northern New York Region**

**RFP #17222**

Bidder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bidder Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bidder must submit a bid price for each of the Volume Level Categories (A & B) for the number of Medicaid enrollees who are eligible to receive fee-for-service (FFS) non-emergency transportation, as indicated in the chart below.** Bids must be provided for each volume level category, even if the region’s total eligible enrollees currently do not reach that level. Bidders are encouraged to reflect volume discounts in higher volume level categories.

|  |  |  |
| --- | --- | --- |
| **Volume Level Category** | **Medicaid Enrollees Eligible to Receive FFS Transportation** | **Per Enrollee, Per Month Cost Bid for Transportation Management Services\*** |
| **A** | 400,000 – 500,000 |  |
| **B** | 500,001 or greater |  |

**\*Prices remain firm for the first three (3) years of the contract. See price adjustment clause in Section 2.3, Term of Agreement and Section 5.4, Payment for years four (4) and five (5).**

Authorized Vendor Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#

# ATTACHMENT D

### REFERENCES

**Submit a total of THREE (3) references (Section 6.0.F) using this form.**

**Expand fields and duplicate this page as necessary.**

|  |
| --- |
| **RFP#17222 – Medicaid Transportation Management – Finger Lakes / Northern New York Region** |
| **BIDDER:** |  |
| **Provide the following information for each reference submitted. Fields will expand as you type.** |
| **Reference Company #1:** | Click here to enter text. |
| **Contact Person:** | Click here to enter text. |
| **Address:** | Click here to enter text. |
| **City, State, Zip:** | Click here to enter text. |
| **Telephone Number:** | Click here to enter text. |
| **Email Address:** | Click here to enter text. |
| **Number of years Bidder provided services to this entity:** | Click here to enter text. |
| **Brief description of the services provided:** | Click here to enter text. |
| **Reference Company #2:** | Click here to enter text. |
| **Contact Person:** | Click here to enter text. |
| **Address:** | Click here to enter text. |
| **City, State, Zip:** | Click here to enter text. |
| **Telephone Number:** | Click here to enter text. |
| **Email Address:** | Click here to enter text. |
| **Number of years Bidder provided services to this entity:** | Click here to enter text. |
| **Brief description of the services provided:** | Click here to enter text. |
| **Reference Company #3:** | Click here to enter text. |
| **Contact Person:** | Click here to enter text. |
| **Address:** | Click here to enter text. |
| **City, State, Zip:** | Click here to enter text. |
| **Telephone Number:** | Click here to enter text. |
| **Email Address:** | Click here to enter text. |
| **Number of years Bidder provided services to this entity:** | Click here to enter text. |
| **Brief description of the services provided:** | Click here to enter text. |

# ATTACHMENT F

### NEW YORK STATE DOH M/WBE RFP REQUIRED FORMS

All DOH procurements have a section entitled **“MINORITY AND WOMEN OWNED BUSINESS ENTERPRISE REQUIREMENTS.”** This section of procurement sets forth the established DOH goal forthat particularprocurement and alsodescribes the forms that should be completed with their bid. Below is a summary of the forms used in the DOH MWBE Participation Program by a bidder.

**Form #1: Bidder MWBE Utilization Plan -** This document should be completed by all bidders responding to RFPs with an MWBE goal greater than zero. The bidder must demonstrate how it plans to meet the stated MWBE goal. In completing this form, the bidder should describe the steps taken to establish communication with MWBE firms and identify current or future relationships with certified MWBE firms. The second page of the form should list the MWBE certified firms that the vendor plans to engage with on the project and the amount that each certified firm is projected to be paid. Plans to work with uncertified firms or women and minority staffed firms do not meet the criteria for participation. The firm must be owned and operated by a Woman and/or Minority and must be certified by NYS Empire State Development to be eligible for participation. If the plan is not submitted or is deemed deficient**,** the bidder may be sent a notice of deficiency. It is mandatory that all awards with goals have a utilization plan on file.

**Form #2: MWBE Utilization Waiver Request -** This document should be filled out by the bidder if the utilization plan (Form #1) indicates less than the stated participation goal for the procurement. In this instance, Form #2 must accompany Form #1 with the bid. If Form #2 is provided and goal was initially set higher, revised goal approval will be necessary from DOB. When completing Form #2, it is important that the bidder thoroughly document the steps that were taken to meet the goal and provide evidence in the form of attachments to the document. The list of bidder generated attachments, documenting the bidder’s good-faith efforts, can be found in the “Detailed Instructions for Completing MWBE Forms 1 & 2”, which is found herein. A bidder can also attach additional evidence outside of those referenced attachments. Without evidence of good-faith efforts, in the form of attachments or other documentation, the Department of Health may not approve the waiver and the bidder may be deemed non-responsive.

