

Rogers C. Anderson
Williamson County Mayor



Leslie Mitchell, CPPO, CPPB
Purchasing Agent

WILLIAMSON COUNTY GOVERNMENT

January 30, 2019

To Whom It May Concern:

Williamson County is accepting proposals for an employee medical and prescription benefit plan. Enclosed are the initial RFP documents. If, after your review of the initial documents, you wish to proceed in the RFP process, initial each item under Summary and Instructions, sign the Intent to Bid/Release of Information and email to leslie.mitchell@williamsoncounty-tn.gov.

Proposals must be received by Tuesday, February 26, 2019, 2:00 p.m. **Three (3) copies of your proposal and an electronic copy of proposal with repricing information must be submitted in a sealed envelope to the County Mayor's Office, 1320 West Main Street, Suite 125, Franklin, TN 37064.** Each envelope should be plainly marked: **RFP-Employee Medical and Prescription Benefit Plan, February 26, 2019, 2:00 p.m.** **Envelope must also include proposer's company name. IF THE SEALED PACKAGE IS NOT LABELED EXACTLY AS SPECIFIED ABOVE, THE PROPOSAL WILL NOT BE OPENED.**

Williamson County reserves the right to reject any and/or all proposals, to waive technicalities or informalities, and to accept any proposal deemed to be in the best interest of Williamson County. **No proposal shall be valid unless signed.** No proposal shall be accepted by FAX machine.

Enclosed is an *Ethical Standards Affidavit*, *Iran Divestment Act Affidavit*, *Fair Employment Affidavit*, *Immigration Attestation and Immigration Compliance Affidavit*, and *Business Tax and License Affidavit*. Please complete these documents and return them with your proposal.

The successful proposer will be required to comply with contract and insurance requirements.

All questions must be e-mailed to Leslie Mitchell at the above e-mail address by 4:00 p.m. Central Standard Time on February 18, 2019. Answers will be sent by 4:30 p.m. CST on February 20, 2019. No addenda will be issued within 48 hours of the proposal due date and time.

If you have any questions, please contact me at leslie.mitchell@williamsoncounty-tn.gov or call me at (615) 790-5868.

Sincerely,

Leslie Mitchell, CPPO, CPPB
Purchasing Agent



Williamson County Employee Benefit Plan

Medical and Prescription Benefits

Request for Proposals

Summary and Instructions:

The Williamson County Employee Benefit Plan (WCEBP) is an employee benefit plan provided to eligible employees, pre-65 retirees and dependents (“Participants”) of Williamson County Government and the Williamson County Board of Education. They have been consolidated into one group, for purposes of managing health care costs.

The WCEBP is a self-funded medical and prescription plan. WCEBP is evaluating the self-funded cost, matching the current medical and prescription plan. Match the current plans as much as possible. If you can’t match the plans, please submit an alternate option and identify in the proposal exactly what the differences are.

The intent of this RFP is to provide Williamson County possible cost savings in the 2019-2020 fiscal year and 2020 calendar plan year.

1. WCEBP reserves the right to reject any and all proposals. If WCEBP elects to award the proposal, it will be based on the best interest of the WCEBP and its participants.
2. WCEBP assumes no responsibility or obligation to cover any costs incurred by a bidder in the preparation of this proposal. Proposals will become the property of WCEBP and will not be returned.
3. The bidder agrees to be bound by their proposals for an effective date of January 1, 2020, with no enrollment limits.
4. Any exceptions to terms, conditions, or other requirements in any part of these specifications must be clearly pointed out in the appropriate section of the proposal. Otherwise, it will be considered that all items offered are in strict compliance with the specifications.
5. No commissions or fees of any kind relating to the medical, prescription or specific stop loss are allowed in this proposal.
6. Bidder must have a minimum Standard & Poor’s (S&P) financial rating requirement of “A”-.
7. Bidder is required as part of this proposal to reprice the claims data for the medical and/or prescription repricing scenarios. Without this repricing information, the RFP cannot be properly evaluated.
8. The proposal must be signed by a legal representative of the bidding firm, who is authorized to bind the firm to a contract in the event of the award. All rates, fees and terms presented will be considered legally binding.
9. All bidder services must adhere to relevant federal and state laws and regulations. It is assumed that all responses submitted adhere to the preceding conditions, unless otherwise noted in the proposal. Failure to meet any of these conditions may result in disqualification of bids. This proposal and your response, including all subsequent documents provided during this process, will become part of your final agreement.
10. The Williamson County Benefits Website may be a useful tool in getting additional information related to cost of programs to employees or benefits descriptions.
www.williamsoncounty-tn.gov/mybenefits

