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

APPLICATION PACKET
NOFA-18-0001R

APPLICATION SIGNATURE PAGE

Type or Print the following information.

APPLICANT'S INFORMATION					
Company:					
Address:					
City:		State:		Zip Code:	
Business Designation:	☐ Individual ☐ Partnership	☐ Sole Proprietorship ☐ Corporation		☐ Public Service Corp ☐ Nonprofit	
Minority and Women-Owned Designation*:	☐ Not Applicable ☐ African American	☐ American Indian ☐ Hispanic American	☐ Asian American ☐ Pacific Islander American	☐ Service Disabled Veteran ☐ Women-Owned	
	AR Certification #: _____		* See *Minority and Women-Owned Business Policy*		

APPLICANT CONTACT INFORMATION *Provide contact information to be used for bid solicitation related matters.*			
Contact Person:		Title:	
Phone:		Alternate Phone:	
Email:			

ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this s*olicitation*, 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 checking the box below, a Prospective Contractor agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.

☐ Prospective Contractor does not and will not boycott Israel.

Geographical Coverage Area: Indicate geographical coverage area as either statewide or by individual counties, alphabetically.

_____
_____
_____
_____

An official authorized to bind the Prospective Contractor to a resultant contract shall sign below.

By signing and submitting a response to this Notice of Funds Availability (NOFA), the prospective recipient 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:** _____

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:** _____

ADDITIONAL INFORMATION

- *The following information is regarding your facility's capacity to incorporate electronic reporting of* antibiotic prescribing and/or antibiotic resistance data. This is for informational purposes and will assist in determining applicant's eligibility.
- *Provide a response to each item/question in this section. Applicant may expand the space under each item/question to provide a complete response.*
- ***Do not** include additional information if not pertinent to the itemized request.*

Organization Name	Enter Legal Name of Organization.		
Address (City, County, Zip Code)	City	County	Zip Code
Federal ID Number	Click here to enter text.	**NHSN* ID Number**	Click here to enter text.
Licensed Number of Beds	Click here to enter text.		
Chief Executive Officer	Name	E-mail	Phone number
Antimicrobial Stewardship Contact	Name	E-mail	Phone number
Application Contact	Name	E-mail.	Phone number

*NHSN = National Healthcare Safety Network

1. Are you applying as a hospital system? ☐ **Yes** ☐ **No**

If yes, how many hospitals within the system would be participating and submitting data? Click here to enter text.
Please list all locations (name, city) that would be participating? Click here to enter text.

2. Please list all counties served by your facility in alphabetical order.

Click here to enter text.

3. Which module is your facility applying assistance for?

☐ **Antibiotic Use (AU)** ☐ **Antibiotic Resistance (AR)†**

If Antibiotic Resistance, when (month/year) did your facility begin reporting data to NHSN's Antibiotic Use module?
Month/Year

†Note: Antibiotic Resistance assistance is only available for facilities already reporting data to the Antibiotic Use module.

4. What electronic health record (EHR) system does your hospital/hospital system use?

Click here to enter text.

5. Does your hospital's EHR system track electronic medication administration record (eMAR) or bar code medication administration (BCMA) data?

☐ **Yes** ☐ **No**

6. Does your hospital/hospital system use a 3rd party vendor (or purchased software) system for antimicrobial stewardship activities?

☐ **Yes** ☐ **No**

If yes, which system is being used? Click here to enter text.
If yes, how long has this system been used at your facility? Click here to enter text.

6. Does your hospital/hospital system use a 3rd party vendor (or purchased software) system for infection control activities?

☐ **Yes** ☐ **No**

If yes, which system is being used? Click here to enter text.
If yes, how long has this system been used at your facility? Click here to enter text.

8. Which route does your facility plan to utilize to implement data reporting?

☐ Purchase a 3rd party vendor software system

☐ Utilize internal IT staff to develop the capacity to report HL7 clinical document architecture for antibiotic use/antibiotic resistance data

7. Does your hospital/hospital system have the internal informatics staff capability to develop a system for measuring antimicrobial utilization days of therapy (DOT) and denominators (i.e., days present and admission counts) for inpatient wards and entire patient facility that would be packaged in HL7 clinical document architecture per NHSN specifications?

☐ **Yes** ☐ **No**

If yes, who (name and title) will be assigned as the IT project manager for this activity?

Click here to enter text.

9. Please provide a brief description of your facility's plan to implement reporting including measurable activities and objectives. (1,000 word limit). Attachments will be accepted.

Click here to enter text.

10. Please provide a brief timeline of your facility's plan to implement reporting of antibiotic use/antibiotic resistance data that includes approximate timing of activities and the responsible parties for completion, as mentioned in your description above. (800 word limit). Attachments will be accepted.

Click here to enter text.

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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 [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 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 [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

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._____