

APPENDIX D

REQUIRED FORMS

FOR

REQUEST FOR PROPOSALS (RFP)

APPENDIX D TABLE OF CONTENTS REQUIRED FORMS

EXHIBITS

BUSINESS FORMS

- 1 PROPOSER'S ORGANIZATION QUESTIONNAIRE/AFFIDAVIT
- 2 PROSPECTIVE CONTRACTOR REFERENCES
- 3 PROSPECTIVE CONTRACTOR LIST OF CONTRACTS
- 4 PROSPECTIVE CONTRACTOR LIST OF TERMINATED CONTRACTS
- 5 CERTIFICATION OF NO CONFLICT OF INTEREST
- 6 FAMILIARITY WITH THE COUNTY LOBBYIST ORDINANCE CERT
- 7 REQUEST FOR LOCAL SBE PREFERENCE PROGRAM CONSIDERATION AND CBE FIRM/ORGANIZATION INFORMATION FORM (Two forms are available)
- 8 PROPOSER'S EEO CERTIFICATION
- 9 ATTESTATION OF WILLINGNESS TO CONSIDER GAIN/GROW PARTICIPANTS
- 10 CONTRACTOR EMPLOYEE JURY SERVICE PROGRAM CERTIFICATION FORM AND APPLICATION FOR EXCEPTION
- 11 MINIMUM MANDATORY REQUIREMENTS CHECKLIST
- 12 ATTESTATION REGARDING PROPOSER'S PENDING AND PAST LITIGATION AND JUDGEMENTS
- 13 PRESCRIPTION DRUG EFFECTIVE RATES & DISPENSING FEE, PRESCRIPTION DRUG PRICING RETAIL QUOTE, ADMINISTRATIVE FEES, AND REBATE GUARANTEES (EXHIBITS 13 - A THROUGH 13 - D)

COST FORMS

- 14 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION AND ACKNOWLEDGEMENT OF RFP RESTRICTIONS
- 15 BUDGET SHEET FORMAT
- 16 EMPLOYEE BENEFITS

LIVING WAGE FORMS

- 17 CONTRACTOR NON-RESPONSIBILITY DEBARMENT - ACKNOWLEDGEMENT AND STATEMENT OF COMPLIANCE
- 18 LABOR/PAYROLL/DEBARMENT HISTORY - ACKNOWLEDGEMENT AND STATEMENT OF COMPLIANCE
- 19 LIVING WAGE DECLARATION
- 20 APPLICATION FOR EXEMPTION
- 21 MODEL STAFFING PLAN

2004 NONPROFIT INTEGRITY ACT (SB 1262, CHAPTER 919)

- 22 CHARITABLE CONTRIBUTIONS CERTIFICATION

TRANSITIONAL JOB OPPORTUNITIES PREFERENCE PROGRAM

**APPENDIX D
TABLE OF CONTENTS
REQUIRED FORMS**

23 TRANSITIONAL JOB OPPORTUNITIES PREFERENCE APPLICATION

DEFAULTED PROPERTY TAX REDUCTION PROGRAM

24 CERTIFICATION OF COMPLIANCE WITH THE COUNTY'S DEFAULTED PROPERTY TAX
REDUCTION PROGRAM

PROPOSAL CHECKLIST

25 PBM SERVICES PROPOSAL CHECKLIST

DISABLED VETERANS BUSINESS ENTERPRISE PREFERENCE PROGRAM

26 REQUEST FOR DISABLED VETERAN BUSINESS ENTERPRISE PREFERENCE PROGRAM
CONSIDERATION

REQUIRED FORMS - EXHIBIT 1

PROPOSER'S ORGANIZATION QUESTIONNAIRE/AFFIDAVIT

Please complete, date and sign this form and place it as the first page of your proposal. The person signing the form must be authorized to sign on behalf of the Proposer and to bind the applicant in a Contract.

1. If your firm is a corporation or limited liability company (LLC), state its legal name (as found in your Articles of Incorporation) and State of incorporation:

Name	State	Year Inc.
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2. If your firm is a limited partnership or a sole proprietorship, state the name of the proprietor or managing partner:

3. If your firm is doing business under one or more DBA's, please list all DBA's and the County(s) of registration:

Name	County of Registration	Year became DBA
_____	_____	_____
_____	_____	_____

4. Is your firm wholly or majority owned by, or a subsidiary of, another firm? ____ If yes,

Name of parent firm: _____

State of incorporation or registration of parent firm: _____

5. Please list any other names your firm has done business as within the last five (5) years.

Name	Year of Name Change
_____	_____
_____	_____

6. Indicate if your firm is involved in any pending acquisition/merger, including the associated company name. If not applicable, so indicate below.

Proposer acknowledges and certifies that it meets and will comply with all of the Minimum Mandatory Requirements listed in Paragraph 1.4 - Minimum Mandatory Requirements, of this Request for Proposal, as listed below.

(list each minimum requirement stated in Paragraph 1.4)

Check the appropriate boxes:

Yes No Proposer must have five (5) years of experience within the last five (5) years, providing continuous PBM Services and providing PBM services to an organization with a minimum volume of 15,000 pharmacy claims per month and 200,000 covered lives. ___

Proposer further acknowledges that if any false, misleading, incomplete, or deceptively unresponsive statements in connection with this proposal are made, the proposal may be rejected. The evaluation and determination in this area shall be at the Director's sole judgment and his/her judgment shall be final.

Proposer's Name:

Address:

E-mail address: _____ Telephone number: _____

Fax number: _____

On behalf of _____ (Proposer's name), I _____ (Name of Proposer's authorized representative), certify that the information contained in this Proposer's Organization Questionnaire/Affidavit is true and correct to the best of my information and belief.

Signature

Internal Revenue Service
Employer Identification Number

Title

California Business License Number

Date

County WebVen Number

REQUIRED FORMS - EXHIBIT 2
PROSPECTIVE CONTRACTOR REFERENCES

Contractor's Name: _____

List Five (5) References where the same or similar scope of services were provided in order to meet the Minimum Requirements stated in this solicitation.

1. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
2. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
3. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
4. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
5. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.

REQUIRED FORMS - EXHIBIT 3
PROSPECTIVE CONTRACTOR LIST OF CONTRACTS

Contractor's Name: _____

List of all public entities for which the Contractor has provided service within the last three (3) years. Use additional sheets if necessary.

1. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
2. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
3. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
4. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.
5. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.	# of Years / Term of Contract		Type of Service	Dollar Amt.

REQUIRED FORMS - EXHIBIT 4
PROSPECTIVE CONTRACTOR LIST OF TERMINATED CONTRACTS

Contractor's Name: _____

List of all contracts that have been terminated within the past three (3) years.

1. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.		Reason for Termination:		
2. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.		Reason for Termination:		
3. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.		Reason for Termination:		
4. Name of Firm	Address of Firm	Contact Person	Telephone # ()	Fax # ()
Name or Contract No.		Reason for Termination:		

REQUIRED FORMS - EXHIBIT 5
CERTIFICATION OF NO CONFLICT OF INTEREST

The Los Angeles County Code, Section 2.180.010, provides as follows:

CONTRACTS PROHIBITED

Notwithstanding any other section of this Code, the County shall not contract with, and shall reject any proposals submitted by, the persons or entities specified below, unless the Board of Supervisors finds that special circumstances exist which justify the approval of such contract:

1. Employees of the County or of public agencies for which the Board of Supervisors is the governing body;
2. Profit-making firms or businesses in which employees described in number 1 serve as officers, principals, partners, or major shareholders;
3. Persons who, within the immediately preceding 12 months, came within the provisions of number 1, and who:
 - a. Were employed in positions of substantial responsibility in the area of service to be performed by the contract; or
 - b. Participated in any way in developing the contract or its service specifications; and
4. Profit-making firms or businesses in which the former employees, described in number 3, serve as officers, principals, partners, or major shareholders.

