Lane County Health & Human Services

Acupuncture Services for

Community Health Centers of Lane County REQUEST FOR PROPOSALS

RFP #21304

7/1/24 through 6/30/26

Renewable through 6/30/33

Submit Proposals to:

Jonathan.Mattingly@lanecountyor.gov

Deadline:

1 PM Pacific, April 16, 2024

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You are hereby requested to respond to the following Request for Proposals by 1 PM Pacific on April 16, 2024. Proposals received after deadline(s) will not be accepted.

PART I - GENERAL INFORMATION

Introduction

Lane County is an Equal Opportunity Employer and the Lane County process of contracting is built on the principles of equity, consistency and understandability.

The Lane County Department of Health & Human Services is seeking proposals from providers to provide Acupuncture Services for Community Health Centers of Lane County.

The term of the contract arising from this Request for Proposals will be July 01, 2024 through June 30, 2026. The contract may be renewed through June 30, 2033 based on revenue availability, contractor performance, and/or need.

Pursuant to ORS 279A and Lane County contracting rules, other public agencies shall have the ability to purchase the awarded goods and services from the awarded Contractor(s) under terms and conditions of the resultant contract. Any such purchases shall be between the Contractor and the participating public agency and shall not impact the Contractor's obligation to Lane County. Any estimated purchase volumes listed herein do not include other public agencies and Lane County makes no guarantee as to their participation.

Any bidder, by written notification included with their solicitation response, may decline to extend the prices and terms of this solicitation to any and/or all other public agencies.

Appropriate accommodations can be made upon notice for individuals with disabilities who wish to respond.

Contract Requirements

A. The contractor must operate the program independently and not as an agent of Lane County. Proposals will be accepted from a consortium of agencies. One joint proposal from each consortium will be required.

B. The contractor must comply with all applicable federal, state, local statutes, and rules governing the operations of the program, including, but not limited to the following:

   1. The Americans with Disabilities Act of 1990, 42 USC 12101 et seq. as well as ORS 30.670 through 30.685, ORS 659.425 and ORS 659.430, and all rules and regulations implementing those laws.

   2. Federal Code, Title 5 USCA 7201 et seq.: Anti-discrimination in employment

   3. ORS 659.010, 659.015, 659.020 and, 659.030: Enforcement of Civil Rights

4. The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

C. Contractor must comply with the following:

1. All contract requirements concerning the provision of insurance must be met. This may include comprehensive liability with Lane County named as additional insured, professional liability, fidelity bonding and workers' compensation coverage.

2. Automobile insurance with Lane County named as additional insured is required if clients are transported or a vehicle is used in conducting agency business under the contract. Professional liability insurance is required if services are provided by licensed staff. Insurance requirements are outlined in Exhibit H of Lane County contract.

Proposal Preparation and Submission

A. To be received and considered, all proposals must be in writing and signed by the bidder or the bidder's authorized representative. Proposals must be submitted in the manner specified in the RFP documents.

B. In your responses, please follow the sequence of questions or documentation requested in all sections of the Request for Proposals. All proposals must be submitted as a single PDF document.

C. By signing and returning a proposal, the proposer acknowledges that the proposer has read and understands the terms and conditions applicable to the proposal documents and that the proposer accepts and agrees to be bound by the terms and conditions of the contract, including to perform the scope of work and meet the performance standards.

D. Each proposer must be an “equal opportunity employer” willing to comply with all applicable provisions of the Civil Rights Act of 1964, as amended by the Equal Opportunity Act of 1972 (see 42 USCA 2000), all regulations there under (see 41 CFR Parts 60 and 60-1), Executive Orders 11246 and 11375 and all Oregon statutes and regulations regarding employment.

E. All proposals submitted are subject to public inspection, with the exception of information covered by an exception in public records law pursuant to ORS 279B.055(5)(c). Each proposer, by submitting a proposal, acknowledges that it is the proposer’s responsibility to defend and indemnify the County for any costs associated with establishing such an exemption. The proposer’s act in submitting a bid constitutes the proposer’s acceptance of this responsibility.

F. A proposer may not modify its proposal after submission. A proposer may withdraw its proposal at any time prior to RFP closure, and may submit a replacement proposal in accordance with the required submission procedures.

G. Proposals will be received by Senior Program Services Coordinator, Jonathan Mattingly, until 1 PM on April 16, 2024. Proposals will be publicly opened immediately following the time proposals are due. Proposals must be submitted to Jonathan.Mattingly@lanecountyor.gov or to

LCHSRFP@lanecountyor.gov. The County will not consider any proposal received after the time and date stated in the RFP document.

H. The County may issue an addendum to modify or add to the terms of the RFP, or to change the time or date for submission of proposals. Any addendum will be issued by the County in writing not less than seventy-two (72) hours prior to the deadline for receipt of proposals, and available on the County-Wide Bid Page. Each proposer is responsible to verify for itself if any addendum has been issued prior to submission of its proposal; the County is not responsible to notify individual prospective proposers of the issuance of an addendum. The requirements or clarifications contained in any addenda issued must be included in the proposal received and will become part of any resulting contract.

I. The County reserves the right to cancel a solicitation, or reject any or all proposals in whole or in part when the cancellation or rejection is in the County's best interests as determined by the County. This includes rejecting any proposal not in compliance with all prescribed public bidding procedures and requirements, and for good cause, rejecting all proposals upon a finding that it is in the public interest to do so The County may also:

1. Issue a subsequent Request for Proposals for the same or similar goods or services
2. Solicit supplemental information only from those bidders that submitted bids, if in the public officer's judgment it is unlikely re-advertising publicly would lead to greater competition
3. Not award a contract for the requested services
4. Waive any irregularities or informalities
5. Issue more than one contract, dividing the services to be rendered and the remuneration to be paid
6. Accept the proposal which the County deems to be the most beneficial to the public and to Lane County
7. Negotiate with any proposer to further amend, modify, redefine or delineate its proposal.
8. Further question any proposer to substantiate claims of experience, background, knowledge and/or ability
9. Waive the need for reference checks, based on current or prior experience with and/or knowledge of the proposer

J. The County will not examine any proposal prior to opening. However, the public officer may, but is not obligated to, examine proposal documents submitted electronically to verify receipt of the electronic submission in an intact condition. All proposals submitted will be opened publicly at the time, date and place designated in the RFP by PSC Jonathan Mattingly, Senior PSC. Any proposal or modification received after the designated deadline will not be opened or

considered. Proposals submitted in response to an RFP may be opened in a manner to avoid revealing contents to competing proposers in accordance with ORS 279B.060(6)(a).

K. Proposals submitted are not subject to public inspection until a notice of intent to award has been issued.

L. All proposals must be irrevocable for not less than thirty (30) days from the time of opening of proposals, unless otherwise stated in the RFP documents. The proposals of all proposers will remain irrevocable and binding, and any proposal securities will be retained by the public officer, until a contract has been executed and the contractor has provided any and all required performance bonds and insurance certificates.

Proposal Evaluation and Award

A. Proposal evaluation will be conducted by the public officer in cooperation with the department requesting the RFP, if any, based on the requirements of the RFP, compliance with procedures, public contracting laws, and the requirements of the Lane Manual, including:

1. Application of preferences for Oregon goods and services, resident bidders, recycled goods, and printing, pursuant to ORS 279A.120 to ORS 279A.128 and ORS 282.210.

