BURLINGTON COUNTY BOARD OF SOCIAL SERVICES
MOUNT HOLLY, NEW JERSEY 08060

SOLICITATION OF QUOTES FOR

EMPLOYEE ASSISTANCE PROGRAM
Request for Quotes -#2023-3

Enclosed are the terms, specifications, contract documents and quote forms.

Request for Quotes Due: **June 29, 2023**
Time: **4:00 p.m.**

HAND DELIVERIES, COURIERS AND MAILING:
RETURN PROPOSAL TO:

Purchasing Department, **CONFIDENTIAL**
Burlington County Board of Social Services
Human Services Facility
795 Woodlane Road
Mt. Holly, NJ 08060

Telephone: (609) 518-4702
Fax: (609) 261-0463

Name of Proposer: _____

Address: _____
(Number and Street)

_____
(City) (State) (Zip Code)

Contact Person: _____

Telephone: _____

Toll-Free Telephone: _____

Fax: _____

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BURLINGTON COUNTY BOARD OF SOCIAL SERVICES
795 WOODLANE ROAD
MOUNT HOLLY, NEW JERSEY 08060-3335

2023 Request for Quotes

The Burlington County Board of Social Services requests qualified individuals and firms to submit quotes to furnish the following services for the period of July 1, 2023 through June 30, 2024:

Employee Assistance Program Provider

Instructions and specifications may be obtained at no charge by prospective agencies between the hours of 8:30 A.M. to 4:00 P.M., Monday through Friday, from the Purchasing Department of the Burlington County Board of Social Services, with offices located at the Burlington County Human Services Facility, 795 Woodlane Road, Mount Holly, New Jersey 08060-3335, Telephone Number: (609) 518-4702.

Quotes will be evaluated by the Burlington County Board of Social Services on the basis of the most advantageous price and other factors considered. The evaluation will consider:

- Qualifications, experience, and reputation in the field;
- Knowledge of the Burlington County Board of Social Services and the subject matter to be addressed under the contract;
- Availability to accommodate any required meetings of the agency;
- Compensation proposal;
- Other factors if demonstrated to be in the best interest of the Burlington County Board of Social Services.

Quotes must comply with the following:

- Furnish complete information addressing each of the selection criteria listed above;
- Prominently reference on the outside of the sealed envelope the service listed above which the quote is being submitted and include the Quote number - specifically **Quote #2023-3**;
- Mail or deliver the quote before the deadline to the following address:

  Purchasing Department, CONFIDENTIAL
  Burlington County Board of Social Services
  Human Services Facility
  795 Woodlane Road
  Mount Holly, New Jersey 08060-3335

The deadline for submitting quotes is June 29, 2023 at 4:00 p.m. Quotes must be received by the Board at its offices on or before this date and time.

Questions should be directed to the agency's Purchasing Department via email to Nicole.LeCates@bcbss.org.

Proposer's Name: _____
Quote #:_____

I. INTENT

The Burlington County Board of Social Services intends to award a contract for Employee Assistance Program Provider for the Burlington County Board of Social Services. The effective date of the contract shall be July 1, 2023 through June 30, 2024.

The General Criteria articulated herein in Section III for the selection of an Employee Assistance Program Provider have been specifically approved by the Burlington County Board of Social Services. Those criteria and the other requirements herein are intended to be non-restrictive for the purpose of obtaining participation of qualified professionals and uniformity in the manner of submission of proposals.

The successful proposal shall become a part of a contract between the parties upon award.

The Burlington County Board of Social Services shall be the sole judge concerning the criteria set forth herein and the merits of the proposals submitted. The Burlington County Board of Social Services shall be the sole judge of the benefits to the Burlington County Board of Social Services by the submissions pursuant to this Request, Solicitation and Invitation for Quotes.

II. PROFESSIONAL EVALUATION AND RANKING METHODOLOGY

GENERAL CRITERIA: (NEED POINTS)

a. Qualifications, experience, and reputation in the field;
b. Knowledge of the Burlington County Board of Social Services and the subject matter to be addressed under the contract;
c. Availability to accommodate any required meetings of the agency;
d. Compensation proposal;
e. Other factors if demonstrated to be in the best interest of the Burlington County Board of Social Services.

