

**SOLICITATION FOR CONTINUING SERVICES
CS #09-015
PHYSICIAN SERVICES FOR THE ROHR HOME**

INTRODUCTION

Polk County, a political subdivision of the State of Florida, seeks the submittal of information from licensed physicians interested in providing physician services for the residents of The Rohr Home, a sixty (60) bed skilled nursing facility owned and operated by the Polk County Board of County Commissioners. Physicians must submit all required documentation listed on the "Submittal Sheet" of this Continuing Service in order to be considered. All physicians submitting the required information shall have an opportunity to participate.

SCOPE OF WORK

Physicians will provide 24-hours-a-day, seven-days-a-week coverage for any patients under their care while they are residents of The Rohr Home. Physicians will be responsible for notifying The Rohr Home twenty four (24) hours in advance that an on call physician is covering for them and the contact information for the on call physician in the event that they will be unavailable and for signing the telephone orders written by the on call physician. Physicians must visit residents of The Rohr Home under their care at a minimum of once monthly and more often if medically indicated. Approved physicians are required to personally make the initial visit and, thereafter, can elect to alternate their visits with an associate physician or a qualified nurse practitioner (NP), clinical nurse specialist or physician assistant (PA) that is under their direct supervision. The alternate must have privileges at The Rohr Home and the physician is responsible for all billing of their physician services to the residents of The Rohr Home. Physicians must provide their own billing to Medicare, Medicaid, other insurances or the resident. The Rohr Home is not financially responsible for any physician-related services provided to the residents of The Rohr Home.

TERM

This is an on-going service and will be reviewed at least annually.

SUBMITTAL OF RESPONSES

Interested parties are invited to submit their responses to the Procurement Division. The requested information may be mailed, delivered, faxed or emailed to:

**Polk County Procurement Division
330 West Church Street
P.O. Box 9005, Drawer AS05
Bartow, Florida 33831-9005
Tel: (863) 534-6757
Fax: (863) 534-6789
Attn: Michael Guerrero
Email: MichaelGuerrero@polk-county.net**

SUBMITTAL SHEET

I agree to abide by all conditions of this Continuing Service and certify that I have read and understand the Continuing Services process. I have completed and submitted all Continuing Services submittal forms, and I am authorized to sign this Continuing Service for the provider.

Vendor must submit the following:

- Copy of State of Florida Medical license
- DEA number
- NPI number
- Certificate of Insurance (See General Conditions-Insurance Requirements)
- Information supplied to The Florida Department of Health, Division of Medical Quality Assurance, for license profile
- Additional documentation, if necessary, to show geriatric experience, including, but not limited to, a reference from another long term care facility serving geriatric patients
- The Rohr Home Physician's Agreement
- Affidavit Certification Immigration Laws

FIRM NAME: _____

CONTACT NAME: _____

TITLE: _____

SIGNATURE: _____

FIRM ADDRESS: _____

EMAIL ADDRESS: _____

PHONE NUMBER: _____

FAX NUMBER: _____

THE ROHR HOME PHYSICIAN'S AGREEMENT

I, _____, am a licensed physician in the State of Florida and agree to accept residents at The Rohr Home as my patients. I will abide by all rules, laws and regulations governing the provision of physician services at a skilled nursing facility in the State of Florida and I will abide by all of The Rohr Home Policies, which shall be in compliance with the same. I further agree to provide 24-hours-a-day, seven-days-a-week coverage for any patients under my care. I will let The Rohr Home know in advance who the on call physician is that's covering for me in the event I will be unavailable for contact. I will sign telephone orders written by the on call physician.

I have attached a copy of my medical license, DEA, NPI and proof of workers compensation and professional and general liability insurance, to be kept on file while accepting residents at The Rohr Home. I will supply my provider numbers, as requested.

I understand that I must visit the residents under my care at least once monthly, and more often if medically indicated. I further understand that I am required to personally make the initial visit and, thereafter, I can elect to alternate my visits with an associate physician or a qualified nurse practitioner (NP), clinical nurse specialist or physician assistant (PA) who is under my direct supervision. I also understand that my alternate must have privileges at The Rohr Home and that I am responsible for all billing of my physician services to the appropriate payor, which shall not be The Rohr Home.

Physician's Signature

License Number

DEA Number

NPI Number

GENERAL CONDITIONS

INDEMNIFICATION

The firm shall, in addition to any other obligation to indemnify the County and to the fullest extent permitted by law, protect, defend, indemnify and hold harmless the County, their agents, elected officials and employees from and against all claims, actions, liabilities, losses, costs arising out of any actual or alleged bodily injury, sickness, disease or death, or injury to or destruction of tangible property including the loss of use resulting therefrom, or any other damage or loss arising out of or resulting from or claims to have resulted in whole or in part from any actual or alleged act or omission of the consultant, any subcontractor, anyone directly or indirectly employed by any of them, of anyone for whose acts any of them may be liable in the performance of the work; or violation of law, statute, ordinance, governmental administration order, rule, regulation or infringement of patent rights by the firm in the performance of the work; or liens, claims or actions made by the firm or any subcontractor or other party performing the work.

