Attachment 1

Vendor's References

1. Company Name:_____
2. Contact Name: _____
3. Contact's Title: _____
4. City:_____State:_____
5. E-Mail Address: _____
6. Telephone Number and Area Code: _____
7. Description of Services Furnished: _____

---

1. Company Name:_____
2. Contact Name: _____
3. Contact's Title: _____
4. City:_____State:_____
5. E-Mail Address: _____
6. Telephone Number and Area Code: _____
7. Description of Services Furnished: _____

---

1. Company Name:_____
2. Contact Name: _____
3. Contact's Title: _____
4. City:_____State:_____
5. E-Mail Address: _____
6. Telephone Number and Area Code: _____
7. Description of Services Furnished: _____

Attachment 2

LETTER OF INTENT

Please complete and return this Letter of Intent Form if your organization intends to submit a response to this RFQ. Completion does not obligate the submission of a response. It does, however, add your organization to the distribution list for updates regarding the RFQ as well as responses to written questions from potential bidders.

Submit form to: Melissa Simpson
AID SHIIP
1200 West Third Street
Little Rock, AR 72201
Fax: 501-371-2781
Email: Melissa.simpson@arkansas.gov

Intent to submit response:

Name of Proposing Organization:_____

Type of Organization (circle one): 501 (c)3 Nonprofit Faith-based Government

Address: _____

City, State, Zip: _____

Contact Person #1:_____

Contact Person #1 Title: _____

Email: _____

Phone: _____ Fax: _____

List a second contact if desired.

Contact Person #2:_____

Contact Person #2 Title: _____

Email: _____

Phone: _____ Fax: _____

Attachment 3 - COVER LETTER

Proposer Information

Agency Name:

Agency Contact Person and Title:

Federal Employer ID Number:

Address:

Telephone:

Fax:

Email:

Project Contact Information

Project Coordinator(s) Name

Address:

Telephone:

Fax:

Email:

Proposal Information

County(ies) Served:

Proposed Service Levels bid:
Proposed Total of Client Contact Forms _____

Proposed Total of Public and Media Forms _____

Proposed Contract Amount _____

I acknowledge the obligations of any contract awarded in connection with this proposal and affirm that the Proposer Agency is a legal entity that will meet the specifications set forth in the RFQ.

_____

Signature in ink by the in individual authorized to legally bind the proposer. Date
Unsigned proposals will not be considered.

Attachment 4

CLIENT CONTACT

Counselor and Agency Information	
Counselor First Name	
Counselor Last Name	
Counselor Zip Code	
Date of Contact	/ /

Client Name and Contact Information – Optional	
Client First Name	
Client Last Name	
Client Representative	
Client Phone Number	( ) -
Client Address	
Client City	
Client Zip Code	
Client County	

First vs. Continuing Contact	
1	First Contact for Issue
2	Continuing Contacts for Issue

Client Age Group	
1	64 or Younger
2	65-74
3	75-84
4	85 or Older
9	Not Collected

Client Gender	
1	Female
2	Male
9	Not Collected

Client Primary Language Other Than English	
1	Primary Language Other Than English
2	English is Client's Primary Language
9	Not Collected

Client Monthly Income	
1	Below 150% FPL *($1,396.25 Single or $1,891.25Couple before deductions)*
2	At or Above 150% FPL
9	Not Collected

Client Assets	
1	Below LIS Asset Limits *($13,070 Single or $26,120 Couple not including HOME or one CAR)*
2	Above LIS Asset Limits
9	Not Collected

Receiving or Applying for Social Security Disability or Medicare Disability	
1	Yes
2	No
9	Not Collected

How Did Client Learn About SHIP	
1	Previous Contact
2	CMS / Medicare
3	Presentations
4	Mailings
5	Another Agency
6	Friend or Relative
7	Media
8	State Website
9	Other
99	Not Collected

Method of Contact	
1	Phone Call
2	Face to Face at Counseling Location or Event Site
3	Face to Face at Client's Home or Facility
4	E-Mail
5	Postal Mail or Fax

Client Race – Ethnicity – Check all that Apply	
1	Hispanic, Latino, or Spanish Origin
2	White, Non-Hispanic
3	Black, African American
4	American Indian or Alaska Native
5	Asian Indian
6	Chinese
7	Filipino
8	Japanese
9	Korean
10	Vietnamese
11	Native Hawaiian
12	Guamanian or Chamorro
13	Samoan
14	Other Asian
15	Other Pacific Islander
16	Some Other Race – Ethnicity
99	Not Collected

Dual Eligible with Mental Illness / Mental Disability	
1	Yes
2	No
9	Not Collected