New MWBE firms are being certified daily and new MWBE firms may now be available to provide products or services that were historically unavailable. If Form #2 is found by DOH to be deficient, the bidder may be sent a deficiency letter which will require a revised form to be returned within 7 business days of receipt to avoid a finding of non-compliance. DOH may work directly with firm to resolve minor deficiencies via e-mail.

**Form #3:**  **Replaced by Online Compliance System -** <https://ny.newnycontracts.com> Contractors will need to login and submit payments to MWBE Firms in this online system once payments to these vendors commence.

**Form #4 – MWBE Staffing Plan-** This form should be completed based on the composition of staff working on the project. Enter the numbers or counts in the corresponding boxes and add up the totals in each column. This form is for diversity research purposes only and has no bearing on MWBE goal achievement.

**Form #5 – EEO and MWBE Policy Statement** -This is a standard EEO policy that needs to be signed and dated and submitted. If Bidder has their own EEO policy it may be submitted instead of endorsing this document.

## - M/WBE Form #1 -

**New York State Department of Health**

**M/WBE UTILIZATION PLAN**

|  |
| --- |
| **Bidder/Contractor Name:** Click here to enter text. |
| **Vendor ID:** Click here to enter text. | **Telephone No.**Click here to enter text.**Email:** Click here to enter text. |
| **RFP/Contract Title:** Click here to enter text. | **RFP/Contract No.**Click here to enter text. |

**Description of Plan to Meet M/WBE Goals**

|  |
| --- |
| Click here to enter text. |

**PROJECTED M/WBE USAGE**

|  |  |  |
| --- | --- | --- |
|  | **%** | **Amount** |
| **1. Total Dollar Value of Proposal Bid** | **100** | Click here to enter text. |
| **2. MBE Goal Applied to the Contract** | Click here to enter text. | **$** Click here to enter text. |
| **3. WBE Goal Applied to the Contract** | Click here to enter text. | **$** Click here to enter text. |
| **4. M/WBE Combined Totals** | Click here to enter text. | **$** Click here to enter text. |

“Making false representation or including information evidencing a lack of good faith as part of, or in conjunction with, the submission of a Utilization Plan is prohibited by law and may result in penalties including, but not limited to, termination of a contract for cause, loss of eligibility to submit future bids, and/or withholding of payments. Firms that do not perform commercially useful functions may not be counted toward MWBE utilization.”

Form #1 -Page 1 of 3

**- M/WBE Form #1 – cont.**

**New York State Department of Health**

**M/WBE UTILIZATION PLAN**

**MINORITY OWNED BUSINESS ENTERPRISE (MBE) INFORMATION**

**In order to achieve the MBE Goals, bidder expects to subcontract with New York State certified MINORITY-OWNED entities as follows:**

|  |  |  |
| --- | --- | --- |
| **MBE Firm****(Exactly as Registered)** | **Description of Work (Products/Services) [MBE]** | **Projected MBE Dollar Amount** |
| **Name****Address****City, State, ZIP****Employer I.D.****Telephone Number****(****)** **-**  |  | **$**  |
| **Name****Address****City, State, ZIP****Employer I.D.****Telephone Number****(   )     -** |  | **$** |
| **Name****Address****City, State, ZIP****Employer I.D.****Telephone Number****(   )     -** |  | **$** |

 Form #1 -Page 2 of 3

- M/WBE Form #1 – cont.

**New York State Department of Health**

**M/WBE UTILIZATION PLAN**

**WOMEN OWNED BUSINESS ENTERPRISE (WBE) INFORMATION**

 **In order to achieve the WBE Goals, bidder expects to subcontract with New York State certified WOMEN-OWNED entities as follows:**

|  |  |  |
| --- | --- | --- |
| **WBE Firm****(Exactly as Registered)** | **Description of Work (Products/Services) [WBE]** | **Projected WBE Dollar Amount** |
| **Name****Address****City, State, ZIP****Employer I.D.****Telephone Number****(   )     -** |  | **$** |
| **Name****Address****City, State, ZIP****Employer I.D.****Telephone Number****(   )     -** |  | **$** |
| **Name****Address****City, State, ZIP****Employer I.D.****Telephone Number****(   )     -** |  | **$** |

