



State of Arkansas
ARKANSAS DEPARTMENT OF HEALTH
4815 West Markham
Little Rock, Arkansas 72205

APPLICATION PACKET

DH-20-0024

Purpose of Sub-Grant:

The Arkansas Department of Health (ADH) issues this Notice of Funds Availability (NOFA) on behalf of the Stroke and STEMI Program to obtain applications for funding to support the development of a mobile communications platform to streamline communications between Emergency Medical Services and hospitals to optimize STEMI patient care with the option of including other conditions as well (i.e. trauma, stroke, sepsis and general patient population).

Due Date: Friday June 12, 2020 by 4:00 PM CST

Email Completed Packet to Issuing Officer. David Vrudny at David.Vrudny@arkansas.gov

NOTE: WORD version of Application Packet available on request – contact issuing officer

APPLICATION SIGNATURE PAGE

Type or Print the following information.

APPLICANT'S INFORMATION			
Company:			
Address:			
City:		State:	Zip Code:
Business Designation:	<input type="checkbox"/> Individual <input type="checkbox"/> Partnership	<input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Corporation	<input type="checkbox"/> Public Service Corp <input type="checkbox"/> Nonprofit <input type="checkbox"/> Intergovernmental
Minority and Women-Owned Designation*:	<input type="checkbox"/> Not Applicable <input type="checkbox"/> African American	<input type="checkbox"/> American Indian <input type="checkbox"/> Hispanic American	<input type="checkbox"/> Asian American <input type="checkbox"/> Pacific Islander American <input type="checkbox"/> Service Disabled Veteran <input type="checkbox"/> Women-Owned
AR Certification #: _____		* See <i>Minority and Women-Owned Business Policy</i>	
APPLICANT CONTACT INFORMATION			
<i>Provide contact information to be used for bid solicitation related matters.</i>			
Contact Person:		Title:	
Phone:		Alternate Phone:	
Email:			
ILLEGAL IMMIGRANT CONFIRMATION			
By signing and submitting a response to this solicitation, the applicant agrees and certifies that they do not employ or contract with illegal immigrants. If selected, the recipient certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract.			
ISRAEL BOYCOTT RESTRICTION CONFIRMATION			
By signing and submitting a response to this solicitation, the applicant agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.			
Geographical Coverage Area: Indicate geographical coverage area as either statewide or by individual counties, alphabetically.			
_____ _____ _____			

An official authorized to bind the prospective recipient to a resultant contract shall sign below.

By signing and submitting a response to this Notice of Funds Availability (NOFA), the applicant agrees to comply with all requirements, and that any exception that conflicts with a requirement of this NOFA will cause the application to be disqualified.

Authorized Signature: _____ **Title:** _____

Use Ink Only.