OTHER: No conflict of interests shall be permitted. Attachment "A" – Conflict of Interest Certification – must be executed and returned with your quote.

III. CONTRACT PERIOD

Contract period is ONE (1) YEAR. The period of responsibility is July 1, 2023 through June 30, 2024. All contracts are contingent on funding.

IV. SPECIFICATIONS

1. DEFINITIONS. The following terms, when utilized, shall have the respective indicated meanings:
   a. "Eligible Employee" shall refer to all employees working on a full or part-time basis.
   b. "Family" shall refer to an Eligible Employee's spouse and children under the age of 26 and living with the Eligible Employee.

2. PROGRAM. During the continuance of this Agreement, CONTRACTOR shall render an Employee Assistance Program (the "Program") providing professional evaluation, short-term counseling,

consultation, and referral for Eligible Employees and members of their Family experiencing personal or emotional problems, including as examples, marital and family problems, substance abuse, psychological difficulties, and psychiatric disease. The Program shall entail the following, all of which shall be provided by CONTRACTOR without charge to the participating individuals:

a. Entrance into the Program shall be via a special telephone number, which shall be monitored by a mental health professional during ordinary business hours. The CONTRACTOR's professional staff shall be available twenty-four (24) hours a day, seven (7) days a week via an on-call beeper system or answering service for clinical emergencies and crisis intervention by telephone.

b. An appointment with a qualified mental health professional shall be made for each Eligible Employee or Family Member who seeks entry into the Program. The mental health professional shall evaluate the problem and shall form a plan, to be agreed to by the participant, aimed at resolution of the difficulty. Qualified mental health professionals shall include and be limited to the following types of professionals: Master's Level Counselors, Ph.D., or Doctoral Level Psychologists, and M.D. or D.O. psychiatrists and psychiatric residents.

c. Each Participant shall be permitted five (5) sessions for assessment and resolution of the difficulty. The sessions shall be with qualified mental health professionals, as determined appropriate by the CONTRACTOR. All services shall be provided at the offices of the designated clinician, with the exception of alcohol/drug detoxification and rehabilitation. Referrals to community resources shall be made when appropriate.

d. At the end of the fifth visit, if the difficulty has not been resolved, the Program shall make an appropriate referral.

e. CONTRACTOR shall be available via telephone to the Director and other administrators of the Employee on an ongoing basis for confidential consultation concerning personnel problems and appropriate strategies for making use of EAP services.

f. CONTRACTOR shall maintain a network of providers in Burlington County for the convenience of the employees. CONTRACTOR shall provide flexible and convenient office hours to accommodate employees and family member work schedules.

3. CONSULTING AND RECORD KEEPING SERVICES. As part of its services to the BOARD hereunder, CONTRACTOR shall:

a. Assist in drafting or revising corporate policy statements pertaining to the Program, if required.
b. Provide Management with a summary to familiarize themselves with the Program.
c. Draft a supervisory guide to be utilized in the supervisory training workshops referred to below.
d. Provide supervisory training workshops annually.
e. Conduct orientation sessions with all Eligible Employees.
f. Provide brochures, supervisory guides, and promotional materials and a letter to Eligible Employees, introducing and promoting the Program.
g. Submit, on a quarterly basis, statistical summaries as to the utilization of the Program.
h. Provide two (2) educational in-services per year, on a request basis by the BOARD.

4. FEES. For the term of this agreement, CONTRACTOR shall receive a fee equal to the number of Eligible Employees, currently two hundred seventy (**255**), multiplied by the proposed cost. The total

contract amount is calculated on a capitated basis for anticipated services and is, therefore, non-refundable. These fees are to be paid on a quarterly basis following submission of an invoice along with a completed BOARD voucher. The BOARD shall make payment within forty-five (45) days of receipt of the invoice and voucher.

5. TERM. The term of this Agreement shall commence on July 1, 2023 and shall continue for a period of one (1) year terminating June 30, 2024.

