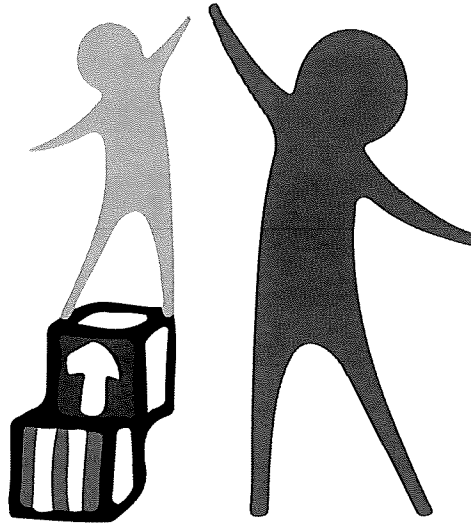


Child-Parent Centers, Inc.



Request for Proposals

2026-2029

- Medical Services
and/or
- Dental Services

June 3, 2026

Summary

Child-Parent Centers, Inc. (CPC) is seeking proposals from individual or group professional medical and/or dental practitioners to provide services on a cost-per-service basis for children enrolled in the Head Start/Early Head Start programs generally between ages three to five years old, with occasional services needed for younger children or pregnant women. Program participants who will be receiving medical and/or dental services are enrollees who are not covered by medical and/or dental insurance, private funds, or AHCCCS/KidsCare in CPC's five-county service area.

Child-Parent Centers, Inc. Background

CPC is a federally funded, private, non-profit organization that provides Head Start and Early Head Start services.

CPC's primary mission is to provide school readiness programs which also ensure access to medical, dental, and nutrition services for low-income children. We serve ages three to five in our Head Start program and birth to three in our Early Head Start program. Our Early Head Start program also serves pregnant women.

CPC is the designated federal grantee serving southeastern Arizona. Our agency currently serves approximately 3,000 children each year from 39 centers and home-based services located in Pima, Santa Cruz, Cochise, Graham and Greenlee counties.

Medical Specifications

1. Services will include scheduled well-child/baby checks/physical exams and immunizations at vendor/clinic sites. Documentation of physical exams will be released to the parent at the time rendered or to CPC Health and Nutrition Services within one week at no charge. Providers must ensure physical exams are completed in accordance with the requirements of the Arizona State AHCCCS EPSDT Schedule.
2. Preapproval by CPC designated Health and Nutrition Services personnel must be obtained for all services including both initial and follow-up services.
3. Participants will primarily be children enrolled in the CPC Head Start/Early Head Start centers or home-based programs located in the CPC five-county service area.
4. Initial examinations will be provided to approximately 50 children across all providers, with around 25% likely to require follow-up which may be through the original provider or by referral to a separate specialist – e.g. cardiology, neurology, EENT, etc. Examinations will include items listed on the CPC 3-5 Year Old Physical/Screening/Exam Form (**EXHIBIT 1**).
5. Participants may occasionally include birth to three year old children or pregnant women. Well baby check-ups will include items listed on the AHCCCS EPSDT Tracking Form for the appropriate age (**EXHIBIT 2 – sample age group of 18 months**).

6. CPC staff screen and approve participants based on being uninsured, underinsured and/or other approved circumstances within Office of Head Start regulations.
7. When there is a need for follow-up or further services, this must be noted on the Physical Exam form and the family notified at the end of the initial examination/service. Eligibility for further CPC support is determined on a case-by-case basis by designated CPC staff. Approvals and scheduling are coordinated between the provider and CPC staff assisting the family.
8. Medical providers should have qualifications and experience as described below:
 - Minimum qualifications require the provider to be a graduate from a medical school accredited by the American Medical Association and possess a current Arizona state license. We need these documents for all providers that will be serving Head Start children. (DO, PA and FNP are also acceptable.)
 - Proof of Liability Insurance and Malpractice Insurance is required for all providers serving Head Start children.
 - Bid information should state your ability to provide services to children with disabilities and the number of years you have worked with young children (under the age of five years).
 - Preference will be given to providers who can provide services to children with disabilities, have experience with young children under the age of five years and provide services in a child/parent friendly environment.
 - The availability of Spanish and English speaking staff or interpreter is required.
 - Ability to provide documentation of services/invoices to CPC in a timely fashion.
 - Providers must be willing to complete and submit paperwork that documents services performed, and bill CPC upon completion of an initial examination and upon completion of necessary follow-up treatment.
 - CPC does not pay in advance for services.
 - The provider shall submit an original invoice for each child served by the 7th of the month for services performed during the previous month. Documentation for reconciliation of individual patient account statements must be available for CPC review.
 - Provider must be able to give parent a copy of the medical exam record with findings and any further recommendations free of charge at the time of services (**EXHIBIT 3**); patient portals may also provide for the obtaining of medical records.
 - Provider must be willing/able to fax/email copies of medical records to CPC's Health and Nutrition Services upon request. Compliance with HIPPA regulations is required. CPC provides a signed, HIPPA-compliant Authorization for the Release of Health Information in order to obtain records on behalf of the family (**EXHIBIT 4**).

