BID RESPONSE PACKET
710-19-1033RR

BID SIGNATURE PAGE

Type or Print the following information.

PROSPECTIVE CONTRACTOR'S INFORMATION					
Company:	Michael E Wyrick PhD				
Address:	1420 Longview Drive				
City:	Booneville	State:	AR	Zip Code:	72927
Business Designation:	☒ Individual ☐ Partnership	☐ Sole Proprietorship ☐ Corporation		☐ Public Service Corp ☐ Nonprofit	
Minority and Women-Owned Designation*:	☒ Not Applicable ☐ African American	☐ American Indian ☐ Hispanic American	☐ Asian American ☐ Pacific Islander American	☐ Service Disabled Veteran ☐ Women-Owned	
	AR Certification #: ____________	* See *Minority and Women-Owned Business Policy*			

PROSPECTIVE CONTRACTOR CONTACT INFORMATION *Provide contact information to be used for bid solicitation related matters.*			
Contact Person:	Michael E Wyrick	Title: PhD	
Phone:	479675 6392	Alternate Phone:	
Email:	mikewy@centurytel.net		

CONFIRMATION OF REDACTED COPY

☐ YES, a redacted copy of submission documents is enclosed.

☐ NO, a redacted copy of submission documents is not enclosed. I understand a full copy of non-redacted submission documents will be released if requested.

Note: If a redacted copy of the submission documents is not provided with Prospective Contractor's response packet, and neither box is checked, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA). See Bid Solicitation for additional information.

ILLEGAL IMMIGRANT CONFIRMATION

By signing and submitting a response to this *Bid Solicitation*, a Prospective Contractor agrees and certifies that they do not employ or contract with illegal immigrants. If selected, the Prospective Contractor certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract.

ISRAEL BOYCOTT RESTRICTION CONFIRMATION

By checking the box below, a Prospective Contractor agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.

☐ Prospective Contractor does not and will not boycott Israel.

An official authorized to bind the Prospective Contractor to a resultant contract must sign below.

The signature below signifies agreement that any exception that conflicts with a Requirement of this *Bid Solicitation* **will cause the Prospective Contractor's bid to be disqualified:**

Authorized Signature: [signature] *Use Ink Only.* **Title:** PhD

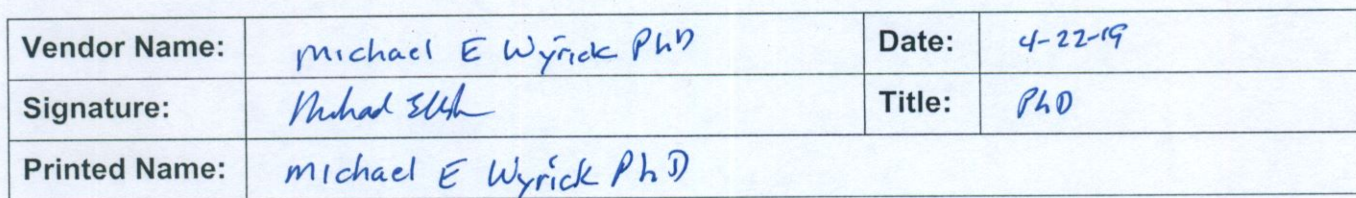
Printed/Typed Name: Michael E Wyrick **Date:** 4-22-19

SECTION 1 - VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*

- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.



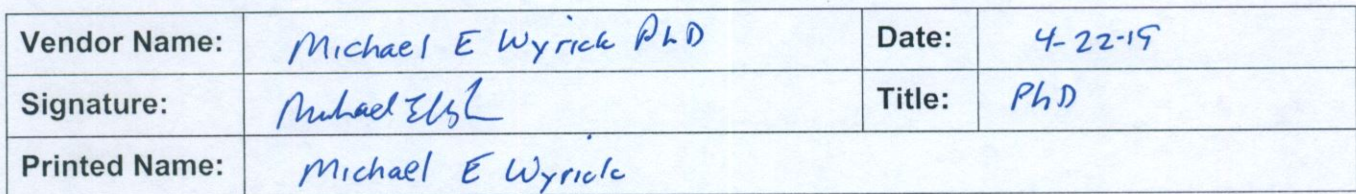
Vendor Name:	Michael E Wyrick PhD	**Date:**	4-22-19
Signature:	Michael E Wyrick	**Title:**	PhD
Printed Name:	Michael E Wyrick PhD		

SECTION 2 - VENDOR AGREEMENT AND COMPLIANCE

- *Any requested exceptions to items in this section which are NON-mandatory **must** be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.*

- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.



