# CONTRACT FOR SERVICES
# MEDICAL & DENTAL
# 2010-014-03-30

STATE OF TEXAS &
&
COUNTY OF HIDALGO &

THIS AGREEMENT (The "Agreement") is made effective the **1st** day of **September, 2010** by and between the HIDALGO COUNTY HEAD START PROGRAM, (hereinafter "The Program") a federally funded program under the auspices of HIDALGO COUNTY, TEXAS, a political subdivision of the State of Texas and **NUESTRA CLINICA DEL VALLE INC.** (hereinafter "Provider") to serve at the pleasure of the Program. This Contract for Services may be extended for an additional year upon mutual agreement based on the same terms at mutual agreement to by the parties. This Agreement terminates on the **31st** day of **August, 2011** or as provided herein.

WITNESSETH:

WHEREAS, Program requires certain services which Provider is licensed to provide, a description of each service is attached hereto as Exhibit "A" and incorporated herein for all purposes; and

WHEREAS, the Provider has agreed to provide the services enumerated in this Agreement for the Program; and

WHEREAS, the Program is the recipient of certain federal funds to be utilized for the provision of services to the participants of the Program; and

WHEREAS, Program participants' (students) are examined and treated by the Provider; and

WHEREAS, the Provider will examined and treat the program participants on the terms and conditions hereinafter set forth; and

NOW, THEREFORE, in consideration of the foregoing and the following Provider and Program agrees as follows:

A. 1. Provider represents that (s)he is licensed by the State of Texas and qualified to perform and execute services provided in this Agreement. If such license is suspended or revoked, this Contract shall automatically be terminated. Provider shall immediately notify the Program of such suspension or revocation.

2. The Provider shall prepare, maintain and submit all records which are designated, required or prescribed by the Program, federal grantor agency, or County of Hidalgo. In addition, the Provider shall permit the Program, the Department of Health and Human Services and the County of Hidalgo to audit, inspect records and reports, review services and /or evaluate the performance of the services provided hereunder at any reasonable time. The Provider shall provide access to all its records, books, reports and other pertinent data and information needed to accomplish review of its activities, services and expenditures billed to the Program.

3. In consideration for the above and foregoing, the Provider shall submit a monthly billing statement to the Program at:

**Hidalgo County Head Start Program**
**P.O. Box 0117**
**Edinburg, Texas, 78540**

Said statement must provide an itemized list of services rendered to the Program during the statement period. Upon receipt of said statement, the Program will process the requisition for payment in the usual customary manner utilized by the Program. The Provider shall be compensated based on the Program's fee schedule, a copy of which is attached as Exhibit "B" hereto.

4. The Provider must comply with all applicable Program and Hidalgo County

policies. Notwithstanding the foregoing sentence, the Provider represents and maintains that (s)he is an independent provider and is not an employee of the Program or Hidalgo County, Texas, or any agency thereof, and further represents and warrants that (s)he does not desire or request any fringe benefits provided to employees of the Program or Hidalgo County, Texas, and/or agency thereof, including, but not limited to benefits associated with Hidalgo County's civil service program. The Provider agrees to be responsible for any federal income tax, withholding or social security tax liability which might arise from payments received pursuant to this Agreement.

5. The Program and the Provider agree that either party may terminate this contract at any time for any reason or no reason at all upon thirty (30) days prior written notice to the other party. Proper Notice shall be submitted through certified letter to:

Teresa Flores, Executive Director
Hidalgo County Head Start Program
P.O. Box 0117
Edinburg, Texas 78540-0117

NUESTRA CLINICA DEL VALLE INC.
P.O. BOX 1689
PHARR TX, 78577

6. Provider agrees to be insured for professional liability, premises liability and auto liability insurance covering his/her employee's activities and services to the Program in coverage limits not less than the minimum amounts prescribed by the Texas Tort Claims Act, §101.001, et seq., Texas Civil Practices and Remedies Code. Provider shall furnish the Program a certificate issued by their insurer that such insurance is in full force and effect.

7. Except as otherwise herein provided, the Provider may not assign the

obligations or rights under this Contract to any person without the prior written consent of the Program.

B. The Provider's employees, if any, who perform services for the Program under this Agreement shall be bound by the provisions of the terms of this Agreement. At the request of the Program, the Provider shall provide adequate evidence that such persons are the Provider's employees.

C. The Provider will indemnify and hold harmless and defend the Program and the County of Hidalgo from any and all claims, actions, liability, and expenses including all cost of judgments, settlements, court cost, and attorney's fees regardless of the outcome of such claim(s) or action(s) caused by, resulting from, or alleging negligent or intentional acts or omission(s) or any failure to perform any obligation(s) undertaken or any covenant(s) in this Agreement, and further, whether such act, omission, or failure to perform any obligation undertaken or any covenant in this Agreement was the Provider's or that of any person providing services hereunder through or for Provider. Upon written notice from the County and the Program, Provider will resist and defend at its own expenses, and by counsel reasonably satisfactory to the County and the Program, any such claim(s) or action(s).

D. This Agreement shall be construed under and in accordance with the laws of the State of Texas, and all obligations of the parties created hereunder are performance in Hidalgo County, Texas.

E. In case any one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision thereof and this Agreement shall be construed as if such invalid, illegal

or unenforceable provision had never been contained herein.

F. Contract Extension. Hidalgo County Head Start Program reserves the right to extend this agreement for ninety (90) days from the date of termination (August 31st, 2011) of the Contract period at the such rate and terms as negotiated by the parties. A thirty (30) day written notice of intention to extend this agreement will be provided prior to its expiration by Hidalgo County Head Start Program.

G. No amendment, modification or alteration of the terms hereof shall be binding unless the same be in writing, dated subsequent to the date hereof and duly executed by the parties hereto.

H. Provider will not discriminate on the basis of race, color, sex, age, religion, national origin, or handicap in providing the services under this Agreement or in the selection of associates, employees, or independent providers.

I. Provider will perform its services at all times in compliance with federal, state, and local laws, rules and regulations, the policies, rule and regulations of the Program, and all currently accepted and approved methods and practices of the professional specialty relating to the services.

IN WITNESS WHEREOF, the parties have caused their names to be hereunto subscribed personally or by a duly authorized officer of agent of each party, effective the day and year first written above. EXECUTED as of the day and year first written above.

PROVIDER:
NUESTRA CLINICA DEL VALLE INC.

BY: _____
(Provider's Name)

_____
(Print Name)

_____
(Title)

HIDALGO COUNTY
HEAD START PROGRAM

BY: _____
Rene Ramirez, County Judge

BY: _____
Teresa Flores, Executive Director

BY: _____
Arturo Guajardo, Jr., County Clerk

APPROVED AS TO FORM:
OXFORD & GONZALEZ

By: _____
Ricardo Gonzalez

APPROVED AS TO FORM:
ATLAS & HALL, L.L.P.

By: _____
Stephen L. Crain

# Exhibit A

## Description of Services – Medical Service

The Provider agrees to provide any services deem necessary to evaluate any and all children referred to the Provider by Head Start.

The Provider agrees to continue such services until such time as the Executive Director of the Program (or designee) determine that there is no longer a need for the services.

Provider shall provide copies of records to Head Start for each child it affords services. Copies of these records shall be free of charge.

The services provided by the Provider will included the following and in addition all services will be provided on schedule with Head Start 1304:

1. The provider will perform a complete physical examination (head to toe assessment) at his/her respective practice or center site on the initial visit. The form **"PROJECT HEAD START: PHYSICAL EXAM AND ASSESSMENT"** will be shown with date of exam, signature of the Provider, referral and or treatment.

2. Any "abnormal findings" or "not evaluated" will be accompanied by an explanation.

3. Minor acute illnesses will be referred to their own family physician, if none is available, clients will be treated on site and a follow-up appointment made for a later date.

4. Chronic illnesses or other abnormalities encountered will be referred for further evaluation or treatment.

5. ALL MEDICAID CHILDREN WILL RECEIVE AN EXAM AS PER THE EPSDT MEDICAL PROCEDURES SCHEDULED BY AGE. (Medicaid Provider Procedure Manual)

6. Physical findings, treatments and or referrals will be discussed with parents upon completion of examination.

7. Confidentiality of medical records will be maintained in accordance of examination.

8. Upon completion of **"HEAD START: PHYSICAL EXAM AND ASSESSMENT"** signature of provider and date will be written on the bottom page. RECOMMENDATIONS will be written accordingly. Remit a copy to the HIDALGO COUNTY HEAD START PROGRAM, a copy for the Provider's records and a copy to the parent. The same procedure will follow the same for a Texas Health Step exam.

9. The Provider's statement, which lists the child's name/center and the total cost of the exam provided is to be returned to HIDALGO COUNTY HEAD START PROGRAM for payment. Six (6) weeks may be required for processing payment.

10. The total number of children provided medical services will be submitted to the HIDALGO COUNTY HEAD START PROGRAM with the provider's name after every examination day.

HIDALGO COUNTY HEAD START PROGRAM will be responsible to:

1. Encourage the child's parent to be present during physical exam. If parent is unable to attend, a brief medical history will be obtained from parent.

2. Provide **"PROJECT HEAD START: PHYSICAL EXAM AND ASSESSMENT"** form with child's name and address.

3. Schedule a minimum of twenty (20) patients for physical exams, when clinics are to be held at center site.

# Exhibit A

## Description of Services-Dental Health Services

The Provider agrees to provide any services deem necessary to evaluate any and all children referred to the Provider by Head Start.

The Provider agrees to continue such services until such time as the Executive Director of the Program (or designee) determine that there is no longer a need for the services.

Provider shall provide copies of records to Head Start for each child it affords services. Copies of these records shall be free of charge.

The services provided by the Provider will included the following and in addition all services will be provided on schedule with Head Start 1304:

1. The provider will perform a complete and comprehensive dental examination at his/her respective practice on the initial visit. The **"Dental Health Form"** will be shown with date of exam, signature of the Provider, referral and or treatment done.

2. A complete and comprehensive dental examination-on the initial examination the dentist will provide a complete examination as agreed to by Medicaid every twelve (12) months. The examination will consist of:
    1. A visual examination
    2. X-Rays
    3. Prophylaxis(cleaning)
    4. Nutritional Counseling
    5. Behavior management, if necessary.

3. Periodic Oral Examination-Every six (6) months the child must receive a periodic oral examination as agreed to by Medicaid guidelines.

4. Referral- If an abnormality arises and provider is not able to treat the condition, the parent will be notified as soon as abnormality is found or detected, and the parent will be given the opportunity to select a specialist (if such an option is available) in the appropriate dental field from a roster of recommended "List of Providers" by the dental provider.

5. Confidentiality of medical records will be maintained in accordance of examination.

6. Upon completion of **"HEAD START: Dental Health Form"** signature of provider and date will be written on the bottom page. RECOMMENDATIONS will be written accordingly. Remit a copy to the HIDALGO COUNTY HEAD START PROGRAM, a copy for the Provider's records and a copy to the parent. The same procedure will follow the same for a Texas Health Step exam.

7. The Provider's statement, which lists the child's name/center and the total cost of the exam provided is to be returned to HIDALGO COUNTY HEAD START PROGRAM for payment. Six (6) weeks may be required for processing payment.