Printed/Typed Name: _____ **Date:** _____

ADH REQUIREMENTS

Provider Application Must Meet or Exceed The Following Requirements

No.	ADH Requirement	Example of Requirement Vendor must Accommodate
1	<p>Pre-hospital notification in which the mobile app allows the capability for EMS to electronically transmit 12-lead EKGs to hospital users and signal that a code STEMI case (or other case) is en-route from scene to the hospital. Hospitals have the ability to attach a pre-existing EKG for comparison so specialists can compare.</p> <p>Vendor must be able to provide a demonstration of this functionality.</p>	<p>For example, EMS has ability to import the 12-lead EKG from the monitor (preferred) or take a photo (acceptable) and then transmit to all hospital users who have access to the app which may include (but not limited to) the charge nurse, cardiologist, ER physician, cath. lab, and other staff as needed. If the patient is transferred to another facility, this EKG may be shared with this hospital team as well. If a pre-existing EKG is available then any team member should be able to add the comparison so all team members associated with the case can view.</p>
2	<p>First responder hand-off in which the mobile app allows the capability for first responders to start a case in the app, update with patient details, and then using the app transmit the patient data to medical control for assistance or EMS for transition of care.</p> <p>Vendor must be able to provide a demonstration of this functionality.</p>	<p>For example, a first responder starts evaluating a chest pain patient and enters details in the mobile app. If needed, the first responder has the ability to use the app (and associated data) to consult medical control. After EMS arrives all of this data is shared with EMS to assist in the patient hand-off. This data may be used for the prehospital notification and flow to ePCR and EHR.</p> <p>In another example, initial prehospital providers determine it is in the patient's best interest to be flown directly to a PCI capable center (or designated trauma center if a trauma patient, or comprehensive stroke center for LVO patient). Initial care and communication done in the app can be transferred to the transporting air medical team as well as the destination hospital.</p>
3	<p>Allow for care team communication no matter how patient enters the system of care: EMS, ED walk-in, inpatient, or interfacility consult / transfer</p> <p>Vendor must be able to provide a demonstration of this functionality.</p>	<p>For example, consider a case where a STEMI patient walks in to the emergency department of a non-PCI capable hospital. The ED staff has the ability to activate the mobile app to alert a predetermined STEMI care team who also has access to the app. Team members need to have access to the 12-lead EKG, patient information, and all data available. At any point, the hospital has the ability to add more team members or resources as well as alert the PCI capable hospital. The PCI capable hospital users are able to add appropriate team members (cardiology, cath lab...) who also have access to the EKG and patient information. If the decision is made to transfer the patient for a heart cath., the transporting EMS agency can also be included and communicate any changes in condition and estimated time of arrival.</p> <p>Another example is if the hospital suspects a patient already admitted as an inpatient to a non-PCI hospital, the floor staff can alert and activate appropriate in house STEMI team members (like rapid response, attending physicians...) and use the app to alert and transfer the patient to a PCI capable center in the same manner as above.</p> <p>Workflows described above should exist for other time sensitive conditions like trauma, stroke, sepsis, as well as more general cases.</p>

<p>4</p>	<p>Live video calls between all team members</p> <p>Vendors must be able to demo this functionality.</p>	<p>The mobile app allows for live video calls for all team members including pre-hospital, intra-facility, and inter-facility. All team members must be identifiable by their organization (EMS, non-PCI facility, PCI facility, medical consultant...) and role (ED physician, Cardiologist, Medic...).</p> <p>For example, EMS in the field activates a real-time video/audio feature to bring in ER Physician at local (non-PCI capable) hospital to visualize the patient and then the physician uses the app to video conference in the cardiologist located at a different hospital (PCI-capable).</p> <p>In another example, a patient is located in the Emergency Department at a rural facility. The provider uses a video call to consult one of their own specialists about a complex patient. It is recommended that the patient be transferred to a higher level of care. The transfer center at the receiving hospital connects their appropriate specialist and an inter-facility video call can be done to assist in appropriate disposition.</p>
<p>5</p>	<p>Ability to dynamically build care team as patient case evolves.</p> <p>Vendor must be able to provide a demonstration of this functionality.</p>	<p>For example, consider a case where a trauma patient in the ER being worked on begins showing signs of a heart attack and a 12-lead confirms STEMI - the mobile app can be used to then activate and mobilize the STEMI Team.</p> <p>In another example, trauma activations are frequently tiered. An inbound EMS patient is initially determined to be a Level 2 activation. Upon arrival, the patient needs to be upgraded to a Level 1 activation. As the case evolves, additional resources like neurosurgery, orthopedics, and ENT is added to the care team.</p> <p>In another example, the EKG for a suspected STEMI case is questionable for an inbound EMS patient. The EKG is forwarded to the cardiologist who wants to see the patient in the ED. After evaluation, it is decided that the patient be taken to the catheterization lab and the app is used to activate the remainder of the care team.</p> <p>In another example, a STEMI patient is in the Emergency Department at 2am and the cath lab team is at home. The House Supervisor is activated to start warming up the cath lab while the cath lab team is en route to the hospital to shave off critical time.</p>

