

Request for Taxpayer Identification Number and Certification

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

Go to www.irs.gov/FormW9 for instructions and the latest information.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

South Arkansas Regional Health Center, Inc

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

Individual/sole proprietor or single-member LLC

C Corporation

S Corporation

Partnership

Trust/estate

Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

Other (see instructions) ▶

Non-Profit

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

715 N College Ave

6 City, state, and ZIP code

El Dorado, AR 71730

Requester's name and address (optional)

7 List account number(s) here (optional)

Print or type.
See Specific Instructions on page 3.

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.

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

Social security number

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OR

Employer identification number

7	1	-	0	3	8	8	0	1	2
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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 *Christi Rose*

Date ▶ *2-22-19*

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.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

DIRECTOR INFORMATION SHEET

FACILITY INFORMATION

NAME: South Arkansas Regional Health Center

STREET ADDRESS: 710 W. Grove

CITY, STATE, & ZIP: El Dorado, AR 71730

DIRECTOR INFORMATION

NAME: Terri Rowe

EXPIRATION DATE OF
CURRENT CERTIFICATE: 4/30/19 RHA

ATTACH A COPY OF ANY/ALL CURRENT CERTIFICATIONS



April 19, 2016

Angela J. Huitt, M.B.A.
South Arkansas Regional Health Center
715 North College Avenue
El Dorado, AR 71730

Dear Ms. Huitt:

It is my pleasure to inform you that South Arkansas Regional Health Center has been issued CARF accreditation based on its recent survey. The Three-Year Accreditation applies to the following program(s):

- Case Management/Services Coordination: Mental Health (Adults)
- Case Management/Services Coordination: Mental Health (Children and Adolescents)
- Community Integration: Mental Health (Adults)
- Crisis Intervention: Mental Health (Adults)
- Crisis Intervention: Mental Health (Children and Adolescents)
- Outpatient Treatment: Mental Health (Adults)
- Outpatient Treatment: Mental Health (Children and Adolescents)

This accreditation will extend through May 31, 2019. This achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served. Services, personnel, and documentation clearly indicate an established pattern of conformance to standards.

The survey report is intended to support a continuation of the quality improvement of your organization's program(s). It contains comments on your organization's strengths as well as any consultation and recommendations. A quality improvement plan (QIP) demonstrating your organization's efforts to implement the survey recommendation(s) must be submitted within the next 90 days to retain accreditation. The QIP form is posted on Customer Connect (customerconnect.carf.org), CARF's secure, dedicated website for accredited organizations and organizations seeking accreditation. Please log on to Customer Connect and follow the guidelines contained in the QIP form.

Your organization should take pride in achieving this high level of accreditation. CARF will recognize this accomplishment in its listing of organizations with accreditation and encourages your organization to make its accreditation known throughout the community. Communication of the accreditation to your referral and funding sources, the media, and local and federal government officials can promote and distinguish your organization. Enclosed are some materials that will help you publicize this achievement.

Your organization's complimentary accreditation certificate will be sent separately. You may use the enclosed form to order additional certificates.

If you have any questions regarding your organization's accreditation or the QIP, you are encouraged to seek support from Daniel Miller by email at dmiller@carf.org or telephone at (888) 281-6531, extension 7129.

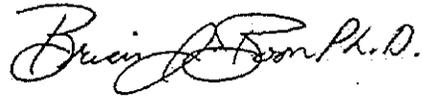
Ms. Huitt

2

April 19, 2016

CARF encourages your organization to continue fully and productively using the CARF standards as part of its ongoing commitment to accreditation. CARF commends your organization's commitment and consistent efforts to improve the quality of its program(s) and looks forward to working with your organization in its ongoing pursuit of excellence.

Sincerely,

A handwritten signature in cursive script that reads "Brian J. Boon Ph.D.".

Brian J. Boon, Ph.D.
President/CEO

Enclosures

BEHAVIORAL HEALTH AGENCY

Arkansas Department of Human Services

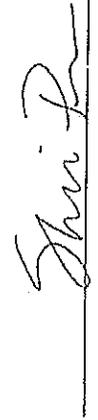
Division of Provider Services and Quality Assurance

This certificate acknowledges the completion of the Arkansas State Certification Process

SOUTH ARKANSAS REGIONAL HEALTH CENTER
710 WEST GROVE STREET
EL DORADO, AR 71730

Dates of Certification: 06/30/2018 - 06/30/2019

Vendor Number: 11124
BHA License Number: 125



Sherri Proffer, RN
Assistant Director Community Services Licensure and Certification
Division of Provider Services and Quality Assurance



EMAIL ADDRESS

For our records, please supply a facility email address below:

angela.hurt@sarhc.org

If there is an additional email address for the administrator, please supply below:

ARKANSAS STATE POLICE
Arkansas Criminal History Report

This report is based on a name search. There is no guarantee that it relates to the person you are interested in without fingerprint verification. This report includes a check of Arkansas files only. Inquiries into FBI files are not permitted for non-criminal justice or employment purposes without specific statutory authority.

Subject of Record

Last: **Pierce** First: **Regina** Middle: **Diane**
Date of Birth: **12/15/1955** Sex: **F** Race: **W**
Social Security Number: **429119351** (not verified, supplied at time of request)

- NO CRIMINAL HISTORY FOUND FOR THIS SUBJECT -

Requestor Information

Transaction Number: **002282285**
Date: **09/01/2017** Agency Reporting: **Arkansas State Police**
Purpose: **I am an employer legally doing business in the State of Arkansas**
Released To: **Geraldene Dollar**
Representing: **South Arkansas Regional Health Center, Inc.**
Mailing Address: **715 North College El Dorado, AR 71730**

This Arkansas criminal history record report should only be used for the purpose that it was requested. A request that is posed for a different purpose may result in more or less information being reported.

This report does not preclude the possible existence of additional records on this person which may not have been reported to the State Identification Bureau and Central Repository. Changes in a criminal history record can occur at any time due to new arrests and/or ongoing legal proceedings.

This Arkansas criminal background check report is for non-criminal justice purposes and may only reflect if a person has any Arkansas felony and misdemeanor conviction(s), any Arkansas felony arrest that occurred in the last three (3) years that has not been to court and whether the person is a registered sex offender or required to register as a sex offender. Juvenile arrest and/or court information will not be released on this report.



ARKANSAS STATE POLICE

Identification Bureau STATE ONLY Individual Record Check Form FOR NON-MANDATED (RN, LPN, ETC.) EMPLOYEES (FOR ALL OTHER EMPLOYEES, COMPLETE THE DMS-736)

NATIONAL BACKGROUND CHECKS ARE NOT AVAILABLE ON "NON-MANDATED" EMPLOYEES

Full Name: REGINA Diane PIERCE Burton / Lavender
First Middle Last Name Maiden/Other

Date of Birth: 12/15/55 State of Birth: AR Race: CAU Sex: F
(Month/Day/Year)

Social Security #: 429-11-9351 Driver's License #: 910638429AR
State

Mailing Address: 800 N. Euclid Ave.; El Dorado AR 71730
Street City State ZIP

Daytime Phone #: 1870-1315-2912

I GIVE MY CONSENT FOR THE ARKANSAS STATE POLICE TO CONDUCT A CRIMINAL RECORD SEARCH ON MYSELF AND RELEASE ANY RESULTS TO THE FOLLOWING PERSON OR ENTITY:

Name: SOUTH ARKANSAS REGIONAL HEALTH CENTER
(First/MI/Last Name) or Full Name of Agency

Mailing Address: 715 N COLLEGE EL DORADO AR 71730
Street City State ZIP

Signature: Regina D Pierce Date: 9/1/17
(First/MI/Last Name) (Month/Day/Year)

(REQUESTS WILL NOT BE PROCESSED WITHOUT A NOTARIZED SIGNATURE)

STATE OF Arkansas
COUNTY OF Union §

GERALDENE DOLLAR
UNION COUNTY
NOTARY PUBLIC - ARKANSAS
My Commission Expires October 6, 2025
Commission No. 12692439

Subscribed and sworn before me, a Notary Public, in and for the county and state aforesaid, this the 1st day of September, 2017

Geraldene Dollar
Notary Public

NATIONAL BACKGROUND CHECKS ARE NOT AVAILABLE ON "NON-MANDATED" EMPLOYEES

82005 Civil Record Check

Attachment P
pg 48

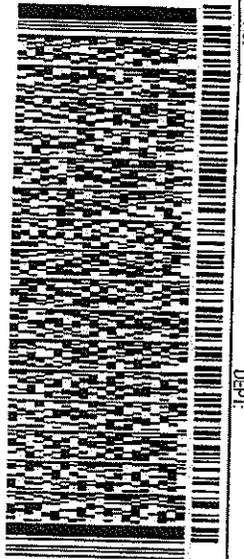
ORIGIN: DELDA (870) 867-7921
KRISTI ROSE
SOUTH ARKANSAS REGIONAL HEALTH
715 N. COLLEGE AVENUE
EL DORADO, AR 71730
UNITED STATES US

SHIP DATE: 19FEB19
ACT WT: 1.00 LB
CAD: 1656450N1E14:100
BILL SENDER

TO ELECTRONIC SUMMARY REQUEST
FBI CJIS DIVISION
1000 CUSTER HOLLOW ROAD

CLARKSBURG WV 26306
REF: (304) 625-5590
PO: DEPT:

565.120E3D23AD

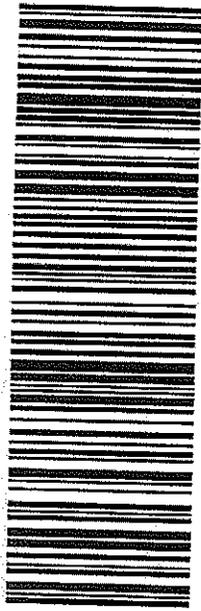


TRK# 7745 0849 6643
0201

WED - 20 FEB 3:00P
STANDARD OVERNIGHT

XHCKBA

26306
WV-US
PIT



After printing this label:

1. Use the 'Print' button on this page to print your label to your laser or inkjet printer.
2. Fold the printed page along the horizontal line.
3. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

Warning: Use only the printed original label for shipping. Using a photocopy of this label for shipping purposes is fraudulent and could result in additional billing charges, along with the cancellation of your FedEx account number. Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide, available on fedex.com. FedEx will not be responsible for any claim in excess of \$100 per package, whether the result of loss, damage, delay, non-delivery, misdelivery, or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim. Limitations found in the current FedEx Service Guide apply. Your right to recover from FedEx for any loss, including intrinsic value of the package, loss of sales, income interest, profit, attorney's fees, costs, and other forms of damage whether direct, incidental, consequential, or special is limited to the greater of \$100 or the authorized declared value. Recovery cannot exceed actual documented loss. Maximum for items of extraordinary value is \$1,000, e.g. jewelry, precious metals, negotiable instruments and other items listed in our Service Guide. Written claims must be filed within strict time limits, see current FedEx Service Guide.