8. The total number of children provided dental services will be submitted to the HIDALGO COUNTY HEAD START PROGRAM with the provider's name after every examination day.

HIDALGO COUNTY HEAD START PROGRAM will be responsible to:

1. Encourage the child's parent to be present during dental exam. If parent is unable to attend, a brief medical history will be obtained from parent.

2. Provide **"HEAD START: Dental Health Form"** with child's name and address.

# Exhibit B
## Fee Schedule

## NUESTRA CLINICA DEL VALLE, INC

2010-2011

**Fee Schedule for Services:** Fees should not exceed Medicaid Allowable reimbursements.

1 The Provider shall be paid only for full and satisfactory completion of the following services:

| Description Of Service | FEE |
|---|---|
| | |
| 1 Complete THS (Head To Toe Assessment) | |
| to include the following: | |
| a. Medical History | n/a |
| b. Physical Examination | $ 20.00 |
| c. Measurements (Height/Weight/BMI/Blood Pressure) | $ n/a |
| d. Sensory Screening (Vision & Hearing) | n/a |
| e. Tuberculin Screening-new patient | $ 18.00 |
| f. Tuberculin Screening-establish patient | 13.00 |
| g. Laboratory (Lead, Hgb or Hct) | $ 30.00 |
| h. Immunizations | 5.00 |
| i Anticipatory Guidance | n/A |
| | |
| | |
| | |
| | |

# Exhibit B
## Fee Schedule

## NUESTRA CLINICA DEL VALLE, INC.
2010-2011

**Fee Schedule for Services:** Fees should not exceed Medicaid Allowable reimbursements.

1 The Provider shall be paid only for full and satisfactory completion of the following services:

| Description Of Service | FEE |
|---|---|
| a. Initial Oral Examination | $ 35.00 |
| b. Periodic Oral Examination | $ 30.00 |
| c. Emergency Oral Examination | $ 30.00 |
| d. Bite-wing Radiographs (four (4) films) | $ 10.00 |
| e. Topical Application of Flouride (including prophylaxis) | $ 30.00 |
| f. Nutritional Counseling | $ n/a |

# ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 04/29/2010

PRODUCER
Community Health Insurance Agency, Inc.
5900 Southwest Parkway
Bldg 3
Austin TX 78735

INSURED
Nuestra Clinica del Valle
P. O. Box 1689
Pharr TX 78577

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

| INSURERS AFFORDING COVERAGE | NAIC # |
|---|---|
| INSURER A: American Physicians Insurance Co. | |
| INSURER B: | |
| INSURER C: | |
| INSURER D: | |
| INSURER E: | |

**COVERAGES**

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| NSR LTR | ADD'L INSRD | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YY) | POLICY EXPIRATION DATE (MM/DD/YY) | LIMITS | |
|---|---|---|---|---|---|---|---|
| | | GENERAL LIABILITY | | | | EACH OCCURRENCE | $ |
| | | COMMERCIAL GENERAL LIABILITY | | | | DAMAGE TO RENTED PREMISES (Ea occurence) | $ |
| | | CLAIMS MADE ☐ OCCUR | | | | MED EXP (Any one person) | $ |
| | | | | | | PERSONAL & ADV INJURY | $ |
| | | | | | | GENERAL AGGREGATE | $ |
| | | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | PRODUCTS - COMP/OP AGG | $ |
| | | POLICY ☐ PRO-JECT ☐ LOC | | | | | |
| | | AUTOMOBILE LIABILITY | | | | COMBINED SINGLE LIMIT (Ea accident) | $ |
| | | ANY AUTO | | | | | |
| | | ALL OWNED AUTOS | | | | BODILY INJURY (Per person) | $ |
| | | SCHEDULED AUTOS | | | | | |
| | | HIRED AUTOS | | | | BODILY INJURY (Per accident) | $ |
| | | NON-OWNED AUTOS | | | | | |
| | | | | | | PROPERTY DAMAGE (Per accident) | $ |
| | | GARAGE LIABILITY | | | | AUTO ONLY - EA ACCIDENT | $ |
| | | ANY AUTO | | | | OTHER THAN AUTO ONLY: EA ACC | $ |
| | | | | | | AGG | $ |
| | | EXCESS/UMBRELLA LIABILITY | | | | EACH OCCURRENCE | $ |
| | | OCCUR ☐ CLAIMS MADE | | | | AGGREGATE | $ |
| | | | | | | | $ |
| | | DEDUCTIBLE | | | | | $ |
| | | RETENTION $ | | | | | $ |
| | | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | | | | WC STATU-TORY LIMITS ☐ OTH-ER | |
| | | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? | | | | E.L. EACH ACCIDENT | $ |
| | | If yes, describe under SPECIAL PROVISIONS below | | | | E.L. DISEASE - EA EMPLOYEE | $ |
| | | | | | | E.L. DISEASE - POLICY LIMIT | $ |
| A | | OTHER Professional Liabili | TX11387508 | 06/30/2010 | 06/30/2011 | $500,000 Each Loss<br>$3,000,000 Aggregate | |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

**CERTIFICATE HOLDER**

Ambrosio Tovar, Procurement Director
Hidalgo County Head Start Program
1901 West State Highway 107
McAllen, Texas 78504

**CANCELLATION**

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 0 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

# ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 04/29/10

PRODUCER
Willis of Texas, Inc.
1400 N McColl Rd Suite 105
P O Drawer 3785
McAllen, TX 78502

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

| INSURERS AFFORDING COVERAGE | NAIC # |
|---|---|
| INSURER A: Travelers Lloyds Insurance Company | 39357 |
| INSURER B: Texas Mutual Insurance Company | 22945 |
| INSURER C: | |
| INSURER D: | |
| INSURER E: | |

INSURED
Nuestra Clinica Del Valle Inc
PO Box 1689
Pharr, TX 78577

## COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR LTR | ADD'L INSRD | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YY) | POLICY EXPIRATION DATE (MM/DD/YY) | LIMITS | |
|---|---|---|---|---|---|---|---|
| A | | GENERAL LIABILITY | PACP9250C993TLC09 | 12/21/09 | 12/21/10 | EACH OCCURRENCE | $1,000,000 |
| | | [X] COMMERCIAL GENERAL LIABILITY | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $300,000 |
| | | [ ] CLAIMS MADE [X] OCCUR | | | | MED EXP (Any one person) | $5,000 |
| | | | | | | PERSONAL & ADV INJURY | $1,000,000 |
| | | | | | | GENERAL AGGREGATE | $2,000,000 |
| | | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | PRODUCTS - COMP/OP AGG | $2,000,000 |
| | | [ ] POLICY [ ] PRO-JECT [ ] LOC | | | | | |
| | | AUTOMOBILE LIABILITY | | | | COMBINED SINGLE LIMIT (Ea accident) | $ |
| | | [ ] ANY AUTO | | | | BODILY INJURY (Per person) | $ |
| | | [ ] ALL OWNED AUTOS | | | | BODILY INJURY (Per accident) | $ |
| | | [ ] SCHEDULED AUTOS | | | | PROPERTY DAMAGE (Per accident) | $ |
| | | [ ] HIRED AUTOS | | | | | |
| | | [ ] NON-OWNED AUTOS | | | | | |
| | | GARAGE LIABILITY | | | | AUTO ONLY - EA ACCIDENT | $ |
| | | [ ] ANY AUTO | | | | OTHER THAN AUTO ONLY: EA ACC | $ |
| | | | | | | AGG | $ |
| | | EXCESS/UMBRELLA LIABILITY | | | | EACH OCCURRENCE | $ |
| | | [ ] OCCUR [ ] CLAIMS MADE | | | | AGGREGATE | $ |
| | | | | | | | $ |
| | | [ ] DEDUCTIBLE | | | | | $ |
| | | [ ] RETENTION $ | | | | | $ |
| B | | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | TSF0001093256 | 12/02/09 | 12/02/10 | [X] WC STATU-TORY LIMITS [ ] OTH-ER | |
| | | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? | | | | E.L. EACH ACCIDENT | $500,000 |
| | | If yes, describe under SPECIAL PROVISIONS below | | | | E.L. DISEASE - EA EMPLOYEE | $500,000 |
| | | | | | | E.L. DISEASE - POLICY LIMIT | $500,000 |
| | | OTHER | | | | | |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

CERTIFICATE HOLDER

Hidalgo County Headstart Program
1901 W State Hwy 107
McAllen, TX 78504

Ambrosio Tovar,
Procurement Director

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
Brian E. Lewis

# ACORD AUTOMOBILE CERTIFICATE OF INSURANCE

CERT # | DATE (MM/DD/YYYY): 5 / 17 / 10

AGENCY
Jesse Trevino Insurance Agency, Inc.
P.O. Box 429
McAllen, Tx. 78505

PHONE (A/C, No, Ext): ( 956 ) 687-7271
FAX (A/C, No): ( )
E-MAIL ADDRESS:
CODE: SUB CODE:
AGENCY CUSTOMER ID #:

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

| INSURERS AFFORDING COVERAGE | NAIC # |
|---|---|
| COMPANY A: Travelers | |
| COMPANY B: | |

INSURED
Nuestra Clinica del Valle
801 W. 1st. St.
San Juan, Tx. 78589

## DESCRIPTION OF AUTO

| | YEAR | MAKE | MODEL | BODY TYPE | VEHICLE IDENTIFICATION NUMBER |
|---|---|---|---|---|---|
| 1. | 2000 | Chevrolet | | | 1GCEC14WXYE301102 *** |

## COVERAGES

THIS IS TO CERTIFY THAT THE POLICY(IES) OF INSURANCE LISTED BELOW HAS/HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD(S) INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICY(IES) DESCRIBED HEREIN IS/ARE SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICY(IES).

| INSR LTR | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YYYY) | POLICY EXPIRATION DATE (MM/DD/YYYY) | LIMITS | |
|---|---|---|---|---|---|---|
| | ☐ AUTO LIABILITY | BA-1614N255-10-SEI | 1 / 22 / 10 | 1 / 22 / 11 | COMBINED SINGLE LIMIT | $ 500,000 |
| | | | / / | / / | BODILY INJURY (Per person) | $ |
| | | | / / | / / | BODILY INJURY (Per accident) | $ |
| | | | | | PROPERTY DAMAGE | $ |
| | AUTO PHYSICAL DAMAGE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YYYY) | POLICY EXPIRATION DATE (MM/DD/YYYY) | LIMITS | DEDUCTIBLE |
| | ☐ COLLISION LOSS | | / / | / / | ☐ ACV ☐ AGREED AMT ☐ ☐ STATED AMT $ | $ |
| | ☐ COMPREHENSIVE ☐ OTHER THAN COLLISION | | / / | / / | ☐ ACV ☐ AGREED AMT ☐ ☐ STATED AMT $ | $ |
| | ☐ | | / / | / / | ☐ ACV ☐ AGREED AMT ☐ ☐ STATED AMT $ | $ |
| | ☐ 6 vehicles | Comb/Coll- Ded $500.00 PIP=$2,500 UMBI/ PD | / / | / / | ☐ ACV ☐ AGREED AMT ☐ ☐ STATED AMT $ | $ |

REMARKS (INCLUDING SPECIAL CONDITIONS / OTHER COVERAGES)

* Additional vehicles
2. 2004 Chevrolet 1GAHG35U741242501
3. 2007 Chevrolet 4XB84B1U07J802700
4. 2000 Ford 1FDRE1428YHB79519
5. 2000 Chevrolet 1GCHG35R3Y1168308
6. 2009 Chevrolet 1GCGG29C291181015 Express Van

CERTIFICATE HOLDER ☐ LENDER ☐ LESSOR ☐

☐ LEASED VEHICLE
LOAN / LEASE NUMBER:
NAME AND ADDRESS OF LENDER / LESSOR
( ) - ( ) -

CERTIFICATE HOLDER
Ambrosio Tovar- Procurement Dir.
1901 W. State 107
McAllen, Texas 78504

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT. BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE Jesse Trevino Jesse Trevino



ACORD 23 (2007/05)
INS023 (200705)

Request for Qualification

"MEDICAL & DENTAL PROVIDERS"
RFQ No: 2010-014-03-30

March 30, 2010

To: Hidalgo County Head Start Program
Ambrosio Tovar, Procurement Director
P.O. Box 0117
Edinburg, Texas 78540-0117

In accordance with the requirements, and subject to all laws and regulations of the United States and state and local laws, the undersigned respondent proposes and commits to furnish all labor, equipment, material, software and services as set forth in the documents hereinbefore mentioned. The undersigned respondent further agrees, upon acceptance of its RFQ, to execute a contract and/or Purchase Order issued by Hidalgo County Head Start Program for performing and completing the work described in the requirements within the time stated and for the prices proposed in the documents attached hereto and made a part hereof.

