

State of Hawaii  
Department of Public Safety  
Health Care Division

## Request for Proposals

**RFP No. : PSD 17-HCD-05**

# **MOBILE DENTISTRY SERVICES FOR CORRECTIONAL FACILITIES STATEWIDE**

October 4, 2016

**Note:** *It is the applicant's responsibility to check the public procurement notice website, the request for proposals website, or to contact the RFP point-of-contact identified in the RFP for any addenda issued to this RFP. The State shall not be responsible for any incomplete proposal submitted as a result of missing addenda, attachments or other information regarding the RFP.*

October 4, 2016

REQUEST FOR PROPOSALS  
RFP No. PSD 17-HCD-05

MOBILE DENTISTRY SERVICES  
FOR CORRECTIONAL FACILITIES STATEWIDE

The Department of Public Safety, Health Care Division, is requesting proposals from qualified applicants to provide general dental services to inmates detained in the State's correctional institutions. This RFP is primarily for dental services provided at Correctional Facilities on the islands of Oahu, Hawaii, Maui and Kauai.

The contract term will be for a twenty-four month period commencing on April 1, 2017, or the start date indicated on the "Notice to Proceed", with an option to extend for two (2) additional twelve month periods. A single contract will be awarded under this request for proposals with approximately \$1,136,000.00, or \$568,000.00 for FY 2017 and \$568,000.00 for FY 2018 (Oahu - \$322,000.00, Hawaii - \$111,000.00 (HCCC: \$68,000.00 and KCF: \$43,000.00), Maui - \$90,000.00 and Kauai - \$45,000.00), subject to availability of funds.

*Note: the contract term for the Halawa Correctional Facility (HCF) may be terminated prior to the initial twenty-four month period, contingent on the permanent dental staffing of personnel at the HCF.*

Proposals shall be mailed, postmarked by the United States Postal Service on or before November 10, 2016, and received no later than 10 days from the submittal deadline. Hand delivered proposals shall be received no later than 4:30 p.m., Hawaii Standard Time (HST), on November 10, 2016, at the drop-off site designated on the Proposal Mail-in and Delivery Information Sheet. Proposals postmarked or hand delivered after the submittal deadline shall be considered late and rejected. There are no exceptions to this requirement.

The Department of Public Safety – Health Care Division will conduct an orientation on October 11, 2016, from 10:00 a.m. to 11:00 a.m. HST, at 919 Ala Moana Boulevard, Room 413, Honolulu, Hawaii 96814. A telephone call-in is also available at 1 (712) 432-1212, enter meeting ID 271-724-223# when prompted. All prospective applicants are encouraged to attend the orientation.

The deadline for submission of written questions is 4:30 p.m., HST, on October 18, 2016. All written questions will receive a written response from the State on or about October 25, 2016.

**PROPOSAL MAIL-IN AND DELIVERY INFORMATION SHEET**

**NUMBER OF COPIES TO BE SUBMITTED:** One (1) Original + Three (3) Copies

ALL MAIL-INS SHALL BE POSTMARKED BY THE UNITED STATES POSTAL SERVICE (USPS) NO LATER THAN November 10, 2016 and received by the state purchasing agency no later than 10 days from the submittal deadline.

**All Mail-ins**

Department of Public Safety  
Administrative Services Office-  
Procurement & Contracts  
919 Ala Moana Boulevard  
Room 413  
Honolulu, Hawaii 96814

**RFP COORDINATOR**

Marc S. Yamamoto, PSS IV  
Telephone: (808) 587-1215  
Facsimile: (808) 587-1244  
[Email: marc.s.yamamoto@hawaii.gov](mailto:marc.s.yamamoto@hawaii.gov)

ALL HAND DELIVERIES SHALL BE ACCEPTED AT THE FOLLOWING SITES UNTIL **4:30 P.M., Hawaii Standard Time (HST), November 10, 2016**. Deliveries by private mail services such as FEDEX shall be considered hand deliveries. Hand deliveries shall not be accepted if received after 4:30 p.m., November 10, 2016.

**Drop-off Sites**

Department of Public Safety  
Administrative Services Office-  
Procurement & Contracts  
919 Ala Moana Boulevard, Room 413  
Honolulu, Hawaii 96814

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## **Section 1**

### **Administrative Overview**

## Section 1 Administrative Overview

**Applicants are encouraged to read each section of the RFP thoroughly. While sections such as the administrative overview may appear similar among RFPs, state purchasing agencies may add additional information as applicable. It is the responsibility of the applicant to understand the requirements of *each* RFP.**

### 1.1 Procurement Timetable

**Note that the procurement timetable represents the State's best estimated schedule. If an activity on this schedule is delayed, the rest of the schedule will likely be shifted by the same number of days. Contract start dates may be subject to the issuance of a notice to proceed.**

<u>Activity</u>	<u>Scheduled Date</u>
Public notice announcing Request for Proposals (RFP)	October 4, 2016
Distribution of RFP	October 4, 2016
RFP orientation session	October 11, 2016
Closing date for submission of written questions for written responses	October 18, 2016
State purchasing agency's response to applicants' written questions	October 25, 2016
Discussions with applicant prior to proposal submittal deadline (optional)	Not Applicable
Proposal submittal deadline	November 10, 2016
Discussions with applicant after proposal submittal deadline (optional)	November 14, 2016 to November 15, 2016
Final revised proposals (optional)	November 22, 2016
Proposal evaluation period	November 14, 2016 to November 30, 2016
Provider selection	December 8, 2016
Notice of statement of findings and decision	December 8, 2016
Contract start date	April 1, 2017, or the commencement date on the Notice to Proceed.

## 1.2 Website Reference

Item	Website
1 Procurement of Health and Human Services	<a href="http://spo.hawaii.gov/for-vendors/vendor-guide/methods-of-procurement/health-human-services/competitive-purchase-of-services-procurement-method/cost-principles-table-hrs-chapter-103f-2/">http://spo.hawaii.gov/for-vendors/vendor-guide/methods-of-procurement/health-human-services/competitive-purchase-of-services-procurement-method/cost-principles-table-hrs-chapter-103f-2/</a>
2 RFP website	<a href="http://hawaii.gov/spo2/health/rfp103f/">http://hawaii.gov/spo2/health/rfp103f/</a>
3 Hawaii Revised Statutes (HRS) and Hawaii Administrative Rules (HAR) for Purchases of Health and Human Services	<a href="http://spo.hawaii.gov">http://spo.hawaii.gov</a> Click on the "References" tab.
4 General Conditions, AG-103F13	<a href="http://spo.hawaii.gov/wp-content/uploads/2013/12/103F13.pdf">http://spo.hawaii.gov/wp-content/uploads/2013/12/103F13.pdf</a>
5 Forms	<a href="http://spo.hawaii.gov">http://spo.hawaii.gov</a> Click on the "Forms" tab.
6 Cost Principles	<a href="http://spo.hawaii.gov">http://spo.hawaii.gov</a> Search: Keywords "Cost Principles"
7 Protest Forms/Procedures	<a href="http://spo.hawaii.gov/for-vendors/vendor-guide/protests-for-health-and-human-services/">http://spo.hawaii.gov/for-vendors/vendor-guide/protests-for-health-and-human-services/</a>
8 Hawaii Compliance Express (HCE)	<a href="http://spo.hawaii.gov/hce/">http://spo.hawaii.gov/hce/</a>
9 Hawaii Revised Statutes	<a href="http://capitol.hawaii.gov/hrscurrent">http://capitol.hawaii.gov/hrscurrent</a>
10 Department of Taxation	<a href="http://tax.hawaii.gov">http://tax.hawaii.gov</a>
11 Department of Labor and Industrial Relations	<a href="http://labor.hawaii.gov">http://labor.hawaii.gov</a>
12 Department of Commerce and Consumer Affairs, Business Registration	<a href="http://cca.hawaii.gov">http://cca.hawaii.gov</a> click "Business Registration"
13 Campaign Spending Commission	<a href="http://ags.hawaii.gov/campaign/">http://ags.hawaii.gov/campaign/</a>
14 Internal Revenue Service	<a href="http://www.irs.gov/">http://www.irs.gov/</a>
<b>(Please note: website addresses may change from time to time. If a State link is not active, try the State of Hawaii website at <a href="http://hawaii.gov">http://hawaii.gov</a>)</b>	

## 1.3 Authority

This RFP is issued under the provisions of the Hawaii Revised Statutes (HRS) Chapter 103F and its administrative rules. All prospective applicants are charged with presumptive knowledge of all requirements of the cited authorities. Submission of a valid executed

proposal by any prospective applicant shall constitute admission of such knowledge on the part of such prospective applicant.

## 1.4 RFP Organization

This RFP is organized into five sections:

**Section 1, Administrative Overview:** Provides applicants with an overview of the procurement process.

**Section 2, Service Specifications:** Provides applicants with a general description of the tasks to be performed, delineates provider responsibilities, and defines deliverables (as applicable).

**Section 3, Proposal Application Instructions:** Describes the required format and content for the proposal application.

**Section 4, Proposal Evaluation:** Describes how proposals will be evaluated by the state purchasing agency.

**Section 5, Attachments:** Provides applicants with information and forms necessary to complete the application.

## 1.5 Contracting Office

The Contracting Office is responsible for overseeing the contract(s) resulting from this RFP, including system operations, fiscal agent operations, and monitoring and assessing provider performance. The Contracting Office is:

Department of Public Safety  
Health Care Division  
919 Ala Moana Boulevard, Room 407  
Honolulu, Hawaii 96814

Mr. Wesley Mun, or his designee  
Telephone: (808)587-2536  
Facsimile: (808) 587-3378

## 1.6 RFP Point-of-Contact

From the release date of this RFP until the selection of the successful provider(s), any inquiries and requests shall be directed to the sole point-of-contact identified below.

Department of Public Safety  
Administrative Services Office – Procurement and Contracts  
919 Ala Moana Boulevard, Room 413  
Honolulu, Hawaii 96814

Marc Yamamoto  
e-mail address: marc.s.yamamoto@hawaii.gov

## 1.7 Orientation

An orientation for applicants in reference to the request for proposals will be held as follows:

**Date:** October 11, 2016      **Time:** 10:00 a.m., H.S.T.  
**Location:** 919 Ala Moana Boulevard, Room 413  
Honolulu, Hawaii 96814

For prospective applicants not able to attend the orientation meeting in Honolulu a call-in number is available:

Call-in: 1 (712) 432-1212  
Meeting ID: 271-724-223#

Applicants are encouraged to submit written questions prior to the orientation. Impromptu questions will be permitted at the orientation and spontaneous answers provided at the state purchasing agency's discretion. However, answers provided at the orientation are only intended as general direction and may not represent the state purchasing agency's position. Formal official responses will be provided in writing. To ensure a written response, any oral questions should be submitted in writing following the close of the orientation, but no later than the submittal deadline for written questions indicated in the subsection 1.8, Submission of Questions.

## 1.8 Submission of Questions

Applicants may submit questions to the RFP point-of-contact identified in Section 1.6. Written questions should be received by the date and time specified in Section 1.1 Procurement Timetable. The purchasing agency will respond to written questions by way of an addendum to the RFP.

Deadline for submission of written questions:

**Date:** October 18, 2016      **Time:** 4:30 p.m., HST

State agency responses to applicant written questions will be provided by:

**Date:** October 25, 2016

## 1.9 Submission of Proposals

A. **Forms/Formats** - Forms, with the exception of program specific requirements, may be found on the State Procurement Office website referred to in Section 1.2, Website Reference. Refer to the Section 5, Proposal Application Checklist for the location of program specific forms.

1. **Proposal Application Identification (Form SPOH-200).** Provides applicant proposal identification.
2. **Proposal Application Checklist.** The checklist provides applicants specific program requirements, reference and location of required RFP proposal forms,

and the order in which all proposal components should be collated and submitted to the state purchasing agency.