11. Bidder may submit RFP on medical only or prescription only. There is no requirement that both medical and prescription must both be submitted by a single bidder.
12. If bidder is only bidding on medical or prescription of the RFP and a question does not pertain to the portion of the RFP you are bidding, indicate N/A for your answer.
13. All bidders must agree to comply with and apply the eligibility rules as currently written. Any deviations must be clearly outlined in writing.
14. Specific Re-insurance includes medical only
15. The WCEBP does not have Aggregate Re-Insurance, however, they are asking for suggested Aggregate claims funding factors.
16. Medical Specific Stop-Loss is currently at \$300,000
17. Stop-Loss contact to be quoted on a 36/12.
18. All premiums/fees proposed are for twelve months.
19. Currently, Cigna administers the Flexible Spending Account and Health Savings Account programs, please provide administrative cost for each program.
20. Bidder is to complete the included Rate Sheet(s) and identify all administrative costs.
21. Bidder is to complete the Questionnaire in full.

Intent to Bid/Release of information To receive additional information a representative of bidding firm must initial all 21 statements under **Summary and Instructions** indicating that all are understood and will be applied to the RFP.

Return completed release to Leslie Mitchell at Leslie.Mitchell@williamsoncounty-tn.gov.

Bidding Firm: _____

Address of Corporation: _____

I, _____ (Officer of Corporation) do hereby certify that all of the information supplied and made part of this proposal for WCEBP is truthful and accurate.

Signature: _____

Name: _____

Title: _____

Date: _____

Williamson County Government Questionnaire

Please provide a response to each of the following questions. **Ensure that each question is copied in its entirety with your answer, in the same order as the questionnaire.** Any variation will be grounds for disqualification.

General Information/Background by bidder of medical and/or prescription RFP

1. Provide the name, address, phone, fax numbers, and email address for the person to contact with questions regarding your proposal.
2. Provide a brief description of current ownership and ownership history over the past three (3) years.
3. Do you have Errors and Omissions Liability coverage (yes or no)? If “yes”, please provide the insurer's name and the amount of coverage (limits of liability-specific and aggregate) currently in-force.
4. Provide the most recent ratings for your company by the major rating organizations (i.e. A.M. Best, Fitch Ratings, Duff & Phelps, Dun & Bradstreet, Moody's, Standard & Poor's, TheStreet.com, and Weiss Ratings).

Account Management

5. Provide address for location / office responsible for providing account management.
6. Will the account service team be the County's primary point of contact? If so, do they provide member services, status updates, coordination with the County consultant/advisor, regularly scheduled reporting, trend updates, benchmarking analysis, clinical program reporting / effectiveness, plan design recommendations, performance guarantee measurement / reporting, vendor coordination (e.g., wellness, DEV, etc.) and new program introduction /impact?
7. Provide the name and qualifications, including experience, length of time with your firm, etc. for the person to be assigned overall responsibility for the County account (i.e., account executive).
8. Please indicate the percentage of the lead account executive's time that will be committed to the County.
9. Are there any limitations as to how often your account services team will meet with the County, its leadership team, and/or its consultants / advisor? The County typically meets quarterly to review utilization and trend metrics.
10. Do you have a cyber-security program in place to protect members from malicious threats?
11. How often does your organization practice cyber security incident response?