Dental Specifications

1. Services will include standard dental preventative and treatment procedures as well as urgent restorative care if needed. Emergency care or injury or other non-standard situations is not covered by this agreement.
2. Preapproval by CPC designated Health and Nutrition Services personnel must be obtained for all services including both initial and follow-up services. Provider must contact CPC for pre-authorization before treatment services greater than \$1,500.00 can begin.
3. Participants will be children enrolled in the CPC Head Start/Early Head Start centers or home-based programs located in the CPC five-county service area.
4. Initial examinations will be provided to approximately 50 children, with around 50% likely to require follow-up. Examinations will include items listed on CPC's Head Start Dental Record Form (**EXHIBIT 5**).
5. Participants will generally be between ages three to five years old, with occasional services needed for younger children or pregnant women.
6. CPC staff screen and approve participants based on being uninsured, underinsured and/or other approved circumstances within Office of Head Start regulations.
7. Appointments for required follow-up services must be made at the end of the initial examination/service or a referral to another provider given. The need for follow-up treatment must be noted in the initial exam record. Eligibility for further CPC support is determined on a case-by-case basis by designated CPC staff, with the exception of treatment billed at less than \$1,500.00 (see above #2). Approvals and scheduling are coordinated between the provider and CPC staff assisting the family.
8. Dental providers should have qualifications and experience as described below:
 - Minimum qualifications require the provider to be a graduate from a dental school accredited by the American Dental Association and possess a current Arizona state license. CPC requires a copy of qualification documents for all providers that will be serving Head Start children. (Licensed dental hygienists also accepted if conducting full exam.)
 - Proof of Liability Insurance and Malpractice Insurance is required for all providers serving Head Start children.
 - Bid information should state your ability to provide services to children with disabilities and the number of years you have worked with young children (under the age of five years).
 - Preference will be given to providers who can provide services to children with disabilities, have experience with young children under the age of five years and provide services in a child/parent friendly environment.
 - The availability of Spanish and English speaking staff or interpreter is required.
 - Ability to provide documentation of services/invoices to CPC in a timely fashion.

- Providers must be willing to complete and submit paperwork that documents services performed, and bill CPC upon completion of an initial examination and upon completion of necessary follow-up treatment.
- CPC does not pay in advance for services.
- The provider shall submit an original invoice for each child served by the 7th of the month for services performed during the previous month. Documentation for reconciliation of individual patient account statements must be available for CPC review.
- Provider must be willing/able to give parent a copy of the dental exam record with findings and any further recommendations free of charge at the time of services (**EXHIBIT 3**); patient portals may also provide for the obtaining of dental records.
- Provider must be willing/able to fax/email copies of dental records to CPC's Health and Nutrition Services upon request. Compliance with HIPPA regulations is required. CPC provides a signed, HIPPA-compliant Authorization for the Release of Health Information in order to obtain records on behalf of the family (**EXHIBIT 4**).