Participant acknowledges receipt of all of the pages of the documents referenced in the Request for Qualifications Checklist presented in connection with this procurement. Participant understands that Hidalgo County Head Start Program reserves the right to reject any or all of the RFQ and further reserves the right to design the evaluation criteria to be used in selecting the lowest and best RFQ.

Participant agrees that this RFQ shall be good and may not be withdrawn for a period of ninety (90) calendar days after the scheduled closing time for accepting the RFQ, as contained in the requirements.

Respectfully submitted,

Respondent: Nuestra Clinica del Valle, Inc.

Address: P.O. Box 1689, Pharr, Texas 78577

By: Lucy Ramirez

Printed Name: Lucy Ramirez

Title: Executive Director

# ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/01/2009

PRODUCER
Community Health Insurance Agency, Inc.
5900 Southwest Parkway
Bldg 3
Austin TX 78735

INSURED
Nuestra Clinica del Valle
P. O. Box 1689
Pharr TX 78577

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

| INSURERS AFFORDING COVERAGE | NAIC # |
|---|---|
| INSURER A: American Physicians Insurance Co. | |
| INSURER B: | |
| INSURER C: | |
| INSURER D: | |
| INSURER E: | |

**COVERAGES**

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR LTR | ADD'L INSRD | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YY) | POLICY EXPIRATION DATE (MM/DD/YY) | LIMITS | |
|---|---|---|---|---|---|---|---|
| | | GENERAL LIABILITY | | | | EACH OCCURRENCE | $ |
| | | COMMERCIAL GENERAL LIABILITY | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $ |
| | | CLAIMS MADE OCCUR | | | | MED EXP (Any one person) | $ |
| | | | | | | PERSONAL & ADV INJURY | $ |
| | | | | | | GENERAL AGGREGATE | $ |
| | | GEN'L AGGREGATE LIMIT APPLIES PER: POLICY PRO-JECT LOC | | | | PRODUCTS - COMP/OP AGG | $ |
| | | AUTOMOBILE LIABILITY | | | | COMBINED SINGLE LIMIT (Ea accident) | $ |
| | | ANY AUTO | | | | | |
| | | ALL OWNED AUTOS | | | | BODILY INJURY (Per person) | $ |
| | | SCHEDULED AUTOS | | | | | |
| | | HIRED AUTOS | | | | BODILY INJURY (Per accident) | $ |
| | | NON-OWNED AUTOS | | | | | |
| | | | | | | PROPERTY DAMAGE (Per accident) | $ |
| | | GARAGE LIABILITY | | | | AUTO ONLY - EA ACCIDENT | $ |
| | | ANY AUTO | | | | OTHER THAN AUTO ONLY: EA ACC | $ |
| | | | | | | AGG | $ |
| | | EXCESS/UMBRELLA LIABILITY | | | | EACH OCCURRENCE | $ |
| | | OCCUR CLAIMS MADE | | | | AGGREGATE | $ |
| | | | | | | | $ |
| | | DEDUCTIBLE | | | | | $ |
| | | RETENTION $ | | | | | $ |
| | | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | | | | WC STATU-TORY LIMITS / OTH-ER | |
| | | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? | | | | E.L. EACH ACCIDENT | $ |
| | | If yes, describe under SPECIAL PROVISIONS below | | | | E.L. DISEASE - EA EMPLOYEE | $ |
| | | | | | | E.L. DISEASE - POLICY LIMIT | $ |
| A | | OTHER Professional Liabili | TX11387507 | 06/30/2009 | 06/30/2010 | $500,000 Each Loss<br>$3,000,000 Aggregate | |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

**CERTIFICATE HOLDER**

Ambrosio Tovar, Procurement Director
Hidalgo County Head Start Program
1901 West State Highway 107
McAllen, Texas 78504

**CANCELLATION**

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 0 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF any KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

ACORD 25 (2001/08)

Client#: 11518 NUESCLI

# ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 05/05/09

PRODUCER
Willis of Texas, Inc.
(956)682-9423 FAX(956)687-1286
1400 N McColl Rd Suite 105
McAllen, TX 78501

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED
Nuestra Clinica Del Valle Inc
PO Box 1689
Pharr, TX 78577

| INSURERS AFFORDING COVERAGE | NAIC # |
|---|---|
| INSURER A: Travelers Lloyds Insurance Company | 39357 |
| INSURER B: Texas Mutual Insurance Company | 22945 |
| INSURER C: | |
| INSURER D: | |
| INSURER E: | |

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR LTR | ADD'L INSRD | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YY) | POLICY EXPIRATION DATE (MM/DD/YY) | LIMITS | |
|---|---|---|---|---|---|---|---|
| A | | GENERAL LIABILITY<br>[X] COMMERCIAL GENERAL LIABILITY<br>[ ] CLAIMS MADE [X] OCCUR<br>GEN'L AGGREGATE LIMIT APPLIES PER:<br>[ ] POLICY [ ] PRO-JECT [ ] LOC | PACP9250C993TLC08 | 12/21/08 | 12/21/09 | EACH OCCURRENCE | $1,000,000 |
| | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $300,000 |
| | | | | | | MED EXP (Any one person) | $5,000 |
| | | | | | | PERSONAL & ADV INJURY | $1,000,000 |
| | | | | | | GENERAL AGGREGATE | $2,000,000 |
| | | | | | | PRODUCTS - COMP/OP AGG | $2,000,000 |
| | | AUTOMOBILE LIABILITY<br>[ ] ANY AUTO<br>[ ] ALL OWNED AUTOS<br>[ ] SCHEDULED AUTOS<br>[ ] HIRED AUTOS<br>[ ] NON-OWNED AUTOS | | | | COMBINED SINGLE LIMIT (Ea accident) | $ |
| | | | | | | BODILY INJURY (Per person) | $ |
| | | | | | | BODILY INJURY (Per accident) | $ |
| | | | | | | PROPERTY DAMAGE (Per accident) | $ |
| | | GARAGE LIABILITY<br>[ ] ANY AUTO | | | | AUTO ONLY - EA ACCIDENT | $ |
| | | | | | | OTHER THAN AUTO ONLY: EA ACC | $ |
| | | | | | | AGG | $ |
| | | EXCESS/UMBRELLA LIABILITY<br>[ ] OCCUR [ ] CLAIMS MADE<br>[ ] DEDUCTIBLE<br>[ ] RETENTION $ | | | | EACH OCCURRENCE | $ |
| | | | | | | AGGREGATE | $ |
| | | | | | | | $ |
| | | | | | | | $ |
| | | | | | | | $ |
| B | | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY<br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?<br>If yes, describe under SPECIAL PROVISIONS below | TSF0001093256 | 12/02/08 | 12/02/09 | [X] WC STATU-TORY LIMITS [ ] OTH-ER | |
| | | | | | | E.L. EACH ACCIDENT | $500,000 |
| | | | | | | E.L. DISEASE - EA EMPLOYEE | $500,000 |
| | | | | | | E.L. DISEASE - POLICY LIMIT | $500,000 |
| | | OTHER | | | | | |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

CERTIFICATE HOLDER

Hidalgo County Headstart Program
1901 W State Hwy 107
McAllen, TX 78504

Ambrosio Tovar,
Procurement Director

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
Brian E Lewis

# ACORD. CERTIFICATE OF INSURANCE

ISSUE DATE (MM/DD/YY)

5-5-2009

PRODUCER

JESSE TREVINO INSURANCE AGENCY
P O BOX 429
MCALLEN, TEXAS 78505

CODE SUB-CODE

INSURED

NUESTRA CLINICA DEL VALLE
801 W. 1st ST
SAN JUAN TEXAS 78589

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW

## COMPANIES AFFORDING COVERAGE

COMPANY LETTER A — TRAVELERS

COMPANY LETTER B

COMPANY LETTER C

COMPANY LETTER D

COMPANY LETTER E

## COVERAGES

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| CO LTR | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YY) | POLICY EXPIRATION DATE (MM/DD/YY) | ALL LIMITS IN THOUSANDS |
|---|---|---|---|---|---|
| | GENERAL LIABILITY | | | | GENERAL AGGREGATE $ |
| | COMMERCIAL GENERAL LIABILITY | | | | PRODUCTS-COMP/OPS AGGREGATE $ |
| | CLAIMS MADE OCCUR. | | | | PERSONAL & ADVERTISING INJURY $ |
| | OWNER'S & CONTRACTOR'S PROT. | | | | EACH OCCURRENCE $ |
| | | | | | FIRE DAMAGE (Any one fire) $ |
| | | | | | MEDICAL EXPENSE (Any one person) $ |
| A | AUTOMOBILE LIABILITY | | | | COMBINED SINGLE LIMIT $500,000 |
| ) | ANY AUTO | BA-1614N255 | 1-22-2009 | 1-22-2010 | |
| | ALL OWNED AUTOS | | | | BODILY INJURY (Per person) $ |
| X | SCHEDULED AUTOS | | | | |
| | HIRED AUTOS | | | | BODILY INJURY (Per accident) $ |
| | NON-OWNED AUTOS | | | | |
| | GARAGE LIABILITY | | | | PROPERTY DAMAGE $ |
| | EXCESS LIABILITY | | | | EACH OCCURRENCE $ / AGGREGATE $ |
| | OTHER THAN UMBRELLA FORM | | | | |
| | WORKER'S COMPENSATION AND EMPLOYERS' LIABILITY | | | | STATUTORY $ (EACH ACCIDENT) / $ (DISEASE—POLICY LIMIT) / $ (DISEASE—EACH EMPLOYE |
| | OTHER | | | | |

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/RESTRICTIONS/SPECIAL ITEMS

4-VEHICALS PIP-$2,500
UMBI/PD
COMP/COLL - DED $500

CERTIFICATE HOLDER

HIDALGO COUNTY HEADSTART PROGRAM
1901 W. STATE 107
MCALLEN, TEXAS 78504

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL _____ DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

JESSE TREVINO

# ACKNOWLEDGMENT FORM

**STATEMENT OF QUALIFICATIONS**
**FOR**
**HIDALGO COUNTY HEAD START PROGRAM**
**"MEDICAL & DENTAL PROVIDERS"**
**RFQ 2010-014-03-30**

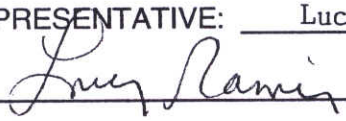
We, as an interested party, agree to the criteria and the requirements of the RFQ and have submitted our statement of qualifications as requested.