6. CONFIDENTIALITY. CONTRACTOR is bound by professional ethics as to the confidentiality of the identity of the participants in the Program and information derived therein, and CONTRACTOR has no duty to disclose to the BOARD any such information. Statistical information is public. The offices of CONTRACTOR and its subcontractors shall reflect an atmosphere of privacy and discretion, and CONTRACTOR shall carefully maintain all of its patient records in restricted, locked file cabinets. Special scheduling arrangements shall be made available to ensure anonymity and confidentiality.

7. HIPAA. CONTRACTOR is required to execute the Confidentiality Affidavit, included as Section "IX", attesting to CONTRACTOR'S understanding of confidentiality requirements, and certifying that they have complied with, or shall comply with, confidentiality provisions contained in the Health Insurance Portability and Accountability Act (HIPAA) enacted on August 21, 1996, and implementing regulations. CONTRACTOR is required to observe the HIPAA Business Associate Contract Provisions, included as Section "VIII", and incorporated herein.

8. CONDITION PRECEDENT. As a condition precedent to this Agreement taking effect, the CONTRACTOR shall be registered with the State of New Jersey, pursuant to P.L. 2004, c. 57, Business Registration of Public Contractors, and shall provide proof of registration by submitting their Business Registration Certificate issued by the New Jersey Department of the Treasury, Division of Revenue to the BOARD prior to execution of this Agreement.

9. INSURANCE. During the entire duration of this Agreement, CONTRACTOR shall maintain and continue in full force the following insurance coverage:

a. Commercial General Liability including Products Completed Operations coverage for Personal Injury and Property Damage of not less than one million dollars ($1,000,000) for each occurrence and two million dollars ($2,000,000) annual aggregate.

b. Professional Liability insurance coverage of not less than one million dollars ($1,000,000) each wrongful act and two million dollars ($2,000,000) aggregate.

A certificate of insurance shall be issued within seven (7) days of the award to:

Burlington County Board of Social Services
Human Services Facility
795 Woodlane Road
Mount Holly, New Jersey 08060
Attention: Purchasing Department

10. INDEMNIFICATION. CONTRACTOR and its mental health professionals are acting hereunder as independent contractors. CONTRACTOR shall be solely responsible for, expressly agrees to indemnify, and shall keep, save, and hold harmless the BOARD and its officers, agents, or employees from and against any and all claims demands, suits, actions, recoveries, judgments, costs, and expenses in connection therewith on account of the loss of life or property of any person, agency, corporations, or government entity,

which shall arise out of the course of or in consequence of any of the negligent acts or omissions or tortious acts or omissions of the CONTRACTOR, its employees, agents, or subcontractors, in the performance of the services covered by this Agreement, or the failure to comply with the terms and conditions of the Agreement for which any forms of civil and/or criminal liability may attach. The CONTRACTOR's liability in this Agreement shall continue after the termination of the Agreement with respect to any liability, loss, expenses, or damage, resulting from negligent acts or omissions or tortious acts or omissions, occurring prior to termination. This indemnification obligation is not limited by but is in addition to other insurance obligations contained in this Agreement.

11. SUCCESSORS. This Agreement shall insure to the benefit of and be binding upon the CONTRACTOR and the BOARD and their respective successors and assigns, nothing in the Agreement, expressed or implied, being intended to confer upon any other persons rights or remedies hereunder.

12. ENTIRE AGREEMENT. This Agreement supersedes all prior negotiations, understandings, and writings between the CONTRACTOR and the BOARD. No change or modification to this Agreement shall be enforceable against any party unless the same is in writing, and signed by the party against whom enforcement is sought.

13. WAIVER. The waiver of a breach of any provision of this Agreement by the BOARD shall not operate or be construed as a waiver of any subsequent breach.

14. SEVERABILITY. If any provision of this Agreement shall become invalid under any law, such invalidity shall not affect the validity or enforceability of any other provision hereof.

15. GOVERNING LAW. This Agreement shall be governed, construed, and enforced in accordance with the laws of the State of New Jersey including the terms of the Local Public Contracts Law, N.J.S.A. 40A:11-1 et seq.

Proposer's Name: _____
Quote #:_____

V. PROPOSER'S QUESTIONNAIRE

Each proposer shall provide the following information as an integral part of his/her/its Quote and failure to answer all questions may render such Quote as irregular and non-responsive.