Proposal Instructions

Complete the following attached documents and include with your proposal:

- RFP Submittal/Decline Form (identify county/counties served in our program area and services provided)
- Vendor/Bidder Fact Sheet and Questionnaire
- Debarment Certification Form
- W-9 Form
- Medical Services Proposal Chart 2026-2026 (**ATTACHMENT A**) and/or
- Dental Services Proposal Chart 2026-2029 (**ATTACHMENT B**)

Include a current copy of the following:

- Certificate of Liability including Workers' Compensation Liability
- Business License for each location

A current copy must be provided once bid awarded and before services can be provided:

- Arizona Medical Board license for each physician
- Triennial Certificate for each dentist
- DEA Certificate for each dentist, if applicable
- Malpractice/Professional Liability for each physician and/or dentist

Proposal must be for specifications only. Any additional services provided must be listed on separate page with listing of any additional cost.

Incomplete bid packets will NOT be considered.

Proposal Guidelines and Requirements

This is an open and competitive process.

If the independent provider or agency is not able to submit a proposal at this time, we ask that the decline box be marked on the Submittal/Decline Form and return it to Kristi Rosing by email to krosing@childparentcenters.org or fax to (520) 884-0605.

Proposals from agencies must contain the signature of a duly authorized officer or agent of the agency submitting the proposal.

Provisions of this RFP and the contents of the successful responses are considered available for inclusion in final contractual obligations. The award decision is based on several evaluating factors and is not based solely on rate.

CPC will negotiate agreement terms upon selection. All agreements are subject to review by CPC legal counsel, and the bid will be awarded upon signing of an agreement, which outlines terms, scope, rates, and other necessary items.

In the event that the awarded business/individual fails to perform the scope of work or becomes insolvent after the agreement is signed, CPC reserves the right to cancel.

Please review the specifications and mail or deliver your sealed proposal to:

Kristi Rosing
Procurement Specialist
Child-Parent Centers, Inc.
602 E. 22nd Street
Tucson, AZ 85713

All proposals must be received by **Friday, July 31, 2026** no later than **3:00 pm**. Proposals must be clearly marked "**Sealed Bid – Medical and/or Dental Services RFP 2026-2029**". Please indicate if you will be providing Medical services, Dental services or both.

If you have additional questions regarding the requirements, please email questions to krosing@childparentcenters.org. All questions must be received by **Wednesday, July 22, 2026**.

Our open competition policies require prospective vendors to submit all questions in writing. Funding requirements do not allow CPC to accept verbal quotes.

All instructions must be followed in order to be considered for this proposal. Prospective vendor will not be considered if all necessary information and documents are not provided with proposal.

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
Primary Care Provider		PCP ph. #	Health Plan	Accompanied By (Name)	Relationship
Admitted to NICU: (Birth) <input type="checkbox"/> Yes <input type="checkbox"/> No		Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss: <input type="checkbox"/> Yes <input type="checkbox"/> No		Temp: <input type="text"/>
				Pulse: <input type="text"/>	Resp: <input type="text"/>
Allergies:		Weight: lb oz %		Length: cm %	
				Head Circumference: cm %	

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?

DEVELOPMENTAL SCREENING TOOL COMPLETED: ASQ MCHAT PEDS

VERBAL LEAD RISK ASSESSMENT: Child At Risk Yes No (If Yes, Appropriate Action to Follow) Lives in High Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing (Twice Daily by Parent) Fluoride Supplement
 Fluoride Varnish by PCP (Once Every 6 Months) First Dental Appointment Completed Scheduled Dental Home Provider: _____

NUTRITIONAL SCREENING: Feeds Self Breastfeeding Whole Milk Nutritionally Balanced Diet Junk Food Soda/Juice
 Solids Activity Supplements _____ Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Uses a cup Walks Says 10-20 Words Says "No" Name One Picture/2 Colors
 Follows Simple Rules/Bring Me the Book Knows Animal Sounds Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning prevention Choking Prevention
 Car/Car Seat Safety (Rear-Facing) Safety at Home/Child-Proofing Sun Safety Helmet Use Never Leave Toddler Alone
 Sibling Interaction Discipline/Limits Growing Independence Encourage Expression of Wide Range of Emotions
 Read to Child Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Appropriate Bonding/Responsive to Needs Self-Calming Frustration/Hitting/Biting/Impulse Control Communication/Language
 Demonstrates Increasing Independence Defiant Behavior/Offer Child Choices Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision/Red Reflex			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: Blood Lead Testing (Child At Risk/Not already Done at 12 Months) Finger Stick (Result: _____) Venous
 TB Skin Test (If at Risk) Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella DTaP Hib IPV PCV Influenza
 Had chicken pox Other _____
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology AzeIP CRS DDD Dental Early Head Start OT PT Speech WIC
Specialist: Developmental Behavioral Other _____

Date/Time _____ Clinician Name (Print) _____ Clinician Signature _____ NPI # _____ See Additional Supervisory Note Yes No

12-2295 . Charges

A. Except as otherwise provided by law, a health care provider or contractor may charge a person who requests copies of medical records or payment records a reasonable fee for the production of the records. Except as necessary for continuity of care, a health care provider or contractor may require the payment of any fees in advance.