3. **Table of Contents.** A sample table of contents for proposals is located in Section 5, Attachments. This is a sample and meant as a guide. The table of contents may vary depending on the RFP.
  4. **Proposal Application (Form SPOH-200A).** Applicant shall submit comprehensive narratives that address all proposal requirements specified in Section 3, Proposal Application Instructions, including a cost proposal/budget, if required.
- B. **Program Specific Requirements.** Program specific requirements are included in Sections 2 and 3, as applicable. Required Federal and/or State certifications are listed on the Proposal Application Checklist in Section 5.
- C. **Multiple or Alternate Proposals.** Multiple or alternate proposals shall not be accepted unless specifically provided for in Section 2. In the event alternate proposals are not accepted and an applicant submits alternate proposals, but clearly indicates a primary proposal, it shall be considered for award as though it were the only proposal submitted by the applicant.
- D. **Provider Compliance.** All providers shall comply with all laws governing entities doing business in the State.
- **Tax Clearance.** Pursuant to HRS §103-53, as a prerequisite to entering into contracts of \$25,000 or more, providers are required to have a tax clearance from the Hawaii State Department of Taxation (DOTAX) and the Internal Revenue Service (IRS). Refer to Section 1.2, Website Reference for DOTAX and IRS website address.
  - **Labor Law Compliance.** Pursuant to HRS §103-55, providers shall be in compliance with all applicable laws of the federal and state governments relating to workers' compensation, unemployment compensation, payment of wages, and safety. Refer to Section 1.2, Website Reference for the Department of Labor and Industrial Relations (DLIR) website address.
  - **Business Registration.** Prior to contracting, owners of all forms of business doing business in the state except sole proprietorships, charitable organizations, unincorporated associations and foreign insurance companies shall be registered and in good standing with the Department of Commerce and Consumer Affairs (DCCA), Business Registration Division. Foreign insurance companies must register with DCCA, Insurance Division. More information is on the DCCA website. Refer to Section 1.2, Website Reference for DCCA website address.

Providers may register with Hawaii Compliance Express (HCE) for online compliance verification from the DOTAX, IRS, DLIR, and DCCA. There is a nominal annual registration fee (currently \$12) for the service. The HCE's online "Certificate of Vendor Compliance" provides the registered provider's current compliance status as of the issuance date, and is accepted for both contracting and final payment purposes. Refer to Section 1.2, Website Reference, for HCE's website address.

Providers not utilizing the HCE to demonstrate compliance shall provide paper certificates to the purchasing agency. All applications for applicable clearances are the responsibility of the providers. All certificates must be valid on the date it is received by the purchasing agency. The tax clearance certificate shall have an original green certified copy stamp and shall be valid for six months from the most recent approval stamp date on the certificate. The DLIR certificate is valid for six months from the date of issue. The DCCA certificate of good standing is valid for six months from date of issue.

- E. **Wages Law Compliance.** If applicable, by submitting a proposal, the applicant certifies that the applicant is in compliance with HRS §103-55, Wages, hours, and working conditions of employees of contractors performing services. Refer to Section 1.2, Website Reference for statutes and DLIR website address.
- F. **Campaign Contributions by State and County Contractors.** HRS §11-355 prohibits campaign contributions from certain State or county government contractors during the term of the contract if the contractors are paid with funds appropriated by a legislative body. Refer to Section 1.2, Website Reference for statutes and Campaign Spending Commission website address.
- G. **Confidential Information.** If an applicant believes any portion of a proposal contains information that should be withheld as confidential, the applicant shall request in writing nondisclosure of designated proprietary data to be confidential and provide justification to support confidentiality. Such data shall accompany the proposal, be clearly marked, and shall be readily separable from the proposal to facilitate eventual public inspection of the non-confidential sections of the proposal.

***Note that price is not considered confidential and will not be withheld.***

- H. **Proposal Submittal.** All mail-ins shall be postmarked by the United States Postal System (USPS) and received by the State purchasing agency no later than the submittal deadline indicated on the attached Proposal Mail-in and Delivery Information Sheet, or as amended. All hand deliveries shall be received by the State purchasing agency by the date and time designated on the Proposal Mail-In and Delivery Information Sheet, or as amended. Proposals shall be rejected when:
  1. Postmarked after the designated date; or
  2. Postmarked by the designated date but not received within 10 days from the submittal deadline; or
  3. If hand delivered, received after the designated date and time.

The number of copies required is located on the Proposal Mail-In and Delivery Information Sheet. Deliveries by private mail services such as FEDEX shall be considered hand deliveries and shall be rejected if received after the submittal deadline. Dated USPS shipping labels are not considered postmarks.

Electronically submitted proposals are not acceptable.

## **1.10 Discussions with Applicants**

- A. **Prior to Submittal Deadline.** Discussions may be conducted with potential applicants to promote understanding of the purchasing agency's requirements.

- B. **After Proposal Submittal Deadline.** Discussions may be conducted with applicants whose proposals are determined to be reasonably susceptible of being selected for award, but proposals may be accepted without discussions, in accordance with HAR §3-143-403.

### 1.11 Opening of Proposals

Upon the state purchasing agency's receipt of a proposal at a designated location, proposals, modifications to proposals, and withdrawals of proposals shall be date-stamped, and when possible, time-stamped. All documents so received shall be held in a secure place by the state purchasing agency and not examined for evaluation purposes until the submittal deadline.

Procurement files shall be open to public inspection after a contract has been awarded and executed by all parties.

### 1.12 Additional Materials and Documentation

Upon request from the state purchasing agency, each applicant shall submit additional materials and documentation reasonably required by the state purchasing agency in its evaluation of the proposals.

### 1.13 RFP Amendments

The State reserves the right to amend this RFP at any time prior to the closing date for final revised proposals.

### 1.14 Final Revised Proposals

If requested, final revised proposals shall be submitted in the manner and by the date and time specified by the state purchasing agency. If a final revised proposal is not submitted, the previous submittal shall be construed as the applicant's final revised proposal. *The applicant shall submit **only** the section(s) of the proposal that are amended, along with the Proposal Application Identification Form (SPOH-200).* After final revised proposals are received, final evaluations will be conducted for an award.

### 1.15 Cancellation of Request for Proposal

The RFP may be canceled and any or all proposals may be rejected in whole or in part, when it is determined to be in the best interest of the State.

### 1.16 Costs for Proposal Preparation

Any costs incurred by applicants in preparing or submitting a proposal are the applicants' sole responsibility.

### 1.17 Provider Participation in Planning

Provider(s), awarded a contract resulting from this RFP,

- are required  
 are not required

to participate in the purchasing agency's future development of a service delivery plan pursuant to HRS §103F-203.

Provider participation in a state purchasing agency's efforts to plan for or to purchase health and human services prior to the release of a RFP, including the sharing of information on community needs, best practices, and providers' resources, shall not disqualify providers from submitting proposals, if conducted in accordance with HAR §§3-142-202 and 3-142-203.

## **1.18 Rejection of Proposals**

The State reserves the right to consider as acceptable only those proposals submitted in accordance with all requirements set forth in this RFP and which demonstrate an understanding of the problems involved and comply with the service specifications. Any proposal offering any other set of terms and conditions contradictory to those included in this RFP may be rejected without further notice.

A proposal may be automatically rejected for any one or more of the following reasons:

- (1) Rejection for failure to cooperate or deal in good faith. (HAR §3-141-201)
- (2) Rejection for inadequate accounting system. (HAR §3-141-202)
- (3) Late proposals (HAR §3-143-603)
- (4) Inadequate response to request for proposals (HAR §3-143-609)
- (5) Proposal not responsive (HAR §3-143-610(a)(1))
- (6) Applicant not responsible (HAR §3-143-610(a)(2))

## **1.19 Notice of Award**

A statement of findings and decision shall be provided to each responsive and responsible applicant by mail upon completion of the evaluation of competitive purchase of service proposals.

Any agreement arising out of this solicitation is subject to the approval of the Department of the Attorney General as to form, and to all further approvals, including the approval of the Governor, required by statute, regulation, rule, order or other directive.

No work is to be undertaken by the provider(s) awarded a contract prior to the contract commencement date. The State of Hawaii is not liable for any costs incurred prior to the official starting date.

## **1.20 Protests**

Pursuant to HRS §103F-501 and HAR Chapter 148, an applicant aggrieved by an award of a contract may file a protest. The Notice of Protest form, SPOH-801, and related forms are available on the SPO website. Refer to Section 1.2, Website Reference for website address. Only the following matters may be protested:

- (1) A state purchasing agency's failure to follow procedures established by Chapter 103F of the Hawaii Revised Statutes;

- (2) A state purchasing agency's failure to follow any rule established by Chapter 103F of the Hawaii Revised Statutes; and
- (3) A state purchasing agency's failure to follow any procedure, requirement, or evaluation criterion in a request for proposals issued by the state purchasing agency.

The Notice of Protest shall be postmarked by USPS or hand delivered to 1) the head of the state purchasing agency conducting the protested procurement and 2) the procurement officer who is conducting the procurement (as indicated below) within five working days of the postmark of the Notice of Findings and Decision sent to the protestor. Delivery services other than USPS shall be considered hand deliveries and considered submitted on the date of actual receipt by the state purchasing agency.

Head of State Purchasing Agency	Procurement Officer
Name: Nolan Espinda	Name: Teresita V. Fernandez
Title: Director	Title: Business Management Officer
Mailing Address: 919 Ala Moana Boulevard, Room 400	Mailing Address: 919 Ala Moana Boulevard, Room 413 Honolulu, Hawaii 96814
Business Address: Same as above.	Business Address: Same as above.

### **1.21 Availability of Funds**

The award of a contract and any allowed renewal or extension thereof, is subject to allotments made by the Director of Finance, State of Hawaii, pursuant to HRS Chapter 37, and subject to the availability of State and/or Federal funds.

### **1.22 General and Special Conditions of Contract**

The general conditions that will be imposed contractually are on the SPO website. Special conditions may also be imposed contractually by the state purchasing agency, as deemed necessary

### **1.23 Cost Principles**

To promote uniform purchasing practices among state purchasing agencies procuring health and human services under HRS Chapter 103F, state purchasing agencies will utilize standard cost principles as outlined on the SPO website. Refer to Section 1.2 Website Reference for website address. Nothing in this section shall be construed to create an exemption from any cost principle arising under federal law.

## **Section 2**

### **Service Specifications**

## Section 2 Service Specifications

### 2.1 Introduction

#### A. Overview, purpose or need

The Department of Public Safety, Health Care Division is responsible for the provision of health care to the individuals who are incarcerated throughout the State of Hawaii. This includes medical, dental and mental health services.

#### B. Planning activities conducted in preparation for this RFP

Pursuant to Hawaii Administrative Rules (HAR), Chapter 3-142-202(e), compliance with the issuance of a request for information has been waived.

#### C. Description of the service goals

The service provider shall provide onsite dental clinics at correctional facilities identified under section 2.1, #E. Geographic coverage of service. The services involve general dentistry and a variety of acute and chronic oral health problems, including but not limited to restorative and prophylactic services. Inmate patients are screened and referred by the facility dental staff and/or nurses.

The Health Care Division will provide the clinical space. The service provider will provide all of the necessary equipment and dental supplies. The service provider shall record all evaluations, dental care, and treatments provided in the patients' individual facility dental records. The service provider shall be subject to all of the policies and procedures of the Health Care Division. The routine dental services required will meet the Department's Oral Care policy and procedure as well as the National Commission on Correctional Health Care Dental standards.

#### **Note for the following facilities:**

##### **OAHU:**

Halawa Correction Facility (HCF): The HCF facility houses men of varied custody levels, in the Halawa Special Needs Facility (HSNF), 132 inmates and in the Halawa Medium Security Facility (HMSF), 987 inmates for a total of 1,109 inmates.

Both the HSNF and the HMSF have dedicated space for dental services. The service provider shall provide onsite dental clinics at the HMSF and the HSNF.

Pursuant to new legislation, all services at HCF may be terminated from the contract tentatively in early 2017. This is contingent upon the State's

ability to hire a full time dentist to provide services at HCF. PSD will submit in writing thirty (30) days notification to the Service Provider, indicating the termination date for services at HCF. Also refer to the State of Hawaii Attorney General General Conditions for Health & Human Services Contracts (AG Form 103F<sub>(10/08)</sub>), page 7 of 11:

*“4.3 Termination for Necessity or Convenience. If the STATE determines, in its sole discretion, that it is necessary or convenient, this Contract may be terminated in whole or in part at the option of the STATE upon ten (10) working days’ written notice to the PROVIDER. If the STATE elects to terminate under this paragraph, the PROVIDER shall be entitled to reasonable payment as determined by the STATE for satisfactory services rendered under this Contract up to the time of termination. If the STATE elects to terminate under this section, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.”*

It is stated on that the available funding amount for Oahu is \$322,000.000. Applicant’s are advised that this amount is based on the full twelve (12) months of services, and may change based on the hiring of a full time dentist to HCF. The Applicant’s proposal should be based on the full twelve (12) months initial contract period, as the plans of when services to HCF will be terminated are still tentative.

