

ARLINGTON COUNTY, VIRGINIA
OFFICE OF THE PURCHASING AGENT
2100 CLARENDON BOULEVARD, SUITE 500
ARLINGTON, VIRGINIA 22201

CONTRACT AMENDMENT COVERPAGE

TO: ARLINGTON FREE CLINIC 2921 11 TH STREET S ARLINGTON, VIRGINIA 22204	ORIGINAL DATE ISSUED: CONTRACT NO: CONTRACT TITLE:	<u>5/22/2020</u> <u>20-777-EP</u> <u>PATIENT CENTERED MEDICAL HOME</u>
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THIS IS A NOTICE OF AMENDMENT OF CONTRACT AND NOT AN ORDER. NO WORK IS AUTHORIZED UNTIL THE VENDOR RECEIVES A VALID COUNTY PURCHASE ORDER ENCUMBERING CONTRACT FUNDS.

The contract documents consist of the terms and conditions of AGREEMENT No. 20-777-EP including any attachments or amendments thereto.

EFFECTIVE DATE: 8/3/2020

EXPIRES: 6/30/2021

RENEWALS: FOUR (4), ONE (1) YEAR RENEWALS FROM JULY 1, 2021 TO JUNE 30, 2025.

COMMODITY CODE(S): 95278

LIVING WAGE: N

ATTACHMENTS:

20-777-EP AMENDMENT 3

EMPLOYEES NOT TO BENEFIT:

NO COUNTY EMPLOYEE SHALL RECEIVE ANY SHARE OR BENEFIT OF THIS CONTRACT NOT AVAILABLE TO THE GENERAL PUBLIC.

VENDOR CONTACT: CORALIE MILLER

VENDOR TEL. NO.:

(703) 979-1425

EMAIL ADDRESS: CMILLER@ARLINGTONFREECLINIC.ORG

COUNTY CONTACT: ERROL CHIN-LOY (PHD)

COUNTY TEL. NO.:

(703) 228-1275

COUNTY CONTACT EMAIL: ECHINLOY@ARLINGTONVA.US

PURCHASING DIVISION AUTHORIZATION

Kaylin Schreiber Title: Procurement Officer Date: 7/31/2020

ARLINGTON COUNTY, VIRGINIA

**AGREEMENT NO. 20-777-EP
AMENDMENT NUMBER 3**

This **Amendment Number 3** is made on **August 3, 2020** and amends **Agreement Number 20-777-EP** (“Main Agreement”) dated May 22, 2020 between **Arlington Free Clinic** (“Contractor”) and the **County Board of Arlington County, Virginia** (“County”).

The County and the Contractor agree to amend the main contract called for under the Main Agreement as follows:

AMEND THE FOLLOWING REQUIREMENTS TO ATTACHMENT A – SCOPE OF WORK AS ADDED TO THE AGREEMENT IN AMENDMENT 2:

The Contractor must provide operational and logistical support to the Arlington Mill coronavirus testing center. Operational and logistical support to be provided shall include:

1. Up to 5.0 bilingual (Spanish/English) administrative full-time equivalents (FTEs) to operate a telephone bank between 9:00 am – 5:00 pm, Monday – Friday. Prior to the first of each month, the Contractor shall submit for staffing approval via email from the Project Officer based on client volume from the month before. The Contractor shall not be reimbursed for any staff exceeding the number approved by the Project Officer.
2. 1.0 on-call, off-site, volunteer registered nurse to be used as needed to provide clinical counseling to clients experiencing acute coronavirus-related symptoms during the intake call. At the client’s request, the nurse shall speak with the client to assist in determining whether the client should seek immediate medical attention.
3. Return all voicemails left outside of normal operating hours within the first two (2) hours of opening on the next date of operation.
4. Verify that all clients receiving testing are Arlington residents by obtaining an Arlington mailing address. The County will mail testing results to the address provided by the client.
5. Prioritize appointment scheduling for clients who self-report household income at or below 60% Area Median Income.
6. Collect personal and medical history information from clients via phone to complete the Application Information and Screening Form (AISF) (Attachment A) and Division of Consolidated Services (DCLS) (see updated Attachment B, attached) Forms. Clients experiencing acute coronavirus-related symptoms shall be referred to the volunteer nurse.
7. Obtain verbal consent for testing from each client and document consent on the AISF (Attachment A).
8. Schedule each client for a ten- (10) minute slot on the appointment log. All clients will be encouraged to be on time for their appointment, wear a face covering to the testing site, maintain social distancing, and come well-hydrated.
9. Provide oversight and management of a OneDrive account that will house all AISF Forms, DCLS Forms, the appointment log, and any other testing site related document deemed essential to the operation of the testing site. Access to the OneDrive account shall be provided to County personnel involved with the project.
10. Submit monthly invoices on a monthly basis using the AFC Invoice Template (see updated Attachment C, provided as a separate attachment).