2. Investigation and determination of responsibility requirements pursuant to ORS 279B.110.

3. Where the proposal includes more than one (1) price or alternative, any calculation and evaluation necessary to determine the most responsive proposal. The County may use the methods described in OAR 137-049-0380(2) or such other method as the public officer deems reasonable Submission of a completed Proposer's Statements and Certifications in the form included in this RFP.

B. Proposals will be reviewed for qualifications and completeness by Jonathan Mattingly, Senior PSC. Proposers must provide the following:

1. Information required by Proposal Content section of the RFP

2. Signed Proposers' Statements and Certifications

C. Proposals will be reviewed by the proposal review committee. The proposal review committee will be made up of CHC Medical Director, an Associate Medical Director for the CHC, and Clinic Supervisor for the CHC. The County will award contracts only to responsible contractors possessing the ability to perform. In determining whether a contractor is responsible, the County will consider the contractor's record of integrity, compliance with public policy, past performance, and technical and financial resources as well as responses received from references, interviews, and follow-up questions, if any. Lane County H&HS expects to conduct interviews in the process of selecting proposers for this opportunity.

D. Minor informalities/mistakes in proposals may be waived. Mistakes discovered in proposals after opening where the intended correct statement or amount is evident or properly substantiated may be corrected. Where the intended correct statement or amount is not evident or cannot reasonably be substantiated or clarified, the proposal may not be accepted. The County reserves the right to waive technical defects, discrepancies and minor irregularities, and to not award a contract when it finds such action to be in the public interest.

E. The County will provide written notice of its intent to award to a given proposer or proposers by June 02, 2023. All proposers recommended for funding must pass the Management Qualifications process prior to Lane County issuing a contract for services. (MQ can also be a requirement of RFP).

Following issuance of a notice of intent to award, all proposals are open to public inspection, except for information examination covered by an exception in public records law pursuant to ORS 279B.055(5)(c). Each proposer, by submitting a proposer, acknowledges that it is the proposer's responsibility to defend and indemnify the County for any costs associated with establishing such an exemption. The proposer's act in submitting a proposal constitutes its acceptance of this responsibility.

F. The County reserves the right to cancel a solicitation or reject any or all proposals in whole or in part when the cancellation or rejection is in the County's best interests as determined by the County. This includes rejecting any proposal not in compliance with all prescribed public solicitation procedures and requirements, and for good cause, rejecting all proposals upon a finding that it is in the public interest to do so.

If all proposals are rejected in whole or in part, the County may advertise for new proposals, or solicit supplemental information only from those proposers that submitted proposals, if in the public officer's judgment, it is unlikely re-advertising publicly would lead to greater competition. PSC Name is delegated the authority to reject all proposals, prepare findings of best interests, and provide written notice of rejection of all proposals.

Clarification and Protest of Solicitation Documents

If a proposer finds discrepancies or omissions in the RFP documents, or is in doubt as to their meaning, the proposer must immediately notify the public officer (Jonathan Mattingly, Jonathan.Mattingly@lanecountyor.gov). If the public officer believes a clarification is necessary, an addendum will be issued in writing not less than seventy-two (72) hours prior to time of bid closure, unless the public officer determines that a shorter period is in the public interest. The terms of any addenda issued are to be included in the proposer's proposal and will become part of the contract documents. Addendums will be posted on the County-Wide Bid Page.

The apparent silence of the solicitation documents regarding any detail, or the apparent omission from the RFP of a detailed description concerning any point, means that only the best commercial or professional practice, material, or workmanship is to be used.

A prospective proposer may protest the competitive selection process or provisions in the RFP documents if the prospective proposer believes the solicitation process is contrary to law or that a solicitation document is unnecessarily restrictive, legally flawed, or improperly specifies a brand name pursuant to the requirements of ORS 279B.405(2). Any written protest must be submitted to Jonathan Mattingly, Jonathan.Mattingly@lanecountyor.gov by 1 PM on February 13, 2024.

Lane County will consider the protest if the protest is timely filed and contains:

A. Sufficient information to identify the solicitation that is the subject of the protest;

B. The grounds that demonstrate how the procurement process is contrary to law or how the solicitation document is unnecessarily restrictive, is legally flawed or improperly specifies a brand name;

C. Evidence or supporting documentation that supports the grounds on which the protest is based; and

D. The relief sought.

If the protest meets these requirements, the County will consider the protest and issue a decision in writing. If the protest does not meet these requirements, the County will promptly notify the prospective proposer that the protest is untimely or that the protest failed to meet these requirements and give the reasons for the failure. The County will issue its decision on the protest not less than three (3) business days before proposals are due, unless a written determination is made by the County that circumstances exist that justify a shorter time limit.

Protest Process

A respondent to an RFP that submitted a responsive proposal, and is not selected for award, may protest the award or recommendation for award of a contract based on RFPs submitted. Any protest must be received by the County within seven 7 days of the notice of recommendation or intent to award or, if no notice is given, of actual award.

Protests of award or intent to award will be considered by the Local Contract Review Board (LCRB), if the Board's action were required to award the contract. All other protests of intent of award will be considered by the County Administrator, or the Administrator's designee.

A. Requirements for protest.

1. A protest of award of a public improvement contract must specify the applicable grounds for protest set forth in OAR 137-049-0450(4)(c), which is hereby adopted into this rule.

2. All other protests of award must be in writing and specify the applicable grounds for the protest as set forth in ORS 279B.410(1).

3. Any protest not in compliance with these rules may be rejected.

B. Review and determination.

1. Upon receipt of a protest, the department must promptly notify both the evaluation committee and the proposer recommended for award that a protest has been received and furnish each with a copy of the protest. Both the recommended proposer and the committee may, within three 3 calendar days from the date the protest was received, respond to the protest in writing.

2. After a protest has been received, the Department that issued the RFP must prepare a written analysis of the protest and make a recommendation to the decision maker as to appropriate action to be taken.

3. Contracts Requiring Board Action to Award. If the public officer determines there is sufficient merit to reject proposals, the public officer may do so. If, following any action by the public officer, any portion of the protest remains, the LCRB must be provided with, and may consider, a complete copy of the written record, and any other evidence provided, at a public meeting. At the public meeting the LCRB may, at the LCRB's discretion, allow the department that issued the RFP and the appellant an opportunity to address the protest. The LCRB may affirm, reverse, or revise an award, or may send the matter back to the Department for further action, and must issue its decision by Board Order.

4. Contracts Not Requiring Board Action to Award. The County Administrator has authority to reject proposals, or to affirm, reverse, or revise the award, or send the matter back to the department for further action. The Administrator must deliver this decision to the LCRB. If, within seven 7 days, the LCRB elects to review the matter, the LCRB must be provided with and may consider a complete copy of the written record, and any other evidence provided, at a public meeting. The LCRB may affirm, reverse, or revise an award, or may send the matter back to the Department for further action, and must issue its decision by Board Order. If the LCRB does not elect to review the matter within seven 7 days, the Administrator's decision will be final.

C. The procedures in this rule are mandatory to the extent they establish the time and manner for protests to be submitted to the County, including that the protest be in writing specifying the grounds and timely filed, and that there be a written response. The other protest procedures above are directory, and failure to follow or complete the action in the manner provided will not invalidate the County’s decision.

PART II – REQUESTED SERVICES

Description

The Community Health Centers of Lane County (CHCLC) is seeking proposals from individuals and entities to provide acupuncture services for CHCLC patients. We are soliciting proposals for one (1) to four (4) acupuncturists to offer services in our alternative medicine clinic.