Contracts submitted to the Board of Supervisors for approval or ratification shall be accompanied by an assurance by the submitting department, district or agency that the provisions of this section have not been violated.

Proposer Name

Proposer Official Title

Official's Signature

Cert. of No Conflict of Interest

REQUIRED FORMS - EXHIBIT 6

FAMILIARITY WITH THE COUNTY LOBBYIST ORDINANCE CERTIFICATION

The Proposer certifies that:

- 1) it is familiar with the terms of the County of Los Angeles Lobbyist Ordinance, Los Angeles Code Chapter 2.160;
- 2) that all persons acting on behalf of the Proposer organization have and will comply with it during the proposal process; and
- 3) it is not on the County's Executive Office's List of Terminated Registered Lobbyists.

Signature: _____ Date: _____

REQUIRED FORMS - EXHIBIT 7

Use this form for County Solicitations which **are not** subject to the Federal Restriction

**Request for Local SBE Preference Program Consideration and
CBE Firm/Organization Information Form**

INSTRUCTIONS: All proposers/bidders responding to this solicitation must complete and return this form for proper consideration of the proposal/bid.

I. LOCAL SMALL BUSINESS ENTERPRISE PREFERENCE PROGRAM:

FIRM NAME: _____
COUNTY VENDOR NUMBER: _____

- As a Local SBE, certified by the County of Los Angeles, Internal Services Department, I request this proposal/bid be considered for the Local SBE Preference.
- Attached is my Local SBE Certification letter issued by the County

II. FIRM/ORGANIZATION INFORMATION: The information requested below is for statistical purposes only. On final analysis and consideration of award, contractor/vendor will be selected without regard to race/ethnicity, color, religion, sex, national origin, age, sexual orientation or disability.

Business Structure: Sole Proprietorship Partnership Corporation Non-Profit Franchise
 Other (Please Specify) _____

Total Number of Employees (including owners): _____

Race/Ethnic Composition of Firm. Please distribute the above total number of individuals into the following categories:

Race/Ethnic Composition	Owners/Partners/ Associate Partners		Managers		Staff	
	Male	Female	Male	Female	Male	Female
Black/African American						
Hispanic/Latino						
Asian or Pacific Islander						
American Indian						
Filipino						
White						

III. PERCENTAGE OF OWNERSHIP IN FIRM: Please indicate by percentage (%) how ownership of the firm is distributed.

	Black/African American	Hispanic/Latino	Asian or Pacific Islander	American Indian	Filipino	White
Men	%	%	%	%	%	%
Women	%	%	%	%	%	%

IV. CERTIFICATION AS MINORITY, WOMEN, DISADVANTAGED, AND DISABLED VETERAN BUSINESS ENTERPRISES:

If your firm is currently certified as a minority, women, disadvantaged or disabled veteran owned business enterprise by a public agency, complete the following and attach a copy of your proof of certification. (Use back of form, if necessary.)

Agency Name	Minority	Women	Dis- advantaged	Disabled Veteran	Expiration Date

V. DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.

Print Authorized Name	Authorized Signature	Title	Date
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REQUIRED FORMS - EXHIBIT 7

Use this form for County Solicitations which **are** subject to the Federal Restriction

**Request for Local SBE Preference Program Consideration and
CBE Firm/Organization Information Form**

INSTRUCTIONS: All proposers/bidders responding to this solicitation must complete and return this form for proper consideration of the proposal/bid.

I. LOCAL SMALL BUSINESS ENTERPRISE PREFERENCE PROGRAM:

FIRM NAME: _____
CAGE CODE: _____ **NAICS CODE:** _____

- As a business registered as 'Small' on the federal Central Contractor Registration (CCR) data base, I request this proposal/bid be considered for the Local SBE Preference.
- The NAICS Code shown corresponds to the services in this solicitation.
- Attached is my CCR certification page.

II. FIRM/ORGANIZATION INFORMATION: The information requested below is for statistical purposes only. On final analysis and consideration of award, contractor/vendor will be selected without regard to race/ethnicity, color, religion, sex, national origin, age, sexual orientation or disability.

Business Structure: Sole Proprietorship Partnership Corporation Non-Profit Franchise
 Other (Please Specify) _____

Total Number of Employees (including owners): _____

Race/Ethnic Composition of Firm. Please distribute the above total number of individuals into the following categories:

Race/Ethnic Composition	Owners/Partners/ Associate Partners		Managers		Staff	
	Male	Female	Male	Female	Male	Female
Black/African American						
Hispanic/Latino						
Asian or Pacific Islander						
American Indian						
Filipino						
White						

III. PERCENTAGE OF OWNERSHIP IN FIRM: Please indicate by percentage (%) how ownership of the firm is distributed.

	Black/African American	Hispanic/Latino	Asian or Pacific Islander	American Indian	Filipino	White
Men	%	%	%	%	%	%
Women	%	%	%	%	%	%

IV. CERTIFICATION AS MINORITY, WOMEN, DISADVANTAGED, AND DISABLED VETERAN BUSINESS ENTERPRISES: *If your firm is currently certified as a minority, women, disadvantaged or disabled veteran owned business enterprise by a public agency, complete the following and attach a copy of your proof of certification. (Use back of form, if necessary.)*

Agency Name	Minority	Women	Dis-advantaged	Disabled Veteran	Expiration Date

V. DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.

Print Authorized Name	Authorized Signature	Title	Date

**REQUIRED FORMS - EXHIBIT 8
PROPOSER'S EEO CERTIFICATION**

Company Name

Address

Internal Revenue Service Employer Identification Number

GENERAL

In accordance with provisions of the County Code of the County of Los Angeles, the Proposer certifies and agrees that all persons employed by such firm, its affiliates, subsidiaries, or holding companies are and will be treated equally by the firm without regard to or because of race, religion, ancestry, national origin, or sex and in compliance with all anti-discrimination laws of the United States of America and the State of California.

CERTIFICATION	YES	NO
1. Proposer has written policy statement prohibiting discrimination in all phases of employment.	()	()
2. Proposer periodically conducts a self-analysis or utilization analysis of its work force.	()	()
3. Proposer has a system for determining if its employment practices are discriminatory against protected groups.	()	()
4. When problem areas are identified in employment practices, Proposer has a system for taking reasonable corrective action to include establishment of goal and/or timetables.	()	()

Signature

Date

Name and Title of Signer (please print)

REQUIRED FORMS - EXHIBIT 9
ATTESTATION OF WILLINGNESS TO CONSIDER
GAIN/GROW PARTICIPANTS

As a threshold requirement for consideration for contract award, Proposer shall demonstrate a proven record for hiring GAIN/GROW participants or shall attest to a willingness to consider GAIN/GROW participants for any future employment opening if they meet the minimum qualifications for that opening. Additionally, Proposer shall attest to a willingness to provide employed GAIN/GROW participants access to the Proposer's employee mentoring program, if available, to assist these individuals in obtaining permanent employment and/or promotional opportunities.

Proposers unable to meet this requirement shall not be considered for contract award.

Proposer shall complete all of the following information, sign where indicated below, and return this form with their proposal.

A. Proposer has a proven record of hiring GAIN/GROW participants.

_____YES (subject to verification by County) _____NO

B. Proposer is willing to consider GAIN/GROW participants for any future employment openings if the GAIN/GROW participant meets the minimum qualifications for the opening. "Consider" means that Proposer is willing to interview qualified GAIN/GROW participants.