12. What are the controls in place to manage the risk of 3rd party vendors that have access to and/or host confidential member data?
13. Does your company address 4th party risk?
14. Please describe the steps you have and are taking to limit the handling of SSNs in core business processes?
15. Describe standard procedures for accepting eligibility files.
16. Describe any fees that could be applicable for accepting eligibility files.
17. Describe procedures for urgent / manual eligibility additions.
18. Provide how you would keep the County in compliance with all Federal and State laws that could have an impact on the medical and prescription plans.
19. Confirm that the County will have online real-time eligibility access for urgent updates.
20. How quickly are direct-adds and direct-deletes accepted by the eligibility system?
21. Confirm that information in the eligibility system is linked to the claim system.
22. What is the lag between the time eligibility updates are loaded to the eligibility system and the time updated eligibility information becomes available to claim processors?
23. How often can you accept eligibility file feeds from the plan sponsor or the benefits administrator?
24. Confirm vendor will receive and maintain eligibility files in the format currently provided by the County's eligibility provider and other third party vendors or work to reach a mutually agreed upon format.
25. Vendor confirms that its systems will be in full compliance with PPACA requirements, including its ability to accurately coordinate with the County's Rx administrator on member out-of-pocket balance requirements without additional fees to the County.
26. Vendor confirms that they will perform real-time information / data exchanges with other vendor partners including the Rx administrator as necessary to share account balances (deductibles and out-of-pocket expenses). Such information / data will be provided in a HIPAA-compliant format directly to the designated vendor(s) contracted by the County or within the required time intervals without additional fees to the County.
27. What enrollment history is stored on the system and do customer services representatives have access to this information?

28. How far back do you allow retroactive terminations and additions?
29. If you are awarded the medical plan but not the prescription plan or vice versa, indicate your ability to work with a separate vendor and if any fees apply.
30. Confirm that you can produce one ID card containing medical and pharmacy information for the County (please provide sample).

Customer Service

31. Where is the location of the customer service center that you propose for the County?
32. What will be the days and hours of operation for the customer service unit(s)?
33. Vendor confirms that they will offer extended call center hours during annual enrollment periods
34. Will the customer service team be designated or dedicated to the County?
35. Does the customer service team provide bi-lingual services and if so, what languages are provided?
36. Number of designated or dedicated full-time customer service representatives (CSRs) at this customer service center.
37. Vendor confirms that their customer service uses a call-tracking / case management system to track the date of initial call, date inquiry closed, representative handling the call, call status, issue was referred for handling, reason for call/issue, and information communicated to the participant.
38. Vendor confirms that they have procedures in place for ensuring accuracy of information and quality of responses that a CSR provides to plan participants in response to customer service calls and written inquiries (e.g., recording of all calls, supervisor listens into "live" calls for quality assurance purposes).
39. What percent of CSR recorded calls are audited for quality assurance?
40. Provide a URL and guest ID for member and plan sponsor websites.

Reporting and Online Access

41. List and briefly describe each standard report that will be available on a monthly, quarterly and annual basis. Do not include copies of the reports with your submission.
42. Vendor confirms that they are able to attend onsite quarterly meetings to review performance metrics (i.e., financial and clinical key utilization metrics).

43. Confirm that you are able to accommodate requests for ad hoc or customized reporting (including utilization information). If you are able to accommodate ad hoc or customized reporting, what is the standard turnaround time to fulfill such requests?
44. How many reports or hours are included at no additional charge for ad hoc or customized reporting?
45. What are the additional charges for ad hoc reporting and when do those charges begin?
46. Are you willing to provide interface with the FSA vendor for medical claims?
47. Confirm the following web tools are available to the HR / Benefits staff (e.g., check claim status, print a temporary ID card, find a network doctor, get plan design information, get information about provider quality and/or outcomes, read provider reviews from other members, contact customer service, view and print my EOBs). Are there any additional fees for these services?
48. Confirm the following web tools are available to members (e.g., check claim status, print a temporary ID card, find a network doctor, provider quality data, transparency tool – provider quality / pricing data, plan design information, information about provider quality and/or outcomes, read provider reviews from other members, contact customer service, view and print my EOBs, treatment cost estimator tools, update eligibility). Are there any additional fees for these services?