 Form #1 -Page 3 of 3

**- M/WBE Form #2 –**

**New York State Department of Health**

**Waiver Request**

|  |  |
| --- | --- |
| **Applicant/Grantee :** Click here to enter text. | **Federal Identification No.:** Click here to enter number. |
| **Address:** Click here to enter text. | **Solicitation/Contract No.:** Click here to enter number. |
| **City, State, Zip Code:** Click here to enter text. | **M/WBE Goals: MBE** %%**% WBE** %%**%**(From Lines 2&3 of Form 1) |
| **By submitting this form and the required information, the officer or/contractor certifies that every Good Faith Effort has been taken to promote M/WBE participation pursuant to the M/WBE requirements set forth under the contract.**  |
| **Contractor is requesting a :** [ ] **MBE Waiver – A waiver of the MBE Goal for this procurement is requested. Total / Partial (circle one)**[ ] **WBE Waiver – A waiver of the WBE Goal for this procurement is requested. Total / Partial (circle one)**[ ]  **Waiver Pending ESD Certification –** (Check here if subcontractors or suppliers of Contractor are not certified M/WBE, but an application for certification has been filed with Empire State Development.)**Date of such filing with Empire State Development:** Click here to enter a date.If a total or partial waiver is requested, appropriate supporting documentation as outlined in the Detailed MWBE Form Instructions is required. |
| **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **PREPARED BY (Signature) Date:** SUBMISSION OF THIS FORM CONSTITUTES THE OFFEROR/CONTRACTOR’S ACKNOWLEDGEMENT AND AGREEMENT TO COMPLY WITH THE M/WBE REQUIREMENTS SET FORTH UNDER NYS EXECUTIVE LAW, ARTICLE 15-A AND 5 NYCRR PART 143. FAILURE TO SUBMIT COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A FINDING OF NONCOMPLIANCE AND/OR TERMINATION OF THE CONTRACT.  |
| **Name and Title of Preparer (Printed or Typed):**  | **Telephone Number:**  | **Email Address:**  |
| **Submit with the bid or proposal or if submitting after award submit to:** **doh.sm.mwbe@health.ny.gov** | **\*\*\*\*\*\*\*\*\* FOR DMWBD USE ONLY \*\*\*\*\*\*\*\***  |
| **REVIEWED BY:** | **DATE:**  |
| **Waiver Granted:** [ ] **YES** [ ] **NO** **MBE:** [ ]  **WBE:** [ ] [ ] **Total Waiver** [ ] **Partial Waiver**[ ] **ESD Certification Waiver** [ ] **\*Conditional** [ ] **Notice of Deficiency Issued \_\_\_\_\_\_\_\_\_\_\_\_** |

## - M/WBE Form #4 –

**New York State Department of Health**

**M/WBE STAFFING PLAN**

**For project staff, consultants and/or subcontractors working on this grant complete the following plan. This has no impact on MWBE utilization goals, or the submitted Utilization Plan - Form#1. This is for diversity research purposes.**

**Contractor Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **STAFF** | **Total** | **Male** | **Female** | **Black** | **Hispanic** | **Asian/****Pacific****Islander** | **Other** |
| **Executive/Senior level Officials** |  |  |  |  |  |  |  |
| **Managers/Supervisors** |  |  |  |  |  |  |  |
| **Professionals** |  |  |  |  |  |  |  |
| **Technicians** |  |  |  |  |  |  |  |
| **Administrative Support**  |  |  |  |  |  |  |  |
| **Craft/Maintenance Workers** |  |  |  |  |  |  |  |
| **Laborers and Helpers** |  |  |  |  |  |  |  |
| **Service Workers** |  |  |  |  |  |  |  |
| **Totals** |  |  |  |  |  |  |  |

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

**(Name and Title)**

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

**(Signature)**

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

**Date**

## - M/WBE Form #5 –

**MINORITY AND WOMEN-OWNED BUSINESS ENTERPRISES – EQUAL**

**EMPLOYMENT OPPORTUNITY POLICY STATEMENT**

M/WBE AND EEO POLICY STATEMENT

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the (awardee/contractor)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to adopt the following policies with respect to the project being developed or services rendered at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| M/WBE |

|  |
| --- |
| EEO |

This organization will and will cause its contractors and subcontractors to take good faith actions to achieve the M/WBE contract participations goals set by the State for that area in which the State-funded project is located, by taking the following steps:

Actively and affirmatively solicit bids for contracts and subcontracts from qualified State certified MBEs or WBEs, including solicitations to M/WBE contractor associations.

Request a list of State-certified M/WBEs from AGENCY and solicit bids from them directly.

Ensure that plans, specifications, request for proposals and other documents used to secure bids will be made available in sufficient time for review by prospective M/WBEs.