**HAWAII:**

Kulani Correctional Facility (KCF): The KCF facility houses male sentenced felons of a minimum custody level. The service provider shall provide an onsite dental clinic at KCF in a location that may not have direct access to running water.

**D. Description of the target population to be served**

The Department of Public Safety, Health Care Division, seeks general dental services for inmates detained at Halawa Correctional Facility (HCF), Hawaii Community Correctional Center (HCCC), Kulani Correctional Facility (KCF), Maui Community Correctional Center, and Kauai Community Correctional Center (KCCC).

**E. Geographic coverage of service**

The required dental services shall be provided at the following correctional facilities on the islands of Oahu, Hawaii, Maui and Kauai.

<b>OAHU:</b>	<b><u>Number of Inmates per facility as of January 2016:</u></b>
Halawa Correctional Facility 99-902 Moanalua Road Aiea, Hawaii 96701	1,109 inmates

**HAWAII:**

Hawaii Community Correctional Center      564 inmates  
 60 Punahale Street  
 Hilo, Hawaii 96720

Kulani Correctional Facility                      200 inmates  
 HC 01 Stainback Highway  
 Hilo, Hawaii 96720

**MAUI:**

Maui Community Correctional Center          469 inmates  
 600 Waiale Drive  
 Wailuku, Hawaii 96793

**KAUAI:**

Kauai Community Correctional Center        202 inmates  
 3-5351 Kuhio Highway  
 Lihue, Hawaii 96766

**F. Probable funding amounts, source, and period of availability**

The funding available for services under this request is estimated at \$1,136,000.00, or \$568,000.00 for FY 2017 and \$568,000.00 for FY 2018 (Oahu - \$322,000.00, Hawaii – \$111,000.00 (HCCC: \$68,000.00 and KCF: \$43,000.00), Maui - \$90,000.00 and Kauai - \$45,000.00), subject to availability of funds, for the twenty-four (24) month period commencing on April 1, 2017 or the start date indicated on the Notice to Proceed. Additional funding may be provided if approved by the legislature.

This contract may be extended for not more than two (2) additional twelve-month periods or fraction thereof, subject to the satisfactory performance of the Provider, availability of funds and upon mutual agreement in writing.

**2.2 Contract Monitoring and Evaluation**

The performance of the contract will be monitored and evaluated for:

- (1) Performance Measures
- (2) Output Measures
- (3) Quality of Services
- (4) Financial Management
- (5) Administrative Requirements

**2.3 General Requirements**

**A. Specific qualifications or requirements, including but not limited to licensure or accreditation**

- 1. Applicants shall demonstrate the following:
  - a. Each dentist proposed shall have a DDS or DMD degree, copy to be submitted with proposal;
  - b. Each dentist proposed shall have a current Hawaii dental license, copy to be submitted with proposal;
  - c. Practical experience of staffing in an institutional setting (care home, hospital, etc);
  - d. Experience as an organization in correctional dentistry;
  - e. Appropriate on-island staffing for the island of services; and
  - f. A minimum of two recent references shall be provided with the proposal including contact information.
- 2. Service provider shall be responsible for providing all equipment and dental supplies necessary for the provision of dental services. Applicant shall show proof of availability of portable dental equipment.
- 3. The service provider shall demonstrate proof of an adequate number of available HI licensed dentists to meet contractual service requirements by identifying the names and listing credentials of dentists providing service under this contract for each island. On-island staffing presence for each island of service is required.
- 4. Service provider shall not be an employee of the State of Hawaii, Department of Public Safety.
- 5. Service provider shall provide ongoing credentialing all dentists and licensed ancillary dental staff providing service under this contract assuring at a minimum a current license to practice in the State of Hawaii, if appropriate, current Federal and State DEA licenses, and current CPR certification.

**B. Secondary purchaser participation**

After-the-fact secondary purchases will be allowed.  
Planned secondary purchases: none.

**C. Multiple or alternate proposals**

- Allowed
- Unallowed

**D. Single or multiple contracts to be awarded**

- Single
- Multiple
- Single & Multiple

Criteria for multiple awards: not applicable

**E. Single or multi-term contracts to be awarded**

- Single term (2 years or less)
- Multi-term (more than 2 years)

Contract terms:

Initial Contract Term:  
 April 1, 2017 to March 31, 2019,  
 or the commencement date  
 stated on the Notice to Proceed  
 for a twenty-four month period.  
 Twelve months  
 Length of each extension:  
 Number of possible extensions:  
 Maximum length of contract:  
 Two  
 Forty-eight months  
 Conditions for extension: The  
 contract may be extended for up  
 to two (2) additional twelve  
 month periods or portions  
 thereof, subject to the  
 satisfactory performance of the  
 Provider; the availability of  
 funds; and upon mutual  
 agreement in writing.

**2.4 Scope of Work**

The scope of work encompasses the following tasks and responsibilities:

**A. Service Activities**  
 (Minimum and/or mandatory tasks and responsibilities)

1. General Information

- a. The Service Provider shall provide dental services to inmates on routinely scheduled weekdays a month as designated by the Clinical Section Administrator and in accordance with the facility in the table below.

Facility	Minimum Number of Routinely Scheduled

	<b>Weekdays a Month</b>
Halawa Correctional Facility (HCF)	Sixteen (16)
Hawaii Community Correctional Center (HCCC)	Four (4)
Kulani Correctional Facility (KCF)	Two (2)
Maui Community Correctional Center (MCCC)	Four (4)
Kauai Community Correctional Center (KCCC)	Two (2)

2. Service provider shall:
- a. Provide general dental services and education related to oral health and hygiene according to *the Department of Public Safety, Health Care Division, Policy and Procedures for Oral Care* attached hereto as Attachment C.
  - b. Examine and diagnose dental and oral diseases.
  - c. The actual number of patients that the Provider shall see on-site per visit shall be based on a standard eight-hour clinical workday, not including a one-hour mid-day meal break. With the exception of lockdown days, a minimum of sixteen inmates to a maximum of thirty-two inmates shall be seen depending upon the specific procedures that are pre-scheduled by the facility nurses.
  - d. Standard inmate appointments that are pre-diagnosed and prioritized at examination appointments through treatment plans to require services from the following categories: Basic Restorative, Periodontics, Fixed or Removal Prosthetics, Adjunctive, or Oral Surgery shall be scheduled at one appointment per half hour, with the exception of severely complicated Oral Surgery appointments where appointments shall be scheduled at one per hour.
  - e. Render indicated treatment for oral and dental diseases, including but not limited to oral diagnoses, dental prostheses, restorative dentistry, oral surgery, treatment of pain and infection in the oral cavity, taking of x-rays, and prescription medications according to the Department of Public Safety policies and procedures.
  - f. Document and maintain records of all care and treatment rendered according to the Department of Public Safety format.

The Service Provider will be expected to document all dental visits, treatment, etc. in the future electronic dental records module which will be run in conjunction with the present electronic medical record (EClinical Works). The State shall provide the Service provider access to the system, with the Service provider reimbursing the State for the License Fee to include the provider's dentist. Upon the implementation of the electronic dental record, the Service provider will be required to utilize digital dental x-ray equipment which would enable the images to be stored and viewed in the electronic dental record.

- g. Service provider shall be responsible for payment on all specialty referrals.
  - h. Service provider shall provide the dental services associated with dental prostheses and will invoice the State for reimbursement for any Laboratory fees related to the fabrication of the prostheses. Patients will be required to complete the Prosthesis Purchase Agreement form per *the Department of Public Safety, Health Care Division, Policy and Procedures for Prostheses* attached hereto as Attachment D.
  - i. Develop and implement infection control practices in compliance with OSHA and HIOSH guidelines. Including the use of standard precautions, personal protective devices and the proper wrapping, cleaning and sterilization of non-disposable dental equipment and instruments including performing monthly autoclave spore testing.
  - j. Administer and maintain the Inmate Medical Co-Payment Plan as it pertains to dental services per *the Department of Public Safety, Health Care Division, Policy and Procedures for Inmate Medical Co-Payment Plan* attached hereto as Attachment E.
  - k. Conduct regular sharps counts and monthly tool inventory counts per *the Department of Public Safety, Health Care Division, Policy and Procedures for Tool/Equipment Control* attached hereto. Provide documentation of above counts to the Clinic Services Administrator.
  - l. Be familiar with and adhere to the Department's policies and procedures relating to Oral Care.
3. The service provider shall receive general supervision from the Department's Corrections Health Care Administrator.
4. Lockdowns
- a. Scheduled Lockdowns: Service provider will be notified in advance of scheduled lockdowns. Service provider shall arrange with the facility's

health care section to have patients called out ahead of the scheduled lock down, so that dental services will be provided on a continuous basis.

- b. **Unscheduled Lockdowns:** The service provider shall be paid for a minimum of two (2) hours show-up time, but shall be required to utilize this time by doing internal audits on dental procedures and documentations.
5. **Travel Time.** Service provider shall not be paid for travel time.
6. Service provider shall sign in and out on the attendance sheet at each health care section. Time submitted shall be verified against this sheet.
7. **Additional Hours.** Dentist shall work only the allocated hours for each facility. Written permission from the Health Care Administrator shall be obtained before working additional hours.
8. Supply and maintain all dental equipment including but not limited to dental chairs, X-ray equipment, autoclaves, dental instruments and disposable supplies.
9. Assure all x-ray equipment is licensed in compliance with HAR Chapter, 11-45. The use of digital x-ray technology is preferred.
10. Use lead aprons and thyroid and cervical collars in compliance HAR, Chapter 16-79, Dentists and Dental Hygienists, Section 16-79-7.
11. Conduct monthly inventory audits to assure adequacy of available supplies and timely removal of expiring supplies. No expired supplies shall be used on PSD patients.

## **B. Management Requirements**

### **1. Personnel**

1. Applicants shall demonstrate:
  - a. Each dentist proposed shall have a DDS or DMD degree, copy to be submitted with proposal;
  - b. Each dentist proposed shall have a current Hawaii dental license, copy to be submitted with proposal;
  - c. Practical experience of staffing in an institutional setting (care home, hospital, etc);
  - d. Experience as an organization in correctional dentistry;
  - e. Appropriate on-island staffing for the island of services; and
  - f. A minimum of two recent references shall be provided with the proposal including contact information.
2. The Service provider shall be responsible for providing all necessary equipment and dental supplies necessary for providing

dental services to inmates. Applicant shall show proof of availability of portable dental equipment.

3. The Service provider shall not be an employee of the State of Hawaii, Department of Public Safety.
4. The Service Provider shall notify each of its employees as well as employees of any subcontractors who provide services to any person committed to the custody of the Director of Public Safety for imprisonment pursuant to Chapter 706, Hawaii Revised Statutes (HRS), including a probationer serving a term of imprisonment pursuant to Section 706-624(2)(a), HRS and a misdemeanor or petty misdemeanor sentenced pursuant to Section 706-663, HRS, about the Hawaii Revised Statutes Section 707-731 relating to sexual assault in the second degree and Section 707-732, relating to sexual assault in the third degree. In addition, the Provider and any subcontractor shall maintain in each of the aforementioned employees and employees of any subcontractors' file, written documentation that the employee has received notice of the statutes.
5. The Provider shall employ staff that is suitable to deal with these offenders. The Provider shall not use persons currently serving a criminal sentence, including any on furlough from a correctional facility, on probation, on parole, or under the terms of a DAG/DANC plea. Any employee with a criminal history shall be subject to review and approval by the Department. The Department of Public Safety will review and agree to the employment of the service provider's staff and sub-providers, in writing. Upon request, the Service Provider shall submit any information necessary to determine whether approval will, at the discretion of the Department, be granted. Any changes to staff shall be subject to the prior written approval of the Department.

## **2. Administrative**

The Service provider shall operate their program in accordance with the rules, regulations, and policies of the Department of Public Safety.

The Service provider is required to meet the qualifying requirements specified in Chapter 103F, Hawaii Revised Statutes.