Proof of Federal Criminal Record Check that's been sent to FBI. Meets requirement per Sherri Proffer. Will send report results as soon as I receive them.

APPLICANT
700001001209

LEAVE BLANK

TYPE OR PRINT ALL INFORMATION IN BLACK
LAST NAME NAM FIRST NAME MIDDLE NAME
PIERCE, REGINA

FBI LEAVE BLANK
*Attachment P
Pg 49*

SIGNATURE OF PERSON FINGERPRINTED
Regina Pierce

ALIASES AKA
OR I
AR0700000
SO
EL DORADO, AR

SEX F RACE W HGT 506 WGT 200 EYES GRN HAIR BRO

DATE OF BIRTH DOB
Month Day Year
12/15/1955
PLACE OF BIRTH POB
AR

DATE 20190207 SIGNATURE OF OFFICIAL TAKING FINGERPRINTS
Jim Wiley

CITIZENSHIP CIZ
US
YOUR NO. OCA

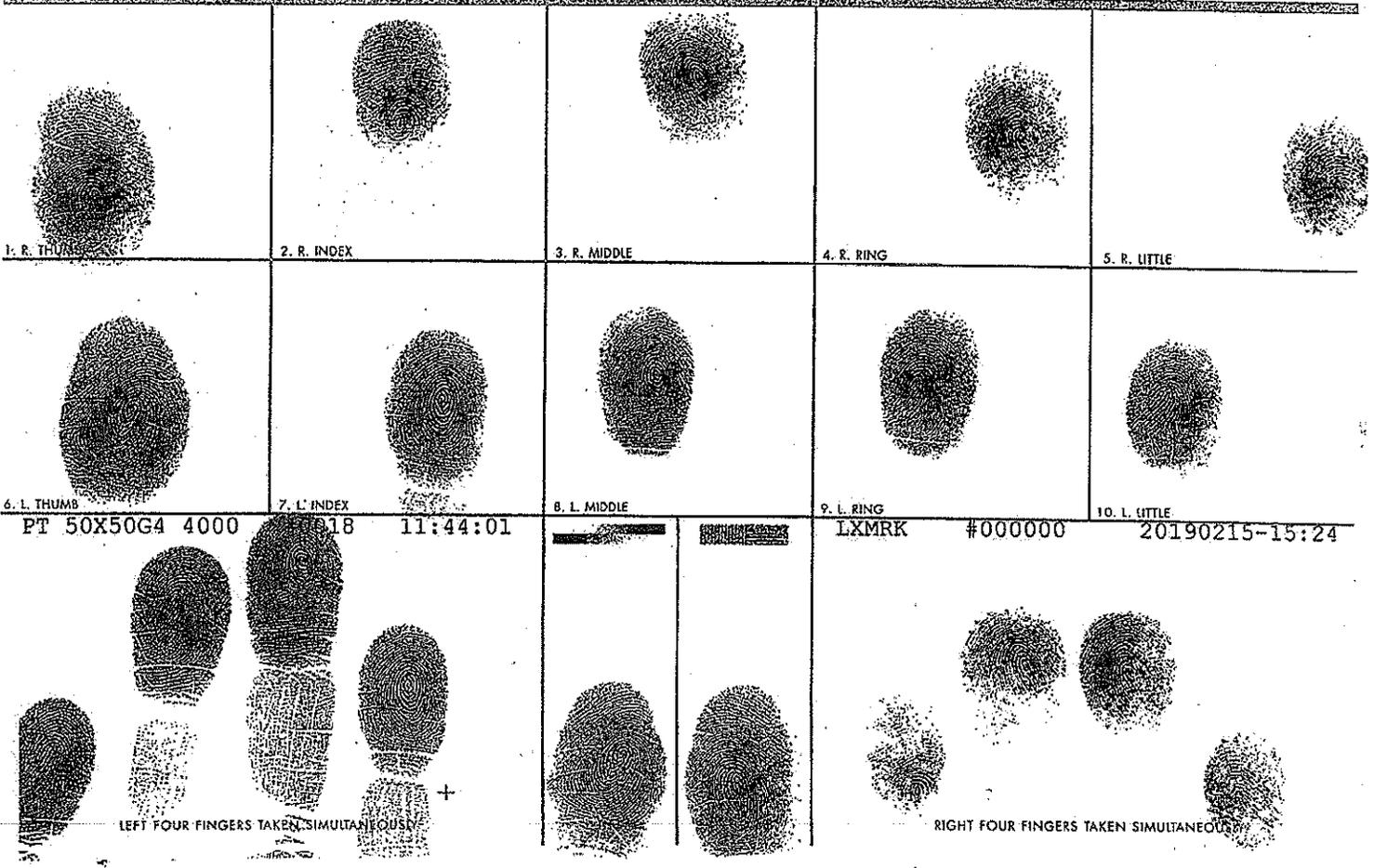
EMPLOYER AND ADDRESS

FBI NO. FBI
ARMED FORCES NO. MNU

LEAVE BLANK
CLASS _____
REF. _____

REASON FINGERPRINTED
APPLICANT

SOCIAL SECURITY NO. SOC
429-11-9351
MISCELLANEOUS NO. MNU



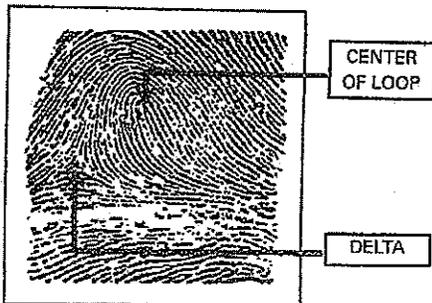
1. R. THUMB 2. R. INDEX 3. R. MIDDLE 4. R. RING 5. R. LITTLE
6. L. THUMB 7. L. INDEX 8. L. MIDDLE 9. L. RING 10. L. LITTLE
PT 50X50G4 4000 11:44:01 LXMRK #000000 20190215-15:24

**FEDERAL BUREAU OF INVESTIGATION
UNITED STATES DEPARTMENT OF JUSTICE
CJIS DIVISION / CLARKSBURG, WV 26306**

Attachment P
Pg 50

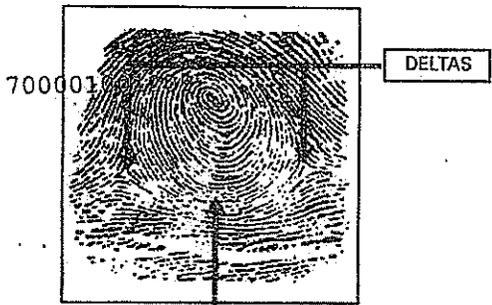
APPLICANT

1. LOOP



THE LINES BETWEEN CENTER OF LOOP AND DELTA MUST SHOW

2. WHORL



THESE LINES RUNNING BETWEEN DELTAS MUST BE CLEAR

3. ARCH



ARCHES HAVE NO DELTAS

TO OBTAIN CLASSIFIABLE FINGERPRINTS:

1. USE BLACK PRINTER'S INK.
2. DISTRIBUTE INK EVENLY ON INKING SLAB.
3. WASH AND DRY FINGERS THOROUGHLY.
4. ROLL FINGERS FROM NAIL TO NAIL, AND AVOID ALLOWING FINGERS TO SLIP.
5. BE SURE IMPRESSIONS ARE RECORDED IN CORRECT ORDER.
6. NOTATE IN THE APPROPRIATE FINGER BLOCKS IF APPLICANT IS MISSING ONE OR MORE FINGERS FOR ANY REASON. IF NOT MISSING, ALL TEN IMPRESSIONS MUST BE PROVIDED WITH SCARS AND DEFORMITIES NOTATED.
7. IF SOME PHYSICAL CONDITION MAKES IT IMPOSSIBLE TO OBTAIN PERFECT IMPRESSIONS, SUBMIT THE BEST THAT CAN BE OBTAINED.
8. EXAMINE THE COMPLETED PRINTS TO SEE IF THEY CAN BE CLASSIFIED, BEARING IN MIND THAT MOST FINGERPRINTS FALL INTO THE PATTERNS SHOWN ON THIS CARD (OTHER PATTERNS OCCUR INFREQUENTLY AND ARE NOT SHOWN HERE).

THIS CARD FOR USE BY:

LEAVE THIS SPACE BLANK

1. LAW ENFORCEMENT AGENCIES IN FINGERPRINTING APPLICANTS FOR LAW ENFORCEMENT POSITIONS.*
2. OFFICIALS OF STATE AND LOCAL GOVERNMENTS FOR PURPOSES OF EMPLOYMENT, LICENSING, AND PERMITS, AS AUTHORIZED BY STATE STATUTES AND APPROVED BY THE ATTORNEY GENERAL OF THE UNITED STATES. LOCAL AND COUNTY ORDINANCES, UNLESS SPECIFICALLY BASED ON APPLICABLE STATE STATUTES DO NOT SATISFY THIS REQUIREMENT.*
3. U.S. GOVERNMENT AGENCIES AND OTHER ENTITIES REQUIRED BY FEDERAL LAW.**
4. OFFICIALS OF FEDERALLY CHARTERED OR INSURED BANKING INSTITUTIONS TO PROMOTE OR MAINTAIN THE SECURITY OF THOSE INSTITUTIONS.