All costs involved in submitting this statement to Hidalgo County Head Start Program shall be borne in full by the RFQ Company.

COMPANY: Nuestra Clinica Del Valle, Inc.

ADDRESS: P.O. Box 1689, Pharr, Texas 78577

AUTHORIZED REPRESENTATIVE: Lucy Ramirez

SIGNATURE: 

TITLE: Executive Director

TELEPHONE: (956) 787-8915 FAX NO. (956) 787-2021

E-MAIL: hchcc@hiline.net

DATE: April 23, 2010

# PROJECT REQUIREMENTS ACKNOWLEDGMENT

This is to certify that I, Nuestra Clinica Del Valle, Inc, possess all of the APPLICABLE;

1. Licenses: See Attached
2. Bonds: _____
3. Certificates: _____
4. Permits: See Attached
5. Other: _____

necessary to carry out the required project. Furthermore, I am providing copies of the required documentation so that, if my company is awarded this bid, I may be eligible to enter into a contract with Hidalgo County Head Start Program and proceed to complete the project in a timely manner.

- Any licenses, bonds, certificates, and permits, etc. which are required must be presented as part of the bid packet in order to expedite the bid evaluation process. Failure to provide said documentation will result in the disqualification of your bid.

Authorized Signature

April 23, 2010
Date

Nuestra Clinica Del Valle, Inc.
Company

P.O. Box 1689
Address

Pharr, Texas 78577
City, State, Zip

## CERTIFICATION
## Regarding Debarment, Suspension Ineligibility

As is required by the Federal Regulations Implementing Executive Order 12549, Debarment and Suspension, 45 CFR Part 76, Government-wide Debarment and Suspension, in the applicant certifies, to the best of his or her knowledge and belief, that both it and its principals:

a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency;

b. Have not within a three-year period preceding this bid/proposal and/or application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, theory, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

c. Are not presently indicted for or otherwise criminally or civilly charged by a government entity with commission of any of the offenses enumerated herein; and

d. Have not within a three-year period preceding this bid/proposal and/or application had one or more public transactions terminated of cause or default

Signature: Lucy Ramirez

Print Name: Lucy Ramirez

Title: Executive Director

Telephone Number: (956) 787-8915

Date: April 23, 2010

If the proposer is unable to certify to all of the statements in this Certification, such proposer should attach an explanation to this proposal.

**EXHIBIT "E"**
**PROPOSER'S AFFIDAVIT**

**PROPOSER'S AFFIDAVIT OF NON-COLLUSION**
**NON-CONFILICT OF INTREST, AND ANTI-LOBBYING**
**FOR "MEDICAL & DENTAL SERVICE PROVIDERS"**

STATE OF TEXAS
COUNTY OF HIDALGO

Affiant, Lucy Ramirez, being first duly sworn, deposes that:

(1) Affiant does hereby state neither the Proposer nor any of the Proposer's officers, partners, owners, agents, representatives, employees, or parties in interest, has in any way colluded, conspired, agreed, directly or indirectly with any person, firm, corporation, or other proposer, or potential proposer, to provide any money or other valuable consideration for assistance in procuring or attempting to procure a contract or fix the prices in the attached proposed or the proposal of any other proposer, and further states that no such money or other reward will be hereinafter paid.

(2) Affiant further states they have neither recommended or suggested to Hidalgo County or any of its officials or employees, any of the terms or provisions set forth in their Request for Proposal and subsequent agreement, except at a meeting open to all interested proposers, of which proper notice was given.

(3) Affiant, further states their officers, employees, or agents have not, and will not attempt to lobby, directly or indirectly, the Hidalgo County Commissioner's Court between proposal submission date and award by the Hidalgo County Commissioner's Court.

(4) Affiant further States no officer, or stockholder of the Proposer is a member of the staff, or related to any employee of the Hidalgo County except as noted herein below:

Signature/ Title: Lucy Ramirez, Executive Director

Subscribed and sworn to before me this 29th day of April, 2010.

Barbara A. Contreras

Notary Public

My Commission expires: 10/25/2012 ~~, 2010~~

BARBARA A. CONTRERAS
Notary Public
STATE OF TEXAS
My Comm Exp 10-25-2012

# HIDALGO COUNTY
# Respondent/Vendor Application

Complete in print or type. Please return this application to the Hidalgo County Head Start Program – Procurement Department thru Facsimile: (956) 381-0439, in person: 1901 West State Highway 107, McAllen, TX 78504 or mailed: P. O. Box 0117, Edinburg, TX 78540

**Company Name:** Nuestra Clinica Del Valle, Inc **Telephone Name: ( )** (956) 787-8915

**dba Name:**

**Legal Name:**

**Mailing Address:** P.O. Box 1689 **Fax Name: ( )** (956) 787-2021

**Physical Address:**

**City, State, Zip:** Pharr, Texas 78577 **Tax I.D. №** 74-1721807

**Remit to Address:** **City, State, Zip**

**E-Mail Address:** hchcc@hiline.net

**Representative(s) Name(s) & Title(s)** Lucy Ramirez, Executive Director

**Type of Organization(check one):** ___Individual ___Partnership _X_Corporation ___Non-Profit ___ LLC ___ Sole Proprietor ___Other, Specify_____

**State Identification №:**_____**(Please attached completed W-9 form with this application)**

**Federal Identification № or (if individual) SS №** 74-1721807

**Type of Business (check one):** ___Manufacturer ___Wholesaler ___Retailer ___Broker ___ Distributor ___Service Organization _X_Other, Specify Community/Migrant Health Center

**Name & Title of Person(s) Authorized to Sign Bids, Proposals, and/or Contracts:**

**Small and/or Disadvantaged Business Information (check application criteria)** Not Applicable

**Small Business:**

Less than 125,000 annual gross receipt ___
Less than 250,000 annual gross receipt ___
Less than 499,000 annual gross receipt ___

**Disadvantaged Business (At Least 51% Ownership)**

Black American ___
Hispanic American ___
Asian Pacific American ___
Native American ___
Women ___
Other ___

**Have you been certified as a HUB or an MBE/WBE source?:** YES__ NO__

**Indicate Certification №(s):**_____ **or are Certificate(s) attached?:** YES__ NO __

**What type of product(s) is/are solicited by your company?:** Not Applicable
**Would you like to be provided with specifications for procurements of such products ?:** YES___ NO__

**To Be Completed by Head Start: Rec'd by (Procurement):**_____**Date Rec'd by (Procurement):**_____

**Date Forwarded Information to Finance Office:**_____ **Entry Date:**_____ **Vendor №:**_____

# Certification For
# Primary Covered Transactions

1. The Nuestra Clinica Del Valle, Inc. (Vendor Name) certifies to the best of its knowledge and belief, that it and its principals:

   a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

   b) Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

   c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and

   d) Have not within a three-year period preceding this request for qualifications had one or more public transactions (Federal, State or local) terminated for cause or default.

2. Where the _____ (Vendor Name) is unable to certify to any of the statements in this certification, such prospective vendor shall attach an explanation to this RFQ.

Signature: Lucy Ramirez

Print Name: Lucy Ramirez

Title: Executive Director

Telephone No.: (956) 787-8915 Date: April 23, 2010

**EXHIBIT D**

2094373

# CONFLICT OF INTEREST QUESTIONNAIRE

FORM CIQ

For vendor or other person doing business with local governmental entity

This questionnaire is being filed in accordance with chapter 176 of the Local Government Code by a person doing business with the governmental entity.

By law this questionnaire must be filed with the records administrator of the local government not later than the 7th business day after the date the person Becomes aware of facts that require the statement to be filed. See Section 176.006, Local Government Code.

A person commits an offense if the person violates Section 176.006 Local Government Code. An Offense under this section is a Class C misdemeanor.

| OFFICE USE ONLY |
| --- |
| Date Received |

1 Name of person doing business with local governmental entity.

Not Applicable

2 ☐ Check this box if you are filling an update to a previously filed questionnaire.

(The law requires that you file an updated completed questionnaire with the appropriate filing authority not later than the 7th business day after the date the originally filed questionnaire becomes incomplete or inaccurate.)

3 Name of local government officer with whom filer has employment or business relationship.

Not Applicable

Name of Officer

This section (item 3 including subparts A,B, C & D) must be completed for each officer with whom the filer has an employment or other business relationship as defined by Section 176.001 (1-a), Local Government Code. Attach additonal pages to this Form CIQ as necessary.

A. Is the local government officer named in this section receiving or likely to receive taxable income other than investment income from the filer of the questionnaire?

☐ Yes ☒ No

B. Is the filer of the questionnaire receiving or likely to receive taxable income, other than investment income, from or at the direction of the local government officer named in this section AND the taxable income is not received from the local government entity?

☐ Yes ☒ No

C. Is the filer of the questionnaire employed by a corporation or other business entity with respect to which the local government officer serves as an officer or director, or holds an ownership of 10 percent or more?

☐ Yes ☒ No

D. Describe each employment or business relationship with the local government officer named in this section.

4 Nuestra Clinica Del Valle, Inc.

Lucy Ramirez

Signature of person doing business with the governmental entity

04/16/2010

Date

Lucy Ramirez, Executive Director

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

# Request for Taxpayer Identification Number and Certification

**Give form to the requester. Do not send to the IRS.**

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)
NUESTRA CLINICA DEL VALLE, INC.

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☒ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ _____
☐ Other (see instructions) ▶

☒ Exempt payee

Address (number, street, and apt. or suite no.)
P.O. BOX 1689

Requester's name and address (optional)

City, state, and ZIP code
PHARR, TEXAS 78577

List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
: :

or

Employer identification number
74 : 1721807

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

**Sign Here** Signature of U.S. person ▶ Lucy Ramirez Date ▶ 4/23/10

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

## Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

# CONTRACT FOR SERVICES
# MEDICAL & DENTAL
# 2009-03-033

STATE OF TEXAS &
&
COUNTY OF HIDALGO &

THIS AGREEMENT (The "Agreement") is made effective the **1st** day of **September, 2009** by and between the HIDALGO COUNTY HEAD START PROGRAM, (hereinafter "The Program") a federally funded program under the auspices of HIDALGO COUNTY, TEXAS, a political subdivision of the State of Texas and **NUESTRA CLINICA DEL VALLE INC.** (hereinafter "Provider") to serve at the pleasure of the Program. This Contract for Services may be extended for an additional year upon mutual agreement based on the same terms at mutual agreement to by the parties. This Agreement terminates on the **31st** day of **August, 2010** or as provided herein.