INSURANCE REQUIREMENTS

Workers' Compensation Insurance providing statutory benefits, including those that may be required by any applicable federal statute. Non-construction industry sole proprietors and partners are automatically exempt by Florida Law from the provisions of Chapter 440, Florida Statutes (Workers' Compensation). The successful vendor must provide a letter stating the exemption status and number of employees.

Admitted in Florida	Yes
Employer's Liability	\$100,000
All States Endorsement	Statutory
Voluntary Compensation	Statutory

Commercial General Liability Insurance \$1,000,000 combined single limit of liability for bodily injuries, death, and property damage, and personal injury resulting from any one occurrence, including the following coverages:

Broad Form Commercial General Liability Endorsement to include blanket contractual liability (specifically covering, but not limited to, the contractual obligations assumed by the Firm); Personal Injury (with employment and contractual exclusions deleted) and Broad Form Property Damage coverages; Independent Contractors;

Professional Liability Insurance \$1,000,000. (Medical malpractice physician services)

The Insurance Certificates to be submitted by the vendor must include the following information.

The Certificate Holder must be stated as:

Polk County, a Political Subdivision of the State of Florida
P.O. Box 9005, Drawer AS05
Bartow, Florida 33831-9005

The County must be named as additional insured in regards to General Liability. The policy shall contain a waiver of subrogation in favor of Polk County.

The County must be an additional named insured in regards to General Liability. Coverage must be provided by an insurer licensed to do business in the State of Florida and must be rated "A VIII" or better by A.M. Best Rating Company for Class VIII financial size category. Waiver of subrogation in favor of Polk County is required for General Liability and Worker's Compensation coverages.

Notation on the certificate reflecting the additional insured status and the waiver of subrogation or copies of the endorsements must be provided to verify requirements. "All work performed for Polk County" must be noted on the certificate.

The acceptable form of the certificate of insurance shall be the industry standard ACORD certificate.

Certificate of insurance must be submitted with response.

SPECIFICATIONS (The Rohr Home)

1. Vendor must meet all rules, laws and regulations for providing physician/medical services in facility (The Rohr Home).
2. Vendor will perform all required background and abuse checks. County personnel may request a copy of the background check and abuse check. The successful vendor must comply within 24 hours.
3. Vendor will ensure compliance with facility's policies and procedures.
4. Vendor will provide 24-hour day, 7-day week and 365-day (or 366-day) year service, as needed by the requesting facility, including weekends and holidays.
5. If the County determines it is in its best interest to revoke privileges, it reserves the right to do so with a thirty day written notice, unless the County determines that the health and safety of the residents and/or staff would be at risk.
6. Vendor must maintain a clear and active license.
7. Vendor must not be restricted from participation in the Medicare and/or Medicaid programs.

**AFFIDAVIT CERTIFICATION
IMMIGRATION LAWS**

SOLICITATION NO.: CS 09-015-MAR PROJECT NAME: Physician Services for The Rohr Home

POLK COUNTY WILL NOT INTENTIONALLY AWARD COUNTY CONTRACTS TO ANY CONTRACTOR WHO KNOWINGLY EMPLOYS UNAUTHORIZED ALIEN WORKERS, CONSTITUTING A VIOLATION OF THE EMPLOYMENT PROVISIONS CONTAINED IN 8 U.S.C. SECTION 1324 a(e) {SECTION 274A(e) OF THE IMMIGRATION AND NATIONALITY ACT ("INA").

POLK COUNTY MAY CONSIDER THE EMPLOYMENT BY ANY CONTRACTOR OF UNAUTHORIZED ALIENS A VIOLATION OF SECTION 274A(e) OF THE INA. **SUCH VIOLATION BY THE RECIPIENT OF THE EMPLOYMENT PROVISIONS CONTAINED IN SECTION 274A(e) OF THE INA SHALL BE GROUNDS FOR UNILATERAL CANCELLATION OF THE CONTRACT BY POLK COUNTY.**

BIDDER ATTESTS THAT THEY ARE FULLY COMPLIANT WITH ALL APPLICABLE IMMIGRATION LAWS (SPECIFICALLY TO THE 1986 IMMIGRATION ACT AND SUBSEQUENT AMENDMENTS).

Company Name: _____

Signature Title Date

STATE OF: _____

COUNTY OF: _____

The foregoing instrument was signed and acknowledged before me this ____ day of _____, 20____, by

_____ who has produced
(Print or Type Name)

_____ as identification.
(Type of Identification and Number)

Notary Public Signature

Printed Name of Notary Public

Notary Commission Number/Expiration