B. A health care provider or contractor shall not charge for the pertinent information contained in medical records provided to:

1. Another health care provider for the purpose of providing continuing care to the patient to whom the medical record pertains.
2. The patient to whom the medical record pertains for the demonstrated purpose of obtaining health care.
3. The health care decision maker of the patient to whom the medical record pertains for the demonstrated purpose of obtaining health care for the patient.
4. The Arizona medical board, the board of osteopathic examiners in medicine and surgery or an officer of the department of health services or the local health department requesting records pursuant to section 36-662.

EXHIBIT 3



CHILD-PARENT CENTERS, INC.
 Head Start Grantee
 602 E. 22nd Street, Tucson, AZ 85713
 P: (520) 882-0100 F: (520) 437-0386

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
 This is a legal document signed by the parent

Participant Information

Participant Name:	Date of Birth:
Parent/Legal Guardian:	Contact Phone #:
Street Address (City, State, Zip):	
Center and Class:	CPC Staff:

Provider Information

Provider Name:	Agency Name:
Business Phone #:	Business Fax #:
Street Address (City, State, Zip):	

Purpose of Request:

Covering Period of Request: 07/31/2025 through 8/1/2027

<input type="checkbox"/> Physical Exam, Well Child Exam, Blood Lead, Hemoglobin <input type="checkbox"/> Dental Exam (Including recent dental treatment) <input type="checkbox"/> Developmental Evaluations/Goals/Progress Notes: Behavioral, Speech, Occupational, Feeding or Physical Therapy <input type="checkbox"/> Mental Health Continuity of Support: Reciprocal verbal and written information to include progress notes, themes and focus of services and strategies of support. This Authorization covers the period from date of MH referral through one year following Mental Health Referral Date: _____ <input type="checkbox"/> Other _____

The Arizona Department of Health Services (Please initial)

_____ (Initials) "The Arizona Department of Health Services, Office of Environmental Health is authorized to release blood lead testing results and test date to Child-Parent Centers, Inc." I understand that, if this information is disclosed to the individual/agency named above, the information may no longer be protected by state and federal privacy regulations and may be re-disclosed by that individual/agency. I understand the matters discussed on this form. I release ADHS, its employees, officers and directors, staff members, and agents from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.
--

Re-Disclosure

_____ (Initials) I am the parent/legal guardian/participant of the above-named child/participant. I understand that the information disclosed by this authorization may be re-disclosed within Child-Parent Centers, Inc.

Time Limit & Right to Revoke Authorization

I understand that I can revoke this authorization at any time by submitting a written notice to Child-Parent Centers, Inc.; however, I understand that if I do not act quickly to revoke this authorization my records may have already been released. This agreement will terminate one (1) year from my signature unless previously revoked.

Signature of Parent/Legal Guardian/Participant

Signature: _____

Print Name: _____ Date: _____

05/2026

EXHIBIT 4



HEAD START DENTAL RECORD AHCCCS/KIDSCARE/INSURANCE

Child's Name: _____ Head Start Center: _____
 Date of Birth: _____ Class: _____
 Name of AHCCCS Plan: _____ Insurance ID #: _____

Dear Dental Provider:

The above named child is enrolled or considering enrollment in our Head Start program. Head Start guidelines require that all children, 3 years old and older, receive an annual dental examination and needed follow-up work. This requirement is consistent with the EPSDT Dental Periodicity Schedule for Arizona. Head Start also promotes the recommendation from the American Academy of Pediatrics that dental visits begin at 1 year of age.