Objectives of the acupuncturist services are to:

1. Provide effective alternatives and/or complementary therapies to pharmaceutical-based therapies to patients with chronic pain or other areas amenable to treatment with acupuncture.
2. Using subjective and objective assessments as appropriate, improve the outcomes of patients receiving these services.
3. Support CHCLC primary care provider teams in providing care to patients with pain management issues.
4. On request, offer recommendations to clinical leadership to support a cost-effective, financially-sustainable model of care.

CHCLC Background:

CHCLC is a federally qualified health center which provides primary care and behavioral health services in eight clinic locations in the Eugene/Springfield area. The CHCLC serves approximately 23,800 primary care patients annually. For more information on CHCLC please visit our website at Community Health Centers of Lane County - Lane County

Services to be Provided:

We are interested in developing a collaborative relationship with partner(s) who can provide acupuncture services to our patients. Our primary focus is services for our adult population, with an emphasis on services for pain management. (We also have a limited number of adolescents who may also benefit from these services.) Our highest need is for pain management for patients with low back pain, fibromyalgia, and/or migraine headaches. Patients will be referred by the CHCLC primary care providers for services.

Key aspects of the services coordination will include the following:

1. We look to have services provided five (5) days a week (Mon. – Fri) at the acupuncture clinic located at our Brookside Clinic site. We understand that we will need to work with the vendor to identify the specifics of facility/space planning and scheduling. These items will be by mutual agreement of the parties.

2. Proposed services should include:

    a. Modalities within the scope of the acupuncturist to support adult patients with chronic conditions, primarily pain issues such as low back pain, fibromyalgia, and/or migraine headaches. Acupuncturists may also be called to support patients with psychological challenges such as anxiety, PTSD, or nightmares, as well as eating disorders, tobacco cessation or other substance use disorders if appropriate. Other clinical issues may include chronic functional gastrointestinal issues (eg, irritable bowel or GERD), eczema, hypertension, palpitations, or other chronic issues on referral from the primary care provider.
    b. Services may also target adolescents as a secondary target group.
    c. Coordination w/ CHC providers for:
        i. Service integration while the patient is receiving care in the pilot program, and
        ii. On-going care after the patient has completed participation in the pilot program.
    d. Participation in evaluation of the pilot program's efficacy and in quality improvement activities related to the program services.

3. Patient scheduling will be maintained by CHCLC staff.

4. Providers will be expected to document services within the CHCLC's electronic health record.

5. All billable services will be billed directly by CHCLC to applicable payers.

CHCLC will coordinate credentialing providers with payers as applicable. Providers for services that are covered by Medicaid will not be able to provide services until their credentials have been approved by applicable Medicaid payers.

Funding

Lane County will consider all proposals for provision of the requested services at a reasonable and/or competitive cost. Final costs will be determined as part of contract negotiations. The initial term of the contract will be between 18 and 24 months, renewable through June 30, 2033. Billing will be based on actual services rendered.

Additional Information

If applicants need additional information about any aspect of the program, questions and requests for information should be addressed to Jonathan Mattingly at Jonathan.Mattingly@lanecountyor.gov. Requested information to the extent it is available, will be posted on the County-Wide Bid Page.

PART III - CALENDAR OF EVENTS

February 08, 2024 ……..	Request for Proposal Released
February 15, 2024, 1 PM ……..	Deadline for Commenting on or Protesting Specifications Believed to Limit Competition
April 16, 2024, 1 PM ……	Proposals Due to PSC; Jonathan.Mattingly@lanecountyor.gov
May 3, 2024 ……..	Notification of Review E-mailed
May 10, 2024, 1 PM ……	Protest of Recommendations Due
May 24, 2024 ……..	Contracts Awarded
July 1, 2024 ……..	Anticipated Start Date of Services

PART IV – PROPOSAL CONTENT

Proposer must submit all items included in this section of the RFP.

Respondents must include a response to each of the following items, organized in the order given here, not including the Proposer Statements and Certifications form:

Proposal Requirements

Please provide the name of the agency (or person if sole proprietorship) that will be coordinating and providing the service, and names of any subcontracting agencies, if any, that are proposed to provide services. Also provide contact information of the person with authority to negotiate contracts.

1. Describe your experience providing acupuncture as effective alternative and/or complementary therapies to pharmaceutical-based therapies to patients with pain management issues. Include information with respect to licensed staff for proposed services where applicable.

2. Describe agency and/or acupuncturists experience with entering clinical data in an Electronic Medical Record:

3. Provide the names, backgrounds, license, and insurance information of principle staff (or self) proposed for the provision of services.

4. Please indicate if individual or agency is currently providing or has provided these services in the past within a primary care practice. Also indicate if individual or agency has provided services within a Federally Qualified Health Center (FQHC). FQHC populations typically serve Medicaid and Medicare patients, please indicate relevant experience along with any other background information that you believe may be applicable to this proposal.

5. Describe the services you will require from the CHCLC including facility space, staffing support, equipment, and/or supplies that may be in addition to what is already being offered in the acupuncture clinic.

6. Outline your agency's fee proposal. We anticipate paying for services on an hourly basis based on staffing hours of the agency's staff for services provided.

7. Credentials. The contractor must be licensed in the State of Oregon as an acupuncture provider. Please provide details regarding licensure and indicate current or any historical credentialing status with Trillium Healthcare and/or PacificSource.

8. Please give a detailed description of strategies used to empower patients to improve overall pain management and reintegrate them back into standard primary care treatment.

9. Please submit a Curriculum Vitae for review.

10. Three professional references who are familiar with their recent work (last 3 years) must be provided.

RESPONDENT STATEMENTS AND CERTIFICATIONS

(CONTRACT FORM D-2, 2020 EDITION)

NOTE: this form is for use with RFQ and RFP responses only. For Bids, use Contract Form D-1.

Respondent's Name: _____

RFQ or RFP Title: _____

RESPONDENT STATEMENTS

Respondent's Offer. Respondent offers to provide the required goods or services in accordance with the requirements of the Request for Proposals (RFP) or Request for Qualifications (RFQ) stated above as stated in the enclosed response. The undersigned Respondent declares that Respondent has carefully examined the above-named RFP or RFQ, and that, if an award is made, Respondent will execute a contract with the County to furnish the goods or services required under the RFP or RFQ response submitted with this form. Respondent attests that the information provided is true and accurate to the best of the personal knowledge of the person signing this document, and that the person signing has the authority to represent the individual or organization in whose name the response is submitted.

Respondent's Acceptance of Terms and Conditions. By execution of this form, the undersigned Respondent accepts all terms and conditions of the RFP or RFQ except as modified in writing in its response. Respondent agrees that the offer made herein will remain irrevocable for a period of 60 days from the date responses are due.

Respondent's Acknowledgement of Public Records Law. By execution of this Form, the undersigned Respondent acknowledges that its entire response is subject to Oregon Public Records Law (ORS 192.410–192.505), and may be disclosed in its entirety to any person or organization making a records request, except for such information as may be exempt from disclosure under the law. Respondent agrees that all information included in this bid that is claimed to be exempt from disclosure has been clearly identified either in the Respondent Statement, or in an itemization attached hereto. Respondent further acknowledges its responsibility to defend and indemnify the County for any costs associated with establishing a claimed exemption.