The Service provider shall maintain and show proof of a liability insurance policy of at least two (2) million dollars. The Department of Public Safety shall be named as an additional insured and shall be notified at least thirty (30) days prior to cancellation.

The Service provider shall provide upon award and annually thereafter, in February submit to the Corrections Health Care Administrator (CHCA) a copy of the current dental license, DEA certificate, and CPR certification for any dental providers servicing the contract. The Service provider will provide these credentials to the

CHCA prior to their first assignment for additional dental providers that may be added to service this contract and then as existing licenses and certificates are renewed. The Health Care Division requires that all current credentials be maintained in its files.

### **3. Quality assurance and evaluation specifications**

The criteria by which the performance of the contract will be monitored and evaluated are:

- Timeliness of access to dental services - no patient will wait longer than 2 weeks for the evaluation and treatment of an acute dental problem such as a toothache, potential infection or acute pain.
- Timeliness of access to routine dental services such as x-rays, fillings, oral examinations, and dental appliance repair – no patient should wait longer than 8 weeks to receive routine services.
- Timeliness of access to appliance fabrication- patients requiring appliance fabrication shall wait not longer than 8 weeks to begin the fabrication process.

Compliance with these criteria will be monitored by the Clinical Section Administrator through monthly observation of dental appointment lists and patient requests for dental services to assure waitlist times are within the above parameters.

### **4. Output and performance/outcome measurements**

This section is not applicable to this RFP.

### **5. Experience**

***REFER TO SECTION 2.3.A AND 2.4.B. FOR REQUIREMENTS.***

### **6. Coordination of services**

This section is not applicable to this RFP.

### **7. Reporting requirements for program and fiscal data**

- a. Service provider shall ensure that an informed consent Form DOC 0427 be completed and signed by the inmate prior to any dental procedures such as tooth extractions, root canal therapy, or other surgical procedures are performed per the Department of Public Safety, Health Care Division, Policy and Procedures for Informed Consent.
- b. Service provider shall ensure that the facility nurse records on Form DOC 0417, "Refusal to Consent to Medical or Surgical Treatment", (Attachment G) any inmate's refusal for treatment.
- c. Service provider shall submit quarterly reports of dental services. As an alternative the service provider may submit three months of Dental Statistics

Monthly reports on a quarterly basis with a written summary. This report is due by the end of the first month following the end of the quarter. Failure to comply with the reporting timeframe may result in a fine of \$50.00/day until the report is received. Any incurred fines shall be deducted from service provider's service payment.

- d. Service provider shall perform monthly autoclave spore count testing. This test result shall be submitted to the facility Clinical Section Administrator. This report is due by the end of the month following the month tested. Failure to comply with the reporting timeframe may result in a fine of \$25.00/day until the report is received. Any incurred fines shall be deducted from the service provider's service payment.
- e. Service provider shall provide to the PSD Administrative Office upon award and prior to expiration proof of all provider's current licensure and CPR certification on and on-going basis.

**C. Facilities**

This section is not applicable to this RFP.

**2.5 Compensation and Method of Payment**

The rates submitted shall be subject to negotiation.

Payments to the service provider will be based on the number of satisfactory completed monthly facility visits.

The amount paid per visit will be calculated as follows:

*The estimated annual amount awarded for the island or facility / The minimum number of facility visits.*

Service provider shall submit monthly itemized invoices, original and three copies, to

Department of Public Safety  
Health Care Division  
919 Ala Moana Boulevard, Room 407  
Honolulu, Hawaii 96814

which shall detail the following:

Inmate name;  
Facility of inmate;  
Procedures completed; and  
Date of the procedure;

The service provider shall not be compensated for downtime. However, once a visit is scheduled, the nurse supervisor shall make every effort to ensure that enough inmate patients are available on the list.

If a lockdown is scheduled, the visit will be rescheduled and the service provider shall be notified in a timely manner. The service provider shall check with the facility before reporting in to work in case of an unscheduled lockdown.

## **Section 3**

# **Proposal Application Instructions**

### Section 3 Proposal Application Instructions

#### General instructions for completing applications:

- *Proposal Applications shall be submitted to the state purchasing agency using the prescribed format outlined in this section.*
- *The numerical outline for the application, the titles/subtitles, and the applicant organization and RFP identification information on the top right hand corner of each page should be retained. The instructions for each section however may be omitted.*
- *Page numbering of the Proposal Application should be consecutive, beginning with page one and continuing through for each section. See sample table of contents in Section 5.*
- *Proposals may be submitted in a three ring binder (Optional).*
- *Tabbing of sections (Recommended).*
- *Applicants must also include a Table of Contents with the Proposal Application. A sample format is reflected in Section 5, Attachment B of this RFP.*
- *A written response is required for **each** item unless indicated otherwise. Failure to answer any of the items will impact upon an applicant's score.*
- *Applicants are **strongly** encouraged to review evaluation criteria in Section 4, Proposal Evaluation when completing the proposal.*
- *This form (SPOH-200A) is available on the SPO website (Refer to Section 1.2 Website Reference). However, the form will not include items specific to each RFP. If using the website form, the applicant must include all items listed in this section.*

#### The Proposal Application is comprised of the following sections:

- *Proposal Application Identification Form*
- *Table of Contents*
- *Program Overview*
- *Experience and Capability*
- *Project Organization and Staffing*
- *Service Delivery*
- *Financial*
- *Other*

#### 3.1 Program Overview

Applicant shall give a brief overview to orient evaluators as to the program/services being offered.

#### 3.2 Experience and Capability

##### A. Necessary Skills

Applicant shall demonstrate that it has the necessary skills, abilities, and knowledge relating to the delivery of the proposed services.

**B. Experience**

The applicant shall demonstrate its experience as described in *Section 2.3.A and 2.4.B.*

**C. Quality Assurance and Evaluation**

This section is not applicable to this RFP.

**D. Coordination of Services**

This section is not applicable to this RFP.

**E. Facilities**

This section is not applicable to this RFP.

**3.3 Service Delivery**

The scope of work encompasses the following tasks and responsibilities:

**A. Service Activities**

Applicant shall include a detailed discussion of the applicant's approach to applicable service activities and management requirements from Section 2, Item III. - Scope of Work, including (if indicated) a work plan of all service activities and tasks to be completed, related work assignments/responsibilities, reporting requirements as discussed in Section 2.4, and timelines/schedules.

Please discuss and attach sample reports indicating the dental work provided to each inmate. This report shall be provided to the Department on a timely basis.

**3.4 Financial**

**A. Pricing Structure**

Payments to the service provider will be based on the number of satisfactory completed monthly facility visits.

The amount paid per visit will be calculated as follows:

*The estimated annual amount awarded for the island or facility / The minimum number of facility visits.*

As stated on page 2-2, the available funding amount for Oahu is \$322,000.000. Applicant's are advised that this amount is based on the full twelve (12) months of services, and may change based on the hiring of a full time dentist to HCF. The Applicant's proposal should be based on

the full twelve (12) months initial contract period, as the plans of when services to HCF will be discontinued are still tentative.

### **3.5 Other**

#### **A. Litigation**

The applicant shall disclose any pending litigation to which they are a party, including the disclosure of any outstanding judgment. If applicable, please explain.  
(Statements regarding litigation will not carry any point value but are required.)

## **Section 4**

### **Proposal Evaluation**

**Section 4  
Proposal Evaluation**

**4.1 Introduction**

The evaluation of proposals received in response to the RFP will be conducted comprehensively, fairly and impartially. Structural, quantitative scoring techniques will be utilized to maximize the objectivity of the evaluation.

**4.2 Evaluation Process**

The procurement officer or an evaluation committee of designated reviewers selected by the head of the state purchasing agency or procurement officer shall review and evaluate proposals. When an evaluation committee is utilized, the committee will be comprised of individuals with experience in, knowledge of, and program responsibility for program service and financing. Each applicant shall receive a notice of award/non-award, which shall contain a statement of findings and decision for the award or non-award of the contract to each applicant.

The evaluation will be conducted in three phases as follows:

- Phase 1 - Evaluation of Proposal Requirements
- Phase 2 - Evaluation of Proposal Application
- Phase 3 - Recommendation for Award

**Evaluation Categories and Thresholds**

<u>Evaluation Categories</u>	<u>Possible Points</u>
<i>Administrative Requirements</i>	
 <i>Proposal Application</i>	
	<b>100 Points</b>
Experience and Capability	20 points
Service Delivery	40 points
Pricing	40 points
 <b>TOTAL POSSIBLE POINTS</b>	 <b>100 Points</b>

**4.3 Evaluation Criteria**

**A. Phase 1 - Evaluation of Proposal Requirements**

**1. Administrative Requirements**

- Application checklist

**2. Proposal Application Requirements**

- Proposal Application Identification Form (Form SPOH-200)
- Table of Contents
- Background and Summary
- Experience and Capability
- Service Delivery
- Financial (All required forms and documents)
- Program Specific Requirements (as applicable)

**B. Phase 2 - Evaluation of Proposal Application (100 Points)**

**Program Overview:** No points are assigned to Program Overview. The intent is to give the applicant an opportunity orient evaluators as to the service(s) being offered.

**1. Experience and Capability (20 Points)**

The State will evaluate Applicant’s experience and capability relevant to the proposal contract, which shall include:

- |           |   |                     |
|-----------|---|---------------------|
| <b>A.</b> | <b>Necessary Skills</b>   | <b><u>5pts</u></b>  |
|           | <ul style="list-style-type: none"> <li>• Demonstrated skills, abilities, and knowledge relating to the delivery of the proposed services.</li> </ul>  |                     |
| <b>B.</b> | <b>Experience</b>   | <b><u>15pts</u></b> |
|           | <ul style="list-style-type: none"> <li>• Demonstrate the practical experience of proposed staffing in an institutional setting (care home, hospital, etc) (4 pts)<br/><i>The State at its sole discretion will determine the applicability of the staffing’s practical experience.</i></li> <li>• Demonstrate experience as an organization in correctional dentistry. (4 pts)</li> <li>• Minimum to two recent references. (7 pts)<br/><i>References shall include contact information.</i></li> </ul> |                     |
| <b>C.</b> | <b>Quality Assurance and Evaluation</b>   | <b><u>N/A</u></b>   |
|           | <ul style="list-style-type: none"> <li>• Sufficiency of quality assurance and evaluation plans for the proposed services, including methodology.</li> </ul>   |                     |
| <b>D.</b> | <b>Coordination of Services</b>   | <b><u>N/A</u></b>   |
|           | <ul style="list-style-type: none"> <li>• Demonstrated capability to coordinate services with other agencies and resources in the community.</li> </ul>  |                     |
| <b>E.</b> | <b>Facilities</b>   | <b><u>N/A</u></b>   |
|           | <ul style="list-style-type: none"> <li>• Not Applicable.</li> </ul>   |                     |

**3. Service Delivery (40 Points)**

Evaluation criteria for this section will assess the applicant's approach to the service activities and management requirements outlined in the Proposal Application.

**4. Pricing (40 Points)**

- Competitiveness and reasonableness of unit of service rate, as applicable
- Applicant's proposal budget is reasonable, given program resources and operational capacity.

**B. Phase 3 - Recommendation for Award**

Each notice of award shall contain a statement of findings and decision for the award or non-award of the contract to each applicant.

## **Section 5**

### **Attachments**

- A. Proposal Application Checklist
- B. Sample Table of Contents
- C. Department of Public Safety, Health Care Division, Policy and Procedures for Oral Care.
- D. Department of Public Safety, Health Care Division, Policy and Procedures for Assistive Devices / Aids to Impairment.
- E. Department of Public Safety, Health Care Division, Policy and Procedures for Inmate Medical Co-Payment Plan.
- F. Department of Public Safety, Health Care Division, Policy and Procedures for Tools / Equipment Control.\*  
(\*will be provided upon request, please contact RFP Point-of-Contact identified on page 1-3)
- G. Department of Public Safety, Health Care Division, Policy and Procedures for Informed Consent & Right to Refuse.

## Proposal Application Checklist

Applicant: \_\_\_\_\_ RFP No.: PSD 17-HCD-05

The applicant's proposal must contain the following components in the order shown below. Return this checklist to the purchasing agency as part of the Proposal Application. SPOH forms are on the SPO website.