PRESCRIPTION DRUG ASSISTANCE

Medicare Prescription Drug Coverage (Part D)

1	Eligibility / Screening
2	Benefit Explanation
3	Plans Comparison
4	Plan Enrollment / Disenrollment
5	Claims / Billing
6	Appeals / Grievances
7	Fraud and Abuse
8	Marketing / Sales Complaints or Issues
9	Quality of Care
10	Plan Non-Renewal

Part D Low Income Subsidy LIS / Extra Help)

11	Eligibility / Screening
12	Benefit Explanation
13	Application Assistance
14	Claims / Billing
15	Appeals / Grievances

Other Prescription Assistance

16	Union / Employer Plan
17	Military Drug Benefits
18	Manufacturer Programs
20	Other _____

MEDICARE (Parts A & B)

21	Eligibility
22	Benefits Explanation
23	Claims / Billing
24	Appeals / Grievances
25	Fraud and Abuse
26	Quality of Care

ADDITIONAL REQUIRED FIELDS	
60	MSP (Medicare Savings Program) Savings $_____
61	LIS (Extra Help) Savings $_____
62	Medigap Savings $_____
63	Claims/Appeals Savings $_____
64	Part D/Manufacturers Assistance Program Savings $_____
65	DMEPOS Savings $_____
66	Fraud Savings $_____
67	Medicare Minutes Attendee (circle one) Yes No

Total Time Spent on This Contact Date			
	Hours		Minutes

Status	
1	General Information and Referral
2	Detailed Assistance – In Progress
3	Detailed Assistance – Fully Completed
4	Problem Solving / Problem Resolution – In Progress
5	Problem Solving / Problem Resolution – Fully Completed

MEDICARE ADVANTAGE (HMO, POS, PPO, PFFS, SNP, MSA, Cost)

27	Eligibility / Screening
28	Benefit Explanation
29	Plans Comparison
30	Plan Enrollment / Disenrollment
31	Claims / Billing
32	Appeals / Grievances
33	Fraud and Abuse
34	Marketing / Sales Complaints or Issues
35	Quality of Care
36	Plan Non-Renewal

MEDICARE SUPPLEMENT / SELECT

37	Eligibility / Screening
38	Benefit Explanation
39	Plans Comparison
40	Claims / Billing
41	Appeals / Grievances
42	Fraud and Abuse
43	Marketing / Sales Complaints or Issues
44	Quality of Care
45	Plan Non-Renewal

MEDICAID

46	Medicare Savings Programs (MSP) Screening (QMB, SLMB, QI)
47	MSP Application Assistance
48	Medicaid (SSI, Nursing Home, MEPD, Elderly Waiver) Screening
49	Medicaid Application Assistance
50	Medicaid / QMB Claims
51	Fraud and Abuse

OTHER

52	Long Term Care (LTC) Insurance
53	LTC Partnership
54	LTC Other
55	Military Health Benefits
56	Employer / Federal Employee Health Benefits (FEHB)
57	COBRA
58	Other Health Insurance
59	Other

OPTIONAL
MCR #:
DOB:
Eff. Date A:
Eff. Date B:

Attachment 5

OMB No. 0938-0850
Updated 3/6/2012

PUBLIC AND MEDIA EVENTS

Start Date of Activity			/			/				
End Date of Activity			/			/				

Presenter.*	First Name	Last Name	Total Hours Spent on Activity
Primary Presenter			
Second Presenter			
Third Presenter			
Fourth Presenter			
Fifth Presenter			
Sixth Presenter			
Seventh Presenter			
Eighth Presenter			
Ninth Presenter			

1	Interactive Presentation to Public. Face to Face In-Person.		
Estimated Number of Attendees			
Estimated Persons Provided Enrollment Assistance			

2	Booth or Exhibit. At Heath Fair, Senior Fair, or Special Event.			
Estimated Number of Direct Interactions with Attendees				
Estimated Persons Provided Enrollment Assistance				

3	Dedicated Enrollment Event Sponsored By SHIP or in Partnership.		
Est Number Persons Reached at Event Regardless of Enroll Assistance			
Estimated Number Persons Provided Any Enrollment Assistance			
Estimated Number Provided Enrollment Assistance with Part D			
Estimated Number Provided Enrollment Assistance with LIS			
Estimated Number Provided Enrollment Assistance with MSP			
Estimated Number Provided Enrollment Assist Other Medicare Program			