ADDENDA

Respondent has received and considered, in the accompanying response, the terms of the following addenda, if any:

_____

CERTIFICATIONS

By signing this Respondent's Certification form, Respondent certifies that:

1. Certification of Resident Bidder Status. Respondent is _____is not _____ (check one) a resident bidder, as defined in ORS 279A.120.

2. Certification of Non-Discrimination. Respondent has not discriminated and will not discriminate against a subcontractor in awarding a subcontract because the subcontractor is a disadvantaged business enterprise, minority-owned business, woman-owned business, a business that a service-disabled veteran owns, or an emerging small business that is certified under ORS 200.055.

3. Certification of Non-Collusion. This bid is made without connection or agreement with any individual, firm, partnership, corporation, or other entity making a bid for the same services, and is in all respects fair and free from collusion or collaboration with any other Respondent.

4. Certification of Compliance with Tax Laws. Respondent has, to the best of Respondent's knowledge, complied with Oregon tax laws in the period prior to the submission of this bid, including:

   a. All tax laws of the State of Oregon, including but not limited to ORS 305.620 and ORS chapters 316, 317, and 318,

   b. Any tax provisions imposed by a political subdivision of this state that applied to Respondent or its property, goods, services, operations, receipts, income, performance of or compensation for any work performed, and

   c. Any rules, regulations, charter provisions, or ordinances that implemented or enforced any of the foregoing tax laws or provisions.

The undersigned, by signature here, acknowledges, accepts, and certifies to the statements and certifications as stated above.

RESPONDENT

_____	_____
Authorized signature	Respondent's legal name
_____	_____
Name of authorized signer	Address
_____	_____
Title	
_____	_____
Date	Federal Tax ID number

CONTACT INFORMATION FOR THIS SUBMISSION

_____
Contact name

_____
Telephone number

_____
Email address

PART V – CRITERIA FOR EVALUATION OF REQUEST FOR PROPOSALS

1. Does the agency/individual have experience providing acupuncture as an alternative and/or complementary therapy to pharmaceutical-based therapies? Is the staff/individual appropriately licensed?

   1 2 3 4 5 6 7 8 9 10 x3 _____

2. Does the individual or agency have any experience using an electronic medical records system?

   1 2 3 4 5 6 7 8 9 10 x2 _____

3. Does the principal staff have backgrounds, licensure, and insurance appropriate for providing acupuncture as an alternative/complementary medicine service in a primary care practice?

   1 2 3 4 5 6 7 8 9 10 x4 _____

4. Does the individual or agency have experience providing these services to the typical FQHC population (usually covered by Medicaid or Medicare, if insured at all, often with lower socioeconomic status and higher rates of psychosocial instability)?

   1 2 3 4 5 6 7 8 9 10 x2 _____

5. Does the proposal describe the services and accommodations they will require from CHCLC? Does it include descriptions of the facility space, staffing support, equipment and supplies that will be needed? Do the requirements appear reasonable?

   1 2 3 4 5 6 7 8 9 10 x1 _____

6. Does the cost for the services appear reasonable?

   1 2 3 4 5 6 7 8 9 10 x3 _____

7. Does the proposal include an acupuncturist currently licensed to practice in the State of Oregon and/or previously credentialed with Trillium Healthcare and/or PacificSource?

   1 2 3 4 5 6 7 8 9 10 x3 _____

8. Does the proposal include a strategy for improving overall health of patients and moving them back to standard primary care.

   1 2 3 4 5 6 7 8 9 10 x2 _____

9. Does the proposal include a Curriculum Vitae with appropriate education and experience and an acupuncturist currently or previously credentialed with Trillium Healthcare and/or PacificSource?

   1 2 3 4 5 6 7 8 9 10 x2 _____

REVIEWER NAME: _____

AGENCY REVIEWED: _____

DATE REVIEWED: _____

PART VI- ATTACHMENTS

Notice Regarding Oregon Corporate Activity Tax

Lane County Contract

Required Documents for Acupuncturists

NOTICE REGARDING OREGON CORPORATE ACTIVITY TAX

The County is providing this notice to ensure Bidders and proposers are informed of the Corporate Activity Tax (CAT), effective January 1, 2020. Bidders and proposers must consider this tax and all other applicable taxes in preparing and submitting bids and proposals; the County will pay according to the contract amount(s) as submitted in the Bid or proposal, in accordance with the contract documents.

The following information is provided from the Oregon Department of Revenue:

In 2019, the Oregon Legislature established the Corporate Activity Tax (CAT) through House Bills 3427 and 2164. The CAT is expected to generate $1 billion of revenue per year. Although the tax is called a Corporate Activity Tax, the tax applies to all business entity types, including sole proprietorships, partnerships, type C and S corporations, and others.

The CAT is measured on a business's commercial activity-the total amount a business realizes from transactions and activity in Oregon, regardless of whether the revenue is received from private parties or contracts with government entities such as Lane County.

The new law requires businesses with Oregon commercial activity in excess of $1 million to file a CAT return, and those businesses with taxable commercial activity in excess of $1 million must pay the tax. The CAT imposes a $250 tax on the first $1 million of gross receipts, after subtractions, and a 0.57 percent tax on gross receipts greater than $1 million, after subtractions. Please be aware the Corporate Activity Tax:

- Is effective January 1, 2020.
- Applies to any business entity that conducts business in Oregon.
- Requires returns to be filed using a calendar tax year.
- Requires registration within 30 days after exceeding the $750,000 registration threshold.
- Requires returns to be filed annually by April15.

For more information and to receive updates by subscribing to the Oregon Department of Revenue (ODR) email notification list, visit the ODR website at www.oregon.gov/dor and click on the Corporate Activity Tax link. Bidders may also follow ODR at @Orrevenue on Twitter.

If you have questions regarding the tax, you may call 503-945-8005 or email ODR at cat.help.dor@oregon.gov.

NOW, THEREFORE, in consideration of the mutual promises and covenants hereinafter contained, and payment to CONTRACTOR by COUNTY as noted on the previous pages, for the periods of this Contract as previously designated, it is mutually agreed as follows-

1. CONTRACTOR will meet all requirements laid out in Exhibit A - Additional Terms and Conditions, including Business Associate Agreement language if included.

2. CONTRACTOR's Services: CONTRACTOR will perform as an independent contractor and not as an agent of the COUNTY, the necessary services to conduct the specific programs described in Exhibit B

− Program Plan by this reference made a part hereof at a funding level described in Exhibit C - Budget Plan by this reference made a part hereof.

3. Match: CONTRACTOR will provide non-federal match at a level indicated in Exhibit D - Match.

4. Lane Manual: CONTRACTOR agrees to comply with the rules and regulations of COUNTY, marked Exhibit F, by this reference incorporated herein.

5. Federal Terms and Conditions: CONTRACTOR agrees to comply with Exhibit G - Federal Terms and Conditions by this reference made a part hereof, if applicable to this Contract.

6. Termination. The parties may jointly agree to terminate this Contract at any time by written agreement. COUNTY may terminate this Contract for its convenience at any time with no liability on its part, except to pay for services previously provided, by giving CONTRACTOR not less than 30 days' advance written notice. If COUNTY reasonably believes that CONTRACTOR is in material breach of CONTRACTOR’s obligations or any representation or warranty contained in this Contract, upon notice to CONTRACTOR of such breach and failure of CONTRACTOR to cure such breach within 7 days of receipt of COUNTY’s notice, COUNTY may terminate this Contract.

7. Multiple Counterparts: This Contract and any subsequent amendments may be executed in several counterparts, facsimile or otherwise, all of which when taken together will constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this Contract and any amendments so executed will constitute anoriginal.