_____YES _____NO

C. Proposer is willing to provide employed GAIN/GROW participants access to its employee-mentoring program, if available.

_____YES _____NO _____N/A (Program not available)

Proposer Organization: _____

Signature: _____

Print Name: _____

Title: _____ Date: _____

Tel.#: _____ Fax #: _____

REQUIRED FORMS - EXHIBIT 10

COUNTY OF LOS ANGELES CONTRACTOR EMPLOYEE JURY SERVICE PROGRAM CERTIFICATION FORM AND APPLICATION FOR EXCEPTION

The County's solicitation for this Request for Proposals is subject to the County of Los Angeles Contractor Employee Jury Service Program (Program), Los Angeles County Code, Chapter 2.203. All proposers, whether a contractor or subcontractor, must complete this form to either certify compliance or request an exception from the Program requirements. Upon review of the submitted form, the County department will determine, in its sole discretion, whether the proposer is granted an exception (or exempt from the Program requirements) from the Program.

Company Name:		
Company Address:		
City:	State:	Zip Code:
Telephone Number:		
Solicitation For _____ Services:		

If you believe the Jury Service Program does not apply to your business, check the appropriate box in Part I (attach documentation to support your claim); or, complete Part II to certify compliance with the Program. Whether you complete Part I or Part II, please sign and date this form below.

Part I: Jury Service Program is Not Applicable to My Business

- My business does not meet the definition of "contractor," as defined in the Program, as it has not received an aggregate sum of \$50,000 or more in any 12-month period under one or more County contracts or subcontracts (this exception is not available if the contract itself will exceed \$50,000). I understand that the exception will be lost and I must comply with the Program if my revenues from the County exceed an aggregate sum of \$50,000 in any 12-month period.
- My business is a small business as defined in the Program. It 1) has ten or fewer employees; and, 2) has annual gross revenues in the preceding twelve months which, if added to the annual amount of this contract, are \$500,000 or less; and, 3) is not an affiliate or subsidiary of a business dominant in its field of operation, as defined below. I understand that the exception will be lost and I must comply with the Program if the number of employees in my business and my gross annual revenues exceed the above limits.

"Dominant in its field of operation" means having more than ten employees and annual gross revenues in the preceding twelve months, which, if added to the annual amount of the contract awarded, exceed \$500,000.

"Affiliate or subsidiary of a business dominant in its field of operation" means a business which is at least 20 percent owned by a business dominant in its field of operation, or by partners, officers, directors, majority stockholders, or their equivalent, of a business dominant in that field of operation.

- My business is subject to a Collective Bargaining Agreement (attach agreement) that expressly provides that it supersedes all provisions of the Program.

OR

Part II: Certification of Compliance

- My business has and adheres to a written policy that provides, on an annual basis, no less than five (5) days of regular pay for actual jury service for full-time employees of the business who are also California residents, or my company will have and adhere to such a policy prior to award of the contract.

I declare under penalty of perjury under the laws of the State of California that the information stated above is true and correct.

Print Name:	Title:
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Signature:

Date:

REQUIRED FORMS – APPENDIX D – EXHIBIT 11

Minimum Mandatory Requirements Checklist

(Please refer to RFP Section 1.4 for more information.)

Proposer must meet each of the following requirements in order to submit a proposal. Please make sure you have included each item on this checklist and make notes as to where it is located in the “LOCATED IN” column.

If you fail to provide the information in the proper section as listed on this checklist, your proposal will be rejected as non-responsive.

CHECK BOX	RFP Section	ITEM	LOCATED IN Please include Section, Page #, etc.
		<i>EXAMPLE</i>	<i>Section A, Executive Summary, Page 35, Paragraph 2</i>
	1.4.1	Accurately complete this checklist – Minimum Mandatory Requirements Checklist, Appendix D, Exhibit 11.	
	1.4.2	Attend Mandatory Proposers’ Conference and sign in at the registration table and submit a Letter of Intent to submit a proposal. There will be a sign-in/sign-out sheet and sign legibly, the doors will be closed and the sign-in/sign-out sheet will be removed 10 minutes after the start time stated for the Conference in the solicitation.	
	1.4.3	Submits a Mandatory Letter of Intent to Submit a Proposal, as set forth in Proposal Submission Requirements.	
	1.4.4	Has five (5) years of experience, providing continuous Pharmacy Benefits Management (PBM) services in Los Angeles County and currently provides PBM services to an organization with a minimum volume of 15,000 pharmacy claims per month.	
	1.4.5	Provide clear documentation of URAC accreditation for Pharmacy Benefits management Services and Drug Therapy Management.	
	1.4.6	Is a Surescripts certified PBM.	
	1.4.7	Has a current pharmacy network that includes a minimum of 100 contracted pharmacies in Los Angeles County that covers all eight (8) LACDMH defined Services Areas.	
	1.4.8	Agrees to abide with a “pass through” pricing model for this RFP, whereby all sources of revenue the PBM receives is passed onto LACDMH, in exchange for administrative fees.	
	1.4.9	Will guarantee financial rates, including any guaranteed financial elements, but not limited to the annual aggregate average Retail Brand Effective Rate and the Maximum Brand name Drug Dispensing Fee and Retail Generic Effective Rate and Maximum Generic Drug Dispensing Fee.	
	1.4.10	Must agree to use Medispan as the pricing source for AWP or any other pricing metric. Must agree to use the same pricing source (Medispan) for participating pharmacies.	

	1.4.11	Comply with RFP Format and Requirements set forth in the Proposal Submission Requirements, Section 2.0.	
	1.4.12	Complete all required forms in Appendix D, Exhibits 1-26.	
	1.4.13	Comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).	
	1.4.14	Proposer must agree to comply with the Contractor Information Security Requirements as contained in Appendix A Sample Contract Exhibits, Exhibit B.	
	1.4.15	Must register in the County's WebVen and provide Provider ID Number as proof of registration. (http://lacounty.info/doing_business/main_db.htm).	
	1.4.16	Must not currently have a Settlement Agreement with DMH for repayment of County funds.	
	1.4.17	Must not be on the Los Angeles County Debarment List (doingbusiness.lacounty.gov/debarmentlist.htm).	
	1.4.18	Proposer must not be on the Office of Inspector General (OIG) Health and Human Services (HHS) Debarment List (oig.hhs.gov/fraud/exclusions.asp) or the General Services Administration Exclusions List (https://www.sam.gov).	
	1.4.19	Proposer must be financially viable as determined by the requirements set forth in this section of the RFP.	

REQUIRED FORMS - EXHIBIT 12

ATTESTATION REGARDING PROPOSER’S PENDING AND PAST LITIGATION AND JUDGMENTS

PROPOSER'S NAME:		
BUSINESS ADDRESS:		
CITY:	STATE:	ZIP CODE:

Please identify by name, case and court jurisdiction any pending and past litigation in which Proposer is involved, or judgments against Proposer in the past five (5) years. Use additional sheets if necessary.

Name of Litigant(s)	Case and Court Jurisdiction	Statement describing the size and scope of pending litigation.

I declare under penalty of perjury under the laws of the State of California that the information herein is true and correct.

PRINT NAME:	TITLE:
SIGNATURE:	DATE:

REQUIRED FORMS - EXHIBIT 13

PRESCRIPTION DRUG EFFECTIVE RATES/ADMINISTRATIVE FEES AND REBATE GUARANTEES

Medi-Span Data: Contractor agrees to rely on current, electronic data provided by Medi-Span to calculate all pricing and guarantees in the Agreement, including without limitation, all: invoices to County, guarantee calculations contained in the Agreement, reconciliations described in the Agreement, and all audits of the Agreement. Contractor further agrees that all such calculations shall be based on Medi-Span data as of the date each prescription is dispensed to Clients. For all dispensed drugs, the dispensing date shall be the date the Participating Pharmacy fills the prescription for the Client (the fill date), not the date the transaction is submitted to Contractor (the adjudication or submittal date).