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Applicant to place "X" for items included in Proposal
<b>General:</b>				
Proposal Application Identification Form (SPOH-200)	Section 1, RFP	SPO Website*	<b>X</b>	
Proposal Application Checklist	Section 1, RFP	Attachment A	<b>X</b>	
Table of Contents	Section 5, RFP	Section 5, RFP	<b>X</b>	
Proposal Application (SPOH-200A)	Section 3, RFP	SPO Website*	<b>X</b>	
Provider Compliance (HCE)	Section 1.9, RFP	SPO Website*	<b>X</b>	
Cost Proposal (Budget)				
SPO-H-205	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions are in Section 5	<b>X</b>	
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions are in Section 5		
SPO-H-206A	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206B	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206C	Section 3, RFP	SPO Website*		
SPO-H-206D	Section 3, RFP	SPO Website*		
SPO-H-206E	Section 3, RFP	SPO Website*		
SPO-H-206F	Section 3, RFP	SPO Website*	<b>X</b>	
SPO-H-206G	Section 3, RFP	SPO Website*		
SPO-H-206H	Section 3, RFP	SPO Website*		
SPO-H-206I	Section 3, RFP	SPO Website*		
SPO-H-206J	Section 3, RFP	SPO Website*		
<b>Certifications:</b>				
<b>Federal Certifications</b>		Section 5, RFP		
Debarment & Suspension		Section 5, RFP		
Drug Free Workplace		Section 5, RFP		
Lobbying		Section 5, RFP		
Program Fraud Civil Remedies Act		Section 5, RFP		
Environmental Tobacco Smoke		Section 5, RFP		
<b>Program Specific Requirements:</b>				
Proof of Insurance	Section 2.3.A.6		<b>X</b>	

\*Refer to Section 1.2, Website Reference for website address.

**SAMPLE Proposal Application  
Table of Contents**

<b>1.0</b>	<b>Program Overview</b> .....	1
<b>2.0</b>	<b>Experience and Capability</b> .....	1
	A. Necessary Skills .....	2
	B. Experience.....	4
	C. Quality Assurance and Evaluation .....	5
	D. Coordination of Services.....	6
	E. Facilities.....	6
<b>3.0</b>	<b>Project Organization and Staffing</b> .....	7
	A. Staffing .....	7
	1. Proposed Staffing .....	7
	2. Staff Qualifications .....	9
	B. Project Organization .....	10
	1. Supervision and Training .....	10
	2. Organization Chart (Program & Organization-wide) (See Attachments for Organization Charts)	
<b>4.0</b>	<b>Service Delivery</b> .....	12
<b>5.0</b>	<b>Financial</b> .....	20
	See Attachments for Cost Proposal	
<b>6.0</b>	<b>Litigation</b> .....	20
<b>7.0</b>	<b>Attachments</b>	
	A. Cost Proposal	
	SPO-H-205 Proposal Budget	
	SPO-H-206A Budget Justification - Personnel: Salaries & Wages	
	SPO-H-206B Budget Justification - Personnel: Payroll Taxes and Assessments, and Fringe Benefits	
	SPO-H-206C Budget Justification - Travel: Interisland	
	SPO-H-206E Budget Justification - Contractual Services – Administrative	
	B. Other Financial Related Materials	
	Financial Audit for fiscal year ended June 30, 1996	
	C. Organization Chart	
	Program	
	Organization-wide	
	D. Performance and Output Measurement Tables	
	Table A	
	Table B	
	Table C	
	E. Program Specific Requirements	

	<b>DEPARTMENT OF PUBLIC SAFETY</b>  <b>CORRECTIONS ADMINISTRATION</b> <b>POLICY AND PROCEDURES</b>	<b>EFFECTIVE DATE:</b> 05/12/2003	<b>POLICY NO.:</b> COR.10.1E.06
		<b>SUPERSEDES (Policy No. &amp; Date):</b> COR.10D.15 01/09/98	
<b>SUBJECT:</b>  <b>ORAL CARE</b>		<b>Page 1 of 5</b>	

No. 2003-468

## 1.0 PURPOSE

To provide oral care to inmates under the direction and supervision of a dentist licensed in the State.

## 2.0 REFERENCES AND DEFINITIONS

### .1 References

- a. HRS, Section 26-14.6, Department of Public Safety; and Section 353C-2, Director of Public Safety, Powers and Duties.
- b. National Commission on Correctional Health Care Standards for Prisons and Jails, (2003), Oral Care.
- c. American Dental Association.
- d. American Correctional Association Standards for Adult Local Detention Facilities, (1991), dental Screening and Examination.
- e. Department of Public Safety Policy and Procedures Manual, COR.10A.16, Inmates Requesting Private Medical Care Provider. COR.10.1G.11, Prostheses COR.10.1H.05, The Transfer of Medical Records.

### .2 Definitions

- a. Universal Dental Recording System: A mean of identifying teeth by number.
- b. Prosthetics: Artificial devices to replace missing body parts; in this case, dentures, bridges, etc.

## 3.0 POLICY

- .1 Dental examinations and treatments for inmates shall be performed by, and under the direction and supervision of, a dentist licensed to practice in the State of Hawaii.

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- .2 Dental care of inmates shall be timely and includes immediate access for urgent or painful conditions. The inmate's serious urgent and emergent dental needs shall be met.

#### 4.0 PROCEDURES

- .1 Dental screening of newly admitted inmates shall occur within fourteen (14) days of admission into the Department of Public Safety (PSD) jail facilities and seven (7) days after admission to prison facilities. Inmates who transfer from one PSD facility to another who received a dental screen while at the sending facility do not require a new screening at the receiving facility if the documentation in the dental record is received within the 14 to 7 days respectively.
- .2 The dental screening shall include visual observation of the teeth and gums, noting any gross abnormalities which require immediate referral to a dentist. Health staff with documented training by a dentist can perform dental screens. The screening shall be recorded in the dental record.
- .3 Instructions in oral hygiene and preventive oral education are given within one (1) month of admission by a dentist, dental hygienist, or health staff with documented training by a dentist.
- .4 A dentist shall perform a dental examination on all inmates within thirty (30) days of admission to a PSD prison facility and within one (1) year of admission to a PSD jail facility. Inmates who transfer from one PSD facility to another who received a dental screen while at the sending facility do not require a new examination at the receiving facility if the documentation in the dental record transfers with the inmate.

Inmates who are re-admitted and who received a dental examination and treatments within the past year do not require a new examination unless so determined by the supervising dentist.

- .5 Dental examinations shall include taking the patient's dental history, and extraoral head and neck examination, charting of teeth and examination of hard and soft tissue of the oral cavity with a mouth mirror, explorer and adequate illumination. The examination results shall be recorded on Form DOC 0424 Dental Examination (Attachment A) utilizing a number system, such as the Universal Dental Recording System (e.g., 1-32, A -T).

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- .6 Oral treatment shall be prioritized for emergencies, acute injuries to the teeth, acute injuries to the oro-facial complex, infection control, pain management, proper mastication and maintaining the patients' health status.
- .7 Bitewing x-rays and additional radiographs may be taken at the time of the patient's first treatment appointment and thereafter as indicated.
- .8 Each inmate shall have access to the preventive benefits of fluorides in a form determined by the dentist to be appropriate for the needs of the individual.
- .9 Extractions shall be performed in a manner consistent with community standards of care and adhering to the American dental association's clinical guidelines. Extractions are limited to the following:
1. Non-restorable teeth;
  2. Periodontally compromised teeth; and
  3. Severe, acute or chronic infection.
- Informed patient consent for extractions is required on DOC 0427, Consent to Operation, Post Operative Care, medical Treatment, Anesthesia or Other Procedure (Attachment B).
- .10 Inmates can seek private dental care at their own expense under COR.10A.16, Inmates Requesting Private Medical Care Provider. For security reasons, dental staff should encourage the private provider to come to the facility to provide the services. Approval for private provider care must be approved by the Correctional Health Care Administrator or designee.
- .11 Medical reviews of any inmates to be transferred to another correctional facility shall include consideration of any pending dental work. Should an inmate's pending transfer involve a facility at which an institutional dentist is not readily available and the inmate has major uncompleted dental work pending, the inmate shall not be transferred until dental services have been completed.
- .12 All dental records shall be confidential. These records shall be maintained for all patients and shall include as indicated the:

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- a. Dental Treatment Record, DOC 0409 (Attachment C).
  - b. Dental Health Questionnaire, DOC 0411 (Attachment D).
  - c. Refusal to consent to Medical/Surgical Treatment/Medication, DOC 0417 (Attachment E).
  - d. Dental Examinations.
  - e. Consent to Operation, Post Operative..., DOC 0427, (Attachment B).
  - f. Perio Chart.
  - g. Dental Problem Sheet, DOC 0475 (Attachment F).
  - h. Medical Needs Memo, DOC 0449 (Attachment G).
  - i. Consultation Record, doc 0406 (Attachment H).
  - j. X-rays.
- .13 When an inmate transfers to another PSD facility, the dental record shall be packed with the medical record and transferred according to P & P COR.10E.03, The Transfer of Medical Records.
- .14 Dental records shall be notated in S-O-A-P or problem oriented format. All notes shall include the client's complaint, the examination, the diagnostic impression, and the treatment and treatment plans.
- .15 Form DOC 0406 Consultation Record shall accompany the inmate to an outside dental referral. DOC 0406 will also be used when a dental consultant comes to the facility. The Consultation Record and the consultant's report shall be filed in the Consultation Index of the medical record. A copy of the consultation Record and consultant's report shall be filed in the dental record.
- .16 All dental staff shall practice universal infection controls and infection controls. Infection control practices are defined by the American Dental Association and the Centers for Disease control and Prevention as including sterilizing

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instruments, disinfecting equipment, and properly disposing of hazardous waste.

No inmate shall be denied dental treatment because of an infectious condition.

- .17 Reviews of dental services will be included in the PSD health services quality assurance program as described in P & P COR.10A.05, Quality Improvement Program.

**5.0 SCOPE**

This policy and procedure applies to all correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

[Redacted Signature]

Medical Director  
5/21/03

[Redacted Signature]

Correctional Health Care Administrator

4/3/03

[Redacted Signature]

Deputy Director for Corrections

5.10.03

Date

APPROVED:

[Redacted Signature]

Director

5/12/03

Date



CONSENT TO OPERATION, POST OPERATIVE CARE, MEDICAL TREATMENT, ANESTHESIA, OR OTHER PROCEDURE

Patient: \_\_\_\_\_
SSN: \_\_\_\_\_ DOB: \_\_\_\_\_
Facility: \_\_\_\_\_ Date: \_\_\_\_\_

You have the right and obligation to make decisions concerning your health care. The physician must provide you with the information and advice concerning the proposed procedure so that you can make an informed decision

(1) Explain the nature of the condition(s) in professional and ordinary language.

PROFESSIONAL: \_\_\_\_\_

ORDINARY LANGUAGE: \_\_\_\_\_

AT \_\_\_\_\_

(2) Describe procedures(s) to be performed in professional and ordinary language, if appropriate.

PROFESSIONAL: \_\_\_\_\_

ORDINARY LANGUAGE: \_\_\_\_\_

AT \_\_\_\_\_

(3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate my above-named physician and his or her assistants, to perform such surgical or other procedures as are necessary to preserve my life and bodily functions.

(4) I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.

(5) No promise or guarantee has been made to me as to result or care.

Any section below which does not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both the physician and the patient.

(6) I consent to the administration of (general, spinal, regional, local) anesthesia by my attending physician, by an anesthesiologist, a nurse anesthetist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney.

These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.

(7) I consent to the use of transfusion of blood and blood products as deemed necessary. I have been informed of the risks which are transmission of disease, allergic reactions, and other unusual reactions.

(8) Any tissue or part surgically removed may be disposed of by the hospital or physician in accordance with accustomed practice.

(9) Any additional comments may be inserted here:

(10) I have had the opportunity to ask questions about this form.

FULL DISCLOSURE

[ ] I AGREE TO AUTHORIZE THE PROCEDURE DESCRIBED ABOVE AND I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF THE:

- a) DIAGNOSIS OR PROBABLE DIAGNOSIS.
b) NATURE OF THE TREATMENT OR PROCEDURE RECOMMENDED.
c) RISKS OR COMPLICATIONS INVOLVED IN SUCH TREATMENT OR PROCEDURES.
d) ALTERNATIVE FORMS OF TREATMENT, INCLUDING NON-TREATMENT, AVAILABLE.
e) ANTICIPATED RESULTS OF THE TREATMENT.