8. Authorized Representative: Any notice, demand, consent, approval, or other communication to be given under this Contract must be in writing and provided by email addressed to the party's authorized representative, except as provided below in this section. However, if, in either party's discretion, email is not the most appropriate method for providing notice, then notice may be provided by personal delivery; certified mail, postage prepaid, return receipt requested; or nationally recognized overnight courier. The effective date of notice shall be: for notice by email, the date and time sent if sent between the hours of 8 am and 5 pm, otherwise effective at 8am the following Business Day; for notice delivered in person, the date and time of delivery; for notice by

U.S. mail, three days after the date of certification; and for notice by overnight courier, the next business day after deposit with the courier. If no representative is identified, notice may be given to the person executing the Contract on behalf of that party.

9. Compliance with Coronavirus Guidelines, Laws, Rules, and Orders: The novel coronavirus ("COVID- 19") has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and believed to spread mainly from person-to-person contact. Each of the parties is and must remain familiar with the Centers for Disease Control Prevention guidelines and

with federal, state, and local laws, rules, and orders regarding COVID-19 throughout the term of this Contract. Each of the parties acknowledges that it understands the circumstances regarding COVID- 19, and in carrying out its obligations under this Contract, each will take all necessary precautions, including those set out in the guidelines, laws, rules and orders described in this paragraph. The parties agree that they have anticipated the costs of compliance with the present guidelines, rules, laws, and orders in establishing their obligations under this Contract, and that no claim will be made by either party for such compliance. However, in the event that after the effective date of this Contract the referenced COVID-19 guidelines, laws, rules, and orders are changed in such a way as to adversely affect the parties' carrying out of their obligations under this Contract, either party so affected must give notice to the other party of any potential need to modify

10. Contractor Certifications: BY EXECUTION OF THIS CONTRACT, THE PERSON SIGNING THIS CONTRACT CERTIFIES TO COUNTY THAT:

a. The person signing this Contract has the power and authority to execute this Contract on behalf of CONTRACTOR, and to bind CONTRACTOR to its terms,

b. CONTRACTOR will, at all times during the term of this Contract, be qualified and professionally competent, and possess any licenses required to perform the Work.

c. CONTRACTOR has not discriminated against minority, women or small business enterprises or a business that is owned or controlled by or that employs a disabled veteran as defined in ORS 408.225,

d. All staff and volunteers used in any program receiving funding from the Department of Human Services (DHS), Oregon Health Authority (OHA), Oregon Youth Authority (OYA), Department of Education (DOE) or the Employment Division or is licensed by DHS, OHA, OYA, DOE or the Employment Division will complete a criminal history check per ORS 181.534 or

181.537 and will not have unsupervised contact with clients prior to approval by DHS, OHA,

OYA, DOE or Employment Division, and

e. CONTRACTOR has, to the best of its knowledge, complied with Oregon tax laws in the period prior to the execution of this Contract, and will continue to comply with such laws during the entire term of this Contract, including:

(i) All tax laws of the State of Oregon, including but not limited to ORS 305.620 and ORS chapters 316, 317, and 318,

(ii) Any tax provisions imposed by a political subdivision of this state that applied to Proposer or its property, goods, services, operations, receipts, income, performance of or compensation for any work performed, and

(iii) Any rules, regulations, charter provisions, or ordinances that implemented or enforced any of the foregoing tax laws or provisions.

f. Pursuant to ORS 305.385(6) and OAR 150-305-0302, CONTRACTOR hereby swears and affirms under penalty of perjury that, to best of my knowledge, CONTRACTOR is not in violation of any tax laws described in ORS 305.380 (4)(a).

REQUIRED DOCUMENTS FOR:
ACCUPUNCTURIST

State of Oregon Acupuncturist License- (copy of original) License must reflect Oregon address by time of hire

Diplomas (copy of originals are fine)- please make sure month and year of start and completion are listed on Resume

National Board Certification (copy of original or web document)

NPI (downloaded copy acceptable) NPI should reflect Oregon address by time of hire

Current BLS/CPR (copy of original is fine)

CV or Resume – must include all employment since graduation, please explain any gap in work history

Government Issued ID card front and back (copy of original is fine)

Date of birth and social security number

Previous 5 years of Certificates of Liability insurance- if same company just note on main page submitted

Current Oregon Practitioner Credentialing Application (see attached)

Lane County Fitness Form (see attached)

Lane County Privileging form (see attached)

Please send all required credentialing documentation to the hiring admin assistant or the Credentialing Coordinator

***IMMUNIZATION RECORDS: Including the following Hepatitis B, Covid 1st series completion(boosters not required) and TB TEST RESULTS (if completed within the last year)**
*** Admin staff can assist with connection to clinic to obtain all immunizations needed**

OREGON PRACTITIONER CREDENTIALING APPLICATION

- **APPLICATION**
- **PROFESSIONAL LIABILITY ACTION DETAIL (ATTACHMENT A)**

PURPOSE: ESTABLISHED BY HOUSE BILL 2144 (1999), THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI) DEVELOPS THE UNIFORM APPLICATIONS USED BY HOSPITALS AND HEALTH PLANS TO CREDENTIAL AND RECREDENTIAL PRACTITIONERS WITHIN OREGON.

REVIEWED, AMENDED & APPROVED
BY THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI)
MARCH 16, 2022

OREGON PRACTITIONER CREDENTIALING APPLICATION

Prior to completing this credentialing application, please read and observe the following:

I. Instructions

This form should be **typed (*using a different font than the form*) or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

- **Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.**
- **Complete the application in its entirety. Keep an unsigned and undated copy of the application on file for future requests. When a request is placed, send a copy of the completed application to the health care related organization to which you are applying, making sure that all information is complete, current and accurate.**
- **Please sign and date page 13, Attestation Questions and page 14, Authorization and Release of Information Form (and Attachment A, Professional Liability Action Detail, if applicable).**
- **Each page of the application requires the applicant's initials and the date on which the application was last reviewed.**
- **Attach copies of the documents requested each time the application is submitted.**
- **If a section does not apply to you or your practitioner type, please check the "Does Not Apply" box at the top of the section.**
- **Submit application to the requesting organization(s).**

Current copies of the following documents must be submitted with this application:

- State Professional License(s)
- DEA Certificate or CSR Certificate
- ECFMG (*if applicable*)
- Face Sheet of Professional Liability Policy or Certificate

A curriculum vitae is optional and not an acceptable substitute.

***Note: Please return completed application to the health care related organization to which you are applying not to the state.**

OREGON PRACTITIONER CREDENTIALING APPLICATION

II. Practitioner Information *Please provide the practitioner's full legal name.*

Last Name (include suffix; Jr., Sr., III):	First:	Middle:	Degree(s):

Is there any other name under which you have been known or have used since starting professional training? Yes ☐ No ☐
Name(s) and Year(s) Used:

Home street address:	Home telephone number: - -	Mobile/alternate number: - -
	Email address:	

City:	State:	ZIP:
Country:	Birth date: Month/Day/Year / /	Birth place:
Citizenship:	Social Security number:	Gender: Male ☐ Female ☐ X ☐

Immigrant Visa number *(if applicable)*:	Visa expiration date:	Status:	Type:

Educational Commission for Foreign Medical Graduates (ECFMG) number *(if applicable)*:	Month/Year Issued: /

III. Specialty Information *This information may be included in directory listings.*

Principal clinical specialty (For most current specialties list, see: http://www.wpc-edi.com/codes):	Do you want to be designated as a primary care practitioner (PCP)? Yes ☐ No ☐

Additional clinical practice specialties:

Category of professional activity, check all boxes that apply:

Clinical practice:

- ☐ Full Time
- ☐ Part Time
- ☐ Locum /Temporary
- ☐ Telemedicine
- ☐ Other (explain)

Other professional activities:

- ☐ Administration
- ☐ Teaching
- ☐ Research
- ☐ Retired
- ☐ Other (explain)

IV. Board Certification/Recertification *This section does not apply to licensure.* Does not apply ☐

List all current and past certifications. Please attach additional sheets, if necessary.