Effective Rates: Complete the following tables (Exhibit 13 – A, pages 1 – 5) using the drug terms that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the contract, Proposers are requested to provide a retail quote, on a pass-through/transparent basis with a minimum guarantee for brands and generics on a post-AWP settlement basis. Columns marked “AWP Discount” are to be completed using discount from 100% AWP and Maximum Brand Name Drug Dispensing Fees. All guarantees shall be based on the Brand or Generic Effective Rate for medication dispensed at the point of sale post rollback, before rebates are subtracted using a full pass-through model.

Guaranteed financial rates include any guaranteed financial element provided by proposer but are not limited to the annual, aggregate average Retail Brand Effective Rate and the Maximum Brand Name Drug Dispensing Fee and the Retail Generic Effective Rate and the Maximum Generic Drug Dispensing Fee.

Mail Order Pharmacy: Complete the following tables (Exhibit 13 – A, pages 1 - 5) using the drug terms that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the contract for mail order pharmacy services. Proposers are requested to provide a retail quote, on a pass-through/transparent basis with a minimum guarantee for brands and generics on a post-AWP settlement basis. Columns marked “AWP Discount” are to be completed using discount from 100% AWP and Maximum Brand Name Drug Dispensing Fees.

Specialty Pharmacy: Complete the following tables (Exhibit 13 – A, pages 1 – 5) using the drug terms that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the contract for mail order pharmacy services. Proposers are requested to provide a retail quote, on a pass-through/transparent basis with a minimum guarantee for brands and generics on a post-AWP settlement basis. Columns marked “AWP Discount” are to be completed using discount from 100% AWP and Maximum Brand Name Drug Dispensing Fees.

PRESCRIPTION DRUG PRICING RETAIL QUOTE: Using the data in Appendix P (RFP), complete the table (Exhibit 13 – B) using the Brand and Generic Effective Rates identified in Exhibit 13A on a pass-through/transparent basis with a minimum guarantee for brands and generics on a post-AWP settlement basis. All guarantees shall be based on the Brand or Generic Effective Rate for medication dispensed at the point of sale post rollback before rebates are subtracted using a full pass-through model.

Administrative Fees: Administrative fees and dispensing fees are requested on a per prescription paid basis (will not be paid on reversed claims and any adjustments, errors and “redos” shall be carved out). Note that these fees are considered direct costs and must be based on prescriptions dispensed (not adjustments, errors, or redo's) and including, but not limited to the following services as outlined in Appendix B SOW. Complete the table (Exhibit 13 - C) and indicate the retail administrative fees by fiscal year, indicate the administrative services (by circling Yes or No) that are to be included in the retail administrative fee. For all services (add-on or ad hoc) that are not included in the retail administrative fee, indicate service in Section II and the fee. For any additional services not included in Section I or II, please indicate them in Section III and include the fee.

Rebate Guarantees: Proposer shall provide a mechanism for analyzing LACDMH prescribing practices to review current LACDMH rebate agreements to ensure DMH is receiving the maximum compensation available on a minimum (not fixed) basis.

Complete the Rebate Guarantee Table (Exhibit 13 - D) and indicate the rebate guarantee terms. This guaranteed minimum annual, aggregate rebate reimbursement is null and void if Contractor fails to adopt the LACDMH Formulary in its entirety or makes changes to the brand and/or generic co-payment amount.

**REQUIRED FORMS - EXHIBIT 13-A
PRESCRIPTION DRUG EFFECTIVE RATES & DISPENSING FEE**

Page 1 of 6

Contract Year One (FY 2015-16)

Broad Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail 3 month supply
Brand Drugs		
Brand Effective Rate	%	%
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Generic Effective Rate	%	%
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

Mail Order	Supply Up to 30 days	Supply 3 month
Brand Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

Specialty Pharmacy	Supply Up to 30 days	Supply 3 month
Brand Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

**REQUIRED FORMS - EXHIBIT 13-A
PRESCRIPTION DRUG EFFECTIVE RATES & DISPENSING FEE**

Page 2 of 6

Contract Year Two (FY 2016-17)

Broad Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail 3 month supply
Brand Drugs		
Brand Effective Rate	%	%
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Generic Effective Rate	%	%
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

Mail Order	Supply Up to 30 days	Supply 3 month
Brand Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

Specialty Pharmacy	Supply Up to 30 days	Supply 3 month
Brand Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

**REQUIRED FORMS - EXHIBIT 13-A
PRESCRIPTION DRUG EFFECTIVE RATE & DISPENSING FEE**

Page 3 of 6

Contract Year Three (FY 2017-18)

Broad Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail 3 month supply
Brand Drugs		
Brand Effective Rate	%	%
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Generic Effective Rate	%	%
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

Mail Order	Supply Up to 30 days	Supply 3 month
Brand Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

Specialty Pharmacy	Supply Up to 30 days	Supply 3 month
Brand Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

**REQUIRED FORMS - EXHIBIT 13-A
PRESCRIPTION DRUG EFFECTIVE RATE & DISPENSING FEE**

Page 4 of 6

Contract Year Four (FY 2018-19)

Broad Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail 3 month supply
Brand Drugs		
Brand Effective Rate	%	%
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Generic Effective Rate	%	%
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

Mail Order	Supply Up to 30 days	Supply 3 month
Brand Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

Specialty Pharmacy	Supply Up to 30 days	Supply 3 month
Brand Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

**REQUIRED FORMS - EXHIBIT 13-A
PRESCRIPTION DRUG EFFECTIVE RATE & DISPENSING FEE**

Page 5 of 6

Contract Year Five (FY 2019-20)

Broad Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail 3 month supply
Brand Drugs		
Brand Effective Rate	%	%
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Generic Effective Rate	%	%
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

Mail Order	Supply Up to 30 days	Supply 3 month
Brand Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

Specialty Pharmacy	Supply Up to 30 days	Supply 3 month
Brand Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx
Generic Drugs		
Actual Drug Acquisition Cost	Plus (+) \$	Plus (+) \$
Dispensing Fee Per Rx:	\$ per Rx	\$ per Rx

**REQUIRED FORMS - EXHIBIT 13-B
PRESCRIPTION DRUG PRICING RETAIL QUOTE**

SIX MONTH SAMPLE Page 6 of 6

Using the data in Appendix P (RFP), complete the table below using the Brand and Generic Effective Rates identified in Exhibit 13-A on a pass-through/transparent basis with a minimum guarantee for brands and generics on a post-AWP settlement basis. All guarantees shall be based on the Brand or Generic Effective Rate for medication dispensed at the point of sale post rollback before rebates are subtracted using a full pass-through model.