INSTRUCTIONS:

1. PRINTS MUST FIRST BE CHECKED THROUGH THE APPROPRIATE STATE IDENTIFICATION BUREAU, AND ONLY THOSE FINGERPRINTS FOR WHICH NO DISQUALIFYING RECORD HAS BEEN FOUND LOCALLY SHOULD BE SUBMITTED FOR FBI SEARCH.
 2. PRIVACY ACT OF 1974 (P.L. 93-579) REQUIRES THAT FEDERAL, STATE, OR LOCAL AGENCIES INFORM INDIVIDUALS WHOSE SOCIAL SECURITY NUMBER IS REQUESTED WHETHER SUCH DISCLOSURE IS MANDATORY OR VOLUNTARY, BASIS OF AUTHORITY FOR SUCH SOLICITATION, AND USES WHICH WILL BE MADE OF IT.
 3. IDENTITY OF PRIVATE CONTRACTORS SHOULD BE SHOWN IN SPACE "EMPLOYER AND ADDRESS". THE CONTRIBUTOR IS THE NAME OF THE AGENCY SUBMITTING THE FINGERPRINT CARD TO THE FBI.
 4. FBI NUMBER, IF KNOWN, SHOULD ALWAYS BE FURNISHED IN THE APPROPRIATE SPACE.
- MISCELLANEOUS NO. - RECORD; OTHER ARMED FORCES NO., PASSPORT NO. (PP), ALIEN REGISTRATION NO. (AR), PORT SECURITY CARD NO. (PS), SELECTIVE SERVICE NO. (SS), VETERANS' ADMINISTRATION CLAIM NO. (VA).

Geraldene Dollar

From: Regina Pierce
Sent: Tuesday, February 12, 2019 4:09 PM
To: Geraldene Dollar
Subject: FW: Identity History Summary Request Confirmation

From: Criminal Justice Information Services [mailto:edo@services.fbi.gov]
Sent: Tuesday, February 12, 2019 4:04 PM
To: Regina Pierce <regina.pierce@SARHC.org>
Subject: Identity History Summary Request Confirmation

Your Identity History Summary Request has been accepted and will be processed in the date order in which it was received.

Regina Diane Pierce
Your Order number is: D49709919043
Your payment verification code is: 26FCJSH9

You indicated your fingerprints would be delivered by: MAIL

Please refer to the following details when submitting your fingerprints:

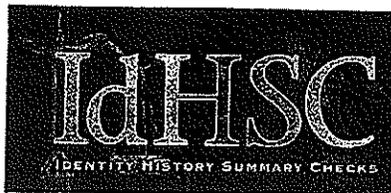
If delivering your fingerprints via Mail, please send your completed fingerprint card along with a copy of this confirmation email to:

FBI CJIS Division
ATTN: ELECTRONIC SUMMARY REQUEST
1000 Custer Hollow Road
Clarksburg, West Virginia 26306

If you have any questions regarding this e-mail contact 304-625-5590 or identity@fbi.gov

This message has been transmitted to you by the FBI Criminal Justice Information Services Division. If you are not the intended recipient of this message, please destroy it promptly without any retention, dissemination, or reproduction (unless required by law), and please notify the sender of the error immediately by separate e-mail to identity@fbi.gov or by calling the Customer Service Group at 304-625-5590.

This is an automated message. Please do not reply to this e-mail.



Need Assistance? [Click Here.](#)

Current processing time for Identity History Summary requests submitted electronically is estimated to be three to five business days upon receipt of the fingerprint card. Allow additional time for mail delivery if this option was selected during the request process.

****We are currently experiencing issues with Google Chrome and Safari browsers. We recommend that Internet Explorer or Mozilla Firefox be used to submit requests to obtain or challenge your Identity History Summary information.****

Overview

For a fee, the FBI can provide individuals with an Identity History Summary, often referred to as a criminal history record or a "rap sheet," listing certain information taken from fingerprint submissions kept by the FBI and related to arrests and, in some instances, federal employment, naturalization, or military service.

If the fingerprint submissions are related to an arrest, the Identity History Summary includes the name of the agency that submitted the fingerprints to the FBI, the date of the arrest, the arrest charge, and the disposition of the arrest, if known. All arrest information included in an Identity History Summary is obtained from fingerprint submissions, disposition reports, and other information submitted by authorized criminal justice agencies.

The U.S. Department of Justice Order 556-73, also known as Departmental Order, establishes rules and regulations for you to obtain a copy of your Identity History Summary for review or proof that one does not exist.

Only you may request a copy of your own Identity History Summary (or proof that one does not exist). You would typically make this request for personal review, to challenge information on record, to meet a requirement for adopting a child, or to meet a requirement to live, work, or travel in a foreign country.

Obtaining Your Identity History Summary

Identity History Summary Checks For Employment Or Licensing

If you are requesting a background check for employment or licensing within the U.S., you may be required by state statute or federal law to submit your request through your state identification bureau, the requesting federal agency, or another authorized channeling agency. The FBI's authority to conduct an Identity History Summary check for noncriminal justice purposes is based upon Public Law (Pub. L.) 92-544. Pursuant to that law, the FBI is empowered to exchange Identity History Summary information with officials of state and local governments for employment, licensing — which includes volunteers — and other similar noncriminal justice purposes, if authorized by a state statute which has been approved by the Attorney General of the United States. The U.S. Department of Justice has advised that the state statute establishing guidelines for a category of employment or the issuance of a license must, in itself, require fingerprinting and authorize the governmental licensing or employing agency to exchange fingerprint data directly with the FBI.

An Identity History Summary search obtained pursuant to U.S. Department of Justice Order 556-73 may not meet employment requirements. Governmental licensing or employing agencies covered by federal laws and/or state statutes may refuse to accept Identity History Summary information directly from the subject of the summary, as there would be no way to verify that the information contained on the summary had not been altered. Also, an Identity History Summary provided to the subject for personal review contains only information maintained by the FBI and may lack dispositional data and/or arrest records that are maintained only at the state level.

How To Submit A Request

An e-mail address must be provided in order to initiate the application process. A secure link, along with a personal identification number, will be sent to the specified address and will be used to complete the online application. The same secure link and personal identification number will be used to check the status of your application and to access your results. You may optionally elect to have your results sent to you by First-Class Mail via the U.S. Postal Service.

Please select each step below to view additional information. Enter your e-mail address below to start the Identity History Summary Check process.

Step 1: Complete the Applicant Information Form ()



Step 2: Select Your Preferences ()



Step 3: Submit Your Fingerprints ()



You may mail your completed fingerprint card along with a copy of your confirmation e-mail to:

FBI CJIS Division
ATTN: ELECTRONIC SUMMARY REQUEST
1000 Custer Hollow Road
Clarksburg, WV 26306

- The FBI will process your request upon receipt of your completed fingerprint card in the date order it was received.
- Your fingerprints should be placed on a standard fingerprint form (FD-258) (artifacts/standard-fingerprint-form-fd-258-1.pdf) commonly used for applicant or law enforcement purposes. The FBI will accept FD-258 fingerprint cards on standard white paper stock.
- You must provide a current fingerprint card. Previously processed cards or copies will not be accepted.
- Your name and date of birth must be provided on the fingerprint card.
- You must include rolled impressions of all 10 fingerprints and impressions of all 10 fingerprints taken at the same time (these are sometimes referred to as plain or flat impressions). If possible, have your fingerprints taken by a fingerprinting technician. This service may be available at a law enforcement agency.
- Fingerprints taken with ink or via live scan are acceptable. If your fingerprints are taken via a live scan device, a hard-copy must be generated so the fingerprint card can be mailed to the FBI.
- To ensure the most legible prints possible, refer to the Recording Legible Fingerprints (<https://www.fbi.gov/services/cjis/fingerprints-and-other-biometrics/recording-legible-fingerprints>) page. If fingerprints are not legible, the fingerprint card will be rejected. This could cause delays in processing and could also result in additional fees.
- The name on your response letter will match the name that you entered on your electronic DO request.
- If the last four digits of your Social Security number are needed on your response letter, then please ensure the full nine-digit or last four digits of your Social Security number is on the fingerprint card when submitting your request.

Step 4: Submit Payment ()



Step 5: Review and Confirm Your Request ()



Step 6: Check Request Status ()



Step 7: Receive Your Results ()



Enter your e-mail address to get started!

Enter your e-mail address

Challenging Your Identity History Summary Or Your Firearm-Related Denial

The FBI is responsible for the storage of fingerprints and related Identity History Summary information for the nation and does not have the authority to modify any Identity History Summary information unless specifically notified to do so by the agency that owns the information. If you believe your Identity History Summary contains inaccurate or incomplete information, you may request a change or correction to your Identity History Summary information.

Challenge Your Identity History Summary: To challenge your Identity History Summary, you must provide either your FBI Universal Control Number (FBI Number) from your Identity History Summary or your State Identification Number (SID) from your state criminal history record. If providing your SID, you must include the two-letter state abbreviation for the state in which your offense occurred. Please select each step below to view additional information. Enter your e-mail address below to start the challenge process.

Challenge Your Firearm-Related Denial: To challenge your firearm-related denial, you must provide either a NICS Transaction Number (NTN), which is a unique number assigned to each valid firearm-related background check inquiry received by the FBI; or a State Transaction Number (STN), which is a unique number assigned by a State Point of Contact to a valid firearm-related background check inquiry. If you are not already in possession of your NTN or STN, you must contact the Federal Firearm Licensee (FFL) or state agency who initiated your firearm-related background check and request the applicable identifier. Please select each step below to view additional information. Enter your e-mail address below to start the challenge process. Click here for more information on challenging your firearm-related denial.

- Step 1: Complete the Challenge Information Form () >
- Step 2: Select Your Preferences () >
- Step 3: Submit Your Fingerprints to Challenge Your Firearm-Related Denial () >
- Step 4: Upload Supporting Documents () >
- Step 5: Review and Confirm Your Request () >
- Step 6: Check Request Status () >
- Step 7: Receive Your Results () >

Enter your e-mail address to get started!

Enter your e-mail address

Request for Taxpayer Identification Number and Certification

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

Go to www.irs.gov/FormW9 for instructions and the latest information.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
South Arkansas Regional Health Center, Inc

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

Individual/sole proprietor or single-member LLC C Corporation S Corporation Partnership Trust/estate

Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

Other (see instructions) ▶ **Non-Profit**

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.
715 N College Ave

6 City, state, and ZIP code
EI Dorado, AR 71730

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.