Vendor Name:	Michael E Wyrick PhD	**Date:**	4-22-19
Signature:	Michael E Wyrick	**Title:**	PhD
Printed Name:	Michael E Wyrick		

SECTION 3 - VENDOR AGREEMENT AND COMPLIANCE

- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

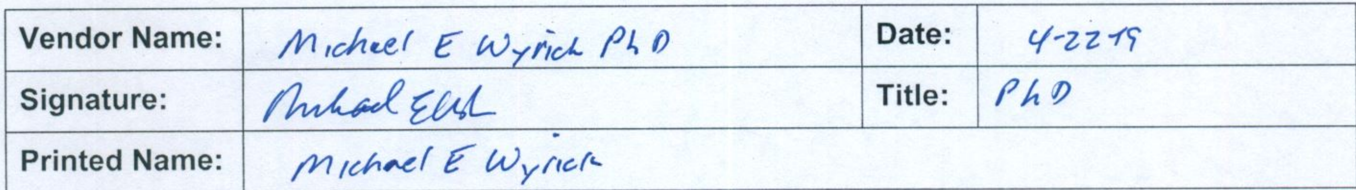
By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

Vendor Name:	Michael E Wyrick PhD	Date:	4-22-19
Signature:	[signature]	Title:	PhD
Printed Name:	michael E Wyrick		

SECTION 4 - VENDOR AGREEMENT AND COMPLIANCE

- *Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.



Vendor Name:	Michael E Wyrick PhD	**Date:**	4-22-19
Signature:	Michael E Wyrick	**Title:**	PhD
Printed Name:	Michael E Wyrick		

PROPOSED SUBCONTRACTORS FORM

- ***Do not*** *include additional information relating to subcontractors on this form or as an attachment to this form.*

PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.

Type or Print the following information

Subcontractor's Company Name	Street Address	City, State, ZIP

☒ **PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

By signature below, vendor agrees to and **shall** fully comply with all Requirements related to subcontractors as shown in the bid solicitation.

Vendor Name:	Michael E Wyrick, PhD	**Date:**	4-22-19
Signature:	Michael E W	**Title:**	PhD
Printed Name:	Michael E Wyrick		

Attachment C

BUSINESS ASSOCIATE AGREEMENT

Between

ARKANSAS DEPARTMENT OF HUMAN SERVICES

And

Michael E Wyrick PhD

(Business Name)

440 50 4496

(Business Taxpayer Identification Number)

This Business Associate Agreement ("Agreement") is made effective on _______________, (the "Effective Date") by and between the Arkansas Department of Human Services ("Covered Entity") and ____, ("Business Associate,") (collectively, the "Parties").

Background

a) Covered Entity has been designated as a hybrid entity for the purposes of the HIPAA Privacy Rule, and it has designated several of its component agencies as health care components.

b) In accordance with the laws of Arkansas, Business Associate provides services for Covered Entity unrelated to treatment, payment, or healthcare operations and therefore the Parties believe a Business Associate Agreement is required. The provision of such services may involve the disclosure of individually identifiable health information from Covered Entity to Business Associate.

c) The relationship between Covered Entity and Business Associate is such that the Parties believe Business Associate is or may be a "business associate" within the meaning of the HIPAA Privacy Rule.

d) The Parties enter into the Agreement with the intention of complying with the HIPAA Privacy and Security Rule provisions and the Health Information Technology for Economic and Clinical Health (HITECH) Act, that a covered entity may disclose protected health information to a business associate, and may allow a business associate to create or receive protected health information on its behalf, if the covered entity obtains satisfactory assurances that the business associate will appropriately safeguard the information.