Where feasible, divide the work into smaller portions to enhanced participations by M/WBEs and encourage the formation of joint venture and other partnerships among M/WBE contractors to enhance their participation.

Document and maintain records of bid solicitation, including those to M/WBEs and the results thereof. Contractor will also maintain records of actions that its subcontractors have taken toward meeting M/WBE contract participation goals.

Ensure that progress payments to M/WBEs are made on a timely basis so that undue financial hardship is avoided, and that bonding and other credit requirements are waived or appropriate alternatives developed to encourage M/WBE participation.

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

Name & Title

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

Signature & Date

(a) This organization will not discriminate against any employee or applicant for employment because of race, creed, color, national origin, sex, age, disability or marital status, will undertake or continue existing programs of affirmative action to ensure that minority group members are afforded equal employment opportunities without discrimination, and shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on state contracts.

(b)This organization shall state in all solicitation or advertisements for employees that in the performance of the State contract all qualified applicants will be afforded equal employment opportunities without discrimination because of race, creed, color, national origin, sex disability or marital status.

c) At the request of the contracting agency, this organization shall request each employment agency, labor union, or authorized representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of this organization’s obligations herein.

(d) Contractor shall comply with the provisions of the Human Rights Law, all other State and Federal statutory and constitutional non-discrimination provisions. Contractor and subcontractors shall not discriminate against any employee or applicant for employment because of race, creed (religion), color, sex, national origin, sexual orientation, military status, age, disability, predisposing genetic characteristic, marital status or domestic violence victim status, and shall also follow the requirements of the Human Rights Law with regard to non-discrimination on the basis of prior criminal conviction and prior arrest.

(e) This organization will include the provisions of sections (a) through (d) of this agreement in every subcontract in such a manner that the requirements of the subdivisions will be binding upon each subcontractor as to work in connection with the State contract.

Form #5 -Page 1 of 1

## Detailed Instructions for Completing MWBE Forms 1 & 2

**Form#1 – MWBE Utilization Plan**

**Page #1 of Form #1**:

**Description of Plan -** Describe any steps/details that support Bidder/Contractor plan to meet the MWBE goals stated in the procurement/contract.

**Line#1** - **Total Dollar Value of Proposal Bid –** This line should represent the total dollar amount of bid. The total value is eligible for MWBE goal setting.

**Line#2 - MBE Goal Applied to the Contract–** Bidder/Contractor lists the amount to be paid/subcontracted to Certified Minority-owned Business Enterprise(s) and the percentage this amount represents of the Total Dollar Value of Proposal Bid listed on Line #1.

*Example:* If paying two MBE firms $100,000 & $50,000 each and Total Dollar Value of Proposal Bid listed on line #1 is $1,000,000, list 15% and $150,000 on Line #2.

**Line#3** - **WBE Goal Applied to the Contract–** Bidder/Contractor lists the amount paid/subcontracted to Certified Woman-owned Business Enterprise(s) and the percentage this amount represents of the Total Dollar Value of Proposal Bid listed on Line 1 of the “Form #1 MWBE Utilization Plan”.

*Example:* If Bidder/Contractor is paying two WBE firms $50,000 & $100,000 each and the Total Dollar Value of Proposal Bid listed on line#1 is $1,000,000 Bidder/Contractor would list 15% and $150,000 on Line #2 of the Utilization Plan.

**Line#4** - **MWBE Combined Totals –** Total of Line #2 and Line #3. [Line #2 + Line #3 = MWBE Combined Totals]

*Example:* Using the above Line #2 and Line #3 examples for payment data, Bidder/Contractor achieves a combined MWBE % of 30% and a combined MWBE dollar amount of $300,000. (15%M and 15%W; $150,000M + $150,000W). MWBE total/Total dollar value of bid = %.

**Page#2 of Form#1:**

**The first column** (left column): Bidder/Contractor lists any Minority-owned Business Enterprises (MBE) that Bidder/Contractor will be subcontracting with or purchasing from and the MBE contact/company information.

**The second column** (center column): Bidder/Contractor describes what type of work certified MBE will be providing or what product certified MBE will be supplying to Bidder/Contractor.

**Third column** (right column): Bidder/Contractor states the amount to be paid to the certified MBE during the term of the contract. The amount totaled from Page #2 should equal the amount listed on Line #2 of Page #1.

**Page#3 of Form#1:**

**The first column** (left column)**:** Bidder/Contractor lists any Woman-owned Business Enterprises (WBE) that Bidder/Contractor will be subcontracting with or purchasing from and WBE contact/company information.