BROAD RETAIL NETWORK	
MONTH	RETAIL QUOTE*
AUGUST	\$
SEPTEMBER	\$
OCTOBER	\$
NOVEMBER	\$
DECEMBER	\$
JANUARY	\$
TOTAL	\$

***Retail quote should include medication costs, dispensing and administrative fees (indirect costs).**

REQUIRED FORMS - EXHIBIT 13-C ADMINISTRATIVE FEES

Page 1 of 4

***Per prescription administrative fees will not be paid on reversed claims and in addition to carving our adjustments, errors, and “redos”**

SECTION I: COMPREHENSIVE ADMINISTRATIVE SERVICES						
ADMINISTRATIVE SERVICES	RESPONSE					
	FY 2015 - 16	FY 2016 - 17	FY 2017 - 18	FY 2018 - 19	FY 2019 - 20	Indicate if there are any limitations (e.g. quantity, frequency, hours of service, etc.)
Retail Administrative Fee:	\$ ___ per Rx					
SERVICES TO BE INCLUDED:						
Ad-hoc reporting	Yes or No					
Claims Adjudication	Yes or No					
Client eligibility and maintenance	Yes or No					
Client Education	Yes or No					
Comprehensive Auditing Services	Yes or No					
Concurrent Drug Utilization Review	Yes or No					
Customer Service including toll free telephone and web-based access for clients and participating pharmacies	Yes or No					
Data Requests	Yes or No					
DMH Portal (development, maintenance, & IT support)	Yes or No					
Formulary Management & Lists	Yes or No					

Fund One Program	Yes or No					
IMP Retail Pharmacy Maintenance	Yes or No					
MAC pricing program administration	Yes or No					
Monthly Clinical Newsletter	Yes or No					
Pharmacy Audit Program	Yes or No					
Pharmacy Directories	Yes or No					
Pharmacy Network Maintenance & Administration	Yes or No					
Prior Authorization Program	Yes or No					
Provider education	Yes or No					
Providing ID Cards (Initial, duplicate, additional and replacement cards)	Yes or No					
Quantity Limit Mgmt.	Yes or No					
Quarterly Formulary Newsletter	Yes or No					
Rebate Management	Yes or No					
Report Development	Yes or No					
Retroactive Terminations and Reversal of Amounts Paid	Yes or No					
Retrospective Drug Utilization Review	Yes or No					
Standard Report Package	Yes or No					

Standard Systems Edits	Yes or No					
Step Therapy	Yes or No					
System Training (Initial)	Yes or No					
System Training (Ongoing)	Yes or No					

REQUIRED FORMS - EXHIBIT 13-C ADMINISTRATIVE FEES

SECTION II: OTHER SERVICES

List all services from Section I that are not to be included in the fee above (i.e. services marked "No" above) and/or add-on/ancillary services and show the separate fees:

DESCRIBE THE SERVICE & HOW INVOICED (e.g. per month, per report, etc.)	FY 2014 - 15	FY 2015 - 16	FY 2016 - 17	FY 2017 - 18	FY 2018 - 19
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$

REQUIRED FORMS - EXHIBIT 13-C ADMINISTRATIVE FEES

Page 4 of 4

List all other services that are not included in Section I and II and show the fee separately:

DESCRIBE THE SERVICE & HOW INVOICED (e.g. per month, per report, etc.)	FY 2014 - 15	FY 2015 - 16	FY 2016 - 17	FY 2017 - 18	FY 2018 - 19
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$
	\$	\$	\$	\$	\$

REQUIRED FORMS - EXHIBIT 13-D
REBATE GUARANTEES

All payments to PBM by pharmaceutical manufacturers or intermediaries that are attributed directly to the claims for Prescription Drug Services paid by LACDMH shall be transferred to LACDMH regardless of whether termed rebates, administrative fees or otherwise.

Based on LACDMH’s current Formulary and plan design (Exhibit 4- Appendix C SOW Exhibits) proposer shall indicate the rebate guarantee on a per claim basis.

FOR THREE-TIERED PLANS	
\$15 or greater differential between preferred and non-preferred brand copayments.	Guaranteed Minimum Aggregate Rebate Reimbursement
	\$_____per all retail claims*
	\$_____per all mail service claims
FOR TWO-TIERED PLANS	
For two-tiered plans <u>OR</u> Plans with less than a \$15 differential between preferred and non-preferred brand copayments.	\$_____per all retail claims*
	\$_____per all mail service claims

*** Retail Claims and Mail Service Claims paid by LACDMH, excluding reversals.**

REQUIRED FORMS - EXHIBIT 14
CERTIFICATION OF INDEPENDENT PRICE DETERMINATION
AND ACKNOWLEDGEMENT OF RFP RESTRICTIONS

- A. By submission of this Proposal, Proposer certifies that the prices quoted herein have been arrived at independently without consultation, communication, or agreement with any other Proposer or competitor for the purpose of restricting competition.
- B. List all names and telephone number of person legally authorized to commit the Proposer.

NAME

PHONE NUMBER

_____	_____
_____	_____
_____	_____

NOTE: Persons signing on behalf of the Contractor will be required to warrant that they are authorized to bind the Contractor.

- C. List names of all joint ventures, partners, subcontractors, or others having any right or interest in this contract or the proceeds thereof. If not applicable, state "NONE".

- D. Proposer acknowledges that it has not participated as a consultant in the development, preparation, or selection process associated with this RFP. Proposer understands that if it is determined by the County that the Proposer did participate as a consultant in this RFP process, the County shall reject this proposal.

Name of Firm

Print Name of Signer

Title

Signature

Date

REQUIRED FORMS - EXHIBIT 15

SAMPLE BUDGET SHEET FOR PBM SERVICES

DIRECT COST

Annualized Projection of Prescription Drug Pricing Retail Quote \$ _____

(Refer to Appendix D, Exhibit 13-A)

Administrative Fee Per Prescription \$ _____

Dispensing Fee Per Prescription \$ _____
(Refer to Appendix P)

Total Annualized Prescription Drug Pricing Retail Quote \$ _____

(List each staff classification)

Payroll:	FTE*	Hourly Rate	Monthly Salary
Employee Classification _____		\$ _____	\$ _____
Employee Classification _____		\$ _____	\$ _____
Employee Classification _____		\$ _____	\$ _____
Others (Please continue to list)			
Total Salaries and Wages			\$ _____

*FTE = Full Time Equivalent Positions

Employee Benefits	No. of Employees	Monthly Cost per FTE
Medical Insurance _____		\$ _____
Dental Insurance _____		\$ _____
Life Insurance _____		\$ _____
Other (list) _____		\$ _____
Total Benefits		\$ _____

Payroll Taxes (List all appropriate, e.g., FICA, SUI, Workers' Compensation, etc.)	Monthly Cost	
_____	\$ _____	
_____	\$ _____	
_____	\$ _____	
_____	\$ _____	
Total Payroll Taxes		\$ _____

Insurance (List Type/Coverage. See Sample Contract, Sub-paragraph 8.25, Insurance Coverage Requirements)	Monthly Cost	
_____	\$ _____	
_____	\$ _____	
_____	\$ _____	
Vehicles _____	\$ _____	
Supplies _____	\$ _____	
Services _____	\$ _____	
Office Equipment _____	\$ _____	
Telephone/Utilities _____	\$ _____	
Other (please continue to list) _____	\$ _____	
Total Insurance/Misc. S & S		\$ _____

TOTAL DIRECT COSTS \$ _____

INDIRECT COST (List all appropriate)

General Accounting/Bookkeeping
Management Overhead (Specify)
Other (Specify)

\$ _____
\$ _____
\$ _____

TOTAL INDIRECT COSTS

\$ _____

TOTAL DIRECT AND INDIRECT COST

\$ _____

PROFIT (Please enter percentage: _____%)

\$ _____

TOTAL MONTHLY COSTS

\$ _____

REQUIRED FORMS - EXHIBIT 16

EMPLOYEE BENEFITS

Medical Insurance/Health Plan:

Employer Pays \$ _____ Employee Pays \$ _____ Total Mo. Premium \$ _____

Annual Deductible
Employee \$ _____ Family \$ _____

Coverage (✓)