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

Social security number

			-					
--	--	--	---	--	--	--	--	--

OR

Employer identification number

7	1	-	0	3	8	8	0	1	2
---	---	---	---	---	---	---	---	---	---

Part II Certification

Under penalties of perjury, I certify that:

- 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
- 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
- I am a U.S. citizen or other U.S. person (defined below); and
- 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 ▶ *Trish Rose* Date ▶ *2-22-19*

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.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

Arkansas Department of Human Services

Licensure Renewal Application for Behavioral Health Agency
To be completed upon initial application to become licensed as a Behavioral Health Agency

Name of Agency: South Arkansas Regional Health Center - Camden Clinic

Chief Executive Officer (or equivalent): Regina D. Pierce

Corporate Compliance Officer (or equivalent): Angela J. Huitt

Site Director: Phyllis Craig, LPC

Administrative Address: 715 N. College Ave El Dorado, AR 71730

Physical Address: 211 Jackson St. SW Camden AR 71701
Street Address City State Zip

Mailing Address: 715 N. College Ave El Dorado AR 71730
Street Address City State Zip

County: Ouachita Phone: 870-836-5143 Fax: 870-836-6924

E-mail: angela.huitt@sarhc.org Website: www.sarhc.org

For existing certification renewal please check below:

- Acute Crisis Unit Residential Community Integration Partial Hospitalization
- Therapeutic Community Level 1 Therapeutic Community Level 2 Substance Abuse

The provider named above is fully accredited and in good standing with one of the following accreditation organizations. (Please check your accreditation organization)

- The Joint Commission (TJC)
- Commission on Accreditation for Rehabilitation Facilities (CARF)
- Council on Accreditation (COA)

Date(s) of most recent survey: March 16-18, 2016 next April 1-3, 2019

Accreditation Period: April 19, 2016 - May 31, 2019

The accredited provider is located within the State of Arkansas.
 Yes No

As the Chief Executive Officer (or equivalent) of the agency named above, I verify that all information contained in this form and in all attachments, is correct and complete.

Regina D. Pierce
Signature of Chief Executive Officer (or equivalent)

2/28/19
Date

Regina D. Pierce
Name of Chief Executive Officer (or equivalent) typed or printed

Department of Human Services
Licensure and Certification Unit
ATTN: Dana "Dee" Briscoe
PO Box 8059, Slot S408
Little Rock, AR 72203
dana.briscoe@dhs.arkansas.gov
501-320-6110

GERALDENE DOLLAR
UNION COUNTY
NOTARY PUBLIC -- ARKANSAS
My Commission Expires October 6, 2025
Commission No. 12692439

Geraldene Dollar
Notary Public

REFERENCE	INVOICE NUMBER	INVOICE DATE	INVOICE AMOUNT	ADJUSTMENT	DISCOUNT	WRITE OFF	NET AMOUNT PAID
INV0025450	2/19 ANNUAL FEE	2/20/2019	\$225.00	\$225.00	\$0.00	\$0.00	\$225.00
1-475.00	715 N. COLLEGE	EL DORADO, AR 71730					
1-475.00	412 N. VINE	MAGNOLIA, AR 71753					
1-475.00	211 JACKSON ST SW	CAMDEN, AR 71701					
			\$225.00	\$225.00	\$0.00	\$0.00	\$225.00

TO VERIFY AUTHENTICITY, SEE REVERSE SIDE FOR DESCRIPTION OF THE 11 SECURITY FEATURES

SOUTH ARKANSAS REGIONAL

HEALTH CENTER, INC.
715 North College Ave.
El Dorado, Arkansas 71730

REGIONS BANK
100 EAST PEACH ST
EL DORADO, AR 71730

007012

DATE: 2/21/2019



\$***225.00

PAY: Two Hundred Twenty Five Dollars and 00 Cents Dollars

VALID FOR 90 DAYS

TO THE ORDER OF: AR DEPT. OF HUMAN SERVICES
DHS-DPSQA
P. O. BOX 8059, SLOT S408
LITTLE ROCK, AR 72203

Regina D. Pierce

⑈007012⑈ ⑆082000109⑆ 0198536885⑈

Original check included in 715 N. College, El Dorado, AR
licensure packet.

DIRECTOR INFORMATION SHEET

FACILITY INFORMATION

NAME: South Arkansas Regional Health Center - Camden Clinic

STREET ADDRESS: 211 Jackson St. SW

CITY, STATE, & ZIP: Camden, AR 71701

DIRECTOR INFORMATION

NAME: Phyllis Craig

EXPIRATION DATE OF
CURRENT CERTIFICATE: 6/30/19 BHA

ATTACH A COPY OF ANY/ALL CURRENT CERTIFICATIONS



April 19, 2016

Angela J. Huitt, M.B.A.
South Arkansas Regional Health Center
715 North College Avenue
El Dorado, AR 71730

Dear Ms. Huitt:

It is my pleasure to inform you that South Arkansas Regional Health Center has been issued CARF accreditation based on its recent survey. The Three-Year Accreditation applies to the following program(s):

- Case Management/Services Coordination: Mental Health (Adults)
- Case Management/Services Coordination: Mental Health (Children and Adolescents)
- Community Integration: Mental Health (Adults)
- Crisis Intervention: Mental Health (Adults)
- Crisis Intervention: Mental Health (Children and Adolescents)
- Outpatient Treatment: Mental Health (Adults)
- Outpatient Treatment: Mental Health (Children and Adolescents)

This accreditation will extend through May 31, 2019. This achievement is an indication of your organization's dedication and commitment to improving the quality of the lives of the persons served. Services, personnel, and documentation clearly indicate an established pattern of conformance to standards.

The survey report is intended to support a continuation of the quality improvement of your organization's program(s). It contains comments on your organization's strengths as well as any consultation and recommendations. A quality improvement plan (QIP) demonstrating your organization's efforts to implement the survey recommendation(s) must be submitted within the next 90 days to retain accreditation. The QIP form is posted on Customer Connect (customerconnect.carf.org), CARF's secure, dedicated website for accredited organizations and organizations seeking accreditation. Please log on to Customer Connect and follow the guidelines contained in the QIP form.

Your organization should take pride in achieving this high level of accreditation. CARF will recognize this accomplishment in its listing of organizations with accreditation and encourages your organization to make its accreditation known throughout the community. Communication of the accreditation to your referral and funding sources, the media, and local and federal government officials can promote and distinguish your organization. Enclosed are some materials that will help you publicize this achievement.

Your organization's complimentary accreditation certificate will be sent separately. You may use the enclosed form to order additional certificates.

If you have any questions regarding your organization's accreditation or the QIP, you are encouraged to seek support from Daniel Miller by email at dmiller@carf.org or telephone at (888) 281-6531, extension 7129.

Ms. Huitt

2

April 19, 2016

CARF encourages your organization to continue fully and productively using the CARF standards as part of its ongoing commitment to accreditation. CARF commends your organization's commitment and consistent efforts to improve the quality of its program(s) and looks forward to working with your organization in its ongoing pursuit of excellence.

Sincerely,



Brian J. Boon, Ph.D.
President/CEO

Enclosures

BEHAVIORAL HEALTH AGENCY

Arkansas Department of Human Services

Division of Provider Services and Quality Assurance

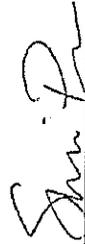
This certificate acknowledges the completion of the Arkansas State Certification Process

**SOUTH ARKANSAS REGIONAL HEALTH CENTER
211 JACKSON STREET SW
CAMDEN, AR 71701**

Dates of Certification: 06/30/2018 - 06/30/2019

Vendor Number: 11126

BHA License Number: 127



Sherri Proffer, RN

Assistant Director Community Services Licensure and Certification
Division of Provider Services and Quality Assurance



SUBSTANCE ABUSE TREATMENT

Arkansas Department of Human Services

Division of Provider Services and Quality Assurance

This certificate acknowledges the completion of the Arkansas State Certification Process

**SOUTH ARKANSAS REGIONAL HEALTH CENTER
211 JACKSON STREET SW
CAMDEN, AR 71701**

Dates of Certification: 07/23/2018 - 06/30/2019

Vendor Number: 11126 Specialty Vendor# 11119
BHA License Number: 127 Specialty Certificate # 152



Sherri Proffer, RN
Assistant Director Community Services Licensure and Certification
Division of Provider Services and Quality Assurance



EMAIL ADDRESS

For our records, please supply a facility email address below:

angela.huitt@sarhc.org

If there is an additional email address for the administrator, please supply below:

ARKANSAS STATE POLICE
Arkansas Criminal History Report

This report is based on a name search. There is no guarantee that it relates to the person you are interested in without fingerprint verification. This report includes a check of Arkansas files only. Inquiries into FBI files are not permitted for non-criminal justice or employment purposes without specific statutory authority.

Subject of Record

Last: **Pierce** First: **Regina** Middle: **Diane**
Date of Birth: **12/15/1955** Sex: **F** Race: **W**
Social Security Number: **429119351** (not verified, supplied at time of request)

- NO CRIMINAL HISTORY FOUND FOR THIS SUBJECT -

Requestor Information

Transaction Number: **002282285**
Date: **09/01/2017** Agency Reporting: **Arkansas State Police**
Purpose: **I am an employer legally doing business in the State of Arkansas**
Released To: **Geraldene Dollar**
Representing: **South Arkansas Regional Health Center, Inc.**
Mailing Address: **715 North College El Dorado, AR 71730**

This Arkansas criminal history record report should only be used for the purpose that it was requested. A request that is posed for a different purpose may result in more or less information being reported.

This report does not preclude the possible existence of additional records on this person which may not have been reported to the State Identification Bureau and Central Repository. Changes in a criminal history record can occur at any time due to new arrests and/or ongoing legal proceedings.

This Arkansas criminal background check report is for non-criminal justice purposes and may only reflect if a person has any Arkansas felony and misdemeanor conviction(s), any Arkansas felony arrest that occurred in the last three (3) years that has not been to court and whether the person is a registered sex offender or required to register as a sex offender. Juvenile arrest and/or court information will not be released on this report.



