Attachment I
REVISED Client History Form
Arkansas Health Insurance Premium Payment
RFP # 710-24-0002

Attachment I

Arkansas Health Insurance Premium Payment (ARHIPP) Client History Form

Instructions: This form is intended to help the State gain a more complete understanding of each Respondent's Medicaid Program experience. This form **must** be completed completely and accurately.

The State reserves the right to verify the accuracy of these answers by contacting any of the listed clients, and all applicable clients **must** be listed. Omission of a client will constitute a failure to complete this form.

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 DHS will be the client. For each listed client, Respondents may (but are not required) provide the contact information for a person at the client entity who is knowledgeable of the named project. If the State contacts clients listed on this form, the State reserves the right to contact the listed individual or another person at the listed client.

The boxes below each prompt will expand if necessary. The form **must** be signed (please see the final page) by the same signatory who signed the Proposal Signature Page.

1. Please list at least three (3) clients (federal, district, state, county, American territory, tribe, or Canadian province) for whom you (the prime contractor only) **served as the prime contractor** on similar insurance contracts for other state Medicaid programs for at least five (5) years . For each client, please specify the organization/agency/division, not just the state or political subdivision. Please briefly describe the scope of the contract. If there are no contracts which meet this definition, please state "none."

2. Please list at least three (3) clients (federal, district, state, county, American territory, tribe, or Canadian province) where a **proposed subcontractor served as the prime contractor** on similar insurance contracts for other state Medicaid programs for at least five (5) years. For each client, please specify the organization/agency/division, not just the state or political subdivision. Please briefly describe the scope of the contract. If there are no contracts which meet this definition, please state "none."

Authorized Signature: _____ **Title:** _____

Use Ink Only.

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