1. How many years experience as an Employee Assistance Program provider has your organization (Agency's parent subsidiary or affiliated corporations) had?

   _____

2. List the governmental units, municipalities, firms, or organizations you or your organization is now providing Employee Assistance Program services for, and the name(s) of the responsible Official or executive to whom you report.

Name	# of Employees	Report to

3. Indicate the local telephone number for your office which shall be available to receive calls and also provide the number (if different) for a responsible party in the event of an emergency:

   _____

   _____

4. Have you or your organization, or any partners of officers thereof, failed to complete a contract or defaulted under any such contract? If so, where and what were the circumstances?

   _____

   _____

   _____

   _____

5. Is your company associated or affiliated with any other company directly and/or indirectly? If Yes, explain:

( ) Yes ( ) No

_____

_____

_____

_____

6. Have you ever traded under a different name for this type of service within the last five (5) years? If so, please explain the circumstances for the change.

( ) Yes ( ) No

_____

_____

_____

_____ _____

7. EAP Provider Locations:

_____

_____

_____

_____ _____

_____

_____

_____

_____ _____

Proposer's Name: _____

Quote #:_____

VI. QUALIFICATION QUESTIONNAIRE

Experience:

Length of Time in Business _____ years

Number of Employees _____

State License Number, if applicable _____
(Attach copy (ies))

I am __ am not __ on the New Jersey Debarred Quote list.

Who will supervise the job?

_____

Name Title

Telephone number: _____

Who is the responsible contractor administrator? _____

Telephone number: _____

REFERENCES: (similar type work completed or currently under contract over the past five years.)

1.

Name of Contract

_____

Description of Contract

_____

Term of Contract

_____

Amount of Contract (Include all changes) $_____

Name of Owner

_____

(To whom service was/is provided)

Address of Owner _____

Telephone number _____ Contract number: _____

2.

Name of Contract
_____

Description of Contract
_____

Term of Contract
_____

Amount of Contract (Include all changes) $_____

Name of Owner
_____
(To whom service was/is provided)

Address of Owner_____

Telephone number _____ Contract number: _____

3.

Name of Contract
_____

Description of Contract
_____

Term of Contract
_____

Amount of Contract (Include all changes) $_____

Name of Owner
_____
(To whom service was/is provided)

Address of Owner
_____

Telephone number _____ Contract number: _____

Proposer's Name: _____
Quote #:_____

I state that the information contained herein is true and correct.

Prepared by: _____

Signature: _____

Title: _____

Business Name: _____

Business Address: _____

_____

_____
City State Zip Code

Telephone: _____

Toll-free Telephone: _____

Fax Telephone: _____

Federal ID No.: _____

_____ _____, 20_____
(Witness) (Date)

NOTE: The Board reserves the right to reject any agency on the basis of the information supplied in the qualification questionnaire.

Proposer's Name: _____
Quote #: _____

VII. STATEMENT OF UNDERSTANDING

Knowledge of Burlington County Board of Social Services and the subject matter to be addressed under this contract.

Briefly explain your understanding of how your services will compliment the services that the Burlington County Board of Social Services provides to the general public (customers):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____
(Agency Name)

_____
(Signature)

_____
(Type or Print Name and Title)

_____, 20_____
(Date Signed)

Proposer's Name: _____
Quote #: _____

VIII. HIPAA BUSINESS ASSOCIATE CONTRACT PROVISIONS

1. Definitions

a. Catch-all definition: Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in the Privacy Rule.

b. Definitions:

(1) Business Associate. Business Associate shall generally mean the same meaning as the term "business associate" at 45 CFR 160.103..
(2) Covered Entity. Covered Entity shall generally mean the same as "covered entity" at 45 CFR 160.103
(3) Individual. Individual shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).
(4) Privacy Rule. Privacy Rule shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.
(5) Protected Health Information. Protected Health Information shall have the same meaning as the term protected health information in 45 CFR 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
(6) Required By Law. Required By Law shall have the same meaning as the term as required by law in 45 CFR 164.501.
(7) Secretary. Secretary shall mean the Secretary of the Department of Health and Human Services or his designee.