Definitions

<u>Catch-all definition</u>:

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care

Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information (PHI), Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) "Breach" shall have the meaning set out in its definition at 45 C.F.R. 164.402, as such provision is currently drafted and as it is subsequently updated, amended, or revised.

(b) "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean [Insert Name of Business Associate].

(c) "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Arkansas Department of Human Services.

(d) "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(e) "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information in 45 CFR 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

(f) "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.103.

(g) "Secretary" shall mean the Secretary of the United States Department of Health and Human Services or his/her designee.

(h) "Unsecured Protected Health Information" shall have the meaning set out in its definition at 45 C.F.R. 164.402; protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of a technology or methodology specified by the U.S. Secretary of DHHS in the guidance issued under section 13402(h)(2) of Pub. L. 111-5; as such provision is currently drafted and as it is subsequently updated, amended, or revised.

Unless otherwise defined in this Agreement, terms used herein shall have the same meaning as those terms have in the HIPAA Privacy Rule.

Obligations and Activities of Business Associate

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

(c) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;

(d) Business Associate agrees to report to Covered Entity any unauthorized acquisition, access, use, or disclosure of unsecured PHI the Business Associate holds on behalf of the covered entity, including the identity of each individual who is the subject of the unsecured PHI of which it becomes aware, no case later than ten calendar days after the discovery of the breach;

(e) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;

(f) Make available protected health information in a designated record set to the covered entity as necessary to satisfy covered entity's obligations under 45 CFR 164.524;

(g) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR 164.526;

(h) Maintain and make available the information required to provide an accounting of disclosures to the Covered Entity as necessary to satisfy covered entity's obligations under 45 CFR 164.528;

(i) To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

(j) Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

Permitted Uses and Disclosures by Business Associate

(a) Business Associate may only use or disclose PHI to perform functions, activities, or services for, or on behalf of, the Covered Entity as specified in:

Contract #_______________________________________, dated _________________,

(known as "the Contract") between the parties, provided that such use or disclosure does not violate the policies and procedures of all HIPAA rules.

(b) Business Associate may use or disclose protected health information as required by law.

(c) Business Associate agrees to make uses and disclosures and requests for protected health information consistent with covered entity's Privacy and Security policies and procedures.

(d) Business Associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity, except for the specific uses and disclosures set forth below.

(e) Business Associate may disclose protected health information for the proper management and administration of business associate or to carry out the legal responsibilities of the business associate, provided the disclosures are required by law, or business associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies business associate of any instances of which it is aware in which the confidentiality of the information has been breached. The Business Associate will notify Covered Entity within 10 calendar days of such a disclosure.

(f) Business Associate may provide data aggregation services relating to the health care operations of the covered entity.

Discovery and Notification of Breach or Incident

(a) Business Associate shall implement reasonable systems, policies, and procedures for discovery of possible HIPAA violations and breaches (as defined by HIPAA rules), and shall ensure that its workplace members and other agents are adequately trained and aware of the importance of timely reporting of possible breaches.

(b) Upon the discovery of any HIPAA violation by the Business Associate or any member of its workforce, (which includes, without limitation, employees, subcontractors and agents), with respect to PHI, the Business Associate shall promptly perform a risk assessment to determine whether a breach of unsecured PHI has occurred and whether or not the breach has resulted in any harm to the owner of the PHI as required by HITECH Act.

(c) The Business Associate shall take immediate steps to mitigate any HIPAA violation with respect to the Covered Entity's PHI that is discovered and shall provide the Covered Entity with written documentation of such steps.

(d) If the Business Associate determines that a breach of unsecured PHI may have occurred, the Business Associate shall notify the Covered Entity of such breach or incident within ten calendar days. The Business Associate will specifically notify the DHS Privacy Officer in writing via posted mail as well as email and will confirm receipt of the email immediately by phone.