Please complete the information below. If no follow-up treatment is needed, please give all copies of this form to the parent. **If follow-up treatment is needed, please give the first 2 copies to the parent and keep the 3rd copy until all work is completed. Parent will return copies to Head Start.**

TREATMENT PROVIDED	YES	NO	DATE
• Examination			
• X-Rays			
• Fluoride and Cleaning			
• Sealants Applied			
• Dental Health Education (Toothbrushing and Nutrition Instructions)			
• Cavities			
• Treatment completed day of Exam			
• Further Treatment Needed			
• Referred to Pediatric Dentist			

FOLLOW-UP TREATMENT PLAN

Number of Cavities: _____ Crowns: _____ Extractions: _____ Pulpotomies: _____ Other: _____

Dates of Treatment: _____

Date Treatment Completed: _____

Comments: _____

Name of Dentist/Clinic: _____ Phone: _____

Signature of Dentist: _____ Date: _____

Name of Pediatric Dentist: _____ Date: _____

Signature of Pediatric Dentist: _____ Phone: _____

For Head Start Staff Only

Date Dental Exam Form Received

Signature of Staff Receiving Form

REV: 2016

White – HNS

Yellow – Child's File

Pink – HNS after final treatment

- Can you work with children under the age of five years? Yes No
- Are you able to provide services to children with disabilities? Yes No
- Can you provide services in both Spanish and English? Yes No
- Can you provide translation services for other languages? Yes No
- Can you provide mobile medical services? Yes No
- Can you schedule appointment(s) for follow-up treatment at time of initial appointment if needed? Yes No
- Are your prices at or below the AHCCCS allowable amount? Yes No

Location of pharmacy/pharmacies: _____

Location of lab(s): _____

Location of medical facility; if more than one, list locations and services available at each (please attach list if more space is needed):

Additional Information/Comments (please attach list if more space is needed):

Dental Services Proposal Chart 2026-2029

Provider Name: _____

Initial Services	Cost	Excluded from Proposed costs and reason
D0150 Comprehensive Oral Evaluation		
D1120/D1201 Prophylaxis W/Fluoride		
D1330 Oral Hygiene Instruction For Parents (Describe how this will be implemented)		
D0272 Radiographs (Two bite-wings, if determined necessary)		
Total Initial Exam		
Follow-Up Services	Cost	Excluded from Proposed costs and reason
D0180 Periodic Oral Evaluation		
D0330 Panoramic Film		
D2930/D2931/D2933/D2934 Stainless Steel Crowns		
D2140/D2150/D2160/D2161 Amalgam per surface (1, 2, 3, 4 +)		
Restorations		
Composite-2 Surfaces-Posterior		
D3230/D3240 Pulpal Therapy		
D7111/D7140 Extractions (single, add'l)		
D2330/D2390 Resin / Restoration		
D7000/D7999 Oral (Maxillofacial) Surgery		
Fluoride tablets, if needed (detail criteria for prescribing fluoride tablets)		
Pre-Med Sedation (specify what method and treatment)		
D1520 Space Maintainers		
D2330/D2331/D2332/D2335 Resin Per Surface (1, 2, 3, 4 +)		
D1351 Sealants		
Behavior Management (Please describe method to be used)		
Limited/Emergency Office Visit		
Other: (Please Specify)		

RFP Submittal/Decline Form

Medical Services and/or Dental Services 2026-2029

Date: _____

Check one of the following:

Submitting a proposal

Indicate county/counties where services will be provided (Pima, Santa Cruz, Cochise, Graham and/or Greenlee):

Medical

Dental

Both

Declining a proposal – We would appreciate if you would please provide a brief explanation of why you are declining at this time. Thank you! _____

Agency Name:	Agency Contact:
Agency Address:	Agency Telephone:
	Agency Fax:
	Agency Email:

If submitting a proposal, please include the following:

1. RFP/Bid Submittal Decline Form
2. Vendor/Bidder Fact Sheet and Questionnaire
3. Debarment Certification Form
4. W-9 Form
5. Certificate of Liability including Workers' Compensation Liability (provide copy)
6. Business License for each location (provide copy)
7. Medical Services Proposal Chart (**ATTACHMENT A**)
8. Dental Services Proposal Chart (**ATTACHMENT B**)

**CPC must receive these to consider you for a bid award or contract.*

Once bid awarded, please provide the following:

1. Arizona Medical Board License for each physician (provide copy)
2. Triennial Certificate for each dentist (provide copy)
3. DEA Certificate for each dentist, if applicable (provide copy)
4. Malpractice/Professional Liability for each physician and/or dentist (provide copy)

To assist us in meeting our reporting guidelines, please return this form with the RFP submittal, or if declining email to Kristi Rosing at krosing@childparentcenters.org or fax to (520) 884-0605.