WITNESSETH:

WHEREAS, Program requires certain services which Provider is licensed to provide, a description of each service is attached hereto as Exhibit "A" and incorporated herein for all purposes; and

WHEREAS, the Provider has agreed to provide the services enumerated in this Agreement for the Program; and

WHEREAS, the Program is the recipient of certain federal funds to be utilized for the provision of services to the participants of the Program; and

WHEREAS, Program participants' (students) are examined and treated by the Provider; and

WHEREAS, the Provider will examined and treat the program participants on the terms and conditions hereinafter set forth; and

NOW, THEREFORE, in consideration of the foregoing and the following Provider and Program agrees as follows:

A. 1. Provider represents that (s)he is licensed by the State of Texas and qualified to perform and execute services provided in this Agreement. If such license is suspended or revoked, this Contract shall automatically be terminated. Provider shall immediately notify the Program of such suspension or revocation.

2. The Provider shall prepare, maintain and submit all records which are designated, required or prescribed by the Program, federal grantor agency, or County of Hidalgo. In addition, the Provider shall permit the Program, the Department of Health and Human Services and the County of Hidalgo to audit, inspect records and reports, review services and /or evaluate the performance of the services provided hereunder at any reasonable time. The Provider shall provide access to all its records, books, reports and other pertinent data and information needed to accomplish review of its activities, services and expenditures billed to the Program.

3. In consideration for the above and foregoing, the Provider shall submit a monthly billing statement to the Program at:

**Hidalgo County Head Start Program**
**P.O. Box 0117**
**Edinburg, Texas, 78540**

Said statement must provide an itemized list of services rendered to the Program during the statement period. Upon receipt of said statement, the Program will process the requisition for payment in the usual customary manner utilized by the Program. The Provider shall be compensated based on the Program's fee schedule, a copy of which is attached as Exhibit "B" hereto.

4. The Provider must comply with all applicable Program and Hidalgo County

policies. Notwithstanding the foregoing sentence, the Provider represents and maintains that (s)he is an independent provider and is not an employee of the Program or Hidalgo County, Texas, or any agency thereof, and further represents and warrants that (s)he does not desire or request any fringe benefits provided to employees of the Program or Hidalgo County, Texas, and/or agency thereof, including, but not limited to benefits associated with Hidalgo County's civil service program. The Provider agrees to be responsible for any federal income tax, withholding or social security tax liability which might arise from payments received pursuant to this Agreement.

5. The Program and the Provider agree that either party may terminate this contract at any time for any reason or no reason at all upon thirty (30) days prior written notice to the other party. Proper Notice shall be submitted through certified letter to:

Teresa Flores, Executive Director
Hidalgo County Head Start Program
P.O. Box 0117
Edinburg, Texas 78540-0117

NUESTRA CLINICA DEL VALLE INC.
P.O. BOX 1689
PHARR TX, 78577

6. Provider agrees to be insured for professional liability, premises liability and auto liability insurance covering his/her employee's activities and services to the Program in coverage limits not less than the minimum amounts prescribed by the Texas Tort Claims Act, §101.001, et seq., Texas Civil Practices and Remedies Code. Provider shall furnish the Program a certificate issued by their insurer that such insurance is in full force and effect.

7. Except as otherwise herein provided, the Provider may not assign the

obligations or rights under this Contract to any person without the prior written consent of the Program.

B. The Provider's employees, if any, who perform services for the Program under this Agreement shall be bound by the provisions of the terms of this Agreement. At the request of the Program, the Provider shall provide adequate evidence that such persons are the Provider's employees.

C. The Provider will indemnify and hold harmless and defend the Program and the County of Hidalgo from any and all claims, actions, liability, and expenses including all cost of judgments, settlements, court cost, and attorney's fees regardless of the outcome of such claim(s) or action(s) caused by, resulting from, or alleging negligent or intentional acts or omission(s) or any failure to perform any obligation(s) undertaken or any covenant(s) in this Agreement, and further, whether such act, omission, or failure to perform any obligation undertaken or any covenant in this Agreement was the Provider's or that of any person providing services hereunder through or for Provider. Upon written notice from the County and the Program, Provider will resist and defend at its own expenses, and by counsel reasonably satisfactory to the County and the Program, any such claim(s) or action(s).

D. This Agreement shall be construed under and in accordance with the laws of the State of Texas, and all obligations of the parties created hereunder are performance in Hidalgo County, Texas.

E. In case any one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision thereof and this Agreement shall be construed as if such invalid, illegal

or unenforceable provision had never been contained herein.

F. Contract Extension. Hidalgo County Head Start Program reserves the right to extend this agreement for ninety (90) days from the date of termination (August 31st, 2010) of the Contract period at the such rate and terms as negotiated by the parties. A thirty (30) day written notice of intention to extend this agreement will be provided prior to its expiration by Hidalgo County Head Start Program.

G. No amendment, modification or alteration of the terms hereof shall be binding unless the same be in writing, dated subsequent to the date hereof and duly executed by the parties hereto.

H. Provider will not discriminate on the basis of race, color, sex, age, religion, national origin, or handicap in providing the services under this Agreement or in the selection of associates, employees, or independent providers.

I. Provider will perform its services at all times in compliance with federal, state, and local laws, rules and regulations, the policies, rule and regulations of the Program, and all currently accepted and approved methods and practices of the professional specialty relating to the services.

IN WITNESS WHEREOF, the parties have caused their names to be hereunto subscribed personally or by a duly authorized officer of agent of each party, effective the day and year first written above. EXECUTED as of the day and year first written above.

PROVIDER:
NUESTRA CLINICA DEL VALLE INC.

BY: _____
(Provider's Name)

_____
(Print Name)

_____
(Title)

HIDALGO COUNTY
HEAD START PROGRAM

BY: _____
J.D. Salinas, County Judge

BY: _____
Teresa Flores, Executive Director

BY: _____
Arturo Guajardo, Jr., County Clerk

APPROVED AS TO FORM:
OXFORD & GONZALEZ

By: _____
Ricardo Gonzalez

APPROVED AS TO FORM:
ATLAS & HALL, L.L.P.

By: _____
Stephen L. Crain

# Exhibit A

## Description of Services – Medical Service

The Provider agrees to provide any services deem necessary to evaluate any and all children referred to the Provider by Head Start.

The Provider agrees to continue such services until such time as the Executive Director of the Program (or designee) determine that there is no longer a need for the services.

Provider shall provide copies of records to Head Start for each child it affords services. Copies of these records shall be free of charge.

The services provided by the Provider will included the following and in addition all services will be provided on schedule with Head Start 1304:

1. The provider will perform a complete physical examination (head to toe assessment) at his/her respective practice or center site on the initial visit. The form **"PROJECT HEAD START: PHYSICAL EXAM AND ASSESSMENT"** will be shown with date of exam, signature of the Provider, referral and or treatment.

2. Any "abnormal findings" or "not evaluated" will be accompanied by an explanation.

3. Minor acute illnesses will be referred to their own family physician, if none is available, clients will be treated on site and a follow-up appointment made for a later date.

4. Chronic illnesses or other abnormalities encountered will be referred for further evaluation or treatment.

5. ALL MEDICAID CHILDREN WILL RECEIVE AN EXAM AS PER THE EPSDT MEDICAL PROCEDURES SCHEDULED BY AGE. (Medicaid Provider Procedure Manual)

6. Physical findings, treatments and or referrals will be discussed with parents upon completion of examination.

7. Confidentiality of medical records will be maintained in accordance of examination.

8. Upon completion of **"HEAD START: PHYSICAL EXAM AND ASSESSMENT"** signature of provider and date will be written on the bottom page. RECOMMENDATIONS will be written accordingly. Remit a copy to the HIDALGO COUNTY HEAD START PROGRAM, a copy for the Provider's records and a copy to the parent. The same procedure will follow the same for a Texas Health Step exam.

9. The Provider's statement, which lists the child's name/center and the total cost of the exam provided is to be returned to HIDALGO COUNTY HEAD START PROGRAM for payment. Six (6) weeks may be required for processing payment.

10. The total number of children provided medical services will be submitted to the HIDALGO COUNTY HEAD START PROGRAM with the provider's name after every examination day.

HIDALGO COUNTY HEAD START PROGRAM will be responsible to:

1. Encourage the child's parent to be present during physical exam. If parent is unable to attend, a brief medical history will be obtained from parent.

2. Provide **"PROJECT HEAD START: PHYSICAL EXAM AND ASSESSMENT"** form with child's name and address.

3. Schedule a minimum of twenty (20) patients for physical exams, when clinics are to be held at center site.

# Exhibit A

## Description of Services-Dental Health Services

The Provider agrees to provide any services deem necessary to evaluate any and all children referred to the Provider by Head Start.

The Provider agrees to continue such services until such time as the Executive Director of the Program (or designee) determine that there is no longer a need for the services.

Provider shall provide copies of records to Head Start for each child it affords services. Copies of these records shall be free of charge.

The services provided by the Provider will included the following and in addition all services will be provided on schedule with Head Start 1304:

1. The provider will perform a complete and comprehensive dental examination at his/her respective practice on the initial visit. The **"Dental Health Form"** will be shown with date of exam, signature of the Provider, referral and or treatment done.

2. A complete and comprehensive dental examination-on the initial examination the dentist will provide a complete examination as agreed to by Medicaid every twelve (12) months. The examination will consist of:
    1. A visual examination
    2. X-Rays
    3. Prophylaxis(cleaning)
    4. Nutritional Counseling
    5. Behavior management, if necessary.

3. Periodic Oral Examination-Every six (6) months the child must receive a periodic oral examination as agreed to by Medicaid guidelines.

4. Referral- If an abnormality arises and provider is not able to treat the condition, the parent will be notified as soon as abnormality is found or detected, and the parent will be given the opportunity to select a specialist (if such an option is available) in the appropriate dental field from a roster of recommended "List of Providers" by the dental provider.

5. Confidentiality of medical records will be maintained in accordance of examination.

6. Upon completion of **"HEAD START: Dental Health Form"** signature of provider and date will be written on the bottom page. RECOMMENDATIONS will be written accordingly. Remit a copy to the HIDALGO COUNTY HEAD START PROGRAM, a copy for the Provider's records and a copy to the parent. The same procedure will follow the same for a Texas Health Step exam.

7. The Provider's statement, which lists the child's name/center and the total cost of the exam provided is to be returned to HIDALGO COUNTY HEAD START PROGRAM for payment. Six (6) weeks may be required for processing payment.

8. The total number of children provided dental services will be submitted to the HIDALGO COUNTY HEAD START PROGRAM with the provider's name after every examination day.

HIDALGO COUNTY HEAD START PROGRAM will be responsible to:

1. Encourage the child's parent to be present during dental exam. If parent is unable to attend, a brief medical history will be obtained from parent.