4	Radio Show. Live or Taped. Not a Public Service Announce or Ad.						
Estimated Number of Listeners Reached							

5	TV or Cable Show. Live or Taped. Not a Public Service Announce or Ad.						
Estimated Number of Viewers Reached							

6	Electronic Other Activity. PSAs, Electronic Ads, Crawls, Video Conf, Web Conf, Web Chat							
Est Persons Viewing or Listening to PSA, Electronic Ad, Crawl Across Entire Campaign, Video Conf, Web Conf, Web Chat								

7	Print Other Activity. Newspaper, Newsletter, Pamphlets, Fliers, Posters, Targeted Mailings							
Est Persons Reading Article, Newsletter, Ad or Pieces of Targeted Mail or Other Printed Across Entire Campaign								

Event or Group Name	
Contact First Name - Optional	
Contact Last Name - Optional	
Contact Phone Number - Optional	( ) -
Street Address of Event	
Event City	
Zip Code of Event	

	Topic Focus - Check All That Apply
1	Medicare Parts A and B
2	Plan Issues - Non-Renewal, Termination, Employer-COBRA
3	Long-Term Care
4	Medigap - Medicare Supplements
5	Medicare Fraud and Abuse
6	Medicare Prescription Drug Coverage - PDP / MA-PD
7	Other Prescription Drug Coverage - Assistance
8	Medicare Advantage
9	QMB - SLMB - QI
10	Other Medicaid
11	General SHIP Program Information
12	Medicare Preventive Services
13	Low-Income Assistance
14	Dual Eligible with Mental Illness Mental Disability
15	Volunteer Recruitment
16	Partnership Recruitment
17	Other Topics - Describe:
18	MSP (Medicare Savings Program) Savings $
19	LIS (Extra Help) Savings $_____
20	Medigap Savings $_____
21	Part D/ Manufacturers Assistance Program Savings $_____
22	DMEPOS Savings$_____
23	Fraud Savings $_____
24	Medicare Minutes Presentation? (circle one) Yes No

	Target Audiences - Check All That Apply
1	Medicare Pre-Enrollees - Age 45-64
2	Medicare Beneficiaries
3	Family Members - Caregivers of Medicare Beneficiaries
4	Low-Income
5	Hispanic, Latino, or Spanish Origin
6	White, Non-Hispanic
7	Black, African American
8	American Indian or Alaska Native
9	Asian Indian
10	Chinese
11	Filipino
12	Japanese
13	Korean
14	Vietnamese
15	Native Hawaiian
16	Guamanian or Chamorro
17	Samoan
18	Other Asian
19	Other Pacific Islander
20	Some Other Race-Ethnicity
21	Disabled
22	Rural
23	Employer-Related Groups
24	Mental Health Professionals
25	Social Work Professionals
26	Dual-Eligible Groups
27	Partnership Outreach
28	Presentations to Groups in Languages Other Than English
29	Other Audiences - Describe:

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM

Failure to complete all of the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

SUBCONTRACTOR: ☐ Yes ☐ No

SUBCONTRACTOR NAME:

TAXPAYER ID NAME:

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

YOUR LAST NAME: FIRST NAME: M.I.:

ADDRESS:

CITY: STATE: ZIP CODE: --- COUNTRY:

AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:

FOR INDIVIDUALS*

Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse *is* a current or former: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/ commission, data entry, etc.]	For How Long?		What is the person(s) name and how are they related to you? [i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.]	
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Relation
General Assembly	☐	☐					
Constitutional Officer	☐	☐					
State Board or Commission Member	☐	☐					
State Employee	☐	☐					

☐ **None of the above applies**

FOR A VENDOR (BUSINESS)*

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

Position Held	Mark (√)		Name of Position of Job Held [senator, representative, name of board/commission, data entry, etc.]	For How Long?		What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control?		
	Current	Former		From MM/YY	To MM/YY	Person's Name(s)	Ownership Interest (%)	Position of Control
General Assembly	☐	☐						
Constitutional Officer	☐	☐						
State Board or Commission Member	☐	☐						
State Employee	☐	☐						

☐ **None of the above applies**

Rev. 08/20/07

Attachment 6

Contract and Grant Disclosure and Certification Form

Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.

As an additional condition of obtaining, extending, amending, or renewing a contract with a *state agency* I agree as follows:

1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete a **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM.** Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.

2. I will include the following language as a part of any agreement with a subcontractor:

   Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.

3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM** completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

I certify under penalty of perjury, to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.

Signature_____ Title_____ Date_____

Vendor Contact Person_____ Title_____ Phone No._____

Agency use only

Agency Number_____ Agency Name_____ Agency Contact Person_____ Contact Phone No._____ Contract or Grant No._____