VENDOR/BIDDER FACT SHEET AND QUESTIONNAIRE

Please return to:
CHILD-PARENT CENTERS, INC.
Procurement Department
602 E. 22nd St.
Tucson, AZ 85713

DATE: _____

NAME OF COMPANY/DIVISION: _____

STREET ADDRESS: _____

MAILING ADDRESS: _____

TELEPHONE: _____ FAX: _____ OFFICE HOURS: _____

REPRESENTATIVE: _____ HOW LONG IN BUSINESS?: _____

REPRESENTATIVE EMAIL ADDRESS: _____

IDENTIFY YOUR BUSINESS OR SERVICES YOUR BUSINESS PROVIDES:

LEGAL STRUCTURE:

Sole Proprietorship: ___ Partnership: ___ Corporation: ___

*Vendors supplying services (contracting, etc.) shall supply the following:

Federal Employers Tax I.D. number (TIN): _____

Contractor license types/numbers held: _____

SELF-CERTIFICATION CATEGORIES – PLEASE CHECK APPROPRIATE CATEGORIES:

NOTE: DEFINITIONS –

"Control" is defined as exercising the power to make policy decisions.

"Operated" is defined as actively involved in the day-to-day management and not merely acting as officers or directors.

_____ LARGE BUSINESS – A domestic concern which, including domestic and foreign divisions and affiliates, normally employees 500 or more persons, is independent or publicly owned or controlled and operated, and which may be a division of another domestic or foreign concern.

_____ SMALL BUSINESS – The term "small business" shall mean a small business as defined pursuant to section 3 of the Small Business Act and in relevant regulations promulgated thereto. Generally, unless your firm is operating in an industry with a special size standard, it is considered small if (a) it has fewer than 500 employees for manufacturing industries, (b) has average annual receipts for three (3) preceding years of less than \$12 million for general construction (c) has average annual receipts for preceding fiscal years of less than \$2 million for service industry.

_____ MINORITY OWNED BUSINESS – A concern that is at least fifty-one percent (51%) owned by one or more minority individuals; or, in the case of any publicly owned business, at least fifty-one percent (51%) of the stock of which is owned by one or more minority individuals, and whose management and daily business operations are controlled by one or more minority individuals. Please check the appropriate group(s) listed here and note percentage of ownership.

___ (F) = Female ___ (M) = Male ___ Black Americans ___ Hispanic Americans
___ Asian-Indian Americans ___ American Indians ___ American Eskimos and Aleuts ___ Other Designated Minority
___ Native Hawaiians

Please specify: _____

_____ ARE YOU A U.S. CITIZEN?

_____ WOMEN OWNED BUSINESS – a concern that is at least fifty-one percent (51%) owned by one or more women; or, in the case of any publicly owned business, at least fifty-one percent (51%) of the stock of which is owned by one or more women, and whose management and daily business operations are controlled by one or more women.

_____ HANDICAPPED-OWNED BUSINESS – A concern that is at least fifty-one percent (51%) owned by one or more individuals who have a physical or mental impairment that substantially limits one or more major life activity. The individuals(s) must either have a record of such impairment or correctly regard him-herself(s) as having such an impairment or in the case of any publicly owned business, at least fifty-one percent (51%) of the stock of which is owned by one or more handicapped persons, and whose management and daily business operations are controlled by one or more such individuals.

* Mandatory

**CERTIFICATION REGARDING DEBARMENT, SUSPENSION AND OTHER
RESPONSIBILITY MATTERS - PRIMARY COVERED TRANSACTIONS**

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76 certifies to the best of his or her knowledge and belief that it and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded from covered transaction by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted or had a civil judgement rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction: violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statement, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1) (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transaction (Federal, State or local) terminated for cause or default.