2. Provide **"HEAD START: Dental Health Form"** with child's name and address.

# Exhibit B
## Fee Schedule

### Nuestra Clinica Del Valle
2009-2010

**Fee Schedule for Services:** Fees should not exceed Medicaid Allowable reimbursements.

1 The Provider shall be paid only for full and satisfactory completion of the following services:

| Description Of Service | FEE |
|---|---|
| a. Initial Oral Examination | $ 30.00 |
| | |
| b. Periodic Oral Examination | $ 30.00 |
| | |
| c. Emergency Oral Examination | $ N/A |
| | |
| d. Bite-wing Radiographs (four (4) films) | $ 35.00 |
| | |
| e. Topical Application of Flouride (including prophylaxis) | $ 35.00 |
| | |
| f. Nutritional Counseling | $ N/A |
| | |
| | |
| | |
| | |

# Exhibit B
## Fee Schedule

Nuestra Clinica Del Valle

2009-2010

**Fee Schedule for Services:** Fees should not exceed Medicaid Allowable reimbursements.

1 The Provider shall be paid only for full and satisfactory completion of the following services:

| Description Of Service | FEE |
|---|---|
| | |
| 1 Complete THS (Head To Toe Assessment) | |
| to include the following: | |
| a. Medical History | |
| b. Physical Examination | $ 20.00 |
| c. Measurements (Height/Weight/BMI/Blood Pressure) | $ 40.00 |
| d. Sensory Screening (Vision & Hearing) | |
| e. Tuberculin Screening | $ |
| f. Laboratory (Lead, Hgb or Hct) | $ 10.00 |
| g. Immunizations | |
| h. Anticipatory Guidance | |
| | |
| | |
| | |
| | |

# ACORD CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 10/01/2009

PRODUCER
Community Health Insurance Agency, Inc.
5900 Southwest Parkway
Bldg 3
Austin TX 78735

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED
Nuestra Clinica del Valle
P. O. Box 1689
Pharr TX 78577

| INSURERS AFFORDING COVERAGE | NAIC # |
|---|---|
| INSURER A: American Physicians Insurance Co. | |
| INSURER B: | |
| INSURER C: | |
| INSURER D: | |
| INSURER E: | |

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR LTR | ADD'L INSRD | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YY) | POLICY EXPIRATION DATE (MM/DD/YY) | LIMITS | |
|---|---|---|---|---|---|---|---|
| | | GENERAL LIABILITY | | | | EACH OCCURRENCE | $ |
| | | COMMERCIAL GENERAL LIABILITY | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $ |
| | | CLAIMS MADE ☐ OCCUR | | | | MED EXP (Any one person) | $ |
| | | | | | | PERSONAL & ADV INJURY | $ |
| | | | | | | GENERAL AGGREGATE | $ |
| | | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | PRODUCTS - COMP/OP AGG | $ |
| | | POLICY ☐ PRO-JECT ☐ LOC | | | | | |
| | | AUTOMOBILE LIABILITY | | | | COMBINED SINGLE LIMIT (Ea accident) | $ |
| | | ANY AUTO | | | | BODILY INJURY (Per person) | $ |
| | | ALL OWNED AUTOS | | | | BODILY INJURY (Per accident) | $ |
| | | SCHEDULED AUTOS | | | | PROPERTY DAMAGE (Per accident) | $ |
| | | HIRED AUTOS | | | | | |
| | | NON-OWNED AUTOS | | | | | |
| | | GARAGE LIABILITY | | | | AUTO ONLY - EA ACCIDENT | $ |
| | | ANY AUTO | | | | OTHER THAN AUTO ONLY: EA ACC | $ |
| | | | | | | AGG | $ |
| | | EXCESS/UMBRELLA LIABILITY | | | | EACH OCCURRENCE | $ |
| | | OCCUR ☐ CLAIMS MADE | | | | AGGREGATE | $ |
| | | | | | | | $ |
| | | DEDUCTIBLE | | | | | $ |
| | | RETENTION $ | | | | | $ |
| | | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | | | | WC STATU-TORY LIMITS ☐ OTH-ER | |
| | | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? | | | | E.L. EACH ACCIDENT | $ |
| | | If yes, describe under SPECIAL PROVISIONS below | | | | E.L. DISEASE - EA EMPLOYEE | $ |
| | | | | | | E.L. DISEASE - POLICY LIMIT | $ |
| A | | OTHER Professional Liabili | TX11387507 | 06/30/2009 | 06/30/2010 | $500,000 Each Loss<br>$3,000,000 Aggregate | |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

CERTIFICATE HOLDER

Ambrosio Tovar, Procurement Director
Hidalgo County Head Start Program
1901 West State Highway 107
McAllen, Texas 78504

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 0 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

Client#: 11518 NUESCLI

# ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 05/05/09

PRODUCER
Willis of Texas, Inc.
956)682-9423 FAX(956)687-1286
1400 N McColl Rd Suite 105
McAllen, TX 78501

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURED
Nuestra Clinica Del Valle Inc
PO Box 1689
Pharr, TX 78577

| INSURERS AFFORDING COVERAGE | NAIC # |
|---|---|
| INSURER A: Travelers Lloyds Insurance Company | 39357 |
| INSURER B: Texas Mutual Insurance Company | 22945 |
| INSURER C: | |
| INSURER D: | |
| INSURER E: | |

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR LTR | ADD'L INSRD | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YY) | POLICY EXPIRATION DATE (MM/DD/YY) | LIMITS | |
|---|---|---|---|---|---|---|---|
| A | | GENERAL LIABILITY | PACP9250C993TLC08 | 12/21/08 | 12/21/09 | EACH OCCURRENCE | $1,000,000 |
| | | [X] COMMERCIAL GENERAL LIABILITY | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $300,000 |
| | | [ ] CLAIMS MADE [X] OCCUR | | | | MED EXP (Any one person) | $5,000 |
| | | | | | | PERSONAL & ADV INJURY | $1,000,000 |
| | | | | | | GENERAL AGGREGATE | $2,000,000 |
| | | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | PRODUCTS - COMP/OP AGG | $2,000,000 |
| | | [ ] POLICY [ ] PRO-JECT [ ] LOC | | | | | |
| | | AUTOMOBILE LIABILITY | | | | COMBINED SINGLE LIMIT (Ea accident) | $ |
| | | [ ] ANY AUTO | | | | BODILY INJURY (Per person) | $ |
| | | [ ] ALL OWNED AUTOS | | | | BODILY INJURY (Per accident) | $ |
| | | [ ] SCHEDULED AUTOS | | | | PROPERTY DAMAGE (Per accident) | $ |
| | | [ ] HIRED AUTOS | | | | | |
| | | [ ] NON-OWNED AUTOS | | | | | |
| | | GARAGE LIABILITY | | | | AUTO ONLY - EA ACCIDENT | $ |
| | | [ ] ANY AUTO | | | | OTHER THAN AUTO ONLY: EA ACC | $ |
| | | | | | | AGG | $ |
| | | EXCESS/UMBRELLA LIABILITY | | | | EACH OCCURRENCE | $ |
| | | [ ] OCCUR [ ] CLAIMS MADE | | | | AGGREGATE | $ |
| | | | | | | | $ |
| | | [ ] DEDUCTIBLE | | | | | $ |
| | | [ ] RETENTION $ | | | | | $ |
| B | | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | TSF0001093256 | 12/02/08 | 12/02/09 | [X] WC STATUTORY LIMITS [ ] OTHER | |
| | | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? | | | | E.L. EACH ACCIDENT | $500,000 |
| | | If yes, describe under SPECIAL PROVISIONS below | | | | E.L. DISEASE - EA EMPLOYEE | $500,000 |
| | | | | | | E.L. DISEASE - POLICY LIMIT | $500,000 |
| | | OTHER | | | | | |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

CERTIFICATE HOLDER

Hidalgo County Headstart Program
1901 W State Hwy 107
McAllen, TX 78504

Ambrosio Tovar,
Procurement Director

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE
Brian E Lewis

# ACORD. CERTIFICATE OF INSURANCE

ISSUE DATE (MM/DD/YY)

5-5-2009

PRODUCER

JESSE TREVINO INSURANCE AGENCY
P O BOX 429
MCALLEN, TEXAS 78505

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW

CODE SUB-CODE

INSURED

NUESTRA CLINICA DEL VALLE
801 W. 1st ST
SAN JUAN TEXAS 78589

## COMPANIES AFFORDING COVERAGE

COMPANY LETTER A — TRAVELERS

COMPANY LETTER B

COMPANY LETTER C

COMPANY LETTER D

COMPANY LETTER E

## COVERAGES

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| CO LTR | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YY) | POLICY EXPIRATION DATE (MM/DD/YY) | ALL LIMITS IN THOUSANDS |
|---|---|---|---|---|---|
| | GENERAL LIABILITY | | | | GENERAL AGGREGATE $ |
| | COMMERCIAL GENERAL LIABILITY | | | | PRODUCTS-COMP/OPS AGGREGATE $ |
| | CLAIMS MADE OCCUR. | | | | PERSONAL & ADVERTISING INJURY $ |
| | OWNER'S & CONTRACTOR'S PROT. | | | | EACH OCCURRENCE $ |
| | | | | | FIRE DAMAGE (Any one fire) $ |
| | | | | | MEDICAL EXPENSE (Any one person) $ |
| A | AUTOMOBILE LIABILITY | | | | COMBINED SINGLE LIMIT $500,000 |
| | ANY AUTO | BA-1614N255 | 1-22-2009 | 1-22-2010 | |
| | ALL OWNED AUTOS | | | | BODILY INJURY (Per person) $ |
| X | SCHEDULED AUTOS | | | | |
| | HIRED AUTOS | | | | BODILY INJURY (Per accident) $ |
| | NON-OWNED AUTOS | | | | |
| | GARAGE LIABILITY | | | | PROPERTY DAMAGE $ |
| | EXCESS LIABILITY | | | | EACH OCCURRENCE $ / AGGREGATE $ |
| | OTHER THAN UMBRELLA FORM | | | | |
| | WORKER'S COMPENSATION AND EMPLOYERS' LIABILITY | | | | STATUTORY / $ (EACH ACCIDENT) / $ (DISEASE—POLICY LIMIT) / $ (DISEASE—EACH EMPLOYE |
| | OTHER | | | | |

DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES/RESTRICTIONS/SPECIAL ITEMS

4-VEHICALS PIP-$2,500
UMBI/PD
COMP/COLL - DED $500

CERTIFICATE HOLDER

HIDALGO COUNTY HEADSTART PROGRAM
1901 W. STATE 107
MCALLEN, TEXAS 78504

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL _____ DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT. BUT FAILURE TO MAIL SUCH NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

JESSE TREVINO

# ACKNOWLEDGMENT FORM

## STATEMENT OF QUALIFICATIONS
## FOR
## HIDALGO COUNTY HEAD START PROGRAM
## "MEDICAL & DENTAL PROVIDERS"
## RFQ 2010-014-03-30

We, as an interested party, agree to the criteria and the requirements of the RFQ and have submitted our statement of qualifications as requested.

All costs involved in submitting this statement to Hidalgo County Head Start Program shall be borne in full by the RFQ Company.

COMPANY: Nuestra Clinica Del Valle, Inc.