Form Instructions Page 1 of 3

**The second column** (center column): Bidder/Contractor describes what type of work certified WBE will be providing or what product certified WBE will be supplying to Bidder/Contractor.

**Third column** (right column): Bidder/Contractor states the amount to be paid to the certified WBE during the term of the contract. The amount totaled from Page#3 should equal the amount listed on Line#3 of Page#1.

**Form#2 – MWBE Waiver Request**

“Form#1 MWBE Utilization Plans” that commit to a goal % less than the stated MWBE goal percentage in procurement, must be accompanied by a “Form#2 MWBE Waiver Request”.

A Bidder/Contractor may qualify for a partial or total waiver of the MWBE goal requirements established on a State contract only upon the submission of a waiver form by a Bidder/Contractor, documenting good-faith efforts by the Contractor to meet the goal requirements of the state contract and a consideration of applicable factors. The ability to subcontract with M/WBEs and separately the ability to purchase with M/WBEs must be addressed in attachments on all waiver requests.

Fill out the header with the name of the Bidder/Contractor requesting the waiver under Offeror/Contractor Name, include your Federal Identification ID, Address, Solicitation/Contract Number, and M/WBE Goals.

Check off the appropriate box for the type of waiver that is being requested and whether it is a total or partial waiver. If the waiver is Pending ESD Certification, meaning the subcontractor has applied for certification with Empire State Development, check off that box and state the date that they applied for certification.

Next, and directly below the Pending ESD Certification area, please sign and date the waiver. Provide the name of the preparer as well as a telephone number and email address (Bidder/Contractor direct contact number of person authorized to discuss submission).

The following attachments should also be provided:

1. A statement setting forth your basis for requesting a partial or total waiver. The statement should at a minimum include the services being subcontracted out and why a portion of those services cannot be subcontracted to Certified MWBE(s). In addition, statement must also include what purchases of equipment and supplies are being made and why those purchases cannot be provided by certified MWBE(s).
2. The names of general circulation, trade association, and M/WBE-oriented publications in which you solicited certified M/WBEs for the purposes of complying with your participation goals related to this contract.
3. A list identifying the date(s) that all solicitations for certified M/WBE participation were published in any of the above publications.
4. A list of all certified M/WBEs appearing in the NYS Directory of Certified Firms that were solicited for purposes of complying with your certified M/WBE participation levels.

Form Instructions Page 2 of 3

1. Copies of notices, dates of contact, letters, and other correspondence as proof that solicitations were made in writing and copies of such solicitations, or a sample copy of the solicitation if an identical solicitation was made to all certified M/WBEs.
2. Provide copies of responses to your solicitations received by you from certified M/WBEs.
3. Provide a description of any contract documents, plans, or specifications made available to certified M/WBEs for purposes of soliciting their bids and the date and manner in which these documents were made available.
4. Provide documentation of any negotiations between you, the Offeror/Contractor, and the M/WBEs undertaken for purposes of complying with the certified M/WBE participation goals.
5. Provide any other information you deem relevant which may help us in evaluating your request for a waiver.

**\*All attachments are created by the entity requesting the waiver. These are self-generated attachments and are not provided by the agency.**

 Form Instructions Page 3 of 3

# ATTACHMENT G

### BIDDER’S DISCLOSURE OF PRIOR NON-RESPONSIBILITY DETERMINATIONS

Procurement Title: [Type text]

RFP #: [Type text]

Bidder Name: [Type text]

Bidder Address: [Type text]

Bidder SFS Vendor ID #: [Type text]

Bidder Federal ID#: [Type text]

Affirmations & Disclosures related to State Finance Law §§ 139-j & 139-k:

Offerer/Bidder affirms that it understands and agrees to comply with the procedures of the Department of Health relative to permissible contacts (provided below) as required by State Finance Law §139-j (3) and §139-j (6) (b).

Pursuant to State Finance Law §§139-j and 139-k, this *Invitation for Bid* *or Request for Proposal* includes and imposes certain restrictions on communications between the Department of Health (DOH) and an Offerer during the procurement process. An Offerer/bidder is restricted from making contacts from the earliest notice of intent to solicit *bids/proposals* through final award and approval of the Procurement Contract by the DOH and, if applicable, Office of the State Comptroller (“restricted period”) to other than designated staff unless it is a contact that is included among certain statutory exceptions set forth in State Finance Law §139-j(3)(a). Designated staff, as of the date hereof, is/are identified on the first page of this *Invitation for Bid, Request for Proposal, or other solicitation document.* DOH employees are also required to obtain certain information when contacted during the restricted period and make a determination of the responsibility of the Offerer/bidder pursuant to these two statutes. Certain findings of non-responsibility can result in rejection for contract award and in the event of two findings within a 4 year period, the Offerer/bidder is debarred from obtaining governmental Procurement Contracts. Further information about these requirements can be found on the Office of General Services Website at: <http://ogs.ny.gov/acpl/>