11. Meet with County staff as requested to provide updates, recommend changes, and discuss Arlington Mill testing center-related issues that may arise.

AMEND THE FOLLOWING IN PARAGRAPH 5. CONTRACT AMOUNT AS ADDED TO THE AGREEMENT IN AMENDMENT 2:

The County will pay up to \$335,228 through June 30, 2021 to reimburse the Contractor for operational and logistical support provided at the Arlington Mill corona virus testing site. Invoices must be submitted to the Project Officer by the 15th of each month and must include documentation for all expenses invoiced. Invoices must be submitted in the format of Attachment C.

All other terms and conditions of the Main Agreement remain in effect.

WITNESS these signatures:

THE COUNTY BOARD OF ARLINGTON
COUNTY, VIRGINIA
DocuSigned by:
AUTHORIZED: Kaylin Schreiber
SIGNATURE: Kaylin Schreiber
NAME: Kaylin Schreiber
TITLE: Procurement officer
DATE: 7/31/2020

ARLINGTON FREE CLINIC
DocuSigned by:
AUTHORIZED: Nancy White
SIGNATURE: Nancy White
NAME: Nancy white
TITLE: President
DATE: 7/31/2020

Commonwealth of Virginia
 Department of General Services
 Division of Consolidated Laboratory Services
 Richmond, Virginia

DCLS COVID-19 Submission Form

PATIENT INFORMATION				SUBMITTER INFORMATION			
Last Name:				Submitting Facility: Arlington County Public Health Division			
First Name:				Address: 2110 Washington Blvd. Suite 350			
Birth Date:		Phone:		City: Arlington		State: VA	Zip code: 22204
Address:				Phone: 703-228-5200 opt. 1 Fax: 703-228-5267			
City:		State:	Zip code:	Attending Clinician: Dr. Reuben Varghese			
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Race:		Attending Clinician Phone: 703-228-5200 opt. 1			
MRN:		Patient ID:		Public Health Dept Contact: Operations Branch Chief			
Client External ID (VDH/DCLS#):				Public Health Contact Phone: 703-228-5200 opt. 1			
PATIENT MEDICAL HISTORY							
Disease Suspected or Diagnosis: COVID-19							
Date of Onset:				Deceased Date:			
Signs/Symptoms: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Body Aches <input type="checkbox"/> Chills <input type="checkbox"/> Cough <input type="checkbox"/> Diarrhea <input type="checkbox"/> Fever <input type="checkbox"/> Headache							
<input type="checkbox"/> Loss of Taste/Smell <input type="checkbox"/> Myalgia/Arthralgia <input type="checkbox"/> Nausea <input type="checkbox"/> Pneumonia <input type="checkbox"/> Productive Cough <input type="checkbox"/> Rash							
<input type="checkbox"/> Respiratory <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Vomiting <input type="checkbox"/> Other:							
Recent Exposure (if applicable): <input type="checkbox"/> Contact w/ COVID-19 Positive Person							
<input type="checkbox"/> Other (Explain):							
OUTBREAK INFORMATION							
VDH Designated Outbreak #:							
Role of Patient: <input type="checkbox"/> Healthcare Provider <input type="checkbox"/> Staff <input type="checkbox"/> Patient <input type="checkbox"/> Resident <input type="checkbox"/> Food Handler <input type="checkbox"/> Other:							
SPECIMEN COLLECTION INFORMATION							
Date Collected:				Time of Collection: : (military time)			
Reason for Test Request: <input type="checkbox"/> Isolate for ID/Confirmation <input type="checkbox"/> VDH Reportable Disease Compliance <input type="checkbox"/> Surveillance <input type="checkbox"/> Diagnosis							
<input type="checkbox"/> PPS <input type="checkbox"/> Contact/Suspected Carrier <input type="checkbox"/> Clearance/Release <input type="checkbox"/> Other:							
Specimen Source: <input type="checkbox"/> Nasopharyngeal Swab <input type="checkbox"/> Oropharyngeal/Throat Swab <input type="checkbox"/> Nose (Nasal Passage) <input type="checkbox"/> Sputum							
<input type="checkbox"/> Bronchial Wash <input type="checkbox"/> BAL <input type="checkbox"/> Blood <input type="checkbox"/> Serum <input type="checkbox"/> Other:							
ADDITIONAL INFORMATION				DCLS STATE LAB USE ONLY:			
Specimen collected at AMCC community testing event				Place DCLS Label in space provided. <div style="border: 1px solid black; width: 100%; height: 100%; margin-top: 10px;"></div>			