Implementation

49. Please provide a detailed transition / implementation plan and identify the resources that will support implementation management and oversight.
50. Please describe in detail how you handle transition of care for plan participants in case management or disease management or currently in the middle of treatment.
51. Please describe in detail how you handle transition of care for plan participants in pharmacy large case management or disease management cases. Does this change if a separate pharmacy vendor is chosen?

Billings and Remittance

52. The County receives their premium invoices split by active and retiree and then by division, location, department and job class. Please confirm that you are capable to provide this level of detail.
53. Describe your typical billing and remittance process / cycle. Please include key dates, invoice and remittance options, invoice disputes, payment discrepancies or partial payments, late payments, etc.
54. Provide your premium guidelines for a retroactive participant enrollment.
55. Provide your premium guidelines for a retroactive participant termination.

Wellness Services

56. Briefly describe the components of your wellness and health promotion programs.
57. Currently Cigna administers the Flexible Spending Account and Health Savings Account programs, please provide administrative cost for each program.
58. Confirm your willingness to:
 - a. Perform data sharing with a 3rd party wellness vendor at no additional cost to the County
 - b. Perform banking / billing processes where a third party fees are built into the rate projections and paid for directly from the administrator / insurer.
59. Confirm that you can provide online health-risk assessments.
60. Please provide a link to a sample health-risk assessment for our review.
61. Confirm that you can report health-risk assessment and biometric screenings completion to the County for purposes of incentives. What is your standard frequency for relaying this information?
62. Confirm the ability to administer on-site or lab-based biometric screenings.
63. Describe the process on how you will administer the biometrics on an ongoing basis for Williamson County and provide whether a third party is involved and who that is (i.e. labs).
64. Are there additional fees associated with managing the biometrics? What biometric fees are included in the base ASO fees and are there other buy-ups for an enhanced program? Please provide.

Performance Guarantees and Amount at Risk

65. Meaningful performance standards will be significant factors in the selection process.
 - a. Please provide your proposed metrics (i.e., claims turnaround time, claims processing accuracy, financial accuracy, procedural accuracy, open / non-open enrollment eligibility updates, member services average speed of answer / abandonment rate / telephone call quality, member satisfaction, customer overall satisfaction) and applicable annual fee / percent of total annual fees, along with the timing of penalty payment (60 days after the completion of the applicable reporting period).
 - b. Bidder confirms and has the understanding that the plan year will begin on 1/1/2020.
 - c. Bidder confirms that all currently covered employees, pre 65 retirees and dependents will continue to be covered.

- d. Bidder understands that Medicare eligible retirees enrolled in the MA plan are excluded from the RFP.
- e. All fees, changes, etc. are disclosed in the financial exhibits. If there are any additional fees that have been disclosed, please provide this information.
- f. Do you offer a fee guarantee? Is so, please describe.

Questions related to Prescriptions RFP

- 66. Do you process your own claims? Describe your claims adjudication process.
- 67. What software do you use to process claims? Do you own your own claims adjudication software? If not, please explain in detail who owns the software and what part you play in the plan set up, changes in plan set up and where the software resides. If you do not own your claim adjudication software please describe in detail what arrangement you have to access the claims adjudication software and the claims data produced by the adjudicated claims.
- 68. Do you own your mail order facility? If not, who do you contract with for that component?
- 69. How do you facilitate/implement the conversion from a group's current PBM to you?
- 70. Are you willing to pay an implementation fee to cover cost of implementation to be determined at the discretion of The County including but not limited to mailing of ID cards and implementation packets?
- 71. You will be required to provide network and/or formulary disruption reports prior to award of contract. Please outline in detail this process and the data necessary to perform the disruption reports. Are you able to utilize Pharmacy NABP and/or NPI numbers?
- 72. Will you provide at no charge a member ID card where the medical and pharmacy is combined?
- 73. Please describe your Account Team set-up and management hierarchy. Please include names and contact information.
- 74. Post go-live, implementation, describe how you will provide a dedicated PBM representative to be available triaging calls the first 30 days.
- 75. Please confirm that you will assist with member communication materials including but not limited to any SPD and SBC language requested by Sponsor at no additional charge.