Such notice shall include:

(i) A brief description of the occurrence, including the date of the breach and the date of discovery, if known;

(ii) To the extent possible, the identity of each individual whose unsecured PHI has been, or is reasonably believed to have been, breached;

(iii) A description of the types of unsecured PHI involved;

(iv) A brief description of what the owners of the PHI can do to protect themselves;

(v) A brief description of what the Business Associate is doing to investigate the breach, mitigate harm to affected individuals, and protect against further breaches; and,

(vi) Any other information that the Covered Entity reasonably believes necessary to enable it to comply with its obligations under HIPAA.

(e) The Business Associate shall continue to provide the Covered Entity with any additional information related to the required disclosures that becomes available following initial notice of the breach. The Business Associate will fully cooperate with the Covered Entity's investigation.

1) For a breach involving unsecured PHI of more than 500 individuals of a state or jurisdiction, the Business Associate shall promptly provide notice of such breach to the Covered Entity, the U.S. Secretary of Health and Human Services and any other federal authorities as required by HIPAA.

2) The Business Associate agrees to maintain documentation of all breaches of unsecured PHI for a minimum of six years after the creation of the documentation, and shall make such documentation available to the U.S. Secretary of Health and Human Services upon request.

(f) The Business Associate hereby agrees to indemnify and hold the Covered Entity harmless from and against liability and costs, including attorney's fees that are created by any breach resulting from the acts of its employees, agents or workforce members.

Permissible Requests by Covered Entity

Covered entity shall not request business associate to use or disclose protected health information in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by covered entity.

Term and Termination

(a) Term. This Agreement shall be effective as of the effective date stated above and shall terminate when all of the protected health information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to the Covered Entity, or if it infeasible to return or destroy the protected health information protections acceptable to Covered Entity are extended to such information in accordance with the termination provisions below, or on the date covered entity terminates for cause as authorized in paragraph (b) of this Section, whichever is sooner.

(b) Termination for Cause. Business associate authorizes termination of this Agreement by covered entity, if covered entity determines business associate has violated a material term of the Agreement and Business Associate has not cured the breach or ended the violation within the time specified by covered entity.

(c) Obligations of Business Associate Upon Termination.

Upon termination of this Agreement for any reason, business associate shall return to covered entity or, if agreed to by covered entity, destroy all protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, that the business associate still maintains in any form. Business associate shall retain no copies of the protected health information.

(d) Survival. The obligations of business associate under this Section shall survive the termination of this Agreement.

Miscellaneous

(a) Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or as amended.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

(c) Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be executed in its name and on its behalf effective as of the Effective Date at the top of this document.

Business Associate: [signature] Pres

By: Michael E Wyrich

Title: Pres

Date: 4-29-19

Division of Developmental Disabilities Services
BOONEVILLE HUMAN DEVELOPMENT CENTER

87 REED ROAD · BOONEVILLE, AR · 72927
479-675-2121 · Fax: 479-675-2518

April 29, 2019

Arkansas Department of Human Services
ATTN Office of Procurement
700 Main Street Slot W345
Little Rock, AR 72201

RE: Recommendation for Michael E. Wyrick, PhD

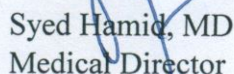
Dear Committee Members:

I am pleased to recommend Dr. Mike Wyrick to you. I worked with him for fours years, until his retirement from the Booneville Human Development Center in January 2018. Dr. Wyrick has 40 years' experience working with people with Intellectual Disability and mental illness, 26 of which were at BHDC.

I worked with Dr. Wyrick in my role as Medical Director at BHDC. To make the best medical decisions for our patients, I relied heavily on Dr. Wyrick's knowledge of specific clients, his vast experience in working with people with ID and mental illness, and his extensive knowledge of BHDC and ICF-IID policies and regulations. I was continually impressed with his professionalism, expertise, and dedication to provide the best possible service to our clients. I simply could not have had a better professional colleague to assist in providing the best service to our clients.

Over the years, I have worked closely with many excellent psychologists. I would rank Dr. Wyrick in the top tier of those with whom I have had the good fortune to work. I would professionally and personally enjoy working with him again. I recommend him to you without reservation.