1. Has any Governmental Entity made a finding of non-responsibility regarding the individual or entity seeking to enter into the Procurement Contract in the previous four years? (Please Check):

[ ] No [ ] Yes

If yes, please answer the next questions:

1a. Was the basis for the finding of non-responsibility due to a violation of State Finance Law §139-j (Please Check):

 [ ] No [ ] Yes

1b. Was the basis for the finding of non-responsibility due to the intentional provision of false or incomplete information to a Governmental Entity? (Please Check):

 [ ] No [ ] Yes

1c. If you answered yes to any of the above questions, please provide details regarding the finding of non-responsibility below.

**Governmental Entity:** [Type text]

**Date of Finding of Non-responsibility:** [Type text] Attachment G Page 1 of 2

**Basis of Finding of Non-Responsibility:** [Type text]

(Add additional pages as necessary)

2a. Has any Governmental Entity or other governmental agency terminated or withheld a Procurement Contract with the above-named individual or entity due to the intentional provision of false or incomplete information? (Please Check):

 [ ] No [ ] Yes

2b. If yes, please provide details below.

**Governmental Entity:** [Type text]

**Date of Termination or Withholding of Contract**: [Type text]

Basis of Termination or Withholding: [Type text]

(Add additional pages as necessary)

**Offerer/Bidder certifies that all information provided to the Department of Health with respect to State Finance Law §139-k is complete, true and accurate.**

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

(Officer Signature) (Date)

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

(Officer Title) (Telephone)

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

(E-mail Address)

 Attachment G Page 2 of 2

# ATTACHMENT H

### ENCOURAGING USE OF NEW YORK BUSINESSES IN CONTRACT PERFORMANCE

**I. Background**

New York State businesses have a substantial presence in State contracts and strongly contribute to the economies of the state and the nation. In recognition of their economic activity and leadership in doing business in New York State, bidders/proposers for this contract for commodities, services or technology are strongly encouraged and expected to consider New York State businesses in the fulfillment of the requirements of the contract. Such partnering may be as subcontractors, suppliers, protégés or other supporting roles.

Bidders/proposers need to be aware that all authorized users of this contract will be strongly encouraged, to the maximum extent practical and consistent with legal requirements, to use responsible and responsive New York State businesses in purchasing commodities that are of equal quality and functionality and in utilizing service and technology. Furthermore, bidders/proposers are reminded that they must continue to utilize small, minority and women-owned businesses, consistent with current State law.

Utilizing New York State businesses in State contracts will help create more private sector jobs, rebuild New York’s infrastructure, and maximize economic activity to the mutual benefit of the contractor and its New York State business partners. New York State businesses will promote the contractor’s optimal performance under the contract, thereby fully benefiting the public sector programs that are supported by associated procurements.

Public procurements can drive and improve the State’s economic engine through promotion of the use of New York businesses by its contractors. The State therefore expects bidders/ proposers to provide maximum assistance to New York businesses in their use of the contract. The potential participation by all kinds of New York businesses will deliver great value to the State and its taxpayers.

**II. Required Identifying Information**

Bidders/proposers can demonstrate their commitment to the use of New York State businesses by responding to the question below:

Will New York State Businesses be used in the performance of this contract?

[ ] YES [ ] NO

If yes, identify New York State businesses that will be used and attach identifying information. Information should include at a minimum: verifiable business name, New York address and business contact information.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **New York Business Identifying Information Business Name** | **Business Address**  | **Contact Name**  | **Contact Phone**  | **Contact Email Address** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

# ATTACHMENT I

### NO-BID FORM

PROCUREMENT TITLE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RFP # \_\_\_\_\_\_\_\_\_\_

Bidders choosing not to bid are requested to complete the portion of the form below:

* We do not provide the requested services. Please remove our firm from your mailing list
* We are unable to bid at this time because:

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

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

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

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

* Please retain our firm on your mailing list.

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

(Firm Name)

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

(Officer Signature) (Date)

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

(Officer Title) (Telephone)

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

(E-mail Address)

FAILURE TO RESPOND TO BID INVITATIONS MAY RESULT IN YOUR FIRM BEING REMOVED FROM OUR MAILING LIST FOR THIS SERVICE.