2. Obligations and Activities of Business Associate

a. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.

b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

c. Business Associate agrees to comply with all relevant provisions of 164.501 et seq.

d. Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.

e. Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.

f. Business Associate agrees to make available Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR 164.524.

g. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR 164.526 at the request of Covered Entity or to take other obligations under 45 CFR 164.526.

h. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or to the Secretary, in a time and manner deemed necessary by the Covered Entity or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

i. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

j. Business Associate agrees to provide to Covered Entity or an Individual, information collected in accordance with section (i) above of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

3. General Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Bid Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

4. Specific Use and Disclosure Provisions

a. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

b. Except as otherwise limited in this Agreement, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

c. Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide Data Aggregation services to Covered Entity as permitted by 42 CFR 164.504(e) (2) (i) (B).

d. Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with CFR 164.502(j) (1).

5. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

d. Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

6. Term and Termination

a. Term. The Term for these provisions shall be effective the same date of the Agreement, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

b. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

(1) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity;

(2) Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or

(3) If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary.

c. Effect of Termination.

(1) Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(2) In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon Covered Entity's agreement with this determination that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

7. Miscellaneous

a. Regulatory References. A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended.

b. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

c. Survival. The respective rights and obligations of Business Associate under Section 6c (Effect of Termination) of this Agreement shall survive the termination of this Agreement.

d. Interpretation. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with the Privacy Rule.

Proposer's Name: _____
Quote #: _____

IX. CONFIDENTIALITY AFFIDAVIT

STATE OF NEW JERSEY :
SS:
COUNTY OF BURLINGTON :

I, _____ , of the City or Township of _____ in the County of _____ , of full age, being duly sworn according to law, upon my oath, depose and say that:

1. I have read and fully understand **Confidentiality Statement** contained in this Request for Quotes.

2. I fully understand that the Federal Social Security Act requires that a State must provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the public assistance programs, and that no information regarding an applicant or recipient of public assistance shall be disclosed to any party except for the purposes directly connected with the administration of the public assistance program.

3. I fully understand that information considered confidential includes but is not limited to the following: (a) names and addresses, including lists; (b) information contained in applications, reports of investigations, reports of medical examinations, correspondence, and other records concerning the condition or circumstances of any person from whom, or about whom information is obtained, and including all such information whether or not it is recorded; (c) records of evaluation of such information.

4. I fully understand that Federal and State law mandate that the Board assign the confidentiality standards imposed on it by Federal and State law to any contracted entity.

5. I fully understand that all client information that we may encounter in performing work for the Board is confidential and, by law, must not be discussed outside the agency or with unauthorized individuals.

6. I fully understand that the Board requires that I maintain a need to know policy which prohibits individuals working for me from accessing information not pertaining to their work responsibilities, and I hereby certify that I have implemented such a policy or will do so prior to commencement of any agreement.

7. I fully understand that the Health Insurance Portability and Accountability Act (HIPAA) enacted on August 21, 1996 includes a variety of provisions relating to the confidentiality of health information. Specifically, HIPAA's privacy rules provide that individually identifiable health information must be protected, and only those with specific business reasons relating to medical information may have access to protected health information. As defined in the regulations, protected health information is individually identifiable health information that is transmitted or maintained electronically or in any other form and includes name, address, names of employers, birth date, telephone numbers, fax numbers, electronic mail address, Social Security number, medical record plan beneficiary number, account number, certificate/license number, any vehicle or other device serial number, web universe locator, internal protocol address, finger or voice print, photographic images, or any unique identifying number, characteristic, or code.

8. I fully understand that it is my responsibility to read and understand the HIPAA law, regulations, and standards, and to implement all applicable provisions. Furthermore, I have read the HIPAA Business Associate Contract Provisions which are annexed hereto and incorporated herein as if set forth at length, and agree to comply with these provisions as part of any agreement that is awarded.

9. I fully understand that the Board requires that I train all employees working for me regarding the confidentiality of client information, and I hereby certify that I have implemented such a policy or will do so prior to commencement of any agreement.

10. I fully understand that questions that arise or inquiries that are received regarding confidentiality of client information must be directed to the Board's attorney.