_____ Hospital Care (In Patient _____ Out Patient _____)
_____ X-Ray and Laboratory
_____ Surgery
_____ Office Visits
_____ Pharmacy
_____ Maternity
_____ Mental Health/Chemical Dependency, In Patient
_____ Mental Health/Chemical Dependency, Out Patient

Dental Insurance:

Employer Pays \$ _____ Employee Pays \$ _____ Total Mo. Premium \$ _____

Life Insurance:

Employer Pays \$ _____ Employee Pays \$ _____ Total Mo. Premium \$ _____

Vacation:

Number of Days _____ and

Any increase after _____ years of employment, number of days or hours _____

Sick Leave:

Number of Days _____ and

Any increase after _____ years of employment, number of days or hours _____

Holidays:

Number of Days _____ per year

Retirement:

Employer Pays \$ _____ Employee Pays \$ _____ Total Premium \$ _____

REQUIRED FORMS – EXHIBIT 17



COUNTY OF LOS ANGELES
LIVING WAGE PROGRAM

CONTRACTOR NON-RESPONSIBILITY DEBARMENT
ACKNOWLEDGEMENT AND STATEMENT OF COMPLIANCE

The undersigned individual is the owner or authorized agent (Agent) of the business entity or organization ("Firm") identified below and makes the following statements on behalf of his or her Firm.

The Agent is required to check each of the following two boxes:

LIVING WAGE ORDINANCE:

[] The Agent has read the County's Living Wage Ordinance (Los Angeles County Code Section 2.201.010 through 2.201.100), and understands that the Firm is subject to its terms.

CONTRACTOR NON-RESPONSIBILITY AND CONTRACTOR DEBARMENT ORDINANCE:

[] The Agent has read the County's Determinations of Contractor Non-Responsibility and Contractor Debarment Ordinance (Los Angeles County Code Section 2.202.010 through 2.202.060), and understands that the Firm is subject to its terms.

LABOR LAW/PAYROLL VIOLATIONS:

A "Labor Law/Payroll Violation" includes violations of any federal, state or local statute, regulation, or ordinance pertaining to wages, hours or working conditions such as minimum wage, prevailing wage, living wage, the Fair Labor Standards Act, employment of minors, or unlawful employment discrimination.

History of Alleged Labor Law/Payroll Violations (Check One):

- [] The Firm HAS NOT been named in a complaint, claim, investigation or proceeding relating to an alleged Labor Law/Payroll Violation which involves an incident occurring within three (3) years of the date of the proposal; OR
[] The Firm HAS been named in a complaint, claim, investigation or proceeding relating to an alleged Labor Law/Payroll Violation which involves an incident occurring within three (3) years of the date of this proposal. (I have attached to this form the required Labor/Payroll/Debarment History form with the pertinent information for each allegation.)

History of Determinations of Labor Law /Payroll Violations (Check One):

- [] There HAS BEEN NO determination by a public entity within three (3) years of the date of the proposal that the Firm committed a Labor Law/Payroll Violation; OR
[] There HAS BEEN a determination by a public entity within three (3) years of the date of the proposal that the Firm committed a Labor Law/Payroll Violation. I have attached to this form the required Labor/Payroll/Debarment History form with the pertinent information for each violation (including each reporting entity name, case number, name and address of claimant, date of incident, date claim opened, and nature and disposition of each violation or finding.) (The County may deduct points from the proposer's final evaluation score ranging from 1% to 20% of the total evaluation points available with the largest deductions occurring for undisclosed violations.)

HISTORY OF DEBARMENT (Check one):

- [] The Firm HAS NOT been debarred by any public entity during the past ten (10) years; OR
[] The Firm HAS been debarred by a public entity within the past ten (10) years. Provide the pertinent information (including each reporting entity name, case number, name and address of claimant, date of incident, date claim opened, and nature and disposition of each violation or finding) on the attached Labor/Payroll/Debarment History form.

I declare under penalty of perjury under the laws of the State of California that the above is true, complete and correct.

Table with 2 columns and 2 rows: Owner's/Agent's Authorized Signature, Print Name and Title, Print Name of Firm, Date

REQUIRED FORMS – EXHIBIT 18



**COUNTY OF LOS ANGELES
LIVING WAGE PROGRAM**

**LABOR/PAYROLL/DEBARMENT HISTORY
ACKNOWLEDGEMENT AND STATEMENT OF COMPLIANCE**

If applicable, Firm must complete and submit a separate form (make photocopies of form) for each instance of any of the following (check the applicable box below):

- An alleged claim, investigation or proceeding relating to an alleged Labor Law/Payroll Violation for an incident occurring within the past three (3) years of the date of the proposal.
- A determination by a public entity within three (3) years of the date of the proposal that the Firm committed a Labor Labor/Payroll Violation.
- A debarment by a public entity listed below within the past ten (10) years.

Print Name of Firm:	Print Name of Owner:
Print Address of Firm:	Owner's/Agent's Authorized Signature:
City, State, Zip Code:	Print Name and Title:

Public Entity Name:		Date of Incident:
Case Number/Date Claim Opened:	Case Number:	Date Claim Opened:
Name and Address of Claimant:	Name:	
	Street Address:	
	City, State, Zip:	
Description of Work: (e.g., janitor)		
Description of Allegation and/or Violation:		
Disposition of Finding (attach disposition letter): (e.g., Liquidated Damages, Penalties, Debarment, etc.)		

REQUIRED FORMS – EXHIBIT 18

**COUNTY OF LOS ANGELES
LIVING WAGE PROGRAM**

Additional Pages are attached for a total of _____ pages.

REQUIRED FORMS – EXHIBIT 19



COUNTY OF LOS ANGELES
LIVING WAGE ORDINANCE

LIVING WAGE DECLARATION

The contract to be awarded pursuant to this Request for Proposal (RFP) is subject to the County of Los Angeles Living Wage Ordinance (Living Wage Program). You must declare your intent to comply with the Living Wage Program.

If you believe that you are exempt from the Living Wage Program, please complete the Application for Exemption form and submit it, as instructed in the RFP, to the County awarding department.

Please check the option that best describes your intention to comply with the Living Wage Program.

- I **do not** have a bona fide health care benefit plan for those employees who will be providing services to the County under the contract. I will pay an hourly wage rate of not less than **\$11.84 per hour** per employee.
- I **do have** a bona fide health care benefit plan for those employees who will be providing services to the County under the contract, but will pay into the plan **less than \$2.20 per hour** per employee. Therefore, I will pay an hourly wage of not less than **\$11.84 per hour** per employee.
- I **do have** a bona fide health care benefit plan for those employees who will be providing services to the County under the contract, and will pay into the plan **at least \$2.20 per hour** per employee. Therefore, I will pay an hourly wage of at least **\$9.64 per hour** per employee.

Health Plan(s):

Company Insurance Group Number:

Health Benefit(s) Payment Schedule:

- Monthly Quarterly Bi-Annual
- Annually Other: (Specify)

REQUIRED FORMS – EXHIBIT 19



**COUNTY OF LOS ANGELES
LIVING WAGE ORDINANCE**

LIVING WAGE DECLARATION

PRINT COMPANY NAME:	
I declare under penalty of perjury under the laws of the State of California that the above is true and correct:	
SIGNATURE:	DATE:
PRINT NAME:	TITLE OR POSITION:

REQUIRED FORMS – EXHIBIT 20



**COUNTY OF LOS ANGELES
LIVING WAGE PROGRAM**

APPLICATION FOR EXEMPTION

Page 1 of 3

The contract to be awarded pursuant to the County’s solicitation is subject to the County of Los Angeles Living Wage Program (LW Program) (Los Angeles County Code, Chapter 2.201). Contractors and subcontractors must apply individually for consideration for an exemption from the LW Program. To apply, Contractors must complete and submit this form with supporting documentation to the County after the Mandatory Proposers Conference and by the due date set forth in the solicitation document. Upon review of the submitted Application for Exemption, the County department will determine, in its sole discretion, whether the contractor and/or subcontractor is/are exempt from the LW Program.