Name of issuing board	Board Certification Number (as applicable)	Specialty	Date certified/ recertified month/year	Expiration date *(if any)* month/year
			/	/
			/	/
			/	/

If not currently board certified, describe your intent for certification, if any, and dates of previous testing and or intended future testing for certification below. Please attach additional sheets, if necessary.

Initials: *Date:*

V. Other Certifications *Please attach copy of certificate(s), if applicable.*

Examples include: ACLS, BLS, ATLS, PALS, NRP, AANA, Fluoroscopy, Radiography, etc.

Type:	Number:	Month/Year of certification:	Month/Year of expiration:
BLS-CPR		/	/
Type:	Number:	Month/Year of certification:	Month/Year of Expiration:
		/	/
Type:	Number:	Month/Year of certification:	Month/Year of Expiration:
		/	/
Type:	Number:	Month/Year of certification:	Month/Year of Expiration:
		/	/

For additional certifications, please attach a separate sheet.

VI. Practice and Employment Information

Name of primary practice/affiliation or clinic:	Department name *(if hospital based)*:
Community Health Centers of Lane County-Riverstone Clinic	

Primary Clinical Practice street address:	Entity type 2 (*group*) NPI number:
2073 Olympic St	1326138314

City:	County:	State:	ZIP:
Springfield	Lane	Oregon	97477-3413

Primary office telephone number:	Primary office fax number:	Patient appointment telephone number:
541 - 682 - 3550 Ext.	541 - 682 - 3551	541 - 682 - 3550 Ext.

Mailing/Billing Address (if different from above):	Attn:
	Billing Department

Office manager:	Office manager's telephone number:	Office manager's fax number:
Suzanne Roelof	541 - 682 - 3584 Ext.	541 - 682 - 3521

Exchange/answering service number:	Pager number:	Office email address:
- - Ext.	- -	Suzanne.Roelof@lanecountyor.gov

Credentialing Contact and Address:
Michelle Peterson 2073 Olympic St., Springfield, Oregon 97477-3413

Credentialing contact's telephone number:	Credentialing contact's fax number:	Credentialing contact's email address:
541 - 682 - 7987 Ext.	541 - 682 - 9926	michelle.peterson@lanecountyor.gov

Federal tax ID number or social security number, if used for business purposes:
93-6002303

Name affiliated with tax ID number:
Lane County

Name of secondary practice/affiliation or clinic:	Department name *(if hospital based)*:
Community Health Centers of Lane County-Charnelton Clinic	

Secondary Clinical Practice street address:	Entity type 2 (*group*) NPI number:
151 W.7th ave	

City:	County:	State:	ZIP:
Eugene	Lane	Oregon	97401-2676

Primary office telephone number:	Primary office fax number:	Patient appointment telephone number:
541 - 682 - 3550 Ext.	541 - 682 - 6703	541 - 682 - 3550 Ext.

Mailing/Billing Address (if different from above):	Attn:

Office manager:	Office manager's telephone number:	Office manager's fax number:
Suzanne Roelof	541 - 682 - 3584 Ext.	541 - 682 - 3521

Exchange/answering service number:	Pager number:	Office email address:
- - Ext.	- -	

Credentialing Contact and Address:
Michelle Peterson 2073 Olympic St., Springfield, Oregon 97477-3413

Credentialing contact's telephone number:	Credentialing contact's fax number:	Credentialing contact's email address:
541 - 682 - 7987 Ext.	541 - 682 - 9926	michelle.peterson@lanecountyor.gov

Federal tax ID number or social security number, if used for business purposes:
93-6002303

Name affiliated with tax ID number:
Lane County

Please list other office locations with above information on a separate sheet.

Initials: *Date:*

VII. Practice Call Coverage

Please provide the name and specialty of those practitioners who provide care for your patients when you are unavailable.

	Name:	Specialty:
1.	Dr. Richard Brunader MD	Family Medicine
2.		
3.		
4.		
5.		

VIII. Undergraduate Education *(Please attach additional sheets, if necessary.)*

Complete school name and street address:	Degree received:	Month/year of start: /
		Month/year of graduation: /
City:	State:	Course of study or major:

IX. Graduate Education *(Please attach additional sheets, if necessary.)*

Does not apply ☑

Complete school name and street address:	Degree received:	Month/year of start: /
		Month/year of graduation: /
City:	State:	Course of study or major:

X. Medical / Professional Education *(Please attach additional sheets, if necessary.)*

Complete medical/professional school name and street address:

City:	State	ZIP:	Contact email:
Degree received:		Phone number: - -	Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /

Did you complete the program? Yes ☑ No ☐ *(if you did not complete the program, please explain on a separate sheet.)*

Complete medical/professional school name and street address:

City:	State	ZIP:	Contact email:
Degree received:		Phone number: - -	Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /

Did you complete the program? Yes ☐ No ☐ *(if you did not complete the program, please explain on a separate sheet.)*

Initials: *Date:*

XI. Post-Graduate Year 1 / Internship *(Please attach additional sheets, if necessary.)*

Does not apply ☑

Complete institution name and street address:

City:	State	ZIP:	Contact email:
Type of internship/specialty:		Phone number: - -	Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /

Did you complete the program? Yes ☐ No ☐ **(if you did not complete the program, please explain on a separate sheet.)**

XII. Residencies *(Please attach additional sheets, if necessary.)*

Does not apply ☐

Complete institution name and street address:

City:	State	ZIP:	Contact email:
Specialty:		Phone number: - -	Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /

Did you complete the program? Yes ☑ No ☐ ***(if you did not complete the program, please explain on a separate sheet.)***

Complete institution name and street address:

City:	State	ZIP:	Contact email:
Specialty:		Phone number: - -	Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /

Did you complete the program? Yes ☐ No ☐ **(if you did not complete the program, please explain on a separate sheet.)**

XIII. Fellowships, Preceptorships, or Other Clinical Training Programs

(Please attach additional sheets, if necessary.)

Does not apply ☑

Complete institution name and street address:

City:	State	ZIP:	Contact email:
Specialty:		Phone number: - -	Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /

Did you complete the program? Yes ☐ No ☐ ***(If you did not complete the program, please explain on a separate sheet.)***

Complete institution name and street address:

City:	State	ZIP:	Contact email:
Specialty:		Phone number: - -	Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /

Did you complete the program? Yes ☐ No ☐ ***(if you did not complete the program, please explain on a separate sheet.)***

Initials: *Date:*

XIV. Health Care Licensure, Registrations, Certificates & ID Numbers

(Please attach additional sheets, if necessary.)