<p>6</p>	<p>Instantly provide case feedback to all team members including EMS, non-PCI capable hospital, and PCI capable hospital team members as appropriate</p> <p>Vendor must be able to provide a demonstration of this functionality.</p>	<p>For example, EMS activates the mobile app to provide an alert that a suspected STEMI patient is in the field and the patient is transported to a local non-PCI hospital. The STEMI patient is then transferred from the non-PCI hospital to a PCI capable hospital. However, during a catherization procedure at the PCI hospital the cardiologist determines the case was a STEMI mimic and the procedure is canceled. The mobile app has the capability to receive an update by the cath lab at the PCI sites and this feedback that the case was a mimic is provided instantly to all members of the STEMI care team for that patient including EMS, the non-PCI hospital staff and the PCI hospital staff.</p> <p>Another example that needs to be accommodated is if EMS activates the mobile app that a STEMI patient is suspected and that patient first arrives to a non-PCI hospital and then is later transferred to a PCI capable hospital to receive a stent. After the stent is provided the PCI hospital staff have the ability to input data into the application so that information is provided to all members of the care team including EMS, non-PCI hospital staff and PCI hospital staff. This feedback information must be able to include, but not limited to, the following: final patient diagnosis, time from first medical contact to device, patient outcome and the image of a CT angiogram pre-procedure and post-procedure.</p> <p>Similar functionality should be available for all time sensitive emergencies.</p>
<p>7</p>	<p>Read notifications built-in to mobile app. Vendor must be able to provide a demonstration of this functionality.</p>	<p>For example, a medic sends a prehospital notification to a hospital to transport a patient to them. When the hospital acknowledges, the medic should receive a notification confirming that the hospital is aware of this inbound patient.</p> <p>In another example, a 12-lead EKG image from the field to the local hospital, a notification is needed to be provided back to the medic as soon as the hospital has opened the message so the medic knows the 12-lead EKG image was received and read.</p> <p>In another example, a cardiologist receives an alert about an active STEMI patient (regardless of location). When the cardiologist acknowledges this alert, all care team members need to know that he/she has received the alert and is aware about the case. If the call list happens to be wrong or the cardiologist is not acknowledging the alert, the care team can assign another cardiologist to ensure a delay to treatment does not occur.</p> <p>This functionality should work across other conditions as well. This data should be available post case for process improvement initiatives.</p>
<p>8</p>	<p>Scalability to other disease processes including stroke, sepsis, trauma as well as more general cases.</p> <p>Vendor must be able to provide a demonstration of this functionality.</p>	<p>For example, a medic has the ability to use the same mobile app to start a stroke, sepsis, trauma, or general medical case as he or she uses for a STEMI case. Similarly, hospitals should be able (if they choose) to use the app for all methods of arrival.</p>
<p>9</p>	<p>Pricing for mobile app is no cost for EMS, paid for by hospitals, and remains consistent for 5-year period</p>	<p>For example, if the pricing for the mobile app for a hospital is \$15,000 for year 1, that price needs to remain \$15,000 for year 2, year 3, year 4, and year 5.</p>

10	Evidence from other PCI and non-PCI capable customers to show improvement in treatment times	Hospital customers show improvement in door-in-door out times and/or Door-to-Door-to-Device from at least 5 customers pre-app vs. post-app by a minimum level of 20%. Client needs to be able to speak with at least five of Vendor's customers verifying this performance has been achieved.
11	Demonstrate ability to accommodate interoperability	App and company must demonstrate emphasis on interoperability. Vendor leverages APIs in such a way that other vendors who generate data in real time should be able to deliver this data in real time using the app. In addition, data should be able to flow out of the app to other vendors (ePCR, EHR, Registries...) and in such a way as to be usable for other purposes. The reason for this requirement is to be able to help reduce the burden of double documentation as well as emphasize the cumulative value of the data being generated by making it useful during active cases as well as upon case completion.
12	Demonstrated adherence to data privacy and security standards.	Vendor has SOC 2 Type 2 certification or other recognized security standard.

Agreement and Compliance

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

1. No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal sub-grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, sub-grant, loan, or cooperative agreement.
2. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this Federal contract, sub-grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," attached hereto, in accordance with its instructions. This disclosure form must be filed with the Arkansas Department of Health (ADH) at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affects the accuracy of the information contained in any disclosure form previously filed. An event that materially affects the accuracy of the information reported includes:
 - a. A cumulative increase of \$25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action; or,
 - b. A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or,
 - c. A change in the officer(s), employee(s), or member(s) contracted to influence or attempt to influence a covered federal action.
3. The undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section.

Authorized Signature: _____
Use Ink Only.