ARKANSAS STATE POLICE

ASP-122
(Rev. 12/10)

Identification Bureau STATE ONLY Individual Record Check Form FOR NON-MANDATED (RN, LPN, ETC.) EMPLOYEES (FOR ALL OTHER EMPLOYEES, COMPLETE THE DMS-736)

NATIONAL BACKGROUND CHECKS ARE NOT AVAILABLE ON "NON-MANDATED" EMPLOYEES

Full Name: REGINA Diane PIERCE Burton/Lavender
First Middle Last Name Maiden/Other

Date of Birth: 12/15/55 State of Birth: AR Race: Can Sex: F
(Month/Day/Year)

Social Security #: 429-11-9351 Driver's License #: 910638429AR
State

Mailing Address: 800 N. Euclid Ave.; El Dorado AR 71730
Street City State ZIP

Daytime Phone #: 870-1315-2912

I GIVE MY CONSENT FOR THE ARKANSAS STATE POLICE TO CONDUCT A CRIMINAL RECORD SEARCH ON MYSELF AND RELEASE ANY RESULTS TO THE FOLLOWING PERSON OR ENTITY:

Name: SOUTH ARKANSAS REGIONAL HEALTH CENTER
(First/MI/Last Name) or Full Name of Agency

Mailing Address: 715 N COLLEGE EL DORADO AR 71730
Street City State ZIP

Signature: Regina D. Pierce Date: 9/1/17
(First/MI/Last Name) (Month/Day/Year)

(REQUESTS WILL NOT BE PROCESSED WITHOUT A NOTARIZED SIGNATURE)

STATE OF Arkansas
COUNTY OF Union §

GERALDENE DOLLAR
UNION COUNTY
NOTARY PUBLIC - ARKANSAS
My Commission Expires October 6, 2025
Commission No. 12692439

Subscribed and sworn before me, a Notary Public, in and for the county and state aforesaid, this the 1st day of September, 2017

Geraldene Dollar
Notary Public

NATIONAL BACKGROUND CHECKS ARE NOT AVAILABLE ON "NON-MANDATED" EMPLOYEES

82005 Civil Record Check

Ag 67

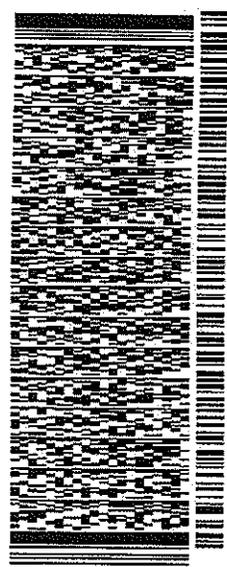
ORIGIN: IDELDA (870) 892-7921
KRISTI ROSE
SOUTH ARKANSAS REGIONAL HEALTH
715 N. COLLEGE AVENUE
EL DORADO, AR 71730
UNITED STATES US

SHIP DATE: 19FEB19
ACTWGT: 1.00 LB
CAD: 1669450/MET4100
BILL SENDER

TO: ELECTRONIC SUMMARY REQUEST
FBI CJIS DIVISION
1000 CUSTER HOLLOW ROAD

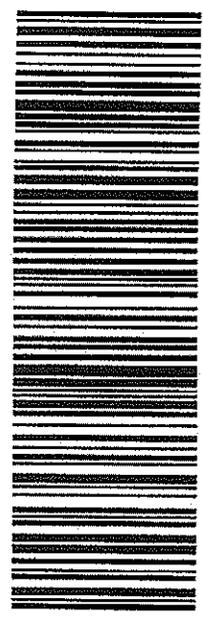
CLARKSBURG WV 26306
REF: (304) 625-5590
PO: 0997

565.2.0E3D23AD



TRK# 7745 0849 6643
WED - 20 FEB 3:00P
STANDARD OVERNIGHT

XH CKBA
WV-US
26306
PIT



After printing this label:

1. Use the 'Print' button on this page to print your label to your laser or inkjet printer.
2. Fold the printed page along the horizontal line.
3. Place label in shipping pouch and affix it to your shipment so that the barcode portion of the label can be read and scanned.

Warning: Use only the printed original label for shipping. Using a photocopy of this label for shipping purposes is fraudulent and could result in additional billing charges, along with the cancellation of your FedEx account number.

Use of this system constitutes your agreement to the service conditions in the current FedEx Service Guide, available on fedex.com. FedEx will not be responsible for any claim in excess of \$100 per package, whether the result of loss, damage, delay, non-delivery, misdelivery, or misinformation, unless you declare a higher value, pay an additional charge, document your actual loss and file a timely claim. Limitations found in the current FedEx Service Guide apply. Your right to recover from FedEx for any loss, including intrinsic value of the package, loss of sales, income interest, profit, attorney's fees, costs, and other forms of damage whether direct, incidental, consequential, or special is limited to the greater of \$100 or the authorized declared value. Recovery cannot exceed actual documented loss. Maximum for items of extraordinary value is \$1,000, e.g. jewelry, precious metals, negotiable instruments and other items listed in our Service Guide. Written claims must be filed within strict time limits, see current FedEx Service Guide.

Proof of Federal Criminal Record Check that's been sent to FBI. Meets requirement per Sherri Proffer. Will send report results as soon as I receive them.

Attachment P

APPLICANT

700001001209

LEAVE BLANK

TYPE OR PRINT ALL INFORMATION IN BLACK
LAST NAME NAM FIRST NAME MIDDLE NAME

PIERCE, REGINA

FBI LEAVE BLANK

Ag 48

SIGNATURE OF PERSON FINGERPRINTED

Regina Pierce

ALIASES AKA

O
R
I

AR0700000
SO

DATE OF BIRTH DOB
Month Day Year
12/15/1955

RESIDENCE OF PERSON FINGERPRINTED

, AR

CITIZENSHIP CITZ

SEX F RACE W HGT 506 WGT 200 EYES GRN HAIR BRO

PLACE OF BIRTH POB
AR

DATE
20190201

SIGNATURE OF OFFICIAL TAKING FINGERPRINTS

Tim Wally

US

YOUR NO. OCA

LEAVE BLANK

EMPLOYER AND ADDRESS

FBI NO. FBI

CLASS _____

ARMED FORCES NO. MNU

REF. _____

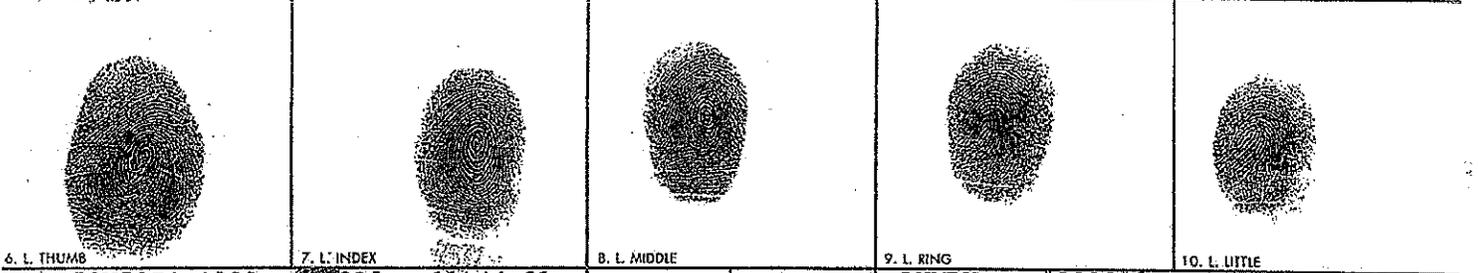
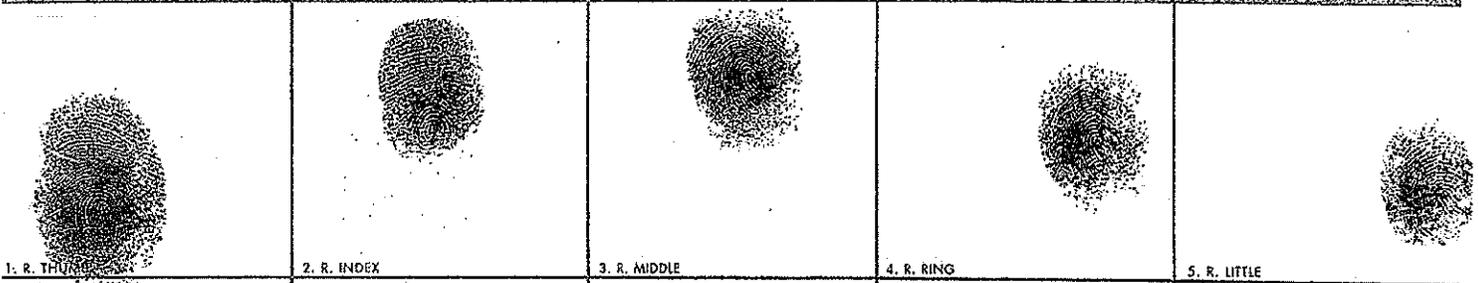
REASON FINGERPRINTED

APPLICANT

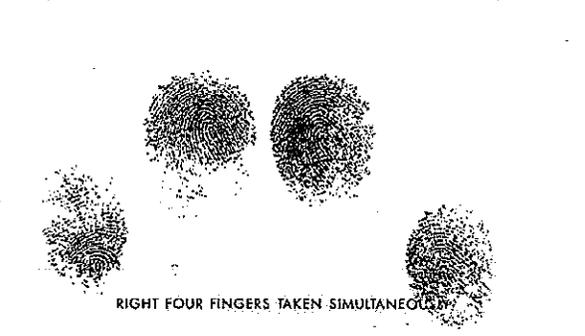
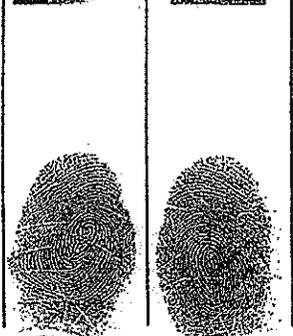
SOCIAL SECURITY NO. SOC

429-11-9351

MISCELLANEOUS NO. MNU



PT 50X50G4 4000 11:44:01 LXMRK #000000 20190215-15:24

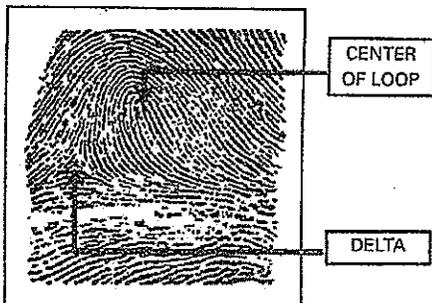


FEDERAL BUREAU OF INVESTIGATION
UNITED STATES DEPARTMENT OF JUSTICE
CJIS DIVISION / CLARKSBURG, WV 26306

Attachment 4
pg 69

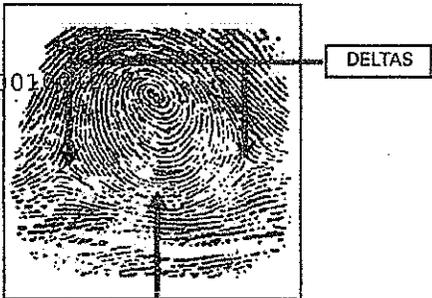
APPLICANT

1. LOOP



THE LINES BETWEEN CENTER OF LOOP AND DELTA MUST SHOW

2. WHORL



THESE LINES RUNNING BETWEEN DELTAS MUST BE CLEAR

3. ARCH



ARCHES HAVE NO DELTAS

TO OBTAIN CLASSIFIABLE FINGERPRINTS:

