**Attachment H**

***Client History Form
RFP # 710-23-0037***

**Client History Form**

*Instructions:* This form is intended to help the State gain a full understanding of each Respondent’s Medicaid and IT PMO and experiences. This form **must** be accurately completed and signed by the same signatory who signed the Proposal Signature Page (please see final page below).

The State reserves the right to verify the accuracy of responses by contacting any of the listed clients; therefore, all applicable clients **must** be listed. For purposes of this form, the “client” is not an individual, but the entity which held the contract. By way of explanation, in the Contract resulting from this RFP, Arkansas’s DHS will be the client. For each listed client, Respondents **must** include the client entity’s name, address, and phone number. Additionally, Respondents are encouraged to provide an individual’s contact information for a person at the client entity who is knowledgeable of the named project. If the State contacts the clients listed, the State reserves the right to either contact the listed individual and/or another person at the client entity. Omission of a relevant client will constitute a failure of form completion.

The boxes below each prompt will expand if necessary. If there are no contracts which meet the definition, Respondent **must** state “none.”

1. Please list three (3) projects where you served as the ***prime contractor*** for a project similar in size, complexity, and scope in the past seven (7) years. Briefly describe the scope of the contract. At least one of the three referenced projects must have transitioned from implementation to operations.

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1. Please list at least two (2) Medicaid agencies you have provided project management services to. Briefly describe the scope of the contract.

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1. Please list every Medicaid agency you have transacted business with in the past seven (7) years. Briefly describe the scope of all contracts. Please include here any experience supporting design, development, implementation and/or operations support for Medicaid modules.

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**Authorized Signature:**  **Title:**

 (*Use Ink Only)*

**Printed/Typed Name:**  **Date:**