Sincerely,



Syed Hamid, MD
Medical Director

Division of Developmental Disabilities Services
BOONEVILLE HUMAN DEVELOPMENT CENTER

87 REED ROAD · BOONEVILLE, AR · 72927
479-675-2121 · Fax: 479-675-2518

April 23, 2019

To Whom It May Concern:

Re: Michael Wyrick, PhD
Licensed Psychologist

It is my pleasure to offer this letter of recommendation for Dr. Michael Wyrick for the Clinical Psychologist contract position at the Booneville Human Development Center (BHDC). Dr. Wyrick has over 30 years of clinical experience working with individuals that have developmental disabilities.

I have worked at BHDC for 20 years and I have known Dr. Wyrick for that duration. I began working in the capacity of Program Coordinator approximately eight years ago. It was at that time that Dr. Wyrick and I served on the same interdisciplinary team. I personally have never worked with a more knowledgeable colleague in this field. Dr. Wyrick served as a mentor to me and was the backbone to this facility. His psychological practice with the population that we serve has certainly been missed and would certainly be welcomed upon his return. The best part of my job is the clients that we serve and those are the individuals that would benefit if this contract position is accepted.

Sincerely,

James J. Jobb
DHS/DDS Program Coordinator
James.Jobb@dhs.arkansas.gov
Phone 479-849-5939

Division of Developmental Disabilities Services

Booneville Human Development Center

87 Reed Road, Hwy 116 South ■ Booneville, AR 72927 ■ 479-675-2121 ■ Fax: 479-675-2518

April 23, 2019

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Licensed Psychologist

Dear Committee,

I am pleased to offer this letter of recommendation for Dr. Michael Wyrick for the Clinical Psychologist contract position at Booneville Human Development Center (BHDC). Dr. Wyrick has over 30 years of clinical experience working with persons that have developmental disabilities.

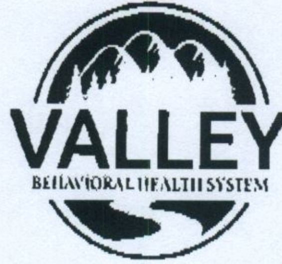
My first professional contact with Dr. Wyrick occurred at the Conway Human Development Center in 2000. As the Interim Chief Psychologist, he provided clinical supervision of Category III Behavior Treatment Programs at that facility. In 2013, Dr. Wyrick hired me to work as a Psychological Examiner in the psychology department at BHDC. I worked directly under his supervision through his retirement in December 2017. Dr. Wyrick demonstrated exceptional clinical knowledge and had a phenomenal ability to discuss clinically complicated topics in a way that was easily understood by others. Conferring with Dr. Wyrick on clinical cases greatly benefited my professional work. His input was psychologically sound, ethical, functionally operational, and complied with ICF-IID policy. Dr. Wyrick has the 3011-D guidelines memorized and ensured that my work always complied with policy. Dr. Wyrick's work ethic was another strength. He easily met paperwork deadlines, responded to the majority of after hour emergencies, managed a clinical case load, and administratively supervised the psychology department. I could always rely on him in my absences, or when double booked with my work schedule.

Under Dr. Wyrick's leadership and clinical guidance, BHDC had many successes in meeting the needs of persons with clinically complicated intellectual disabilities and mental illness. This population is very challenging. I miss Dr. Wyrick's clinical mind, and vast psychological practice with this specialized population. His return to BHDC would be greatly welcomed, and most of all would benefit the clients at BHDC.

Sincerely,

K Edwards

Kathy Edwards, MS
Licensed Psychological Examiner-Independent
479-675-1438 work
Kathy.Edwards@dhs.arkansas.gov



April 23, 2019

Arkansas Department of Human Services
ATTN Office of Procurement
700 Main Street Slot W345
Little Rock, AR 72201

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Over the years, I have worked closely with many excellent psychologists. I would rank Dr. Wyrick in the top tier of those with whom I have had the good fortune to work. I would professionally and personally enjoy working with him again. I recommend him to you without reservation.