ADDRESS: P.O. Box 1689, Pharr, Texas 78577

AUTHORIZED REPRESENTATIVE: Lucy Ramirez

SIGNATURE: Lucy Ramirez

TITLE: Executive Director

TELEPHONE: (956) 787-8915 FAX NO. (956) 787-2021

E-MAIL: hchcc@hiline.net

DATE: April 23, 2010

# PROJECT REQUIREMENTS ACKNOWLEDGMENT

This is to certify that I, Nuestra Clinica Del Valle, Inc, possess all of the APPLICABLE;

1. Licenses: See Attached
2. Bonds: _____
3. Certificates: _____
4. Permits: See Attached
5. Other: _____

necessary to carry out the required project. Furthermore, I am providing copies of the required documentation so that, if my company is awarded this bid, I may be eligible to enter into a contract with Hidalgo County Head Start Program and proceed to complete the project in a timely manner.

Any licenses, bonds, certificates, and permits, etc. which are required must be presented as part of the bid packet in order to expedite the bid evaluation process. Failure to provide said documentation will result in the disqualification of your bid.

Authorized Signature

April 23, 2010
Date

Nuestra Clinica Del Valle, Inc.
Company

P.O. Box 1689
Address

Pharr, Texas 78577
City, State, Zip

## CERTIFICATION
## Regarding Debarment, Suspension Ineligibility

As is required by the Federal Regulations Implementing Executive Order 12549, Debarment and Suspension, 45 CFR Part 76, Government-wide Debarment and Suspension, in the applicant certifies, to the best of his or her knowledge and belief, that both it and its principals:

a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency;

b. Have not within a three-year period preceding this bid/proposal and/or application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, theory, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

c. Are not presently indicted for or otherwise criminally or civilly charged by a government entity with commission of any of the offenses enumerated herein; and

d. Have not within a three-year period preceding this bid/proposal and/or application had one or more public transactions terminated of cause or default

Signature: Lucy Ramirez

Print Name: Lucy Ramirez

Title: Executive Director

Telephone Number: (956) 787-8915

Date: April 23, 2010

If the proposer is unable to certify to all of the statements in this Certification, such proposer should attach an explanation to this proposal.

**EXHIBIT "E"**
**PROPOSER'S AFFIDAVIT**

**PROPOSER'S AFFIDAVIT OF NON-COLLUSION**
**NON-CONFILICT OF INTREST, AND ANTI-LOBBYING**
**FOR "MEDICAL & DENTAL SERVICE PROVIDERS"**

STATE OF TEXAS
COUNTY OF HIDALGO

Affiant, Lucy Ramirez, being first duly sworn, deposes that:

(1) Affiant does hereby state neither the Proposer nor any of the Proposer's officers, partners, owners, agents, representatives, employees, or parties in interest, has in any way colluded, conspired, agreed, directly or indirectly with any person, firm, corporation, or other proposer, or potential proposer, to provide any money or other valuable consideration for assistance in procuring or attempting to procure a contract or fix the prices in the attached proposed or the proposal of any other proposer, and further states that no such money or other reward will be hereinafter paid.

(2) Affiant further states they have neither recommended or suggested to Hidalgo County or any of its officials or employees, any of the terms or provisions set forth in their Request for Proposal and subsequent agreement, except at a meeting open to all interested proposers, of which proper notice was given.

(3) Affiant, further states their officers, employees, or agents have not, and will not attempt to lobby, directly or indirectly, the Hidalgo County Commissioner's Court between proposal submission date and award by the Hidalgo County Commissioner's Court.

(4) Affiant further States no officer, or stockholder of the Proposer is a member of the staff, or related to any employee of the Hidalgo County except as noted herein below:

Signature/ Title: Lucy Ramirez, Executive Director

Subscribed and sworn to before me this 29th day of April, 2010.

Barbara A. Contreras

Notary Public

My Commission expires: 10/25/2012 ~~, 2010~~

BARBARA A. CONTRERAS
Notary Public
STATE OF TEXAS
My Comm Exp 10-25-2012

# HIDALGO COUNTY
# Respondent/Vendor Application

Complete in print or type. Please return this application to the Hidalgo County Head Start Program – Procurement Department thru Facsimile: (956) 381-0439, in person: 1901 West State Highway 107, McAllen, TX 78504 or mailed: P. O. Box 0117, Edinburg, TX 78540

**Company Name:** Nuestra Clinica Del Valle, Inc **Telephone Name: ( )** (956) 787-8915

**dba Name:**

**Legal Name:**

**Mailing Address:** P.O. Box 1689 **Fax Name: ( )** (956) 787-2021

**Physical Address:**

**City, State, Zip:** Pharr, Texas 78577 **Tax I.D. №** 74-1721807

**Remit to Address:** **City, State, Zip**

**E-Mail Address:** hchcc@hiline.net

**Representative(s) Name(s) & Title(s)** Lucy Ramirez, Executive Director

**Type of Organization(check one):** ___Individual ___Partnership _X_Corporation ___Non-Profit ___ LLC ___ Sole Proprietor ___Other, Specify_____

**State Identification №:**_____ **(Please attached completed W-9 form with this application)**

**Federal Identification № or (if individual) SS №** 74-1721807

**Type of Business (check one):** ___Manufacturer ___Wholesaler ___Retailer ___Broker ___ Distributor ___Service Organization _X_Other, Specify Community/Migrant Health Center

**Name & Title of Person(s) Authorized to Sign Bids, Proposals, and/or Contracts:**

**Small and/or Disadvantaged Business Information (check application criteria)** Not Applicable

**Small Business:**

Less than 125,000 annual gross receipt ___
Less than 250,000 annual gross receipt ___
Less than 499,000 annual gross receipt ___

**Disadvantaged Business (At Least 51% Ownership)**

Black American ___
Hispanic American ___
Asian Pacific American ___
Native American ___
Women ___
Other ___

**Have you been certified as a HUB or an MBE/WBE source?:** YES__ NO__

**Indicate Certification №(s):**_____ **or are Certificate(s) attached?:** YES__ NO __

**What type of product(s) is/are solicited by your company?:** Not Applicable
**Would you like to be provided with specifications for procurements of such products ?:** YES___ NO__

**To Be Completed by Head Start: Rec'd by (Procurement):**_____ **Date Rec'd by (Procurement):**_____

**Date Forwarded Information to Finance Office:**_____ **Entry Date:**_____ **Vendor №:**_____

# Certification For
# Primary Covered Transactions

1. The Nuestra Clinica Del Valle, Inc. (Vendor Name) certifies to the best of its knowledge and belief, that it and its principals:

a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

b) Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and

d) Have not within a three-year period preceding this request for qualifications had one or more public transactions (Federal, State or local) terminated for cause or default.

2. Where the _____ (Vendor Name) is unable to certify to any of the statements in this certification, such prospective vendor shall attach an explanation to this RFQ.

Signature: Lucy Ramirez

Print Name: Lucy Ramirez

Title: Executive Director

Telephone No.: (956) 787-8915 Date: April 23, 2010

**EXHIBIT D**

2094373

# CONFLICT OF INTEREST QUESTIONNAIRE

FORM CIQ

For vendor or other person doing business with local governmental entity

This questionnaire is being filed in accordance with chapter 176 of the Local Government Code by a person doing business with the governmental entity.

By law this questionnaire must be filed with the records administrator of the local government not later than the 7th business day after the date the person Becomes aware of facts that require the statement to be filed. See Section 176.006, Local Government Code.

A person commits an offense if the person violates Section 176.006 Local Government Code. An Offense under this section is a Class C misdemeanor.

| OFFICE USE ONLY |
| --- |
| Date Received |

1 Name of person doing business with local governmental entity.

Not Applicable

2 ☐ Check this box if you are filling an update to a previously filed questionnaire.

(The law requires that you file an updated completed questionnaire with the appropriate filing authority not later than the 7th business day after the date the originally filed questionnaire becomes incomplete or inaccurate.)

3 Name of local government officer with whom filer has employment or business relationship.

Not Applicable

Name of Officer

This section (item 3 including subparts A,B, C & D) must be completed for each officer with whom the filer has an employment or other business relationship as defined by Section 176.001 (1-a), Local Government Code. Attach additonal pages to this Form CIQ as necessary.

A. Is the local government officer named in this section receiving or likely to receive taxable income other than investment income from the filer of the questionnaire?

☐ Yes ☒ No

B. Is the filer of the questionnaire receiving or likely to receive taxable income, other than investment income, from or at the direction of the local government officer named in this section AND the taxable income is not received from the local government entity?

☐ Yes ☒ No

C. Is the filer of the questionnaire employed by a corporation or other business entity with respect to which the local government officer serves as an officer or director, or holds an ownership of 10 percent or more?

☐ Yes ☒ No

D. Describe each employment or business relationship with the local government officer named in this section.

4 Nuestra Clinica Del Valle, Inc.

Lucy Ramirez

Signature of person doing business with the governmental entity

04/16/2010

Date

Lucy Ramirez, Executive Director

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

# Request for Taxpayer Identification Number and Certification

**Give form to the requester. Do not send to the IRS.**

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)
NUESTRA CLINICA DEL VALLE, INC.

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☒ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ► _____
☐ Other (see instructions) ►

☒ Exempt payee

Address (number, street, and apt. or suite no.)
P.O. BOX 1689

Requester's name and address (optional)

City, state, and ZIP code
PHARR, TEXAS 78577

List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
___ : __ : ____

or

Employer identification number
74 : 1721807

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

**Sign Here** Signature of U.S. person ► Lucy Ramirez Date ► 4/23/10

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

## Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

# CONTRACT FOR SERVICES
# MEDICAL & DENTAL
# 2010-014-03-30

STATE OF TEXAS &
&
COUNTY OF HIDALGO &

THIS AGREEMENT (The "Agreement") is made effective the **1st** day of **September, 2010** by and between the HIDALGO COUNTY HEAD START PROGRAM, (hereinafter "The Program") a federally funded program under the auspices of HIDALGO COUNTY, TEXAS, a political subdivision of the State of Texas and **George M. Angelos, DMD, PA dbaThe Children's Dentist** (hereinafter "Provider") to serve at the pleasure of the Program. This Contract for Services may be extended for an additional year on terms as maybe mutually agreed to by the parties. This agreement terminates on the **31st** day of **August, 2011**or as provided herein.

WITNESSETH:

WHEREAS, Program requires certain services which Provider is licensed to provide, a description of each service is attached hereto as Exhibit "A" and incorporated herein for all purposes; and

WHEREAS, the Provider has agreed to provide the services enumerated in this Agreement for the Program; and

WHEREAS, the Program is the recipient of certain federal funds to be utilized for the provision of services to the participants of the Program; and

WHEREAS, Program participants' (students) are examined and treated by the Provider; and

WHEREAS, the Provider will examined and treat the program participants on the terms and conditions hereinafter set forth; and

NOW, THEREFORE, in consideration of the foregoing and the following Provider and Program agrees as follows:

A. 1. Provider represents that (s)he is licensed by the State of Texas and qualified to perform and execute services provided in this Agreement. If such license is suspended or revoked, this Contract shall automatically be terminated. Provider shall immediately notify the Program of such suspension or revocation.

2. The Provider shall prepare, maintain and submit all records which are designated, required or prescribed by the Program, federal grantor agency, or County of Hidalgo. In addition, the Provider shall permit the Program, the Department of Health and Human Services and the County of Hidalgo to audit, inspect records and reports, review services and /or evaluate the performance of the services provided hereunder at any reasonable time. The Provider shall provide access to all its records, books, reports and other pertinent data and information needed to accomplish review of its activities, services and expenditures billed to the Program.