CLINICAL PROGRAMS

76. How do you monitor Controlled Substance drug usage? Are there additional fees for any of these services? Please be specific.
77. How do you monitor Therapeutic Duplications? Are there additional fees for any of these services? Please be specific.
78. How do you monitor Drug to Drug Interactions? Are there additional fees for any of these services?
79. What are your parameters for fraud/abuse edits at the member, pharmacy, and physician levels? Are there additional fees for any of these services? Please be specific.
80. Can you provide online member access to a specific formulary?
81. Will a specific formulary change the rebate guarantees? If so, please explain.
82. How will clinical criteria be applied to mail order?

PHARMACY NETWORK:

83. Describe your proposed pharmacy network in terms of size and nationwide coverage.
84. Describe your pharmacy credentialing processes.
85. Describe the function of your Customer Service Department, time's available, certified pharmacy techs and contact information for head of department.
86. What is your position on the following pharmacy network pricing criteria?
 - a. Do you use more than one source of AWP? What references are used and what criteria are used to select a specific AWP among sources?
 - b. Can you support different pharmacy network pricing for the employer group?
 - c. Can you support unique contract parameters, i.e., \$2.50 minimum reimbursement or a 50% co-payment plan?
 - d. Is there any system limit to calculating ~~lesser~~ prices between?
 - i. AWP discount and dispensing fee
 - ii. Usual and Customary Pricing
 - iii. Maximum Allowable Cost (MAC) and dispensing fee
87. What options do you have for pricing prescriptions less than the member's copay?

88. Do you capture and compare the usual and customary charge with each retail claims submission?
89. How do your mail-order and retail prescription claims processing systems integrate? Please be specific how retail and mail services integrate concerning Refill Too Soon parameters
90. Can you support non-traditional dispensing units, i.e., home infusion companies?
91. Is your specialty pharmacy program in-house or outsourced? If it is outsourced, who is the provider? If multiple providers, please list all providers.
92. Please describe any advantages available by using an exclusive Specialty Pharmacy.
93. Please describe the process a member would undergo to utilize the specialty pharmacy program.
94. Describe the audit process of the provider pharmacies in your Retail Network. How are discrepancies reported and the County reimbursements made? Please verify that you will audit at least 3% of your pharmacy network per year.

CLAIMS PROCESSING & BENEFIT PLAN DESIGN AND IMPLEMENTATION

95. Describe how long it takes to set up a new benefit design with
- a. Initial benefit design
 - b. One change compared to an existing plan
 - c. Multiple changes
96. What does your system transmit to the pharmacy when the maximum is reached?
97. Can your system support maximum quantity edits for quantity or dose unit limitations?
98. Can you maintain a tier co-payment for maintenance supply of 90 days?
99. How much paid history do you retain, for reporting, clinical editing and for third party claims audit purposes
100. After a new benefit plan is designed and implemented, what audit steps are taken to verify proper design and how much The County will be involved in this audit process.
101. Describe your pricing methodology for compounded medications. Please provide detail of the fields provided to audit compound claims

102. How does your organization ensure that the formulary generated is based on available evidence?
103. Certify the greater of the rebates received from manufacturers or aggregators or the guaranteed rebates will be paid to the County within 180 days after the end of the calendar quarter in which they were processed. Also, certify the total rebates received from manufacturers or aggregators will continue to be paid to the County at the end of the calendar quarter in which they were received.
104. Define any percentages or fees taken from *total monies* received from manufacturers that result in revenue to PBM, a PBM subsidiary, or a subcontracted entity.
105. Vendor confirms that they will perform real-time information / data exchanges with other vendor partners including the Rx administrator as necessary to share account balances (deductibles and out-of-pocket expenses). Such information / data will be provided in a HIPAA-compliant format directly to the designated vendor(s) contracted by the County or within the required time intervals without additional fees to the County.