1. USE BLACK PRINTER'S INK.
2. DISTRIBUTE INK EVENLY ON INKING SLAB.
3. WASH AND DRY FINGERS THOROUGHLY.
4. ROLL FINGERS FROM NAIL TO NAIL, AND AVOID ALLOWING FINGERS TO SLIP.
5. BE SURE IMPRESSIONS ARE RECORDED IN CORRECT ORDER.
6. NOTE IN THE APPROPRIATE FINGER BLOCKS IF APPLICANT IS MISSING ONE OR MORE FINGERS FOR ANY REASON. IF NOT MISSING, ALL TEN IMPRESSIONS MUST BE PROVIDED WITH SCARS AND DEFORMITIES NOTATED.
7. IF SOME PHYSICAL CONDITION MAKES IT IMPOSSIBLE TO OBTAIN PERFECT IMPRESSIONS, SUBMIT THE BEST THAT CAN BE OBTAINED.
8. EXAMINE THE COMPLETED PRINTS TO SEE IF THEY CAN BE CLASSIFIED, BEARING IN MIND THAT MOST FINGERPRINTS FAIL INTO THE PATTERNS SHOWN ON THIS CARD (OTHER PATTERNS OCCUR INFREQUENTLY AND ARE NOT SHOWN HERE).

THIS CARD FOR USE BY:

LEAVE THIS SPACE BLANK

1. LAW ENFORCEMENT AGENCIES IN FINGERPRINTING APPLICANTS FOR LAW ENFORCEMENT POSITIONS.*
2. OFFICIALS OF STATE AND LOCAL GOVERNMENTS FOR PURPOSES OF EMPLOYMENT, LICENSING, AND PERMITS, AS AUTHORIZED BY STATE STATUTES AND APPROVED BY THE ATTORNEY GENERAL OF THE UNITED STATES. LOCAL AND COUNTY ORDINANCES, UNLESS SPECIFICALLY BASED ON APPLICABLE STATE STATUTES DO NOT SATISFY THIS REQUIREMENT.*
3. U.S. GOVERNMENT AGENCIES AND OTHER ENTITIES REQUIRED BY FEDERAL LAW.**
4. OFFICIALS OF FEDERALLY CHARTERED OR INSURED BANKING INSTITUTIONS TO PROMOTE OR MAINTAIN THE SECURITY OF THOSE INSTITUTIONS.

INSTRUCTIONS:

1. PRINTS MUST FIRST BE CHECKED THROUGH THE APPROPRIATE STATE IDENTIFICATION BUREAU, AND ONLY THOSE FINGERPRINTS FOR WHICH NO DISQUALIFYING RECORD HAS BEEN FOUND LOCALLY SHOULD BE SUBMITTED FOR FBI SEARCH.
 2. PRIVACY ACT OF 1974 (P.L. 93-579) REQUIRES THAT FEDERAL, STATE, OR LOCAL AGENCIES INFORM INDIVIDUALS WHOSE SOCIAL SECURITY NUMBER IS REQUESTED WHETHER SUCH DISCLOSURE IS MANDATORY OR VOLUNTARY, BASIS OF AUTHORITY FOR SUCH SOLICITATION, AND USES WHICH WILL BE MADE OF IT.
 3. IDENTITY OF PRIVATE CONTRACTORS SHOULD BE SHOWN IN SPACE "EMPLOYER AND ADDRESS". THE CONTRIBUTOR IS THE NAME OF THE AGENCY SUBMITTING THE FINGERPRINT CARD TO THE FBI.
 4. FBI NUMBER, IF KNOWN, SHOULD ALWAYS BE FURNISHED IN THE APPROPRIATE SPACE.
- MISCELLANEOUS NO. - RECORD: OTHER ARMED FORCES NO., PASSPORT NO. (PP), ALIEN REGISTRATION NO. (AR), PORT SECURITY CARD NO. (PS), SELECTIVE SERVICE NO. (SS), VETERANS' ADMINISTRATION CLAIM NO. (VA).

Attachment
Pg 70

Geraldene Dollar

From: Regina Pierce
Sent: Tuesday, February 12, 2019 4:09 PM
To: Geraldene Dollar
Subject: FW: Identity History Summary Request Confirmation

From: Criminal Justice Information Services [mailto:edo@services.fbi.gov]
Sent: Tuesday, February 12, 2019 4:04 PM
To: Regina Pierce <regina.pierce@SARHC.org>
Subject: Identity History Summary Request Confirmation

Your Identity History Summary Request has been accepted and will be processed in the date order in which it was received.

Regina Diane Pierce
Your Order number is: D49709919043
Your payment verification code is: 26FCJSH9

You indicated your fingerprints would be delivered by: MAIL

Please refer to the following details when submitting your fingerprints:

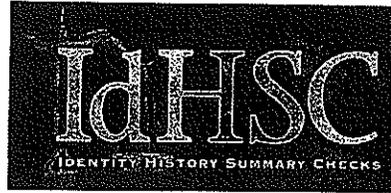
If delivering your fingerprints via Mail, please send your completed fingerprint card along with a copy of this confirmation email to:

FBI CJIS Division
ATTN: ELECTRONIC SUMMARY REQUEST
1000 Custer Hollow Road
Clarksburg, West Virginia 26306

If you have any questions regarding this e-mail contact 304-625-5590 or identity@fbi.gov

This message has been transmitted to you by the FBI Criminal Justice Information Services Division. If you are not the intended recipient of this message, please destroy it promptly without any retention, dissemination, or reproduction (unless required by law), and please notify the sender of the error immediately by separate e-mail to identity@fbi.gov or by calling the Customer Service Group at 304-625-5590.

This is an automated message. Please do not reply to this e-mail.



Need Assistance? [Click Here.](#)

Current processing time for Identity History Summary requests submitted electronically is estimated to be three to five business days upon receipt of the fingerprint card. Allow additional time for mail delivery if this option was selected during the request process.

****We are currently experiencing issues with Google Chrome and Safari browsers. We recommend that Internet Explorer or Mozilla Firefox be used to submit requests to obtain or challenge your Identity History Summary Information.****

Overview

For a fee, the FBI can provide individuals with an Identity History Summary, often referred to as a criminal history record or a "rap sheet," listing certain information taken from fingerprint submissions kept by the FBI and related to arrests and, in some instances, federal employment, naturalization, or military service.

If the fingerprint submissions are related to an arrest, the Identity History Summary includes the name of the agency that submitted the fingerprints to the FBI, the date of the arrest, the arrest charge, and the disposition of the arrest, if known. All arrest information included in an Identity History Summary is obtained from fingerprint submissions, disposition reports, and other information submitted by authorized criminal justice agencies.

The U.S. Department of Justice Order 556-73, also known as Departmental Order, establishes rules and regulations for you to obtain a copy of your Identity History Summary for review or proof that one does not exist.

Only you may request a copy of your own Identity History Summary (or proof that one does not exist). You would typically make this request for personal review, to challenge information on record, to meet a requirement for adopting a child, or to meet a requirement to live, work, or travel in a foreign country.

Obtaining Your Identity History Summary

Identity History Summary Checks For Employment Or Licensing

If you are requesting a background check for employment or licensing within the U.S., you may be required by state statute or federal law to submit your request through your state identification bureau, the requesting federal agency, or another authorized channeling agency. The FBI's authority to conduct an Identity History Summary check for noncriminal justice purposes is based upon Public Law (Pub. L.) 92-544. Pursuant to that law, the FBI is empowered to exchange Identity History Summary information with officials of state and local governments for employment, licensing — which includes volunteers — and other similar noncriminal justice purposes, if authorized by a state statute which has been approved by the Attorney General of the United States. The U.S. Department of Justice has advised that the state statute establishing guidelines for a category of employment or the issuance of a license must, in itself, require fingerprinting and authorize the governmental licensing or employing agency to exchange fingerprint data directly with the FBI.

Pg 12

An Identity History Summary search obtained pursuant to U.S. Department of Justice Order 556-73 may not meet employment requirements. Governmental licensing or employing agencies covered by federal laws and/or state statutes may refuse to accept Identity History Summary information directly from the subject of the summary, as there would be no way to verify that the information contained on the summary had not been altered. Also, an Identity History Summary provided to the subject for personal review contains only information maintained by the FBI and may lack dispositional data and/or arrest records that are maintained only at the state level.

How To Submit A Request

An e-mail address must be provided in order to initiate the application process. A secure link, along with a personal identification number, will be sent to the specified address and will be used to complete the online application. The same secure link and personal identification number will be used to check the status of your application and to access your results. You may optionally elect to have your results sent to you by First-Class Mail via the U.S. Postal Service.

Please select each step below to view additional information. Enter your e-mail address below to start the Identity History Summary Check process.