Sincerely,

Fayz Hudefi, MD

10301 Mayo Drive
Barling AR 72923

Phone 479-494-5700
Administration x 1582
Administration Fax 479-494-5777

DATE: 4/29/19

TO: Mike FAX: 479-675-3636

PHONE: EXT:

FROM: DR Hudefi FAX:

PHONE: EXT:

TOTAL PAGES INCLUDING COVERSHEET:

COMMENTS

This facsimile contains information which (a) may be LEGALLY PRIVILEDGED. PROPRIETARY IN NATURE, OR OTHERWISE-PROTECTED BY LAW FROM DISCLOSURE, and (b) is intended only for the use of the Addressee(s) named above. If you are not the Addressee, or the person responsible for delivering this to the Addressee(s), you have received this facsimile in error, please telephone us immediately and mail the facsimile back to us at the above address.

Thank you.
If you have any problems receiving this message or any of the following material, please contact

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM

F-1

Failure to complete all the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

SUBCONTRACTOR: ☐ YES ☒ NO

SUBCONTRACTOR NAME:

Contractor for which this is a subcontractor:

Estimated dollar amount of subcontract:

IS THIS FOR: ☐ **Goods?** ☒ **Services** ☐ **Both?**

TAXPAYER ID NAME: Michael E Wyrick PhD

YOUR LAST NAME: Wyrick **FIRST NAME:** Michel **MI:** E

ADDRESS: 1420 Longview Drive

CITY: Booneville **STATE:** AR **ZIP CODE:** 72927 **COUNTRY:** UNITED STATES OF AMERICA

AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, *OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:*

*FOR INDIVIDUALS**

Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse is a current or former: Member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:

Position Held	Mark (✓)		Name of Position of Job Held [senator, representative, name of board/commission, data entry, etc.]	For How Long?		What is the person(s) name and how are they related to you? (i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.)	
	Current	Former		From MM/YY	To MM/YY	Person's name(s)	Relation
General Assembly	☐	☐					
Constitutional Officer	☐	☐					
State Board or Commission Member	☐	☐					
State Employee	☒	☒	Admin (S) Psychologist (mw)	08/10 05/92	present 01/18	Vanessa Wyrick Michael Wyrick	Spouse Self

☐ **None of the above applies**

*FOR A VENDOR (BUSINESS)**

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

Position Held	Mark (✓)		Name of Position of Job Held (senator, representative, name of board/commission, data entry, etc.	For How Long?		What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control?		
	Current	Former		From MM/YY	To MM/YY	Person's name(s)	Ownership Interest (%)	Position of Control
General Assembly	☐	☐						
Constitutional Officer	☐	☐						
State Board or Commission Member	☐	☐						
State Employee	☐	☐						

☐ **None of the above applies**

* NOTE: PLEASE LIST ADDITIONAL DISCLOSURES ON SEPARATE SHEET OF PAPER IF MORE SPACE IS NEEDED

CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM F-2

Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.

As an additional condition of obtaining, extending, amending, or renewing a contract with a state agency I agree as follows:

1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete a **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM**. Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.
2. I will include the following language as a part of any agreement with a subcontractor:

   Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.

3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM** completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

I certify under penalty of perjury, to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.

Signature [signature] **Title** psychologist **Date** 4/21/19

Vendor Contact Person Michael E Wyrick PhD **Title** Psychologist **Phone No.** 4796756392

AGENCY USE ONLY

Agency Number	Agency Name	Agency Contact Person	Contact Phone No.	Contract or Grant No.
0710	Department of Human Services			

** NOTE: PLEASE LIST ADDITIONAL DISCLOSURES ON SEPARATE SHEET OF PAPER IF MORE SPACE IS NEEDED*

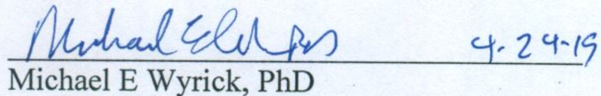
Michael E. Wyrick, PhD
1420 Longview Drive
Booneville, AR 72927
479 675 6392 mikewy@centurytel.net

Equal Employment Opportunity Policy

Policy

Michael E Wyrick, PhD provides equal employment opportunities to all employees and applicants for employment and prohibits discrimination and harassment of any type without regard to race, color, religion, age, sex, national origin, disability status, genetics, protected veteran status, sexual orientation, gender identity or expression, or any other characteristic protected by federal, state or local laws.