DISEASE MANAGEMENT PROGRAMS /PROVIDER INITIATIVES

106. Describe all disease management programs included in your proposal. Be specific as to topic, identification process for member, provider and member intervention, outcome assessment process, number of lives currently enrolled, fees associated, and direct and, indirect savings to be gained with each program.
107. Will you provide a monthly data feed of prescription drug claims, in a standard format, to a medical carrier, consultant at no charge for the purposes of disease management services? Are there additional fees for any of these services?
108. Do you have a program for drug intervention to provide cost savings? Please describe both to member selection process and types of interventions done. Are there additional fees for any of these services? Please be specific.
109. For an HSA-compatible benefit with combined Medical and Pharmacy deductibles and out-of-pocket limits:
- Is your organization able to administer this type of benefit design?
 - Describe your data interchange procedures for this administer.

FORMULARY

110. What is your policy on time frame for newly approved drugs by the FDA and addition of the drug to the formulary?
111. What is your ability for a member to access his drug history online and have the program suggest therapeutic equal drugs like generic?

112. How are new therapies to the market incorporated into your tiered benefit structure?
113. When a formulary brand gains a generic equivalent, is the branded therapy automatically moved off of the formulary?
114. How often is the formulary updated?
115. Considering only brand name drugs, what is the % of Formulary brands to all Brands given average utilization?
116. Does your organization provide the member and/or employer materials to help assist in promoting generic utilization? Do you supply these materials for a fee?

Signature Page

The bidder has received the following addenda:

Addendum # _____ Dated _____

Addendum # _____ Dated _____

Addendum # _____ Dated _____

Company Name _____

Physical Address _____

Remittance Address _____

Authorized Signature _____

Printed Name _____

Phone _____ Fax _____

Email Address _____

Date _____

Medical Pricing Table

Aso Fee	
Contract Basis	36/12
Specific Stop Loss PEPM (preferred)	\$ -
Spec EE (If needed)	
Spec EE+1 (If needed)	
Spec Fam (If needed)	
Disease Management	\$ -
Claims Fiduciary Service	\$ -
H S A Fee	\$ -
FSA Fee	\$ -
PPO Access Fee	\$ -
Cobra Admin Fee	\$ -
Total Single Admin Cost	\$ -
Specific Stop Loss Level	\$ 300,000
Total Stop Loss Premium	\$ -
Annual Estimated RX Rebate	\$ -
Redline or Laser Liability	\$ -

Pharmacy Pricing Table

Mail

Brand	\$
Generic	\$
Administration Fee	\$
Dispensing Fee	\$

Retail

Brand	\$
Generic	\$
Administration Fee	\$
Dispensing Fee	\$

Rebates

Mail	\$
Retail	\$

Specialty Drugs

Brand	\$
Generic	\$
Administration Fee	\$
Dispensing Fee	\$

Miscellaneous

%of Generic drugs are on the MAC list proposed?	
Initial setup cost	\$

**IMMIGRATION ATTESTATION
AND IMMIGRATION COMPLIANCE ACT AFFIDAVIT**

CONTRACTOR'S LEGAL ENTITY NAME _____

CONTRACTOR'S TENNESSEE LICENSE NUMBER _____

The Contractor, identified above, does hereby attest, certify, warrant, and assure that the Contractor shall not knowingly utilize the services of an illegal immigrant in the performance of the Agreement and shall not knowingly utilize the services of any subcontractor who will utilize the services of an illegal immigrant in the performance of any Services under this Agreement.

By executing this affidavit, the undersigned person or entity verifies its compliance with the Tennessee Lawful Employment Act codified at *Tennessee Code Annotated, Section 50-1-701, et. seq.*, stating affirmatively that the Contractor which is contracting with Williamson County government has registered with and is participating in the federal work authorization program commonly known as E-Verify or has obtained and maintains copies of the required documents in accordance with the applicable provisions of the Tennessee Lawful Employment Act.

The Contractor further agrees that it will continue to comply with all provisions of the Tennessee Lawful Employment Act, and it will contract for the physical performance of services in satisfaction of such contract only with subcontractors who comply with the applicable provisions of the Tennessee Lawful Employment Act.

The undersigned person or entity further agrees to maintain records of the documents or of such compliance including documentation for all subcontractor(s) retained to perform such service on behalf of the Contractor for the minimum period provided in the Tennessee Lawful Employment Act.