- Step 1: Complete the Applicant Information Form () >
- Step 2: Select Your Preferences () >
- Step 3: Submit Your Fingerprints () >

You may mail your completed fingerprint card along with a copy of your confirmation e-mail to:

FBI CJIS Division
ATTN: ELECTRONIC SUMMARY REQUEST
1000 Custer Hollow Road
Clarksburg, WV 26306

- The FBI will process your request upon receipt of your completed fingerprint card in the date order it was received.
- Your fingerprints should be placed on a standard fingerprint form (FD-258) (artifacts/standard-fingerprint-form-fd-258-1.pdf) commonly used for applicant or law enforcement purposes. The FBI will accept FD-258 fingerprint cards on standard white paper stock.
- You must provide a current fingerprint card. Previously processed cards or copies will not be accepted.
- Your name and date of birth must be provided on the fingerprint card.
- You must include rolled impressions of all 10 fingerprints and impressions of all 10 fingerprints taken at the same time (these are sometimes referred to as plain or flat impressions). If possible, have your fingerprints taken by a fingerprinting technician. This service may be available at a law enforcement agency.
- Fingerprints taken with ink or via live scan are acceptable. If your fingerprints are taken via a live scan device, a hard-copy must be generated so the fingerprint card can be mailed to the FBI.
- To ensure the most legible prints possible, refer to the Recording Legible Fingerprints (<https://www.fbi.gov/services/cjis/fingerprints-and-other-biometrics/recording-legible-fingerprints>) page. If fingerprints are not legible, the fingerprint card will be rejected. This could cause delays in processing and could also result in additional fees.
- The name on your response letter will match the name that you entered on your electronic DO request.
- If the last four digits of your Social Security number are needed on your response letter, then please ensure the full nine-digit or last four digits of your Social Security number is on the fingerprint card when submitting your request.

- Step 4: Submit Payment () >
- Step 5: Review and Confirm Your Request () >
- Step 6: Check Request Status () >
- Step 7: Receive Your Results () >

Enter your e-mail address to get started!

Challenging Your Identity History Summary Or Your Firearm-Related Denial

The FBI is responsible for the storage of fingerprints and related Identity History Summary information for the nation and does not have the authority to modify any Identity History Summary information unless specifically notified to do so by the agency that owns the information. If you believe your Identity History Summary contains inaccurate or incomplete information, you may request a change or correction to your Identity History Summary information.

Challenge Your Identity History Summary: To challenge your Identity History Summary, you must provide either your FBI Universal Control Number (FBI Number) from your Identity History Summary or your State Identification Number (SID) from your state criminal history record. If providing your SID, you must include the two-letter state abbreviation for the state in which your offense occurred. Please select each step below to view additional information. Enter your e-mail address below to start the challenge process.

Challenge Your Firearm-Related Denial: To challenge your firearm-related denial, you must provide either a NICS Transaction Number (NTN), which is a unique number assigned to each valid firearm-related background check inquiry received by the FBI; or a State Transaction Number (STN), which is a unique number assigned by a State Point of Contact to a valid firearm-related background check inquiry. If you are not already in possession of your NTN or STN, you must contact the Federal Firearm Licensee (FFL) or state agency who initiated your firearm-related background check and request the applicable identifier. Please select each step below to view additional information. Enter your e-mail address below to start the challenge process. Click here for more information on challenging your firearm-related denial.

- Step 1: Complete the Challenge Information Form () >
- Step 2: Select Your Preferences () >
- Step 3: Submit Your Fingerprints to Challenge Your Firearm-Related Denial () >
- Step 4: Upload Supporting Documents () >
- Step 5: Review and Confirm Your Request () >
- Step 6: Check Request Status () >
- Step 7: Receive Your Results () >

Enter your e-mail address to get started!

Enter your e-mail address

Request for Taxpayer Identification Number and Certification

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

► Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type.
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.
South Arkansas Regional Health Center, Inc

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

Individual/sole proprietor or single-member LLC

Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Other (see instructions) ► **Non-Profit**

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.
715 N College Ave

6 City, state, and ZIP code
El Dorado, AR 71730

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.

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

Social security number

			-			-				
--	--	--	---	--	--	---	--	--	--	--

OR

Employer identification number

7	1	-	0	3	8	8	0	1	2
---	---	---	---	---	---	---	---	---	---

Part II Certification

Under penalties of perjury, I certify that:

- 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
- 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
- I am a U.S. citizen or other U.S. person (defined below); and
- 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 ► *Joseph Rose*

Date ► *2-22-19*

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.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
 - Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
 - Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
 - Form 1099-S (proceeds from real estate transactions)
 - Form 1099-K (merchant card and third party network transactions)
 - Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
 - Form 1099-C (canceled debt)
 - Form 1099-A (acquisition or abandonment of secured property)
- Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.

MEMORANDUM OF AGREEMENT

This Memorandum of Agreement is made on 03/07/2019 by and between Birch Tree Communities, Inc., 1781 Old Hot Springs Highway, Benton, Arkansas, 72018, and South Arkansas Regional Healthcare System, Inc., 715 North College Avenue, El Dorado, AR 71730. The parties hereby bind themselves to undertake a Memorandum of Agreement ("Agreement") under the following terms and conditions:

TERM. The term of this Agreement shall be one year unless terminated sooner in accordance with the terms of the Agreement (the "Term").

GOALS AND OBJECTIVES. South Arkansas Regional Healthcare System Inc. is enlisting the help of Birch Tree Communities, Inc. to provide "Therapeutic Community" services for Adult clients with a Serious Mental Illness as defined by the Arkansas Department of Behavioral Health in the state contract with Community Mental Health Centers. The parties of this agreement shall abide by the terms of this agreement to achieve the following goals and objectives:

OBLIGATIONS OF THE PARTIES.

Birch Tree Communities, Inc., shall perform the following obligations:

The process for evaluation will be established between each CMHC and TC provider, specifying the medium of exchange, the form of notification of unsuitability, and individuals to be notified. The response time to notification of unsuitability by a provider shall be no later than forty-eight hours. If the response time is longer then the provider may begin billing at 1.5 times the billing rate after the forty-eight-hour period.

South Arkansas Regional Healthcare System shall perform the following obligations:

Pre-Tiering Requirements

Prior to the acceptance of a member by a licensed Therapeutic Communities provider ("provider" or "TC Provider") the member must be appropriately tiered as either Level 1 or Level 2 ("TC 1" and "TC 2") as defined in the Arkansas Department of Human Services Therapeutic Communities Certification Manual or the equivalent of a TC 1 or TC 2 member as outlined by any of the Arkansas Provider-Led Shared Savings Entities ("PASSEs").

If a referred member has not been tiered, then providers have the option to deny admission into a TC 1 or TC 2 program until the member has been tiered. Alternatively, the referring Community Mental Health Center ("CMHC") may offer to reimburse the TC provider for the days not tiered until the date of tier at the rate determined by the DHS or PASSE billing manuals for the appropriate level of care. This agreement shall be in writing. The TC provider has the right to deny this request.

Evaluation Term

A provider is granted an evaluation term of thirty days in which the provider may determine whether a member is an appropriate fit for the Therapeutic Communities ("TC") program. A provider also has the right to deny acceptance of a member, tiered or non-tiered, without a thirty-day evaluation. If a member has been accepted by a TC program and deemed unsuitable then the referring CMHC must

re-admit the member or make plans to admit the member to a new program no later than seven calendar days after the thirty-day evaluation term ends.

The TC provider shall be reimbursed for each day during the evaluation term at the rate determined by the DHS or PASSE billing manuals for the appropriate level of care. If a member is still in the care of a TC program after the thirty-day evaluation period and the member has been deemed unsuitable then the TC provider may bill at 1.5 times the billing rate so long as the member remains under the provider's care.

Medicaid Eligibility Status

A TC provider may deny a referral of a member that has no Medicaid, Medicare or private health insurance coverage. A TC provider also has the option to deny a member if the member is in the Medicaid Spend Down program. Alternatively, if the provider accepts a Spend Down member then the CMHC must reimburse the TC provider for services performed by the TC provider that must be delivered to activate Medicaid for that member.

These "uncovered services" required to activate Medicaid are recurring and vary based on the member's income. Once the amount of uncovered services meets the Medicaid threshold that activates coverage, that member will have a window of active Medicaid coverage for three months. After this period then the coverage expires, and the member must again meet the threshold to activate Medicaid coverage. As long as the member is under the provider's care and is not referred back to a CMHC then the provider will continue to be reimbursed for uncovered services by the CMHC.

CONFIDENTIALITY. Subject to sub-clause (2) below, each party shall treat as strictly confidential all information received or obtained as a result of entering into or performing this Agreement.

Each party may disclose information which would otherwise be confidential if and to the extent:

- (i) required by the law of any relevant jurisdiction;
- (ii) the information has come into the public domain through no fault of the party; or
- (iii) the other party has given prior written approval to the disclosure, provided that any such information disclosed shall be disclosed only after consultation with and notice to the other party.

REPRESENTATIONS AND WARRANTIES. Each party to this Agreement represents and warrants to the other party that it:

- (a) has full power, authority, and legal right to execute and perform this Agreement;
- (b) has taken all necessary legal and corporate action to authorize the execution and performance of this Agreement.

MEMORANDUM OF AGREEMENT SUMMARIZATION.

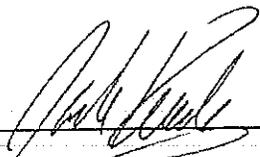
Furthermore, the parties to this Agreement have mutually acknowledged and agreed to the following:

- The parties to this Agreement shall work together in a cooperative and coordinated effort, and in such in manner and fashion to bring about the achievement and fulfillment of the goals and objectives of this partnership.
- It is not the intent of this Agreement to restrict the parties to this agreement from their involvement or participation with any other public or private individuals, agencies or organizations.
- The parties to this Agreement shall mutually contribute and take part in any and all phases of the planning and development of this partnership, to the fullest extent possible.
- It is the intent or purpose of this Agreement to create any rights, benefits and/or trust responsibilities by or between the parties.
- The Agreement shall in no way hold or obligate either party to supply or transfer funds to maintain and/or sustain the partnership
- Should there be any need or cause for the reimbursement or the contribution of any funds to or in support of the partnership, it shall then be controlled in accordance with Arkansas governing laws, regulations and/or procedures.
- In the event that contributed funds should become necessary, any such endeavor shall be outlined in a separate and mutually agreed upon written agreement by the parties or representatives of the parties in accordance with current governing laws and regulations, and in no way does this Agreement provide such right or authority.
- The Parties to this Agreement have the right to individually or jointly terminate their participation in this Agreement provided that advanced written notice is delivered to the other party.
- Upon the signing of this Agreement by both parties, this Agreement shall be in full force and effect.

AUTHORIZATION AND EXECUTION.

The signing of this Memorandum of Agreement does not constitutes a formal undertaking, and as such it simply intends that the signatories shall strive to reach, to the best of their abilities, the goals and objectives stated in this MOU.

This agreement shall be signed by Birch Tree Communities, Inc., and South Arkansas Regional Healthcare System, Inc. and shall be effective as of the date first written above.