Patient/Other Legally Responsible Person Sign, If Applicable

Date

Physician

Date





STATE OF HAWAII  
DEPARTMENT OF PUBLIC SAFETY

REFUSAL TO CONSENT TO MEDICAL/SURGICAL/DENTAL TREATMENT/MEDICATION

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ SID: \_\_\_\_\_

DOB: \_\_\_\_\_ FACILITY: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

I, the undersigned patient, refuse the following treatment and/or medication: \_\_\_\_\_

\_\_\_\_\_

(Describe Treatment and/or Medication)

The risk of refusing treatment or medication has been explained to me and I accept the risk involved. I release the State, the Department, the facility, the Health Care Division, and its medical personnel from any responsibility whatever for any unfavorable reaction, outcome, or any untoward results due to this refusal on my part to accept treatment or medication.

\_\_\_\_\_  
(Print Name of Patient)

\_\_\_\_\_  
(Signature of Patient)\*

\_\_\_\_\_  
(Date)

I, the undersigned, have explained to the above named patient the risk involved in refusing treatment or medication recommended for the patient's continued good health.

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature & Title)

\_\_\_\_\_  
(Date)

A referral has been made to the attending physician:      YES                      NO

I have reviewed this case and if necessary have further counseled this patient on the risk of refusing treatment or medication.

\_\_\_\_\_  
(Print Name of Provider)

\_\_\_\_\_  
(Signature & Title)

\_\_\_\_\_  
(Date)

*\* If the patient refuses treatment and/or medication and refuses to sign this consent, please have refusal witnessed by another correctional employee.*

I have witnessed the above named patient refuse the recommended treatment or medication and I have also witnessed the patient's refusal to sign this consent form.

\_\_\_\_\_  
(Print Name & Title)

\_\_\_\_\_  
(Signature & Title)

\_\_\_\_\_  
(Date)

STATE OF HAWAII

DEPARTMENT OF PUBLIC SAFETY

**DENTAL PROBLEM SHEET**

Name: \_\_\_\_\_

Facility: \_\_\_\_\_

	Problem	Date Observed	Date Completed	NOTES
1.				
2.				
3.				
4.				
5.				
6.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				

**MEDICAL NEEDS MEMO**

Facility: \_\_\_\_\_

Date: \_\_\_\_\_

TO: \_\_\_\_\_

FROM: \_\_\_\_\_  
(Signature/Title of Provider)

Inmate \_\_\_\_\_  
(Print Inmate's Name)

Housed in \_\_\_\_\_

DURATION: \_\_\_\_\_ Days; \_\_\_\_\_ Weeks; \_\_\_\_\_ Months; \_\_\_\_\_ Indefinitely

*\*Duration not to exceed three months for medication reviews for chronic illnesses.*

*\*Health Status Classification Report required if there is a significant change in health status.*

Original: UTM/ACO/Work Supervisor

Canary: Medical Record

Pink: Inmate

DOC 0449 (12/2002)

**CONFIDENTIAL**



	<b>DEPARTMENT OF PUBLIC SAFETY</b>	<b>EFFECTIVE DATE:</b> DEC 10 2014	<b>POLICY NO.:</b> COR.10.1G.10
	<b>CORRECTIONS ADMINISTRATION  POLICY AND PROCEDURES</b>	<b>SUPERSEDES (Policy No. &amp; Date):</b> COR.10.1G.10 (12/29/08)	
	<b>SUBJECT:</b> <b>ASSISTIVE DEVICES/AIDS TO IMPAIRMENT</b>		Page 1 of 5

## 1.0 PURPOSE

To purpose of this policy is to establish guidelines for the purchase of medically indicated prostheses, orthosis and mechanical devices.

## 2.0 REFERENCES AND DEFINITIONS

### .1 References

- a. Hawaii Revised Statutes, Section 26-14.6, Department of Public Safety; and Section 353-2, Director of Public Safety, Powers and Duties.
- b. National Commission on Correction Health Care, Standards for Health Services in Prisons and Jails (2008).
- c. American Correctional Association, Standards for Adult Correctional Institutions.

### .2 Definitions

- a. Prosthesis: Artificial devices to replace missing body parts or augment the function of a natural function such as a limb, eye, hearing aid, full plate dentures, etc.
- b. Orthotic Devices: appliances for the immobilization or stabilization of a body part to prevent deformity, protect against injury, or assist with function can include slings, splints, braces, etc.
- c. Mechanical Device: wheelchairs, patient lifts, motorized assistive devices, CPAP.
- d. Assistive Device: Any single or combination of prosthetic, orthosis or mechanical devices that assist a person in performing their daily activities of living.
- e. Dental Appliance – Partial, bridges, crowns, orthodontic braces, retainers, braces, spacers, implants, bite planes.
- f. Basic Level Prosthetics – The level of prosthetic devices such as limbs, hearing aides, eyes that would be covered under the State of Hawaii Medicaid Program.

**NOT-CONFIDENTIAL**

<b>COR</b>  <b>P &amp; PM</b>	<b>SUBJECT:</b>  <b>ASSISTIVE DEVICES/AIDS TO IMPAIRMENT</b>	<b>POLICY NO.:</b> <b>COR.10.1G.10</b>
		<b>EFFECTIVE DATE:</b> <b>DEC 10 2014</b>
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### 3.0 POLICY

- .1 Physicians and dentists may prescribe medically necessary clinically indicated prosthetics when required to assist the retention or improvement of physical function or when the health of the patient would otherwise be adversely affected.
- .2 Prosthetic devices must be authorized as medically necessary through the Special Utilization Review Panel (SURP) before being approved for purchase through the Department. The Department will cover basic level replacement limbs, hearing aides, eyes and the necessary supporting medical supplies such as stockings, batteries, etc. for a patient, who is expected to demonstrate according to their physician's assessment, a retention or improvement in physical function as a result of the device. This device will be provided at no cost to the patient.
- .3 Mechanical Devices that are deemed medically necessary to support or sustain the life of a patient such as continuous positive airway pressure (CPAP) and biphasic positive airway pressure (BIPAP) machines for sleep apnea, alternating pressure mattresses, oxygen, feeding pumps, etc., and all medical supplies necessary to operate these devices will be covered at no cost to the patient.
- .4 Medical devices other than those listed above such as, but not limited to, appliances for the immobilization or stabilization of a body part to prevent deformity, protect against injury, or to assist with function, including slings, splints, braces, wheelchairs, motorized assistive devices and dental appliances shall be the financial responsibility of the patient. The patient shall pay for all fees, costs including the care of the prosthetic, orthosis or mechanical device.
- .5 The Department will cover the cost of medical equipment listed under .4 above, for those patients who have been determined to be indigent under the Health Care Payment plan. The patient must sign a Purchase Agreement allowing any funds deposited above a ten dollar (\$10.00) minimum balance in their patient account, be withdrawn from the account until the equipment cost is paid in full. The following conditions apply:
  - The patient has a mandatory minimum sentence or parole date with sufficient remaining incarceration time to allow for the potential repayment of the cost of the equipment.
  - The equipment is determined to be medically necessary by a State physician.

**NOT-CONFIDENTIAL**

<b>COR</b>  <b>P &amp; PM</b>	<b>SUBJECT:</b>  <b>ASSISTIVE DEVICES/AIDS TO IMPAIRMENT</b>	<b>POLICY NO.:</b> <b>COR.10.1G.10</b>
		<b>EFFECTIVE DATE:</b> <b>DEC 10 2014</b>
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- The patient is determined to be indigent; and therefore, unable to pay for the cost of the equipment in advance.
  - All more cost effective alternatives to the equipment have been considered.
  - The patient signs a purchase agreement document.
- .6 Prior authorization through the Special Utilization Review Panel (SURP) is required for medically recommended prosthetics, orthoses and mechanical devices that cost in excess of two hundred dollars (\$200).
- .7 All outstanding medical cost obligations owed by the patient shall be deducted from the patient's account prior to the release of any account balance to the patient.
- .8 Prosthetics purchased for the patient shall not be replaced within a frequency period of less than five (5) years, unless the patient's physical condition has changed necessitating a new prosthetic.
- .9 Prosthetic devices deliberately damaged by the patient will not be replaced.

#### **4.0 PROCEDURES**

- .1 Prostheses, orthoses or mechanical devices shall be searched during intake, including the removal of the device, if necessary. The Health Care Section (HCS) shall be notified immediately when a device is to be confiscated. A physician shall determine the medical necessity of the device. If deemed not medically necessary, it will be removed, recorded and managed as an item of the patient's property.
- .2 Provisions shall be made for a patient to purchase and maintain an assistive device including corrective eyeglasses, hearing aids, dentures, artificial limbs, wheelchairs and orthopedic appliances, when ordered by a treating State physician or dentist.
- .3 Any patient with a physical disability or impairment may request an assistive device through the sick call process. The patient shall be referred to the facility physician or dentist, who shall determine whether or not the requested device is medically necessary. Only devices deemed medically necessary shall be considered for use in the facility.

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		<b>EFFECTIVE DATE:</b> <b>DEC 10 2014</b>
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- .4 Approval from the SURP is required prior to the purchase, when the applicable provider fee and the cost of the prosthetic exceed two hundred dollars (\$200) and the patient is using the health care payment plan to pay for the cost of the device. The facility health authority or designee is responsible for reviewing and approving purchases totaling less than two hundred dollars (\$200).
- .5 The patient's mandatory minimum sentence and/or parole date, ability to pay and the availability of cost effective alternatives shall be considered during the approval process.
- .6 When a payment plan is utilized for authorized purchases by patients with insufficient funds; funds shall be withdrawn from the patient's account whenever there is more than ten dollars (\$10) in the account. A joint voucher will be used to transfer funds from the patient's account to the facility's HCS operating fund if the transfer is made during the fiscal year that the prosthesis is purchased. Patients refusing to sign the purchase authorization shall not be provided with the equipment.
- .7 After completion of the fiscal year, the funds shall be made out to the Director of Finance and transferred to the state general fund. The patient shall sign form DOC 0477, Purchase Agreement (Attachment A) to authorize the withdrawal of funds to pay for the device.
- .8 Furloughed patients require the collection of at least one-half the cost of applicable fees and the prosthetic, at the time of the initial examination and measurement. Any purchase that will result in a balance in excess of two hundred dollars (\$200.00) requires the authorization of the SURP. The balance shall be an agreed upon amount paid at regular intervals. Payment shall be made to the HCS by cashier's check, facility check or money order. The furloughed patient shall sign Form DOC 0477-B Furloughee Purchase Agreement (Attachment B).
- .9 A patient may refuse the purchase of a recommended prosthetic. A refusal of a prosthetic by a patient shall be documented on form DOC 0417, Refusal to Consent to Medical/Dental Treatment/Medications (Attachment C).

**NOT-CONFIDENTIAL**

COR  P & PM	<b>SUBJECT:</b>  <b>ASSISTIVE DEVICES/AIDS TO IMPAIRMENT</b>	<b>POLICY NO.:</b> COR.10.1G.10
		<b>EFFECTIVE DATE:</b> DEC 10 2014
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**5.0 SCOPE**

This policy and procedure applies to all correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:



Medical Director Date  


Health Care Division Administrator Date

Deputy Director for Corrections Date

APPROVED:



Director

12/10/14  
Date

STATE OF HAWAII  
DEPARTMENT OF PUBLIC SAFETY  
HEALTH CARE DIVISION

**PURCHASE AGREEMENT**

\_\_\_\_\_  
(Print Inmate's Name) (SID) (DOB)

\_\_\_\_\_  
(List Item(s) to be Purchased)

- \_\_\_\_\_  
(Initial) 1. I have been informed that the items I wish to purchase are not covered benefits under my health plan. I understand that by agreeing to purchase the item(s) listed above. I am responsible for the cost of the item(s) and that I am buying the item(s) from a private business and not from the Department of Public Safety.
- \_\_\_\_\_  
(Initial) 2. I understand by agreeing to purchase the item(s), and I must have sufficient funds in my account to pay for the full cost of the requested item(s), and the entire amount will be deducted from my account.
- \_\_\_\_\_  
(initial) 3. The Health Care Division (HCD) has a reimbursement payment plan available if I do not have sufficient money in my account to pay for the entire cost of the prosthesis. If I agree to the payment plan, the HCD will purchase the items (s) from the private business so I can have it right away. I will then be obligated to the terms of the payment plan until the entire cost of the item has been repaid.
- \_\_\_\_\_  
(initial) 4. I understand I have the right to refuse the recommended item(s) listed above and participation in the payment plan.
- \_\_\_\_\_  
(Initial) 5. If I agree to the payment plan, I understand that whenever there are funds in my account in excess of ten dollars (\$10.00), the excess amount will be withdrawn until the cost of the requested item(s) is paid in full.
- \_\_\_\_\_  
(Initial) 6. I understand that if I agree to the payment plan and I am released from jail or prison before I have finished paying for the items(s), any funds remaining in my inmate account will be applied to my debt. I understand that if I ever return to jail or prison, I will be obligated to pay any outstanding balance owed the Health Care Division for the purchase of the requested item(s) as soon as funds are deposited into my account, for any reason, from any source.
- \_\_\_\_\_  
(Initial) 7. I understand that the purchase of the item(s) listed above is non-refundable once the order is placed. An item(s) may be substituted for an item of equal value if the vendor's regulations allow for exchanges.