BY: Authorized Officer or Agent Date
(Name of Person or Entity)

Title of Authorized Officer or Agent

Printed Name of Authorized Officer or Agent

Witness: _____

Date: _____

Business Tax and License Affidavit

Business Tax and License Affidavit. The undersigned, ("Affiant"), states that he/she has the legal authority to swear to this on behalf of _____, ("Contractor"); that Contractor is not in any manner in violation of *Tennessee Code Annotated, Section, 5-14-108(l)* which provides that "(n)o purchase shall be made or purchase order or contract of purchase issued for tangible personal property or services by county officials or employees, acting in their official capacity, from any firm or individual whose business tax or license is delinquent." Affiant affirms and warrants that Contractor's licenses are currently valid and all business taxes have been paid and are current as of the date of this affidavit. Contractor is licensed and pays business taxes in _____ (County), Tennessee.

Affiant

By: _____

Title: _____

Date: _____

Witness: _____

Date: _____

Ethical Standard Affidavit.

State of Tennessee

County of Williamson County

Ethical Standard Affidavit. After first being duly sworn according to law, the undersigned ("Affiant") states that he/she has the legal authority to swear to this on behalf of _____ ("Contractor") that no part of any other governmental monies provided for the services or products contemplated in this Agreement which was received from the State of Tennessee and/or Williamson County shall be paid directly to an employee or official of the State of Tennessee or Williamson County as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the County or the Contractor in connection with any work contemplated or performed relative to this Agreement. Affiant and Contractor further swears that no federally, state, or county appropriated funds have been paid or will be paid, by or on behalf of the Contractor, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, any employee of the State of Tennessee, or employee of Williamson County in connection with the awarding of any federal, state, or county contract, the making or awarding of any government grant, the making of any government loan, and entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal, state or county contract, grant, loan, or cooperative agreement.

Affiant

By: _____

Title: _____

Witness: _____

Date: _____

**CERTIFICATION OF COMPLIANCE WITH
THE IRAN DIVESTMENT ACT**

Effective July 1, 2016, this form must be submitted for any contract that is subject to the Iran Divestment Act, Tenn. Code Ann. § 12-12-101, et seq., ("Act"). This form must be submitted with any bid or proposal regardless of where the principal place of business is located.

Pursuant to the Act, this certification must be completed by any corporation, general partnership, limited partnership, limited liability partnership, joint venture, nonprofit organization, or other business organization that is contracting with a political subdivision of the State of Tennessee.

Certification Requirements.

No state agency or local government shall enter into any contract subject to the Act, or amend or renew any such contract with any bidder/contractor who is found ineligible under the Act.

Complete all sections of this certification and sign and date it, under oath, in the presence of a Notary Public or a person authorized to take an oath in another state.

CERTIFICATION:

I, the undersigned, certify that by submission of this bid, each bidder and each person signing on behalf of any Respondent certifies, and in the case of a joint bid or contract each party thereto certifies, as to its own organization, under penalty of perjury, that to the best of its knowledge and belief that each bidder is not on the list created pursuant to Tenn. Code Ann. § 12-12-106.

Respondent represents it has the full power, knowledge, and authority to make this Certification and that the signatory signing this Certification on behalf of bidder/contractor has been duly authorized to do so on behalf of the bidder/contractor.

Sworn as true to the best of my knowledge and belief, subject to the penalties of false statement.

Printed Respondent Name Printed Name of Authorized Official

Signature of Authorized Official

Witness: _____

Date: _____

FAIR EMPLOYMENT PRACTICES AFFIDAVIT

State of _____ County of _____

Fair Employment Practices Affidavit: After first being duly sworn according to law, the undersigned (Affiant) states that he/she is the _____ (Offeror) and that by its employment policy, standards, and practices the Offeror does not subscribe to any personnel policy which permits or allows for the promotion, demotion, employment, dismissal, or laying off of any individual due to his/her race, creed, color, national origin, age, or sex, and that the Offeror is not in violation of and will not violate any applicable laws concerning the employment of individuals with disabilities.

And Further Affiant sayeth not:

By: _____

Title: _____

Address: _____