Company Name:			
Company Address:			
City:		State:	Zip Code:
Telephone Number:	Facsimile Number:		Email Address:
Awarding Department:			Contract Term:
Type of Service:			
Contract Dollar Amount:			Contract Number (if any):

I am requesting an exemption from the LW Program for the following reason(s) (*attach to this form all documentation that supports your claim*):

- My business is a non-profit corporation qualified under Internal Revenue Code Section 501(c)(3) (*attach IRS Determination Letter*).
- My business is a Small Business (as defined in the Living Wage Ordinance) which is not an affiliate or subsidiary of a business dominant in its field of operation **AND** during the contract period will have 20 or fewer full- and part-time employees; **AND**
 - Has less than \$1 million in annual gross revenues in the preceding fiscal year including the proposed contract amount; **OR**
 - Is a technical or professional service that has less than \$2.5 million in annual gross revenues in the preceding fiscal year including the proposed contract amount.

REQUIRED FORMS – EXHIBIT 20



**COUNTY OF LOS ANGELES
LIVING WAGE PROGRAM**

APPLICATION FOR EXEMPTION

- My business has received an aggregate sum of less than \$25,000 during the preceding 12 months under one or more Proposition A contracts and/or cafeteria services contracts, including the proposed contract amount.

Page 2 of 3

Continued from previous page

- My business is subject to a bona fide Collective Bargaining Agreement (*attach agreement*); **AND**
 - the Collective Bargaining Agreement expressly provides that it supersedes all of the provisions of the Living Wage Program; **OR**
 - the Collective Bargaining Agreement expressly provides that it supersedes the following specific provisions of the Living Wage Program (I will comply with all provisions of the Living Wage Program not expressly superseded by my business' Collective Bargaining Agreement):

I declare under penalty of perjury under the laws of the State of California that the information herein is true and correct.

PRINT NAME:	TITLE:
SIGNATURE:	DATE:

REQUIRED FORMS – EXHIBIT 20



**COUNTY OF LOS ANGELES
LIVING WAGE PROGRAM**

APPLICATION FOR EXEMPTION

Continued from previous page

Additional Information

The additional information requested below is for information purposes only. It is not required for consideration of this Application for Exemption. The County will not consider or evaluate the information provided below by Contractor, in any way whatsoever, when recommending selection or award of a contract to the Board of Supervisors.

I, **or my collective bargaining unit, have** a bona fide health care benefit plan for those employees who will be providing services to the County under the contract.

Health	Plan	Company	Name(s):
--------	------	---------	----------

Company Insurance Group Number(s): _____

Health Premium Amount Paid by Employer: _____

Health Premium Amount Paid by Employee: _____

Health Benefit(s) Payment Schedule:

Monthly Quarterly Bi-Annual

Annually Other: _____

(Specify)

I, **or my collective bargaining unit, do not** have a bona fide health care benefit plan for those employees who will be providing services to the County under the contract.

LIVING WAGE - CONTRACTOR STAFFING PLAN

Exhibit 21

DATE: 02/02/2010
 COMPANY NAME: XYZ COMPANY
 COMPANY ADDRESS: 1234 STREET, CITY STATE ZIP
 PROJECT: SECURITY SERVICES
 DEPARTMENT NAME: XXXX DEPT

FACILITY OR LOCATION	EMPLOYEE NAME	POSITION TITLE	ROVER(S)	WORK SCHEDULE	HOURS WORKED PER DAY	FULL TIME/PART TIME	HOURLY RATE	HEALTH INS. YES/NO	HOURS							COUNTY TOTAL HRS	NON-CNTY TOTAL HRS	HIRE DATE	TERMINATION DATE
									MON.	TUES	WEDS	THURS	FRI	SAT	SUN				
LANCASTER	NAME	OFFICER		8:00 TO 17:00	8	FULL TIME	\$11.84	No	8	8	8	8	8			40		5/1/2001	
1150 AVENUE J																			
LANCASTER																			
POMONA	NAME	OFFICER		8:00 - 19:00	10	FULL TIME	\$9.64	YES	10	10	10	10				40		11/13/2001	
100 W. SECOND STREET	NAME	OFFICER		8:00 TO 18:00	10	FULL TIME	\$9.64	No					10	10	10	30	10		
POMONA																			
SANTA FE SPRINGS	NAME	OFFICER		8:00 - 17:00	11	FULL TIME	\$11.84	No	8	8	8	8	8			40		5/5/2001	
10288 S.SLUSHER DRIVE				17:00 TO 20:00			\$17.76	No	3	3	3	3	3			15 OT			
SANTA FE SPRINGS																			
SHATIO	NAME	OFFICER		7:00 TO 18:00	10	FULL TIME	\$11.84	No	10	10	10	10				40		7/2/2001	
418 SHATIO PLACE	NAME		ROVER	7:00 TO 18:00	10	PART TIME	\$11.84	No					10			10		8/30/2001	
LOS ANGELES																			
WILSHIRE	NAME	OFFICER 0-1		8:00 TO 18:00	8	FULL TIME	\$11.84	No	8	8	8	8	8			40		5/20/2001	
9078 WILSHIRE BLVD.		OFFICER 0-2		18:00 TO 24:00	8	FULL TIME	\$11.84	No	8	8	8	8	8			40		5/21/2001	
LOS ANGELES		OFFICER 0-3		24:00 TO 8:00	8	FULL TIME	\$11.84	No	8	8	8	8	8			40		5/21/2001	
	NAME		ROVER	8:00 TO 18:00	8	FULL TIME	\$11.84	No						8	8	16 OT		7/28/2001	
	NAME		ROVER	18:00 TO 24:00	8	FULL TIME	\$11.84	No						8	8	16 OT		7/7/2001	
	NAME		ROVER	24:00 TO 8:00	8	PART TIME	\$11.84	No						8	8	16		7/12/2001	
	NAME	SUPVR 4			2	FULL TIME	\$24.00	YES	2	2	2	2	2			10	30	5/1/2001	

Sector 1 Lancaster, North Hollywood
 Sector 2 Covina, Pomona, and Monterey Park
 Sector 3 Pasadena, Torrance, Commerce, El Monte and Lakewood
 Sector 4 Los Angeles

REQUIRED FORMS - EXHIBIT 22
CHARITABLE CONTRIBUTIONS CERTIFICATION

Company Name

Address

Internal Revenue Service Employer Identification Number

California Registry of Charitable Trusts "CT" number (if applicable)

The Nonprofit Integrity Act (SB 1262, Chapter 919) added requirements to California's Supervision of Trustees and Fundraisers for Charitable Purposes Act which regulates those receiving and raising charitable contributions.

Check the Certification below that is applicable to your company.

Proposer or Contractor has examined its activities and determined that it does not now receive or raise charitable contributions regulated under California's Supervision of Trustees and Fundraisers for Charitable Purposes Act. If Proposer engages in activities subjecting it to those laws during the term of a County contract, it will timely comply with them and provide County a copy of its initial registration with the California State Attorney General's Registry of Charitable Trusts when filed.

OR

Proposer or Contractor is registered with the California Registry of Charitable Trusts under the CT number listed above and is in compliance with its registration and reporting requirements under California law. Attached is a copy of its most recent filing with the Registry of Charitable Trusts as required by Title 11 California Code of Regulations, sections 300-301 and Government Code sections 12585-12586.

