ATTACHMENT A

PROPOSAL DOCUMENT CHECKLIST

Please reference Section 7.0 for the appropriate format and quantities for each proposal submission. A separate and distinct proposal must be received for each region bid upon.

RFP#: 17965 – Medicaid Transportation Management Long Island Region and Western NY Region		
FOR THE ADMINISTRATIVE PROPOSAL for each region bid upon		
RFP §	**SUBMISSION**	**INCLUDED**
§ 6.1. A	Attachment 1 – Bidder's Disclosure of Prior Non-Responsibility Determinations, completed and signed.	☐
§ 6.1.B	Freedom of Information Law – Proposal Redactions (If Applicable)	☐
§ 6.1.C	Attachment 3- Vendor Responsibility Attestation	☐
§ 6.1.D	Attachment 4 - Vendor Assurance of No Conflict of Interest or Detrimental Effect	☐
§ 6.1.F	M/WBE Participation Requirements:	☐
	Attachment 5 Form 1	☐
	Attachment 5 Form 2 (If Applicable)	☐
§ 6.1.F	Attachment 6- Encouraging Use of New York Businesses	☐
§ 6.1.G	Attachment M - Bidder's Certified Statements, completed & signed.	☐
§ 6.1.H	Attachment 9 – References	☐
§ 6.1.I	Attachment 11 - Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination	☐
FOR THE TECHNICAL PROPOSAL for each region bid upon		
RFP §	**SUBMISSION**	**INCLUDED**
§ 6.2.A	Title Page	☐
§ 6.2.B	Table of Contents	☐
§ 6.2.C	Documentation of Bidder's Eligibility (Requirement)	☐
§ 6.2.D	Executive Summary	☐
§ 6.2.E	Technical Proposal Narrative	☐
§ 6.2.F	Diversity Practices Questionnaire	☐
FOR THE COST PROPOSAL REQUIREMENT		
RFP §	**REQUIREMENT for each Region bid upon**	**INCLUDED**
§ 6.3	Attachment B1- Cost Proposal for Long Island Region	☐
§ 6.3	Attachment B2- Cost Proposal for Western NY Region	☐

ATTACHMENT B1

NEW YORK STATE DEPARTMENT OF HEALTH

RFP: 17965
COST PROPOSAL BID FORM: LONG ISLAND REGION

Bidder Name: _____

Bidder Address: _____

Bidder must submit a bid price (for Years 1-3 and Years 4-5) 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. Failure to comply with the format and content requirements in Section 6.3 Cost Proposal and Attachment B1 may result in disqualification.

Bids should be in whole cents only. Any fraction of a cent will not be considered in the determination of the cost proposal score. Example: a submission of $0.125 per member, per month (PMPM) will be evaluated as $0.12 PMPM. There will be no rounding.

LONG ISLAND REGION			
Volume Level Category	**Medicaid Enrollees Eligible to Receive FFS Transportation**	**Per Enrollee, Per Month Price Bid for Transportation Management Services***	
		Bid Price Years 1-3	**Bid Price Years 4-5**
A	500,000 or less		
B	500,001 or greater		

*Prices for the transportation management services shall remain firm for years 1-3 and 4-5 throughout the lifetime of this contract.

Authorized Vendor Signature_____ Date:_____

ATTACHMENT B2

NEW YORK STATE DEPARTMENT OF HEALTH

RFP: 17965
COST PROPOSAL BID FORM: WESTERN NY REGION

Bidder Name: _____

Bidder Address: _____

Bidder must submit a bid price (for Years 1-3 and Years 4-5) 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 indicate 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. Failure to comply with the format and content requirements in Section 6.3 Cost Proposal and Attachment B2 may result in disqualification.

Bids should be in whole cents only. Any fraction of a cent will not be considered in the determination of the cost proposal score. Example: a submission of $0.125 per member, per month (PMPM) will be evaluated as $0.12 PMPM. There will be no rounding.

WESTERN NY REGION			
Volume Level Category	**Medicaid Enrollees Eligible to Receive FFS Transportation**	**Per Enrollee, Per Month Price Bid for Transportation Management Services***	
		Bid Price Years 1-3	**Bid Price Years 4-5**
A	500,000 or less		
B	500,001 or greater		

*Prices for the transportation management services shall remain firm for years 1-3 and 4-5 throughout the lifetime of this contract.

Authorized Vendor Signature_____ Date:_____

ATTACHMENT M

BIDDER'S CERTIFIED STATEMENTS

To be completed and included in the Administrative Proposal documents

RFP#17965 – Medicaid Transportation Management – Long Island Region and Western NY Region
1. Information with regard to the Bidder
A. Provide the Bidder's name, address, telephone number, and fax number.
Name:
Address:
City, State, Zip Code:
Telephone Number (including area code):
Fax Number (including area code):
B. Provide the name, address, telephone number, and email address of the Bidder's Primary Contact with DOH with regard to this proposal.
Name:
Address:
City, State, ZIP Code:
Telephone Number (including area code):
Email Address:
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.
By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies its own organization, under penalty of perjury, that the bidder has and has implemented a written policy addressing sexual harassment prevention in the workplace and provides annual sexual harassment prevention training to all of its employees. Such policy shall, at a minimum, meet the requirements of section two hundred one-g of the labor law.

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:

a. **Complete name of the subcontractor, including DBA and the names of controlling interests for each entity;**
b. **Complete address of the subcontractor;**
c. **A general description of the scope of work to be performed by the subcontractor;**
d. **Percentage of work the subcontractor will be providing;**
e. **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.

A. 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**

B. 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 DOH Agreement (Attachment 8), NOTICES.

Name:

Title:

Address:

City, State, ZIP Code:

Telephone Number (including area code):

Email Address:

C. Bidder's Taxpayer Identification Number:

D. Bidder's NYS Vendor Identification Number as discussed in Section 6.1.C, if enrolled:

3. 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