

# ERIE COUNTY DEPARTMENT OF SOCIAL SERVICES

## QUESTIONS & ANSWERS REGARDING RFP # 1604VF: MEDICAL EVALUATIONS OF EMPLOYABILITY FOR TEMPORARY ASSISTANCE APPLICANTS

*Questions submitted via e-mail and at the Bidder's Conference on March 15, 2016*

QUESTION	ANSWER
1) Is there a specific specialty or specialties that the County requires or prefers to perform these evaluations?	Evaluations must be completed by a licensed provider of healthcare/medical services.
2) Will the County be requesting various specialties based on the medical condition the examination will focus on or will a generalist suffice? (Family Practice or Internal Medicine)	The focus of the evaluation is to determine the employability for applicants of Temporary Assistance.
3) Is there a medical exam template that the County wants the provider to follow, or is the doctor performing the medical evaluation and then writing a report using their own format?	The 'Applicant Medical Evaluation' form (B-5106) is to be completed. (see attached)
4) Are these evaluations all medical in nature, or will mental health evaluations be necessary as well?	The evaluations are medical in nature. Mental health evaluations will not be necessary.
5) Is the county only requesting a medical diagnosis, or is the expectation that the provider will render a medical opinion as to whether an applicant is able to work or not?	A medical diagnosis and opinion regarding an applicant's employability is required.
6) Are medical records of the applicant going to be provided for the doctor to review, or are medical records not a consideration?	The applicant would be responsible to provide any medical records available to the evaluating physician.
7) Is there any testing that the County will be asking for or requiring? (x-rays, diagnostics, lab results, etc.)	No
8) If there is testing required, is that a separate billing line item, or does the County want one "all in" price that covers every evaluation regardless of any testing for the specific evaluation?	N/A
9) If additional testing is determined to be needed, by our providers, are we able to add on the day of appointment? Or is prior authorization needed from the county?	N/A
10) Page 2 General Requirements number 1 refers to Appendix A. Could you provide us with this Appendix?	Appendix A refers to the Technical and Organization sections of the proposal outlined on pages 8-10.

<p>11) Page 3, V.B Project Description refers to Form B5106 Applicant Medical Evaluation. Could you provide us with this form?</p>	<p>The 'Applicant Medical Evaluation' form (B-5106) is attached.</p>
<p>12) One of the requirements for this RFP is that the medical office be certified by the Division of Disability Determinations within the Office of Temporary Disability Assistance. Where is this obtained?</p>	<p>OTDA has indicated that the 1996 State statute requiring such is inaccurate, and no certification from DDD is required. Only appropriate State medical licensing is necessary.</p>
<p>13) How will the psychological component of these exams be handled?</p>	<p>Mental health evaluations will not be necessary.</p>
<p>14) What is the process when a psychological issue arises in the course of a medical evaluation?</p>	<p>The diagnosis/assessment should be based on physical functioning. Psychological issues encountered can be noted on the evaluation form for follow up.</p>
<p>15) Will ancillary testing i.e. PFT, EKG, X-ray, Labs, etc., be considered in the examination process? If so, how will they be priced, as the current fee schedule does not list these items?</p>	<p>No</p>
<p>16) Page 3, V. Scope of Professional Services Required, B. Project Description: Findings are to be reported within seven (7) days of the original request. Is this referencing (7) business days or (7) calendar days?</p>	<p>Calendar days</p>
<p>17) Page 3, V. Scope of Professional Services Required, B. "Provide the individual with a copy of the report". Is this referring to the individual that referred the examination to the provider or the individual that was examined?</p>	<p>A copy of the report must be provided to the agency representative.</p>
<p>18) Page 3, V. Scope of Professional Services Required, B. "Provide the individual with a copy of the report", may we have a copy of the LDSS-901 form?</p>	<p>Authorization for Medical Examination and Payment Request (LDSS-901) attached.</p>
<p>19) Page 8, Section A. Technical Proposal, states all proposals must be limited to fifteen pages:</p> <ol style="list-style-type: none"> <li>a. Is the financial proposal included in the 15 page limit?</li> <li>b. Are resumes and licenses and certifications included in the 15 page limit?</li> <li>c. Does the 15 page limit mean 1 page=front and back or is it one sided?</li> <li>d. Can items such as references and organizational charts be included as appendices and therefore outside the 15 page limit?</li> </ol>	<p>The Technical Proposal must be limited to fifteen pages.</p>