Oregon license or registration number:	Type:	Month/Day/Year of Expiration: / /
Drug Enforcement Administration (DEA) registration number (*if applicable*):		Month/Day/Year of Expiration: / /
Controlled substance registration (CSR) number (*if applicable*):		Month/Day/Year of Issue: / /
Entity type 1 (*individual*) NPI number:	Medicare number:	Oregon Medicaid provider number:

Physician Assistant Supervising Physician Full Name and Oregon License Number:

XV. Other State Health Care Licenses, Registrations & Certificates

Does not apply ☑

Please include all ever held. (Please attach additional sheets, if necessary.)

State/Country:	Number:	Type:
Year obtained:	Month/Day/Year of expiration: / /	Year relinquished:

Reason:

State/Country:	Number:	Type:
Year obtained:	Month/Day/Year of expiration: / /	Year relinquished:

Reason:

State/Country:	Number:	Type:
Year obtained:	Month/Day/Year of expiration: / /	Year relinquished:

Reason:

Please attach additional sheets, if necessary.

Initials: *Date:*

XVI. Hospital and Other Health Care Facility Affiliations

Please list in reverse chronological order, with the current affiliation(s) first, all health care institutions where you have and/or have had clinical privileges and/or staff membership. Include (A) current affiliations, (B) applications in process, and (C) previous hospitals, and other facility affiliations (e.g., hospitals, surgery centers or any other health care related facility). If more space is needed, please attach additional sheets. Do not list residencies, internships or fellowships. Please list employment in Section XVII, Professional Practice/Work History.

A. Current Affiliations

Does not apply ☑

Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (*e.g. active, courtesy, provisional, allied health, etc.*):		Month/day/year of appointment / /	
Contact email			
Do you have admitting privileges at this facility? Yes ☐ No ☐		Professional liability carrier:	
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (*e.g. active, courtesy, provisional, allied health, etc.*):		Month/day/year of appointment / /	
Contact email			
Do you have admitting privileges at this facility? Yes ☐ No ☐		Professional liability carrier:	
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (*e.g. active, courtesy, provisional, allied health, etc.*):		Month/day/year of appointment / /	
Contact email			
Do you have admitting privileges at this facility? Yes ☐ No ☐		Professional liability carrier:	
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (*e.g. active, courtesy, provisional, allied health, etc.*):		Month/day/year of appointment / /	
Contact email			
Do you have admitting privileges at this facility? Yes ☐ No ☐		Professional liability carrier:	

If you do not have hospital admitting privileges at any of the affiliations listed in this section, please explain on a separate sheet your plan for continuity of care for patients who require admitting.

B. Applications in Process

Does not apply ☑

Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (*e.g. active, courtesy, provisional, allied health, etc.*):	Month / day / year of submission / /		
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (*e.g. active, courtesy, provisional, allied health, etc.*):	Month / day / year of submission / /		

Continued - XVI. Hospital and Other Health Care Facility Affiliations

Please list in reverse chronological order, with the current affiliation(s) first, all health care institutions where you have and/or have had clinical privileges and/or staff membership. Include (A) current affiliations, (B) applications in process, and (C) previous hospitals, and other facility affiliations (e.g., hospitals, surgery centers or any other health care related facility). If more space is needed, please attach additional sheets. Do not list residencies, internships or fellowships. Please list employment in Section XVII, Professional Practice/Work History.

C. Previous Affiliations

Please attach additional sheets, if necessary. Does not apply ☑

Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
From month / day / year: / /	To month / day / year: / /		
Professional liability carrier:	Reason for leaving:		
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
From month / day / year: / /	To month / day / year: / /		
Professional liability carrier:	Reason for leaving:		
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
From month / day / year: / /	To month / day / year: / /		
Professional liability carrier:	Reason for leaving:		

Initials: *Date:*

XVII. Professional Practice / Work History

Curriculum vitae is not sufficient.

A. **Please account for all periods of time from the date of entry into medical/professional school to present. Chronologically list all work, professional and practice history activities since completion of postgraduate training, including military service. Please explain in section B any gaps greater than two (2) months. (*Please attach additional sheets, if necessary.*)**

Name of current practice / employer: Community Health Centers Of Lane County		Contact's name: Carla Giana
Telephone number: 541 - 682 - 3550 Ext	Fax number: - -	Complete address: 2073 Olympic St. Springfield, OR 97477
From month / year: 06 / 2023	To month / year: / CURR	
Contact's email address, if available: Carla.Giana@lanecountyor.gov		Professional liability carrier: FTCA-HRSA
Name of previous practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Complete address:
From month / year: /	To month / year: /	
Contact's email address, if available:		Professional liability carrier:
Name of previous practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Complete address:
From month / year: /	To month / year: /	
Contact's email address, if available:		Professional liability carrier:
Name of previous practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Complete address:
From month / year: /	To month / year: /	
Contact's email address, if available:		Professional liability carrier:

Initials: *Date:*

B. ***Please explain any gaps greater than two (2) months*. Include activities and/or names and dates where applicable. (*Please attach additional sheets, if necessary.*)** Does not apply ☑

Activities and/or names:	From month / year:	To month / year:
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/

XVIII. Peer References

Please list three (3) references, from peers who through recent observations are directly familiar with your clinical skills and current competence. Do not include relatives. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

Name of reference: Specialty: Professional relationship:		Complete address, include department if applicable:
Telephone number: - - ext	Fax number: - -	Email address, if available:
Name of reference: Specialty: Professional relationship:		Complete address, include department if applicable:
Telephone number: - - ext	Fax number: - -	Email address, if available:
Name of reference: Specialty: Professional relationship:		Complete address, include department if applicable:
Telephone number: - - ext	Fax number: - -	Email address, if available:

XIX. Continuing Medical Education

Please list activities for which you have received CME credit(s) during the past two (2) years.
(Please attach a separate sheet, if needed.)

Does not apply ☑

Name:	**Month / year attended:** /	**Hours:**
Name:	**Month / year attended:** /	**Hours:**
Name:	**Month / year attended:** /	**Hours:**
Name:	**Month / year attended:** /	**Hours:**
Name:	**Month / year attended:** /	**Hours:**
Name:	**Month / year attended:** /	**Hours:**

Initials: *Date:*

XX. Professional Liability Insurance

Current insurance carrier / provider of professional liability coverage: HRSA/FTCA		Policy number: 1-F00000556-20-02/H80CS0144	Type of coverage (*check one*): Claims-made ☐ Occurrence ☑
Name of local contact:		Mailing address:	
Contact's telephone number: 877 - 974 - 2742 Ext	Fax number, if available: - -		
Per claim limit of liability: $1,000,000	Aggregate amount: $3,000,000	Contact's email address, if available: BPHCHelpline@HRSA.gov	
Month / day / year effective: 01 / 01 / 2022	Month / day / year retroactive date, if applicable: 01 / 18 / 2005		Month / day / year of expiration: 12 / 31 / 2024

Please list all previous professional liability carriers within the past five (5) years.
(Please attach additional sheets, if necessary.)

Does not apply ☐

Insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (*check one*): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / day / year effective: / /	Month / day / year retroactive date, if applicable: / /		Month / day / year of expiration: / /
Insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (*check one*): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / day / year effective: / /	Month / day / year retroactive date, if applicable: / /		Month / day / year of expiration: / /
Insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (*check one*): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / day / year effective: / /	Month / day / year retroactive date, if applicable: / /		Month / day / year of expiration: / /
Insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (*check one*): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / day / year effective: / /	Month / day / year retroactive date, if applicable: / /		Month / day / year of expiration: / /

Initials: *Date:*

XXI. Attestation Questions – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. Please sign and date each additional sheet.