# ATTACHMENT J

### VENDOR RESPONSIBILITY ATTESTATION

To comply with the Vendor Responsibility Requirements outlined in Section 6.1.c, Administrative Proposal Vendor Responsibility Questionnaire, I hereby certify:

**Choose one:**

 An on-line Vendor Responsibility Questionnaire has been updated or created at OSC's website: <https://portal.osc.state.ny.us> within the last six months.

 A hard copy Vendor Responsibility Questionnaire is included with this proposal/bid and is dated within the last six months.

 A Vendor Responsibility Questionnaire is not required due to an exempt status. Exemptions include governmental entities, public authorities, public colleges and universities, public benefit corporations, and Indian Nations.

Signature of Organization Official: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print/type Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# ATTACHMENT K

### DIVERSITY PRACTICES QUESTIONNAIRE

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, as \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (title) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_firm or company (hereafter referred to as the company), swear and/or affirm under penalty of perjury that the answers submitted to the following questions are complete and accurate to the best of my knowledge:

1. Does your company have a Chief Diversity Officer or other individual who is tasked with supplier diversity initiatives? Yes or No

 If Yes, provide the name, title, description of duties, and evidence of initiatives performed by this individual or individuals.

2. What percentage of your company’s gross revenues (from your prior fiscal year) was paid to New York State certified minority and/or women-owned business enterprises as subcontractors, suppliers, joint- venturers, partners or other similar arrangement for the provision of goods or services to your company’s clients or customers?

3. What percentage of your company’s overhead (i.e. those expenditures that are not directly related to the provision of goods or services to your company’s clients or customers from your prior fiscal year) was paid to New York State certified minority- and women-owned business enterprises as suppliers/contractors?1

4. Does your company provide technical training2 to minority- and women-owned business enterprises? Yes or No

 If Yes, provide a description of such training which should include, but not be limited to, the date the program was initiated, the names and the number of minority- and women-owned business enterprises participating in such training, the number of years such training has been offered and the number of hours per year for which such training occurs.

**5. Is your company participating in a government approved minority- and women-owned business enterprise mentor-protégé program? Yes or No**

**If Yes, identify the governmental mentoring program in which your company participates and provide evidence demonstrating the extent of your company’s commitment to the governmental mentoring program.**

6. Does your company include specific quantitative goals for the utilization of minority- and women-owned business enterprises in its non-government procurements? Yes or No

 If Yes, provide a description of such non-government procurements (including time period, goal, scope, and dollar amount) and indicate the percentage of the goals that were attained.

7. Does your company have a formal minority- and women-owned business enterprise supplier diversity program? Yes or No

 If Yes, provide documentation of program activities and a copy of policy or program materials.

8. Does your company plan to enter into partnering or subcontracting agreements with New York State certified minority- and women-owned business enterprises if selected as the successful respondent? Yes or No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do not include onsite project overhead~~.~~ 2Technical training is the process of teaching employees how to more accurately and thoroughly perform the technical components of their jobs. Training can include technology applications, products, sales and service tactics, and more. Technical skills are job-specific as opposed to soft skills, which are transferable. Attachment K Page 1 of 2

# ATTACHMENT K Cont’d

### DIVERSITY PRACTICES QUESTIONNAIRE

|  |  |
| --- | --- |
| Signature of Owner/Official |  |
| Printed Name of Signatory |  |
| Title |       |
| Name of Business |  |
| Address |       |
| City, State, Zip |       |

**Attachment K Page 2 of 2**

**ATTACHMENT L**

**Vendor Assurance of No Conflict of Interest or Detrimental Effect**

The CONTRACTOR offering to provide services pursuant to this Contract, as a contractor, joint venture contractor, subcontractor, or consultant, attests that its performance of the services outlined in this contract does not and will not create a conflict of interest with nor position the CONTRACTOR to breach any other contract currently in force with the State of New York.

Actual or potential conflicts of interest are those relationships, financial or otherwise, which could be in conflict or interfere with the proper discharge of responsibilities under this RFP/contract. This includes but is not limited to any business relationship or financial interests with entities which provide or utilize transportation services and companies whose reimbursement for transportation of Medicaid enrollees is made via eMedNY or through another Medicaid reimbursement method, except where the successful bidder has a financial or other relationship to perform transportation services under a contract with a Managed Long Term Care Program. (See Section 8.8 Award Recommendation, Conditional Award). If the successful bidder has a contract with a Managed Long Term Care Plan, all records and bookkeeping will be kept separate and will be producible to the Department of Health upon request. If the successful bidder has a contract or a subcontract with a Managed Long Term Care plan to provide transportation, the Contractor will inform the Department where there may be a conflict of interest and demonstrate how such conflict or potential conflict will be avoided.