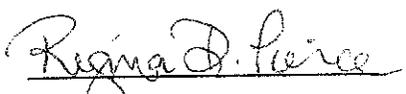


 First Party Signature

3/7/19

 Date

Birch Tree Communities, Inc.



 Second Party Signature

3/7/19

 Date

South Arkansas Regional Healthcare System, Inc.

South Arkansas Regional Health Center, Inc

Attachment

**Memorandum of Agreement Between
Mid South Health Systems, Inc. and
South Arkansas Regional Health Center, Inc.**

WHEREAS, Mid-South Health Systems, Inc.(MSHS) is a non-profit community mental health center serving persons with mental illness in Northeast Arkansas; and

WHEREAS, South Arkansas Regional Health Center, Inc. (Provider) is also a non-profit community mental health center serving persons with mental illness in South Arkansas; and

WHEREAS, both entities have similar interests in meeting the needs of Arkansas' citizens and wish to be able to utilize resources of each other;

NOW THEREFORE, both MSHS and Provider agree to the following:

1. Each party is familiar with the services offered by the other party and shall exchange specific contact information in order for each party to make referrals to the other party.
2. Provider shall, where appropriate, refer individuals to MSHS as needed for the service of Therapeutic Communities, Level 1 and Level 2.
3. This agreement does not create any on-going obligation, financial or otherwise, to the other party but merely creates a relationship for purposes of referrals.

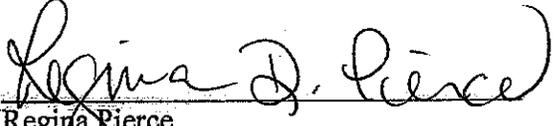
AGREED, this the 11th day of March, 2019.



Ruth Allison Dover
Mid South Health Systems

3/11/19

Date



Regina Pierce
South Arkansas Regional Health Center, Inc.

3/11/19

Date

Memorandum of Agreement Between
South Arkansas Regional Health Center and
Ouachita Behavioral Health and Wellness

Attachment 5

WHEREAS, South Arkansas Regional Health Center, (SARHC) is a non-profit community mental health center serving persons with mental illness in South Arkansas; and

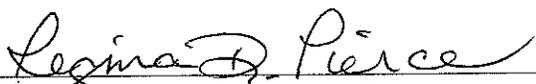
WHEREAS, Ouachita Behavioral Health and Wellness (OBHAW) is also a non-profit community mental health center serving persons with mental illness in Central Arkansas; and

WHEREAS, both entities have similar interests in meeting the needs of Arkansas' citizens and wish to be able to utilize resources of each other;

NOW THEREFORE, both SARHC and OBHAW agree to the following:

1. Each party is familiar with the services offered by the other party and shall exchange specific contact information in order for each party to make referrals to the other party.
2. SARHC shall, where appropriate, refer individuals to OBHAW as needed for the service of Partial Hospitalization.
3. This agreement does not create any on-going obligation, financial or otherwise, to the other party but merely creates a relationship for purposes of referrals.

AGREED, this the 8th day of March, 2019.



 Regina D. Pierce, LCSW, CEO
 South Arkansas Regional Health Center

3/8/19

 Date



 Robert Gershon, Ph.D., CEO
 Ouachita Behavioral Health and Wellness

3/8/19

 Date

Acute Crisis Unit Contract

Service and Affiliation Agreement

This contractual agreement is made and entered into this ____ day of _____, 20____, by and between _____ (hereinafter referred to as "Contractor") and _____ (hereinafter referred to as "Provider.")

WHEREAS, South Arkansas Regional Health Center is a non-profit community mental health center and is desirous of contracting with the Provider to provide crisis stabilization services to adult residents of its catchment area who are in need of sub-acute stabilization treatment for mental illness and have been evaluated by Single Point of Area (SPOE) assessment, and

WHEREAS, the Provider has Crisis Unit facilities and staff which can provide such services in a safe, sub-acute crisis unit to referred patients and has agreed to accept appropriate referrals for crisis care.

NOW, THEREFORE, it is hereby mutually agreed by and between the parties of this Service and Affiliation Agreement as follows:

1. **Term:** The initial term of this Service and Affiliation Agreement shall be for a period of one year and may be automatically renewed each year unless indicated otherwise in writing at anytime by either party with a 30 day notice.
2. **Services:** Provider agrees to provide all inclusive services, including sub-acute crisis stabilization, psychiatry, laboratory, and pharmacy to mutually agreed upon patients who are initially referred by the Contractor, in a manner that is consistent with the communities' prevailing psychiatric practice as space is available on a first come, first served basis. Daily all inclusive services cost is \$350.00.
3. **Medically stable:** All patients referred by Contractor from a medical facility must be determined medically stable by physician before they are accepted for treatment by the Provider. All patients routinely receive a physical and psychiatric evaluation upon admission to the Provider; however, it is understood that Provider is contracting for the provision of mental health services only and not for the treatment of non-psychiatric disorders on its psychiatric unit. Therefore, Provider will accept only patients with minor medical problems (or no medical problems) for treatment at its crisis unit. Provider retains the freedom to request medical clearance in cases in which the patient's medical condition may be compromised.
4. **Continuity of services:** The Provider and Contractor agree to expend all necessary efforts to promote continuity of services. The Contractor will have a

designated staff person who will have regular telephonic contact and/or meetings with a designated Provider staff in order to evaluate the status of referred patients and to facilitate discharge planning. The Provider agrees to initiate all discharge planning activities for Contractor referred patients with Contractor personnel. The Provider will provide Contractor with patients' discharge summaries including current medications within 48 hours of discharge. Follow up appointments must be set prior to discharge with the Contractor.

5. **Medical records:** Appropriate patient records (subject to state and federal laws in compliance with HIPAA) will be readily transferable between parties when a patient is referred or admitted to the other party. The referring party previously responsible for the care of the patient will also be readily available to provide consultation and other assistance to the staff of the receiving party and vice versa.
6. **Licensing:** Provider's program services shall be licensed by the Arkansas Department of Health Division of Facilities Services and Arkansas Division of Provider Services and Quality Assurance, which shall meet the State's regulations for program structure and facility design.
7. **Indigent contract services:** The Provider agrees to provide sub-acute Crisis Unit stabilization treatment for indigent patients (as designated by the Division of Mental Health Services in Arkansas for the uninsured: below 200% of the designated poverty level) referred by the Contractor. (It is understood that "Indigents" with probability of needing extensive inpatient treatment beyond acute stabilization will/may not be appropriate for referral to Provider but will either be directed where longer term care is provided or will be expected to transfer from Provider to another appropriate facility when/as appropriate.) Provider and Contractor shall work cooperatively in initiating application for SSI/SSD or Medicaid Spenddown whenever possible. Any subsequent reimbursements by Medicaid or other third party sources may be used by the Provider to offset any unpaid days.
8. **Utilization review:** Provider shall work cooperatively with Contractor in the management of Contractor's indigent patient days. In the event the Contractor's representative determines the patient no longer meets criteria for stabilization, the Contractor shall either provide appropriate disposition to another treatment facility or outpatient setting. The mutual objective will be for minimum necessary length of stay and authorization may be applied as indicated.
9. **Involuntary commitments:** Provider agrees to provide follow up as the law permits/directs for involuntarily committed patients (or as courts direct or permit) in accordance with Arkansas Acts 861, 10, and 911 for follow up in appropriate court system under Sections 5, 9, and 10 of Act 861 if the situation is warranted.
10. **Relationship of parties:** The relationship of Provider to Contractor shall be that of an independent contractor.

- 11. **Program rules:** The Contractor's staff and attending physicians agree to abide by the policies and procedures of Provider and vice versa.
- 12. **Modifications:** Any modification or changes to this agreement must be made in writing and approved by the parties.
- 13. **Termination:** Provider or Contractor may terminate this agreement with thirty (30) days written notice to the other party with or without cause.
- 14. **Medication:** In addition to inpatient psychiatric unit services, medication access plans will be attempted by Provider for all patients. Provider will provide assistance and planning where able via MD/pharmaceutical company programs and in cooperation with Contractor as indicated. Provider cannot be responsible for medication costs post discharge beyond a minimum necessary transition planning time and will require cooperation from Contractor for continued needed medication access planning.
- 15. **Standards of conduct:** Contractor recognizes that it is essential to the core values of Provider that Provider at all times conduct itself in compliance with the highest standards of business ethics and integrity and applicable legal requirements. Contractor acknowledges and hereby agrees that so long as this Agreement remains in effect, Provider shall act in a manner consistent with, and shall at times abide by, such standards of conduct.
- 16. **Other regulations:** Provider and Contractor agree to abide by all relevant and applicable state and federal laws and regulations regarding the treatment and communications related to mutual patients.

IN WITNESS WHEREOF, this Service and Affiliation Agreement has been executed as of the date and year written above.

CONTRACTOR

By: _____

Title: _____

Date: _____

PROVIDER

By: _____

Title: _____

Date: _____

State of Arkansas
DEPARTMENT OF HUMAN SERVICES
700 South Main Street
P.O. Box 1437 / Slot W345
Little Rock, AR 72203
501-320-6511

ADDENDUM 1

DATE: February 25, 2019

SUBJECT: 710-19-1024 Crisis and Forensic Mental Health Services

The following change(s) to the above referenced Invitation for Bid for DHS has been made as designated below:

Change of specification(s)

- Additional specification(s)
 Change of bid opening date and time
 Cancellation of bid
 Other – Removing the following language from section 2.3.2 C, page 26, of the RFQ.

* Information provided on forensic services is under review and may be subject to revision for future posting.

BID OPENING DATE AND TIME

Bid opening date and time **will not be changed.**

BIDS WILL BE ACCEPTED UNTIL THE TIME AND DATE SPECIFIED. THE BID ENVELOPE MUST BE SEALED AND SHOULD BE PROPERLY MARKED WITH THE BID NUMBER, DATE AND HOUR OF BID OPENING AND BIDDER'S RETURN ADDRESS. IT IS NOT NECESSARY TO RETURN "NO BIDS" TO THE DEPARTMENT OF HUMAN SERVICES.

If you have questions, please contact the buyer at nawania.williams@dhs.arkansas.gov or 501-320-6511

Regina D. Peice
Vendor Signature

2/19/2019
Date

South Arkansas Regional Health Center, Inc.
Company