I refuse the payment plan and I do not wish to purchase the item(s) listed above at this time. \_\_\_\_\_  
(Initial)

I consent to the purchase of the item(s) listed at the top of the page and authorize the amount of \$ \_\_\_\_\_ to be deducted in full or by the reimbursement payment plan if I have insufficient funds in my account at this time. \_\_\_\_\_  
(Initial)

\_\_\_\_\_  
(Inmate Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Staff Signature/Title)

\_\_\_\_\_  
(Date)

Item(s) ordered on \_\_\_\_\_ from \_\_\_\_\_

Item(s) received on \_\_\_\_\_ Issued to inmate on \_\_\_\_\_  
(Pt Initial)

Original sent to fiscal on \_\_\_\_\_

Copy to inmate & medical record

STATE OF HAWAII  
DEPARTMENT OF PUBLIC SAFETY  
HEALTH CARE DIVISION

**FURLOUGHEE PURCHASE AGREEMENT**

If my funds are insufficient to cover the cost of the requested item(s), I understand that a cashier's check or money order amounting to half the cost of the requested item(s) shall be paid to the Department to purchase the following prosthetic:

\_\_\_\_\_

List Item(s)

A minimum of \$\_\_\_\_\_ shall be paid at regular intervals every \_\_\_\_\_  
until the cost of the item(s) is paid in full.

\_\_\_\_\_  
Furlougee's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Nurse Signature

\_\_\_\_\_  
Date

Copy:   Fiscal Office  
          Medical Record  
          Inmate

DEPARTMENT OF PUBLIC SAFETY  
HEALTH CARE DIVISION

**REFUSAL TO CONSENT TO MEDICAL/SURGICAL/DENTAL TREATMENT/MEDICATION**

NAME: \_\_\_\_\_ SID: \_\_\_\_\_ DOB: \_\_\_\_\_

FACILITY: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

I, the undersigned patient, refuse the following treatment and/or medication: \_\_\_\_\_

\_\_\_\_\_  
(Describe Treatment and/or Medication)

The risk of refusing treatment or medication has been explained to me and I accept the risk involved. I release the State, the Department, the facility administration and personnel, the Health Care Division administration and medical personnel from any responsibility or liability for any unfavorable reaction, outcome, or any untoward results due to this refusal on my part to accept treatment or medication.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

I, the undersigned, have explained to the above named patient the risk involved in refusing treatment or medication recommended for the patient's continued good health and I witness the patient's refusal of the recommended treatment or medication

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature & Title)

\_\_\_\_\_  
(Date)

A referral has been made to a provider:      YES                      NO

I have reviewed this case and if necessary have further counseled this patient on the risk of refusing treatment or medication.

\_\_\_\_\_  
(Print Name of Provider)

\_\_\_\_\_  
(Signature & Title)

\_\_\_\_\_  
(Date)

*\* If the patient refuses treatment and/or medication and refuses to sign this consent, please have refusal witnessed by another correctional employee.*

I have witnessed the above named patient refuse the recommended treatment or medication and I have also witnessed the patient's refusal to sign this consent form.

\_\_\_\_\_  
(Print Name & Title)

\_\_\_\_\_  
(Signature & Title)

\_\_\_\_\_  
(Date)

	<b>DEPARTMENT OF PUBLIC SAFETY</b>  <b>CORRECTIONS ADMINISTRATION</b> <b>POLICY AND PROCEDURES</b>	<b>EFFECTIVE DATE:</b> MAR 30 2010	<b>POLICY NO.:</b> COR.10.1A.13
		<b>SUPERSEDES (Policy No. &amp; Date):</b> COR.10.1A.13 (10/09/07)	
<b>SUBJECT:</b> <b>INMATE MEDICAL CO-PAYMENT</b>		Page 1 of 4	

## 1.0 PURPOSE

The purpose of this policy is to provide guidelines and an organized process for inmate co-payments of certain medical services.

## 2.0 REFERENCES AND DEFINITIONS

### .1 References

- a. Hawaii Revised Statutes; Section 26-14.6, Department of Public Safety; and Section 353C-2, Director of Public Safety, Powers and Duties.
- b. National Commission on Correctional Health Care, Standards for Health Services in Prisons and Jails, Position Statement, (2003).

### .2 Definitions

- a. Co-payment: A nominal amount paid by an individual for certain health care services.
- b. Indigent: An inmate with less than ten dollars (\$10.00) of income in his or her spendable or restricted accounts.
- c. Episode of care: From the beginning of treatment for a particular injury or illness until there is no longer any required follow-up care as determined by the health care provider.
- d. Infirmary: A designated area within a facility that is expressly set up and operated for the purpose of caring for patients who do not need hospitalization, but whose care cannot be managed safely in the general population setting.
- e. Retrospective Billing System: This is not an accounting method. The terminology describes a system that charges the patient for medical services after the service is rendered to ensure access to health care.

## 3.0 POLICY

- .1 Inmates shall not be denied access to health care or necessary medical treatment because of their inability to pay the co-payment fee.
- .2 There shall be a retrospective billing system for medical services rendered.

## 4.0 PROCEDURES

- .1 Within twenty-four (24) hours of admission inmates shall be given written information about their responsibility to the medical co-payment plan; the self-purchase/self-

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administration over-the-counter medication program, prosthetic purchases and other information regarding health care services.

- .2 During the time of the fourteen (14) day physical, the inmate shall review and sign an agreement informing him or her of the medical co-payment for inmate initiated services, and the inmate's responsibility regarding other medical services, on Form DOC 0459, Medical Co-Payments, Over-The-Counter Medications, Prosthetics Purchase Agreement (Attachment A).
- .3 There shall be a co-payment charge of three dollars (\$3.00) per visit for identified medical and dental services requested by the inmate. There will be no charge for a return to clinic if ordered by the physician for an episode of care requested by the inmate. Subsequent visits related to the initial request shall include a co-payment if not initiated or scheduled by a health care provider.
- .4 Assigned medical staff shall total the co-payment cost of services and provide it to each inmate on request. Form DOC 0414, Co-Payment Cost For Medical Services (Attachment B) shall be submitted to the facility fiscal office every Monday. On holidays that fall on a Monday, the forms should be submitted to the facility fiscal office on the Friday preceding the Monday holiday.
- .5 For infirmary services related to inmate elective medical procedures, the inmate shall pay the full cost of the infirmary stay per day. Infirmary cost shall be estimated using per day cost of semi-private rooms in a community hospital (e.g. Hilo Hospital, Maui Memorial, Leahi Hospital). The inmate will pay the full cost of any medications or medical supplies that by necessity are prescribed by the health care provider. The inmate must have sufficient funds to cover the estimated cost of the infirmary stay prior to the elected procedure. The charges shall be totaled and submitted to the facility fiscal office on the day of discharge. To calculate the infirmary length of stay, the date of admission shall not be counted and the date of discharge shall be counted. An admission and release on the same day is counted as one day.
- .6 The co-payment charge shall be deducted from the inmate's account at the time the charges are filed provided there is a balance of over ten dollars (\$10.00) in the account. If there is more than ten dollars in the account but less than the total co-payment amount owed by the inmate, the difference shall be deducted from the account.
- .7 If an inmate is indigent at the time the charge is posted, the facility fiscal officer shall so indicate on DOC Form 0414 and return the form to the Health Care Section. The inmates debt will be resubmitted with the next batch of names on the following Monday and so forth.
- .8 If an inmate disputes a bill relating to the medical co-payment, he or she may request a review of the medical co-payment bill and his or her account record. If the review fails to resolve the error, the inmate may grieve items still in dispute.
- .9 The facility fiscal office shall submit to the Director through the chain-of-command, with a copy to the facility nurse manager, the annual amount of funds recovered by the facility through the inmate co-payment plan for the calendar year.
- .10 The following services are exempt from the medical co-payment fee:

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- a. Medical, mental health, and dental admission screenings, examinations, and diagnostic tests required by law, regulations, out-of-court settlements, the Department or the National Commission on Correctional Health Care standards for jails and prisons.
- b. Inmates requesting Mental Health services.
- c. Mental health referrals by medical staff or correctional employees.
- d. Inmate requested diagnostic testing for suspected sexually transmitted diseases, HIV/AIDS, tuberculosis, or hepatitis.
- e. Clinic visits to assess or clear an inmate for transfer, assignment to programs, work assignments, treatment facilities, or therapeutic communities.
- f. Physician ordered infirmary admissions.
- g. Industrial injuries.
- h. Visits scheduled at the request of a health care provider. These visits may include, but are not limited to:
  1. Diagnosis, treatment and care of communicable diseases;
  2. Diagnosis, treatment and care of chronic illnesses, including regularly scheduled clinics or workshops for chronic disease management;
  3. Dietetic consultations for chronic disease management;
  4. Pre- and post-natal care and examination.

.11 Inmates shall be charged a co-payment for the following services:

- a. Inmate requested medical and dental treatment;
- b. Inmate requests for a dietetic consultation not related to a medical condition or a chronic disease.

.12 Special needs inmates with mental health disabilities or disorders that interfere with the ability to carry our normal activities are exempt from the co-payment plan. This includes, but is not limited to, instances of self-mutilation, suicide attempts or inmates in special holding or therapeutic housing units.

Inmates are required to pay the co-payment fee when treated for self-induced injury. This includes, but is not limited to:

- a. Instigated fights with other inmates or staff, or deliberately punching, kicking, hitting, banging, etc., movable or immovable objects;
- b. Recreational injuries.

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5.0 SCOPE

This policy and procedure applies to all Correctional facilities and their assigned personnel.

APPROVAL RECOMMENDED:

  
 Medical Director 3/22/10  
 Date  
  
 Health Care Division Administrator 3/22/10  
 Date  
  
 Deputy Director for Corrections 3/24/10  
 Date

APPROVED:

  
  
 Director 3/30/10  
 Date

DEPARTMENT OF PUBLIC SAFETY

INMATE MEDICAL CO-PAYMENT, PROSTHETICS, AND OVER-THE-COUNTER  
MEDICATION PURCHASES AGREEMENT

Facility \_\_\_\_\_

Date: \_\_\_\_\_

1. Did you receive a pamphlet at intake that describes the Department's medical services for inmates? YES  NO
2. If you answered no to question number one, have you been issued a pamphlet by the nurse during this interview? YES  NO  N/A
3. Have you been informed by the nurse about inmate medical co-payments? YES  NO
4. Have you been informed by the nurse about inmate prosthetic purchases? YES  NO
5. Have you been informed by the nurse about over-the-counter medication purchases from the commissary (inmate store)? YES  NO

By signing this form, you are agreeing that you have been informed of the inmate medical co-payment plan and your responsibility to pay a three-dollar (\$3.00) co-payment fee when you seek non-emergency medical treatment. Treatment for communicable diseases, chronic diseases, emergency treatment, and medical screenings are exempt from the inmate medical co-payment. By signing this form you are also agreeing that you have been informed about purchasing prosthetics and over-the-counter medications.