The CONTRACTOR will disclose any existing or contemplated relationship with any other person or entity, including relationships with any member, shareholders of 5% or more, parent, subsidiary, or affiliated contractor, which would constitute an actual or potential conflict of interest or appearance of impropriety, relating to other clients/customers of the Respondent or former officers and employees of the Contractor or their Affiliates, in connection with your rendering services enumerated in this Contract. If a conflict does or might exist, please attach a description of how you would eliminate or prevent it. Indicate what procedures will be followed to detect, notify the Agencies of, and resolve any such conflicts. If no such conflicts exists, please indicate.

In addition, the Contractor must disclose whether it, or any of its members, shareholders of 5% or more, parents, affiliates, or subsidiaries, have been the subject of any investigation or disciplinary action by the New York State Commission on Public Integrity or its predecessor State entities (collectively, “Commission”). If so, attached a brief description indicating how any matter before the Commission was resolved or whether it remains unresolved. If no such action exists, please indicate that as well.

Furthermore, the CONTRACTOR attests that it will not act in any manner that is detrimental to any State project on which the CONTRACTOR is rendering services. Specifically, the CONTRACTOR attests that:

1. The fulfillment of obligations by the CONTRACTOR, as proposed in the response, does not violate any existing contracts or agreements between the CONTRACTOR and the State;

2. The fulfillment of obligations by the CONTRACTOR, as proposed in the response, does not and will not create any conflict of interest, or perception thereof, with any current role or responsibility that the CONTRACTOR has with regard to any existing contracts or agreements between the CONTRACTOR and the State;

3. The fulfillment of obligations by the CONTRACTOR, as proposed in the response, does not and will not compromise the CONTRACTOR’s ability to carry out its obligations under any existing contracts between the CONTRACTOR and the State;

4. The fulfillment of any other contractual obligations that the CONTRACTOR has with the State will not affect or influence its ability to perform under any contract with the State resulting from this RFP;

5. During the negotiation and execution of any contract resulting from this RFP, the CONTRACTOR will not knowingly take any action or make any decision which creates a potential for conflict of interest or might cause a detrimental impact to the State as a whole including, but not limited to, any action or decision to divert resources from one State project to another;

6. In fulfilling obligations under each of its State contracts, including any contract which results from this RFP, the CONTRACTOR will act in accordance with the terms of each of its State contracts and will not knowingly take any action or make any decision which might cause a detrimental impact to the State as a whole including, but not limited to, any action or decision to divert resources from one State project to another;

7. No former officer or employee of the State who is now employed by the CONTRACTOR, nor any former officer or employee of the CONTRACTOR who is now employed by the State, has played a role with regard to the administration of this contract procurement in a manner that may violate section 73(8)(a) of the State Ethics Law; and

8. The CONTRACTOR has not and shall not offer to any employee, member or director of the State any gift, whether in the form of money, service, loan, travel, entertainment, hospitality, thing or promise, or in any other form, under circumstances in which it could reasonably be inferred that the gift was intended to influence said employee, member or director, or could reasonably be expected to influence said employee, member or director, in the performance of the official duty of said employee, member or director or was intended as a reward for any official action on the part of said employee, member or director.

 9. The Contractor, for the entire life of the contract, must meet and maintain the conflict of interest disclosures and abrogate any ownership, affiliation, subsidiary relationship, management or operating interest, or participation of any kind in a company or entity that provides or utilizes Medicaid transportation in any part of the region covered by this RFP, except where the contractor has a financial or other relationship to perform transportation services under a contract with a Managed Long Term Care Program.

10. The Contractor must not be co-located with any Medicaid transportation provider.

11. If, during the term of a resulting contract, the Contractor becomes aware of a relationship, actual or potential, which may be considered a conflict of interest with the proper discharge of responsibilities under this RFP/contract, the Contractor shall notify the Department of Health in writing immediately and seek the Department of Health’s approval on any proposed mitigation plans or corrective measures to be taken.

CONTRACTORs responding to this contract should note that the State recognizes that conflicts may occur in the future because a CONTRACTOR may have existing or new relationships. The State will review the nature of any such new relationship and reserves the right to terminate the contract for cause if, in its judgment, a real or potential conflict of interest cannot be cured.

Failure to comply with these provisions may result in termination of the contract and criminal proceedings as required by law.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form must be signed by an authorized executive or legal representative.