_____

(Name)

Sworn and Subscribed before me this _____ day

of _____, 20_____.

Notary Public of _____

(Notary Seal)

Proposer's Name: _____
Quote #: _____

X. PRICING SHEET

Please indicate below the cost for the following activities:

Fee is equal to the number of eligible employees <u>255</u> multiplied by cost per employee $_____ for a monthly amount totaling $_____.

_____
(Name)

Sworn and Subscribed before me this _____ day

of _____, 20_____.

Notary Public of _____

(Notary Seal)

Proposer's Name: _____
Quote #: _____

XI. FACTORS OF INTEREST

The Quote will be evaluated on the following factors:

a. Qualifications, experience, and reputation in the field;
b. Knowledge of the Burlington County Board of Social Services and the subject matter to be addressed under the contract;
c. Availability to accommodate any required meetings of the agency;
d. Compensation proposal;
e. Other factors if demonstrated to be in the best interest of the Burlington County Board of Social Services.

Please supply in this section any information below that you want the Board to consider:

_____

_____

_____

_____

_____

_____

_____

_____
(Name)

Sworn and Subscribed before me this _____ day

of _____, 20_____.

Notary Public of _____

(Notary Seal)

Proposer's Name: _____
Quote #: _____

XII. SUBMISSION LETTER

Burlington County Board of Social Services
795 Woodlane Road
Mount Holly, New Jersey 08060-3335

Dear Members of the Board:

The undersigned hereby submits the enclosed proposal as Employee Assistance Program Provider.

The undersigned hereby undertakes and promises to serve as Employee Assistance Program Provider for the Burlington County Board of Social Services and to do all work requested as appropriate and required herein as well as the contract documents concerning the same, including all written amendments and changes thereto, if any, which are incorporated herein by reference and made a part of this proposal.

_____	_____
SIGNATURE	BUSINESS NAME
_____	_____
Type or Print Full Name	Title Date
_____	_____
Telephone Number	Fax-Telephone Number

ATTACHMENT A

CONFLICT OF INTEREST CERTIFICATION

THE UNDERSIGNED CERTIFIES TO THE BURLINGTON COUNTY BOARD OF SOCIAL SERVICES, COUNTY OF BURLINGTON, STATE OF NEW JERSEY THAT IN PERFORMING SERVICES TO THE BOARD HE/SHE IS AWARE OF NO CIRCUMSTANCE THAT WOULD CONSTITUTE A CONFLICT OF INTEREST, FINANCIAL OR OTHERWISE, BETWEEN HIMSELF/HERSELF (OR HIS/HER FIRM) AND THE INTERESTS OF THE BURLINGTON COUNTY BOARD OF SOCIAL SERVICES. THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS MADE A SEARCH OF HIS/HER FIRM'S CLIENT BASE AND HAS EXECUTED THIS CERTIFICATION SUBSEQUENT TO SUCH SEARCH.

THE UNDERSIGNED ACKNOWLEDGES THIS IS A CONTINUING CERTIFICATION, AND SHALL REMAIN IN EFFECT FOR THE TERM OF THE SERVICES CONTAINED IN THE SOLICITED REQUEST FOR PROPOSAL. I CERTIFY THAT THE FOREGOING STATEMENTS MADE BY ME ARE TRUE. I AM AWARE THAT IF ANY OF THE FOREGOING STATEMENTS MADE BY ME ARE FALSE, THE BURLINGTON COUNTY BOARD OF SOCIAL SERVICES IS FREE TO TERMINATE ANY PROFESSIONAL SERVICE AGREEMENT ENTERED INTO WITH THE UNDERSIGNED AND/OR HIS OR HER BUSINESS.

Applicant Signature: _____

Typed Firm Name: _____

Title: _____

Date: _____

ATTACHMENT B

I HEREBY CERTIFY THE INFORMATION CONTAINED IN THIS PROPOSAL IS CORRECT AND ACCURATE TO MY PERSONAL KNOWLEDGE. I AM MAKING THIS CERTIFICATION IN GOOD FAITH.

CERTIFYING OFFICIAL:

NAME: _____

TITLE: _____

SIGNATURE: _____

DATE: _____