This policy applies to all terms and conditions of employment, including recruiting, hiring, placement, promotion, termination, layoff, recall, transfer, leaves of absence, compensation and training.


4-24-19

Michael E Wyrick, PhD

ARKANSAS PSYCHOLOGY BOARD

101 E. Capitol Ave., Ste. 415
Little Rock, AR 72201-3824
(501) 682-6167

THIS CERTIFIES THAT

Michael E. Wyrick

IS DULY LICENSED IN THE STATE OF ARKANSAS AS A

Psychologist License • License No: 80-15P

Expires: 6/30/2019 Issue Date: 6/20/1980

Signature: Michael E Wyrick PhD

Certificate of Liability Insurance

Date Issued: 04/22/2019

Underwritten by: Philadelphia Indemnity Insurance Company · One Bala Plaza, Suite 100 · Bala Cynwyd, PA 19004 · NAIC #: 18058
Administered by: CPH & Associates · 711 S. Dearborn St. Ste 205 · Chicago, IL 60605 · P 800.875.1911 · F 312.987.0902 · info@cphins.com

DISCLAIMER: This certificate is issued as a matter of information only and confers no rights upon the certificate holder. The Certificate of Insurance does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend, or alter the coverage afforded by the policies listed thereon.

Insured: Michael E Wyrick
1420 Longview Drive
Booneville, AR 72927

Policy Number: 074559
Policy Term: 07/01/2019 to 07/01/2020
Occupation: Licensed Psychologist

Covered Locations

Professional Liability: Portable coverage, not location specific

Coverage Type (Occurrence Form)	Per Incident (Per individual claim)	Aggregate (Total amount per year)
Professional Liability	$ 1,000,000	$ 3,000,000
Supplemental Liability	$ 1,000,000	$ 3,000,000
Licensing Board Defense	$ 35,000	$ 35,000
Commercial General Liability	N/A	N/A
▫ *Fire/Water Legal Liability*	N/A	N/A
Business Personal Property	N/A	N/A

Comments/Special Descriptions:

Certificate Holder

PROOF OF COVERAGE

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s). **Notice of Cancellation** will only be provided to the first named insured in accordance with policy provisions, who shall act on behalf of all additional insureds with respect to giving notice of cancellation.

C. Philip Hodson

Authorized Representative
C. Philip Hodson

Certificate of Liability Insurance

Date Issued: 04/30/2018

Underwritten by: Philadelphia Indemnity Insurance Company · One Bala Plaza, Suite 100 · Bala Cynwyd, PA 19004 · NAIC #: 18058
Administered by: CPH & Associates · 711 S. Dearborn St. Ste 205 · Chicago, IL 60605 · P 800.875.1911 · F 312.987.0902 · info@cphins.com

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Insured: Michael E Wyrick
1420 Longview Drive
Booneville, AR 72927

Policy Number: 074559
Policy Term: 07/01/2018 to 07/01/2019
Occupation: Licensed Psychologist

Covered Locations

Professional Liability: Portable coverage, not location specific

Coverage Type (Occurrence Form)	Per Incident (Per individual claim)	Aggregate (Total amount per year)
Professional Liability	$ 1,000,000	$ 3,000,000
Supplemental Liability	$ 1,000,000	$ 3,000,000
Licensing Board Defense	$ 35,000	$ 35,000
Commercial General Liability	N/A	N/A
▫ *Fire/Water Legal Liability*	N/A	N/A
Business Personal Property	N/A	N/A

Comments/Special Descriptions:

Certificate Holder

PROOF OF COVERAGE

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