Printed/Typed Name: _____ **Date:** _____

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether sub awardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the sub-awardee, e.g., the first sub-awardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "Sub awardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitations for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Included prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

(b) Enter the full names of the individual(s) performing services and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including

suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503

Approved by OMB
0348-0046

Disclosure of Lobbying Activities

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

<p>1. Type of Federal Action: a. contract _____ b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance</p>	<p>2. Status of Federal Action: a. bid/offer/application _____ b. initial award c. post-award</p>	<p>3. Report Type: a. initial filing _____ b. material change For material change only: Year _____ quarter _____ Date of last report _____</p>
<p>4. Name and Address of Reporting Entity: _____ Prime _____ Subawardee Tier _____, if Known: Congressional District, if known:</p>	<p>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, if known:</p>	
<p>6. Federal Department/Agency:</p>	<p>7. Federal Program Name/Description: CFDA Number, if applicable: _____</p>	
<p>8. Federal Action Number, if known:</p>	<p>9. Award Amount, if known: \$ _____</p>	
<p>10. a. Name and Address of Lobbying Registrant <i>(if individual, last name, first name, MI):</i></p>	<p>b. Individuals Performing Services <i>(including address if different from No. 10a)</i> <i>(last name, first name, MI):</i></p>	
<p>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</p>	<p>Signature: _____ Print Name: _____ Title: _____ Telephone No.: _____ Date: _____</p>	
<p>Federal Use Only</p>	<p>Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)</p>	

RESTRICTION OF BOYCOTT OF ISRAEL CERTIFICATION

Pursuant to Arkansas Code Annotated § 25-1-503, a public entity **shall not** enter into a contract valued at \$1,000 or greater with a company unless the contract includes a written certification that the person or company is not currently engaged in, and agrees for the duration of the contract not to engage in, a boycott of Israel.

By signing below, the Contractor agrees and certifies that they do not boycott Israel and will not boycott Israel during the remaining aggregate term of the contract.

If a company does boycott Israel, see Arkansas Code Annotated § 25-1-503.

Bid Number/Contract Number	DH-20--0024
Description of product or service	
Contractor name	

Contractor Signature: _____
Signature must be handwritten, in ink

Date: _____

VENDOR NAME

IDENTIFY THE NAME OF THE VENDOR THE APPLICANT SELECTS TO PROVIDE THE MOBILE APPLICATION PLATFORM.

NOTE: In an effort to achieve seamless data integration and maximum user benefit it has been determined that the communications network must be hosted by a single provider. A single provider network will allow a seamless data transmission across all pre-hospital, intra-facility and inter-facility communications links. Because each vendor's software is different and they each use different coding and file types to pass data across their network it would be necessary for some type of data conversion or in a worst-case the data would have to be manually entered. The required data conversion and/or manual intervention would severely degrade the overall effectiveness of the network.

Type or Print the following information

Company Name	Street Address	City, State, ZIP

EQUAL EMPLOYMENT OPPORTUNITY POLICY

INCLUDE A COPY OF THE APPLICAN'TS EEO POLICY

ILLEGAL IMMIGRANT CERTIFICATION

INCLUDE A HARD COPY OF THE APPLICANT'S ILLEGAL IMMIGRANT CERTIFICATION. THIS MAY BE COMPLETED ON THIS WEB PAGE:

<https://www.ark.org/dfa/immigrant/index.php/user/welcome>

BUDGET WORKSHEET

ENTER THE DOLLAR AMOUNTS REQUIRED FOR IMPLEMENTATION AND APPLICATION LICENSE FEE.

Budget Categories	Amount
One-Time Implementation	\$
Justification: Fee including system set-up, configuration and all training-related expenses for users of the mobile communications platform.	
Ongoing Annual License Fee	\$
Justification: Annual license fee for mobile communications platform include vendor customer and technical support associated with the system.	
Total:	\$



State of Arkansas
 ARKANSAS DEPARTMENT OF HEALTH
 4815 West Markham
 Little Rock, Arkansas 72205

ATTACHMENT A

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

None of the above applies

FOR AN ENTITY (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 <small>[senator, representative, name of board/commission, data entry, etc.]</small>	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	<input type="checkbox"/>	<input type="checkbox"/>					
Constitutional Officer	<input type="checkbox"/>	<input type="checkbox"/>					
State Board or Commission Member	<input type="checkbox"/>	<input type="checkbox"/>					
State Employee	<input type="checkbox"/>	<input type="checkbox"/>					

None of the above applies

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. _____