The inability of a person to provide the certification required above will not necessarily result in denial of participation in this covered transaction. If necessary, the prospective participant shall submit an explanation of why it cannot provide the certification. The Department of Health and Human Services' (HHS) determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

The prospective primary participant agrees that by submitting this proposal, it will include the clause entitled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," provided below without modification in all lower tier covered transactions.

**CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY
AND VOLUNTARY EXCLUSION - LOWER TIER COVERED TRANSACTIONS
(TO BE SUPPLIED TO LOWER TIER PARTICIPANTS)**

By signing and submitting this lower tier proposal, the prospective lower tier participant, as defined in 45 CFR, Part 76, certifies to the best of its knowledge and belief that it and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
- b. where the prospective lower tier participant is unable to certify to any of the above, such prospective participant shall attach an explanation to this proposal.

The prospective lower tier participant further agrees by submitting this proposal that it will include this clause entitled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions," without modification in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

**CERTIFICATION REGARDING LOBBYING FOR CONTRACTS, GRANTS, LOANS
AND COOPERATIVE AGREEMENTS**

The undersigned certifies to the best of his or her knowledge and belief, that:

- 1. No Federal appropriate funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement.
- 2. If any funds other than Federal appropriated funds have been paid or will be paid to any person influencing or attempting to influence an officer or employee or an agency, a member of congress, an officer or employee of congress, or an employee of a member of congress in connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.
- 3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty or not less than \$10,000 and not more than \$100,000 for each such failure.

I hereby agree to the above certifications and assurances.

Signature of Certifying Official

Title

Applicant Organization

Date

04/09/26

**Request for Taxpayer
 Identification Number and Certification**
 Go to www.irs.gov/FormW9 for instructions and the latest information.

Give form to the
 requester. Do not
 send to the IRS.

Before you begin. For guidance related to the purpose of Form W-9, see *Purpose of Form*, below.

Print or type. See Specific Instructions on page 3.	1	Name of entity/individual. An entry is required. (For a sole proprietor or disregarded entity, enter the owner's name on line 1, and enter the business/disregarded entity's name on line 2.)
	2	Business name/disregarded entity name, if different from above.
	3a	Check the appropriate box for federal tax classification of the entity/individual whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor <input type="checkbox"/> C corporation <input type="checkbox"/> S corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Trust/estate <input type="checkbox"/> LLC. Enter the tax classification (C = C corporation, S = S corporation, P = Partnership) Note: Check the "LLC" box above and, in the entry space, enter the appropriate code (C, S, or P) for the tax classification of the LLC, unless it is a disregarded entity. A disregarded entity should instead check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) _____
	4	Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from Foreign Account Tax Compliance Act (FATCA) reporting code (if any) _____ (Applies to accounts maintained outside the United States.)
	3b	If on line 3a you checked "Partnership" or "Trust/estate," or checked "LLC" and entered "P" as its tax classification, and you are providing this form to a partnership, trust, or estate in which you have an ownership interest, check this box if you have any foreign partners, owners, or beneficiaries. See instructions <input type="checkbox"/>
	5	Address (number, street, and apt. or suite no.). See instructions.
	6	City, state, and ZIP code
7	List account number(s) here (optional)	
		Requester's name and address (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN*, later.

Social security number										
					-					
or										
Employer identification number										

Note: If the account is in more than one name, see the instructions for line 1. See also *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person	Date
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

What's New

Line 3a has been modified to clarify how a disregarded entity completes this line. An LLC that is a disregarded entity should check the appropriate box for the tax classification of its owner. Otherwise, it should check the "LLC" box and enter its appropriate tax classification.

New line 3b has been added to this form. A flow-through entity is required to complete this line to indicate that it has direct or indirect foreign partners, owners, or beneficiaries when it provides the Form W-9 to another flow-through entity in which it has an ownership interest. This change is intended to provide a flow-through entity with information regarding the status of its indirect foreign partners, owners, or beneficiaries, so that it can satisfy any applicable reporting requirements. For example, a partnership that has any indirect foreign partners may be required to complete Schedules K-2 and K-3. See the Partnership Instructions for Schedules K-2 and K-3 (Form 1065).

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS is giving you this form because they