\_\_\_\_\_  
Print Name of Inmate

\_\_\_\_\_  
Name and Title of Health Care Staff

\_\_\_\_\_  
Inmate's Signature

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Original: Medical Record (Consent Index)  
Canary: Inmate's Copy

DOC 0459 (7/98)

CONFIDENTIAL



Department of Public Safety

Health Care Division

Policy and Procedure for Tools / Equipment Control

PROVIDED UPON REQUEST, PLEASE CONTACT RFP CONTACT ON PAGE 1-3

	<b>DEPARTMENT OF PUBLIC SAFETY</b>  <b>CORRECTIONS ADMINISTRATION</b> <b>POLICY AND PROCEDURES</b>	<b>EFFECTIVE DATE:</b> <b>MAR 09 2010</b>	<b>POLICY NO.:</b> <b>COR.10.11.05</b>
		<b>SUPERSEDES (Policy No. &amp; Date):</b> <b>COR.10.11.05 (12/29/2008)</b> <b>COR.10.11.06 (12/29/2008)</b>	
	<b>SUBJECT:</b> <b>INFORMED CONSENT &amp; RIGHT TO REFUSE</b>		<b>Page 1 of 4</b>

## 1.0 PURPOSE

The purpose of this policy is to provide guidelines for medical and mental health examinations, treatments, and other medical procedures that require informed consent by the patient and provide guidelines on how to manage a patient's refusal of medical interventions and treatments

## 2.0 REFERENCES AND DEFINITIONS

### .1 References

- a. Hawaii Revised Statutes; Section 26-14.6, Department of Public Safety; Section 353C-2, Director of Public Safety, Powers and Duties; Section 352-8, Guardianship and Custody of Persons Committed; and Section 671-3, Informed Consent.
- b. National Commission on Correctional Health Care, Standards for Health Services in Prisons and Jails, (2008).

### .2 Definitions

Informed Consent: Voluntary consent or agreement by a patient to a treatment, examination, or procedure after they have received the significant facts regarding the condition being treated and the nature, consequences, risks (e.g. side effects), benefits, and alternatives concerning the proposed examination, procedure, or treatment, including the right of refusal.

## 3.0 POLICY

- .1 Information exchanged between a health care provider and a patient while rendering health care is privileged and confidential except where mandated or allowed by law.
- .2 Informed consent shall be required for patients undergoing those examinations, treatments, and procedures that are intrusive or governed by informed consent standards in the community, or that are associated with any significant risks to the patient.

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- 3 The health care provider attending to the patient shall be responsible for informing the patient of the condition and recommended procedure or treatment and any risks that may be involved in the treatment, including available alternatives.
- 4 In the case of treatment or procedures performed in the community by a specialist or by a provider of a community hospital, or by any other non-state employee providing services to an inmate/patient, the specialist or community provider is responsible for securing the informed consent from the patient.
- 5 A competent patient has the right to refuse medical care of any sort including diagnostic or laboratory procedures and blood products, unless their refusal represents a danger to themselves or others; or is otherwise the subject of an exception according to policy, procedure, or state or federal law.
- 6 In every case in which the health care provider waives consent, reasons for the decision to undertake the procedure without consent of the patient shall be documented in the medical record. The informed consent requirement may be waived for the following reasons:
  - a. An emergency that requires immediate medical intervention for the preservation of life or the safety of the patient unless there is an established initiative by the inmate, such as a living will, waiving such intervention.
  - b. If in the professional opinion of the provider, the facility security and operations or the safety of individuals is endangered by the patient.
  - c. When a psychiatrist, or court of law, judges an inmate to be incapable of understanding the necessary medical information according to the standard, legally defined criteria of competence.
- 7 Inmates shall not participate in experimental projects involving medical, pharmaceutical or cosmetic research, including aversive conditioning, psycho-surgery or the application of cosmetic substances to the body that are being tested for possible ill effects prior to sale to the general public.
  - a. This policy statement does not preclude the use of experimental medical procedures or treatments as part of a research protocol passed by an institutional human research review committee and subject to informed consent.

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- b. This policy statement does not preclude the collection of statistical or epidemiological data on inmates.

#### **4.0 PROCEDURE**

- .1 When a patient consents to a treatment or procedure provided by a Health Care section, the health care provider shall ensure that Form DOC 0427 , Consent to Operation, Post Operative Care, Medical/Mental Health Treatment, Anesthesia, or Other Procedure or DOC 0448 Informed Consent for Hepatitis C Combination Therapy Introm A and Ribavirin (as appropriate) is reviewed with and signed by the patient, if applicable. The attending physician/psychiatrist shall enter a narrative progress note indicating the information provided and the results of the discussion with the patient. The clinic or mental health nurse shall ensure the form is completed and health information staff shall file the form under the Consent index in the medical record.
- .2 When a patient refuses a scheduled medical appointment, medical or mental health treatment, surgical procedure, or medications, the patient shall be informed by health care staff of the consequences of such a refusal and shall be asked to sign form DOC 0417, Refusal To Consent To Medical, Mental Health Or Surgical Treatment. The provider shall record a narrative statement on the progress notes. The health care provider shall review the refusal and sign form DOC 0417 indicating the refusal was reviewed. If appropriate, the patient shall be counseled regarding consequences associated with the refusal of the treatment and record the refusal in the patient's medical record regarding the encounter and the patient's refusal.
- .3 If the refusal will have adverse effects on a serious medical condition, the nurse shall refer the refusal to a health care provider for review. The provider shall counsel the patient regarding the refusal and the consequences of refusing the procedure, treatment or medications. The physician shall sign the appropriate line on Form DOC 0417 to indicate a review was conducted and, if appropriate, shall further document the encounter on the progress notes in the patient's medical record.
- .4 When an inmate refuses medical care, and declines to sign Form DOC 0417, the refusal shall be signed by health care staff and witnessed by a corrections facility employee who both shall sign their names and write, "inmate refused to sign" on Form DOC 0417 and the date of refusal.

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Inmates diagnosed with contagious diseases who refuse treatment may be medically quarantined or isolated by the health care authority, if necessary, to control the spread of the disease.

**5.0 SCOPE**

This policy and procedure applies to all correctional facilities and their assigned personnel.

**APPROVAL/RECOMMENDED:**

Medical Director	<u>3/2/10</u> Date
Corrections Health Care Administrator	<u>3/2/10</u> Date
Deputy Director for Corrections	<u>3/8/10</u> Date

**APPROVED:**

Director	
<u>3/9/10</u> Date	

CONSENT TO OPERATION, POST OPERATIVE CARE, MEDICAL TREATMENT, ANESTHESIA, OR OTHER PROCEDURE

Patient: \_\_\_\_\_
SSN: \_\_\_\_\_ DOB: \_\_\_\_\_
Facility: \_\_\_\_\_ Date: \_\_\_\_\_

You have the right and obligation to make decisions concerning your health care. The physician must provide you with the information and advice concerning the proposed procedure so that you can make an informed decision

(1) Explain the nature of the condition(s) in professional and ordinary language.
PROFESSIONAL: \_\_\_\_\_

ORDINARY LANGUAGE: \_\_\_\_\_
AT \_\_\_\_\_

(2) Describe procedures(s) to be performed in professional and ordinary language, if appropriate.
PROFESSIONAL: \_\_\_\_\_

ORDINARY LANGUAGE: \_\_\_\_\_
AT \_\_\_\_\_

(3) I recognize that, during the course of the operation, post operative care, medical treatment, anesthesia, or other procedure, unforeseen conditions may necessitate my above-named physician and his or her assistants, to perform such surgical or other procedures as are disposed necessary to preserve my life and bodily functions. accustomed

(4) I have been informed that there are many significant risks, such as severe loss of blood, infection, cardiac arrest and other consequences that can lead to death or permanent or partial disability, which can result from any procedure.

(5) No promise or guarantee has been made to me as to result or care.

Any section below which does not apply to the proposed treatment may be crossed out. All sections crossed out must be initialed by both the physician and the patient.

(6) I consent to the administration of (general, spinal, regional, local) anesthesia by my attending physician, by an anesthesiologist, a nurse anesthetist, or other qualified party under the direction of a physician as may be deemed necessary. I understand that all anesthetics involve risks that may result in complications and possible serious damage to such vital organs as the brain, heart, lungs, liver and kidney.

These complications may result in paralysis, cardiac arrest and related consequences or death from both known and unknown causes.

(7) I consent to the use of transfusion of blood and blood products as deemed necessary. I have been informed of the risks which are transmission of disease, allergic reactions, and other unusual reactions.

(8) Any tissue or part surgically removed may be of by the hospital or physician in accordance with

practice.

(9) Any additional comments may be inserted here:

(10) I have had the opportunity to ask questions about this form.

FULL DISCLOSURE

[ ] I AGREE TO AUTHORIZE THE PROCEDURE DESCRIBED ABOVE AND I AGREE THAT MY PHYSICIAN HAS INFORMED ME OF THE:

- a) DIAGNOSIS OR PROBABLE DIAGNOSIS.
b) NATURE OF THE TREATMENT OR PROCEDURE RECOMMENDED.
c) RISKS OR COMPLICATIONS INVOLVED IN SUCH TREATMENT OR PROCEDURES.
d) ALTERNATIVE FORMS OF TREATMENT, INCLUDING NON-TREATMENT, AVAILABLE.
e) ANTICIPATED RESULTS OF THE TREATMENT.

Patient/Other Legally Responsible Person Sign, If Applicable

Date

Physician

Date

DEPARTMENT OF PUBLIC SAFETY  
HEALTH CARE DIVISION

**REFUSAL TO CONSENT TO MEDICAL/SURGICAL/DENTAL TREATMENT/MEDICATION**

NAME: \_\_\_\_\_ SID: \_\_\_\_\_ DOB: \_\_\_\_\_

FACILITY: \_\_\_\_\_ DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

I, the undersigned patient, refuse the following treatment and/or medication: \_\_\_\_\_

\_\_\_\_\_  
(Describe Treatment and/or Medication)

The risk of refusing treatment or medication has been explained to me and I accept the risk involved. I release the State, the Department, the facility administration and personnel, the Health Care Division administration and medical personnel from any responsibility or liability for any unfavorable reaction, outcome, or any untoward results due to this refusal on my part to accept treatment or medication.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date)

I, the undersigned, have explained to the above named patient the risk involved in refusing treatment or medication recommended for the patient's continued good health and I witness the patient's refusal of the recommended treatment or medication

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Signature & Title)

\_\_\_\_\_  
(Date)

A referral has been made to a provider:      YES                      NO

I have reviewed this case and if necessary have further counseled this patient on the risk of refusing treatment or medication.

\_\_\_\_\_  
(Print Name of Provider)

\_\_\_\_\_  
(Signature & Title)

\_\_\_\_\_  
(Date)

*\* If the patient refuses treatment and/or medication and refuses to sign this consent, please have refusal witnessed by another correctional employee.*

I have witnessed the above named patient refuse the recommended treatment or medication and I have also witnessed the patient's refusal to sign this consent form.

\_\_\_\_\_  
(Print Name & Title)

\_\_\_\_\_  
(Signature & Title)

\_\_\_\_\_  
(Date)

**INFORMED CONSENT FOR HEPATITIS C  
COMBINATION THERAPY INTRON A AND RIBAVIRIN**

**I AGREE THAT:**

1. Combination therapy (Intron A and Ribavirin) has been explained to me in terms and language I understand;
2. I have been given the opportunity to ask questions related to the combination therapy (Intron A and Ribavirin);
3. No promise or guarantee has been made to me as to positive results or cures related to the combination therapy (Intron A and Ribavirin).

**MY PHYSICIAN HAS INFORMED ME OF:**

4. The diagnosis or probable diagnosis related to my condition;
5. The nature of the recommended treatment plan;
6. The risk, side effects, complications, or other consequences involved in such treatment;
7. Alternative forms of treatment available including no treatment if I so choose;
8. At any time during the course of treatment that I have a positive drug test, treatment will be terminated;
9. I understand I will be subject to random drug testing throughout the course of treatment;
10. Anticipated results of the treatment.

**I ACCEPT COMBINATION THERAPY FOR HEPATITIS C**

**I REFUSE COMBINATION THERAPY FOR HEPATITIS C**

\_\_\_\_\_  
PRINT NAME OF PATIENT

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME OF WITNESS

\_\_\_\_\_  
SIGNATURE/TITLE OF WITNESS

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME OF PHYSICIAN

\_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
DATE

Original: Medical Record

Canary: Patient