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction ever been denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you ever been fined or received a letter of reprimand or is any such action pending or under review?	YES ☐	NO ☐
B.	Have you ever been suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES ☐	NO ☐
C.	Have you ever been denied clinical privileges, membership, or contractual participation by any health care related organization*. or have clinical privileges, membership, participation or employment at any such organization ever been placed on probation, suspended, restricted, revoked, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES ☐	NO ☐
D.	Have you ever surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	YES ☐	NO ☐
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* ever been withdrawn on your request prior to the organization's final action?	YES ☐	NO ☐
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, limited, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES ☐	NO ☐
G.	Have you ever voluntarily or involuntarily left or been discharged from the education program leading to your current licensure or any subsequent training programs?	YES ☐	NO ☐
H.	Have you ever had board certification revoked?	YES ☐	NO ☐
I.	Have you ever been the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES ☐	NO ☐
J.	Have you ever been charged with a criminal violation (*felony or misdemeanor*)?	YES ☐	NO ☐
K.	Do you presently use any illegal drugs?	YES ☐	NO ☐
L.	Do you currently have any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that currently affects your ability to practice, with or without reasonable accommodation, the privileges requested?	YES ☐	NO ☐
	If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.		
M.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES ☐	NO ☐
N.	Have any professional liability claims or lawsuits ever been closed and/or filed against you?	YES ☐	NO ☐
	If yes, please complete **Attachment A, Professional Liability Action Detail**, for each past or current claim and/or lawsuit.		
O.	Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance?	YES ☐	NO ☐

*e.g. ***hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system***

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature:	**Date:**

OREGON PRACTITIONER CREDENTIALING APPLICATION

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system*] indicated on this application , I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.

2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and Credentialing process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.

5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.

7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.

8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.

9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed name:	
Signature:	**Date:**

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

Oregon

Kate Brown, Governor

Attachment A

Professional Liability Action Detail — Confidential

Please list any past or current professional liability claim or lawsuit, which has been filed against you. **Photocopy this page as needed and submit a separate page for EACH professional liability claim/lawsuit.** It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary.

Practitioner's name *(print or type)*:

Month/day/year of the incident: - - and clinical details:

Your role and specific responsibilities in the incident:

Subsequent events, including patient's clinical outcome:

Month/day/year the suit or claim was filed: - -

Name and address of insurance carrier/professional liability provider that handled the claim:

Your status in the legal action *(primary defendant, co-defendant, other)*:

Current status of suit or other action:

Month/day /year of settlement, judgment, or dismissal: - -

If case was settled out-of-court, or with a judgment, settlement amount attributed to you:

I verify the information contained in this form is correct and complete to the best of my knowledge.

Signature: Date:

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

Fitness for Duty

Your response to the questions below is requested to support documented fitness of our clinical staff. Exact language from HRSA states:

Fitness for duty means the ability to perform the duties of the job in a safe, secure, productive, and effective manner.
All Health Centers shall assess the credentials of each licensed or certified health care practitioner to determine if they meet Health Center standards. This assessment must meet the requirement of 42 U.S.C.§233(h)(2) that calls for review and verification of "the professional credentials, references, claims history, fitness, professional review organization findings, and license status of its physicians and other licensed or certified health care practitioners."

Name: _____

Please indicate your responses to each question in the space provided. Please note that your responses to the questions and signature indicate you are able to perform the duties of the job in a safe, secure, productive and effective manner.

	Please indicate YES/NO	REMARKS
Are you currently on any medication(s) that may affect either your clinical/professional judgment or motor skills and, therefore, your ability to perform the privileges requested?		
Do you currently have any workload or activity limitation(s) which would affect your ability to perform the privileges requested, including, without limitation, your ability to fulfill your obligations to provide call coverage, as assigned?		
Are you currently under the care of a physician or psychologist for a condition that would affect your ability to perform the privileges requested or are you currently in any mandated recovery program established pursuant to a state or other statute that affects your ability to perform the privileges requested?		

Signed: _____ **Dated:** _____

I have reviewed this form with the employee and their attestation to be able to perform the duties of the job in a safe, secure, productive and effective manner.

Reviewed by Supervisor: _____ **Dated:** _____

CONFIDENTIAL DOCUMENT

Revised 06/14/2021

Community Health Centers of Lane County

Medical Acupuncture Provider Privileging Request Form

All Health Centers shall assess the credentials of each licensed or certified health care practitioner to determine if they meet Health Center standards. This assessment must meet the requirement of 42 U.S.C.§233(h)(2) that calls for review and verification of "the professional credentials, references, claims history, fitness, professional review organization findings, and license status of its physicians and other licensed or certified health care practitioners." HRSA PIN 01-16

INSTRUCTIONS

Initial in the "Requested" box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Chief Medical Officer for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Name and Title:_____

GENERAL PRIVILEGING INFORMATION

- Note that the privileges granted may only be exercised at the site(s) and setting(s) that have the appropriate equipment, license, beds, staff and other support required to provide the services defined in this document. Site-specific services may be defined in the department policy.
- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.
- Providers will be expected to:
  - Provide care within the scope of their respective licenses
  - Provide care within the scope of services provided by the Community Health Centers of Lane County (CHCLC) at each of their clinic sites
  - In conjunction with other CHCLC providers, LAc will seek and provide and consultation regarding patient care and management as appropriate. Significant updates regarding referral status are expected to be passed to other providers via EHR communications
  - When Possible, Practitioner should provide and chart education for and monitoring of self-care plans, as an important component of patient care.
- Except in an emergency, privileges exclude management of conditions that are potentially life threatening or complex and require hospitalization and/or management by a specialist. Under these circumstances, the provider is expected to refer the patient to the PCP, BH, other specialist or hospital, and then may work cooperatively with those providers to manage the patient on a long term basis.

Privilege Description	Requested	Chief Medical Officer Recommendation
Care and treatment within scope of practice for patients aged 16 and under		
Care and treatment within scope of practice for patients aged 16 and over		
Evaluate, manage, treat and provide consultation as a medically appropriate compliment or alternative to western medical care plans.		
Assess and treat patients consistent with medical staff policy regarding consultative call services.		

Initial Privileging Re-privileging

Community Health Centers of Lane County

Medical Acupuncture Provider Privileging Request Form

Privilege Description	Requested	Chief Medical Officer Recommendation
Documentation of PARQ conference, rationale for LAc care in each referral, proper evaluation of response to care, charting to meet appropriate standards required for insurance billing.		
Diagnostic Examination , testing and Procedures Establish Diagnoses within the traditional Framework of Western Medical Thought		
Stimulate acupuncture points using needles, also may include use of acupressure, magnets, heat or cold therapies.		
Perform physical medicine modalities and procedures, including manual therapy.		

I attest that I am qualified to perform the privileges as requested and to independently perform the following minimum required privileges:

- Perform emergency procedures necessary to save a life, regardless of privileges

Signed: _____ Date: _____

Printed name: _____

Provider Category: _____ Date of Hire: _____

Date of Last Privileging Review: _____

Chief Medical Officer Comments:

☐ Provider is qualified and competent to perform the privileges as recommended, and to independently perform the minimum required privileges listed above.

Recommended by Chief Medical Officer:

Signed: _____ Date: _____

Patrick F. Luedtke, MD, MPH

Recommended by Division Manager:

Signed: _____ Date: _____

Initial Privileging Re-privileging