<p>20) Page 2, IV General Requirements, 3. One original and one pdf copy of the proposal must be submitted. Is it permissible for proposals to be submitted via email to Carrie Godfrey at the email address listed?</p>	<p>Yes, the pdf copy of the proposal may be submitted via email to Carrie Godfrey at <a href="mailto:Carrie.Godfrey@erie.gov">Carrie.Godfrey@erie.gov</a>.</p>
<p>21) Page 8, A.6, Accommodation of those with special needs including translation and cultural differences. Is the county requiring the contractor to provide a translator for examinations?</p>	<p>The proposal is to include the service delivery plan including accommodation of language translation.</p>
<p>22) Page 9, 10. Please clarify what type of verification is required for these two components i.e. licensed healthcare/medical services and certified by DDD.</p>	<p>Verification that evaluators are licensed with NYS to provide healthcare/medical services.</p>



**AUTHORIZATION FOR MEDICAL EXAMINATION AND PAYMENT REQUEST**

NEW YORK STATE

DEPARTMENT OF HEALTH

PROVIDER-NAME AND ADDRESS	ORIGINATING AGENCY
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**SECTION I: AUTHORIZATION FOR SERVICE**

<input type="checkbox"/> Examination	<input type="checkbox"/> Consultation
NAME OF PATIENT	CASE NO. (if any)
ADDRESS (City, State, Zip code)	
REMARKS	
Please complete the PAYMENT REQUEST SECTION and return original and duplicate of this form to the above originating agency accompanied by:	
<input type="checkbox"/> PHYSICIANS STATEMENT FOR DETERMINATION OF DISABILITY FORM LDSS-486 OR DSS-486T	<input type="checkbox"/> MANDATORY EYE EXAMINATION REPORT DSS-3377
<input type="checkbox"/> MEDICAL EXAMINATION FOR EMPLOYABILITY DISABILITY SCREENING DSS-4526	<input type="checkbox"/> YOUR MEDICAL REPORT
SIGNATURE OF CASEWORKER	DATE
SIGNATURE OF AUTHORIZING OFFICIAL	DATE

**SECTION II: RELEASE**

I hereby grant permission to the physician indicated below to release results of the above noted examination or consultation to the originating Department of Social Services			
PATIENTS SIGNATURE	DATE	WITNESS (if patient cannot write)	DATE
X		X	

**SECTION III: PAYMENT REQUEST SECTION- TO BE COMPLETED BY PHYSICIAN**

DATE OF EXAM:	FEE SCHEDULE	AMOUNT BILLED
PAYEE CERTIFICATION – I certify that the care, service and supplies itemized have been furnished; the amounts listed are due and, except as noted, no part thereof has been paid, payment of fees made in accordance with established compliance with the Title IV of the Federal Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973 without discrimination on the basis of race, color, national origin or handicap; that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid Program will be kept, and information will be furnished regarding any payment claimed therefore as the local social services agency or the State Department of health may request; and that the vendor understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he may be prosecuted under applicable Federal and State laws for any false claims, statements, or documents or concealment of material fact.		
PROVIDER'S I.D. NUMBER	PROVIDER'S SIGNATURE	DATE

**LEAVE BLANK AGENCY USE ONLY**

CHARGE TO ACCOUNT NO	PROVIDER'S SIGNATURE	MONTH OF PAYMENT
AUDITED BY		DATE