Signature

Date

Name and Title of Signer (please print)

**REQUIRED FORMS - EXHIBIT 23
TRANSITIONAL JOB OPPORTUNITIES PREFERENCE APPLICATION**

COMPANY NAME:		
COMPANY ADDRESS:		
CITY:	STATE:	ZIP CODE:

I hereby certify that I meet all the requirements for this program:

- My business is a non-profit corporation qualified under Internal Revenue Services Code - Section 501(c)(3) and has been such for 3 years (*attach IRS Determination Letter*);
- I have submitted my three most recent annual tax returns with my application;
- I have been in operation for at least one year providing transitional job and related supportive services to program participants; and
- I have submitted a profile of our program; including a description of its components designed to help the program participants, number of past program participants and any other information requested by the contracting department.

I declare under penalty of perjury under the laws of the State of California that the information herein is true and correct.

PRINT NAME:	TITLE:
SIGNATURE:	DATE:

REVIEWED BY COUNTY:

SIGNATURE OF REVIEWER	APPROVED	DISAPPROVED	DATE

REQUIRED FORMS EXHIBIT 24

**CERTIFICATION OF COMPLIANCE WITH THE COUNTY'S
DEFAULTED PROPERTY TAX REDUCTION PROGRAM**

Company Name:		
Company Address:		
City:	State:	Zip Code:
Telephone Number:	Email address:	
Solicitation/Contract For _____ Services:		

The Proposer/Bidder/Contractor certifies that:

- It is familiar with the terms of the County of Los Angeles Defaulted Property Tax Reduction Program, Los Angeles County Code Chapter 2.206; **AND**

To the best of its knowledge, after a reasonable inquiry, the Proposer/Bidder/Contractor is not in default, as that term is defined in Los Angeles County Code Section 2.206.020.E, on any Los Angeles County property tax obligation; **AND**

The Proposer/Bidder/Contractor agrees to comply with the County's Defaulted Property Tax Reduction Program during the term of any awarded contract.

- OR -

- I am exempt from the County of Los Angeles Defaulted Property Tax Reduction Program, pursuant to Los Angeles County Code Section 2.206.060, for the following reason:

I declare under penalty of perjury under the laws of the State of California that the information stated above is true and correct.

Print Name:	Title:
Signature:	Date:

Date: _____

PBM SERVICES PROPOSAL CHECKLIST

Exhibit 25

The following required documents are included in the Proposal Package (check box to indicate that the required document is included). Two (2) separate proposals must be submitted to make up the final submission:

- Labeled as Proposal Package and Proposal Checklist (see Section 2.10).
- Labeled as Cost Proposal including prescription drug pricing, dispensing fee, administrative fee, and rebate guarantees (see Section 2.11).

Proposal Cover Page

Transmittal Letter (on Proposer's stationery)

Minimum Mandatory Requirements Checklist (Exhibit 11)

Table of Contents

Executive Summary (labeled Section A)

Proposer's Qualifications (labeled Section B)

Background and Experience (labeled Section B.1)

References (labeled Section B.2)

Pending Litigation and Judgments (labeled Section B.3)

Approach to Providing Required Services (labeled Section C)

Staffing Plan (labeled Section D)

Quality Control Plan (labeled Section E)

Green Initiatives (labeled Section F)

Terms and Conditions in Sample Contract and Requirements of the Statement of Work (SOW):
Acceptance of/or Exceptions to (labeled Section G)

Proposal Required Forms – Exhibits 1 through 25 (labeled Section H)

Exhibit 1 Proposer's Organization Questionnaire/Affidavit

Exhibit 2 Proposer's References

Exhibit 3 Proposer's List of Contracts

Exhibit 4 Proposer's List of Terminated Contracts

Exhibit 5 Certification of No Conflict of Interest

Exhibit 6 Familiarity with the County Lobbyist Ordinance
Certification

Exhibit 7 Request for Local Small Business Enterprise (SBE) Preference Program

Consideration and Certified Business Enterprise (CBE) Firm/Organization Information

- Exhibit 8 Proposer's Equal Employment Opportunity (EEO) Certification
- Exhibit 9 Attestation of Willingness to Consider GAIN/GROW Participants
- Exhibit 10 Contractor Employee Jury Service Program – Certification Form and Application for Exception
- Exhibit 11 Minimum Mandatory Requirements Checklist
- Exhibit 12 Attestation Regarding Proposer's Pending and Past Litigations and Judgements
- Exhibit 13A – 13D Prescription Drug, Administrative Fees, And Rebate Guarantee PRICING Sheets Exhibit 17 through 21 Living Wage Forms
- Exhibit 22 Charitable Contributions Certification (SB1262)
- Exhibit 23 Transitional Job Opportunities Preference Application
- Exhibit 24 Default Property Tax Reduction Program
- Exhibit 25 Proposal Checklist
- Supplemental Documents
 - Exhibit 1 PBM Background and Experience Table
 - Exhibit 2 Participating Pharmacy Network Directory
 - Exhibit 3 Implementation of Hard Edit "Exceptions"
 - Exhibit 4 Samples of Standard and Customized Reports
 - Exhibit 5 Current Pharmacy Network Audits
 - Exhibit 6 LACDMH PBM Services Staff
- Cost Proposal (Separate Proposal Package)
 - Exhibit 14 CERTIFICATION OF INDEPENDENT PRICE DETERMINATION AND ACKNOWLEDGEMENT OF RFP RESTRICTIONS
 - Exhibit 15 BUDGET SHEET FORMAT
 - Exhibit 16 EMPLOYEE BENEFITS

Failure to follow this format and sequence order of sections/subsections may result in disqualification or a lower Proposal Narrative evaluation score.

REQUIRED FORMS EXHIBIT 26

REQUEST FOR DVBE PREFERENCE PROGRAM CONSIDERATION

INSTRUCTIONS: All proposers/bidders responding to this solicitation must complete and return this form for proper consideration of the proposal/bid.

In evaluating bids/proposals, the County will give preference to businesses that are certified by the State of California as a Disabled Veteran Business Enterprise (DVBE) or by the Department of Veterans as a Service Disabled Veteran Owned Small Business (SDVOSB) consistent with Chapter 2.211 of the Los Angeles County Code.

Vendor understands that in no instance shall the disabled veteran business enterprise preference program price or scoring preference be combined with any other County preference program to exceed eight percent (8%) in response to any County solicitation.

Information about the State's Disabled Veteran Business Enterprise certification regulations is in the California Code of Regulations, Title 2, Subchapter 8, Section 1896 et seq., and is also available on the California Department of General Services Office of Disabled Veteran Business Certification and Resources Website at <http://www.pd.dgs.ca.gov/>

Information on the Veteran Affairs Disabled Business Enterprise certification regulations made be found in the Code of Federal Regulations, 38CFR 74 and is also available on the Veterans Affairs Website at: <http://www.vetbiz.gov/>

- I AM NOT** a Disabled Veteran Business Enterprise certified by the State of California or a Service Disabled Veteran Owned Small Business with the Department of Veteran Affairs.
- I AM** certified as a Disabled Veteran Enterprise with the State of California or a Service Disabled Veteran Owned Small Business with the Department of Veteran Affairs as of the date of this proposal/bid submission and I request this proposal be considered for the DVBE Preference.

DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.

Name of Firm	County Webven No.
Print Name:	Title:
Signature:	Date:

<i>SIGNATURE OF REVIEWER</i>	<i>APPROVED</i>	<i>DISAPPROVED</i>	<i>DATE</i>