3. In consideration for the above and foregoing, the Provider shall submit a monthly billing statement to the Program at:

**Hidalgo County Head Start Program**
**P.O. Box 0117**
**Edinburg, Texas, 78540**

Said statement must provide an itemized list of services rendered to the Program during the statement period. Upon receipt of said statement, the Program will process the requisition for payment in the usual customary manner utilized by the Program. The Provider shall be compensated based on the Program's fee schedule, a copy of which is attached as Exhibit "B" hereto.

4. The Provider must comply with all applicable Program and Hidalgo County

policies. Notwithstanding the foregoing sentence, the Provider represents and maintains that (s)he is an independent provider and is not an employee of the Program or Hidalgo County, Texas, or any agency thereof, and further represents and warrants that (s)he does not desire or request any fringe benefits provided to employees of the Program or Hidalgo County, Texas, and/or agency thereof, including, but not limited to benefits associated with Hidalgo County's civil service program. The Provider agrees to be responsible for any federal income tax, withholding or social security tax liability which might arise from payments received pursuant to this Agreement.

5. The Program and the Provider agree that either party may terminate this contract at any time for any reason or no reason at all upon thirty (30) days prior written notice to the other party. Proper Notice shall be submitted through certified letter to:

Teresa Flores, Executive Director
Hidalgo County Head Start Program
P.O. Box 0117
Edinburg, Texas 78540-0117

George M. Angelos, DMD, PA
The Children's Dentist DBA
1717 E. HARRISON
HARLINGEN TX, 78550

6. Provider agrees to be insured for professional liability, premises liability and auto liability insurance covering his/her employee's activities and services to the Program in coverage limits not less than the minimum amounts prescribed by the Texas Tort Claims Act, §101.001, et seq., Texas Civil Practices and Remedies Code. Provider shall furnish the Program a certificate issued by their insurer that such insurance is in full force and effect.

7. Except as otherwise herein provided, the Provider may not assign the obligations or rights under this Contract to any person without the prior written consent of the Program.

B. The Provider's employees, if any, who perform services for the Program under this Agreement shall be bound by the provisions of the terms of this Agreement. At the request of the Program, the Provider shall provide adequate evidence that such persons are the Provider's employees.

C. The Provider will indemnify and hold harmless and defend the Program and the County of Hidalgo from any and all claims, actions, liability, and expenses including all cost of judgments, settlements, court cost, and attorney's fees regardless of the outcome of such claim(s) or action(s) caused by, resulting from, or alleging negligent or intentional acts or omission(s) or any failure to perform any obligation(s) undertaken or any covenant(s) in this Agreement, and further, whether such act, omission, or failure to perform any obligation undertaken or any covenant in this Agreement was the Provider's or that of any person providing services hereunder through or for Provider. Upon written notice from the County and the Program, Provider will resist and defend at its own expenses, and by counsel reasonably satisfactory to the County and the Program, any such claim(s) or action(s).

D. This Agreement shall be construed under and in accordance with the laws of the State of Texas, and all obligations of the parties created hereunder are performance in Hidalgo County, Texas.

E. In case any one or more of the provisions contained in this Agreement shall for any reason be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision

thereof and this Agreement shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

F. Contract Extension. Hidalgo County Head Start Program reserves the right to extend this agreement for ninety (90) days from the date of termination (August 31st, 2011) of the Contract period at the such rate and terms as negotiated by the parties. A thirty (30) day written notice of intention to extend this agreement will be provided prior to its expiration by Hidalgo County Head Start Program.

G. No amendment, modification or alteration of the terms hereof shall be binding unless the same be in writing, dated subsequent to the date hereof and duly executed by the parties hereto.

H. Provider will not discriminate on the basis of race, color, sex, age, religion, national origin, or handicap in providing the services under this Agreement or in the selection of associates, employees, or independent providers.

I. Provider will perform its services at all times in compliance with federal, state, and local laws, rules and regulations, the policies, rule and regulations of the Program, and all currently accepted and approved methods and practices of the professional specialty relating to the services.

IN WITNESS WHEREOF, the parties have caused their names to be hereunto subscribed personally or by a duly authorized officer of agent of each party, effective the day and year first written above. EXECUTED as of the day and year first written above.

PROVIDER:
GEORGE M. ANGELOS, DMD, PA
THE CHILDREN'S DENTIST

BY: _____
(Provider's Name)

_____
(Print Name)

_____
(Title)

HIDALGO COUNTY
HEAD START PROGRAM

BY: _____
Rene Ramirez, County Judge

BY: _____
Teresa Flores, Executive Director

BY: _____
Arturo Guajardo, Jr., County Clerk

APPROVED AS TO FORM:
OXFORD & GONZALEZ

By: _____
Ricardo Gonzalez

APPROVED AS TO FORM:
ATLAS & HALL, L.L.P.

By: _____
Stephen L. Crain

# Exhibit A

## Description of Services-Dental Health Services

The Provider agrees to provide any services deem necessary to evaluate any and all children referred to the Provider by Head Start.

The Provider agrees to continue such services until such time as the Executive Director of the Program (or designee) determine that there is no longer a need for the services.

Provider shall provide copies of records to Head Start for each child it affords services. Copies of these records shall be free of charge.

The services provided by the Provider will included the following and in addition all services will be provided on schedule with Head Start 1304:

1. The provider will perform a complete and comprehensive dental examination at his/her respective practice on the initial visit. The **"Dental Health Form"** will be shown with date of exam, signature of the Provider, referral and or treatment done.

2. A complete and comprehensive dental examination-on the initial examination the dentist will provide a complete examination as agreed to by Medicaid every twelve (12) months. The examination will consist of:
    1. A visual examination
    2. X-Rays
    3. Prophylaxis(cleaning)
    4. Nutritional Counseling
    5. Behavior management, if necessary.

3. Periodic Oral Examination-Every six (6) months the child must receive a periodic oral examination as agreed to by Medicaid guidelines.

4. Referral- If an abnormality arises and provider is not able to treat the condition, the parent will be notified as soon as abnormality is found or detected, and the parent will be given the opportunity to select a specialist (if such an option is available) in the appropriate dental field from a roster of recommended "List of Providers" by the dental provider.

5. Confidentiality of medical records will be maintained in accordance of examination.

6. Upon completion of **"HEAD START: Dental Health Form"** signature of provider and date will be written on the bottom page. RECOMMENDATIONS will be written accordingly. Remit a copy to the HIDALGO COUNTY HEAD START PROGRAM, a copy for the Provider's records and a copy to the parent. The same procedure will follow the same for a Texas Health Step exam.

7. The Provider's statement, which lists the child's name/center and the total cost of the exam provided is to be returned to HIDALGO COUNTY HEAD START PROGRAM for payment. Six (6) weeks may be required for processing payment.

8. The total number of children provided dental services will be submitted to the HIDALGO COUNTY HEAD START PROGRAM with the provider's name after every examination day.

HIDALGO COUNTY HEAD START PROGRAM will be responsible to:

1. Encourage the child's parent to be present during dental exam. If parent is unable to attend, a brief medical history will be obtained from parent.

2. Provide **"HEAD START: Dental Health Form"** with child's name and address.

# Exhibit B
## Fee Schedule

GEORGE M. ANGELOS, DMD.

2010-2011

**Fee Schedule for Services:** Fees should not exceed Medicaid Allowable reimbursements.

1 The Provider shall be paid only for full and satisfactory completion of the following services:

| Description Of Service | FEE |
|---|---|
| a. Initial Oral Examination | $ 36.04 |
| | |
| b. Periodic Oral Examination | $ 29.44 |
| | |
| c. Emergency Oral Examination | $ 19.16 |
| | |
| d. Bite-wing Radiographs (four (4) films) | $ 35.32 |
| | |
| e. Topical Application of Flouride (including prophylaxis) | $ 15.00 |
| | |
| f. Nutritional Counseling | $ 12.50 |
| | |
| | |
| | |
| | |

# CERTIFICATE OF LIABILITY INSURANCE

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

INSURANCE AGENCY
Bell Insurance Group
P.O. Box 426
Addison, Texas 75001
Telephone: (972) 581-4873
(800) 521-2355
Fax: (972) 980-1813

INSURANCE COMPANY AFFORDING COVERAGE
Fortress Insurance Co.
6133 N. River Road, Suite 650
Rosemont, IL. 60018

INSURED
George M. Angelos, DMD
1717 E. Harrison
Harlingen, TX 78550

COVERAGES

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED, NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE | POLICY EXPIRATION DATE | LIMITS |
|---|---|---|---|---|
| Med/Professional Liab | 3000265 | 04/24/2010 | 04/24/2011 | $2,000,000 per occ.<br>$4,000,000 total |

DESCRIPTION OF COVERAGE:
Professional liability is provided on a claims-made basis with a retroactive date of 7/26/1994.

CERTIFICATE HOLDER
Hidalgo County Headstart Program
P. O. Box 0117
Edinburg, TX 78540-0117

CANCELLATION
SHOULD ANY OF THE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED ABOVE, BUT FAILURE TO MAIL SUCH A NOTICE SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE COMPANY, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

95

Kyle Wallace, Program Director 6/15/10

Client#: 66297 CHILD15

# ACORD™ CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) 6/15/2010

PRODUCER
817-347-7013
Higginbotham & Assoc., Inc.
P O Box 908
Fort Worth, TX 76101

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.

| INSURERS AFFORDING COVERAGE | NAIC # |
|---|---|
| INSURER A: Maryland Casualty Company | 19356 |
| INSURER B: | |
| INSURER C: | |
| INSURER D: | |
| INSURER E: | |

INSURED
The Children's Dentist
1717 E Harrison
Harlingen, TX 78550

COVERAGES

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR LTR | ADD'L INSRD | TYPE OF INSURANCE | POLICY NUMBER | POLICY EFFECTIVE DATE (MM/DD/YY) | POLICY EXPIRATION DATE (MM/DD/YY) | LIMITS | |
|---|---|---|---|---|---|---|---|
| A | | GENERAL LIABILITY | PAS002711457 | 12/06/09 | 12/06/10 | EACH OCCURRENCE | $2,000,000 |
| | | [X] COMMERCIAL GENERAL LIABILITY | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $2,000,000 |
| | | [ ] CLAIMS MADE [X] OCCUR | | | | MED EXP (Any one person) | $10,000 |
| | | | | | | PERSONAL & ADV INJURY | $2,000,000 |
| | | | | | | GENERAL AGGREGATE | $4,000,000 |
| | | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | PRODUCTS - COMP/OP AGG | $4,000,000 |
| | | [ ] POLICY [ ] PRO-JECT [ ] LOC | | | | | |
| A | | AUTOMOBILE LIABILITY | PAS002711457 | 12/06/09 | 12/06/10 | COMBINED SINGLE LIMIT (Ea accident) | $1,000,000 |
| | | [ ] ANY AUTO | | | | BODILY INJURY (Per person) | $ |
| | | [ ] ALL OWNED AUTOS | | | | | |
| | | [ ] SCHEDULED AUTOS | | | | BODILY INJURY (Per accident) | $ |
| | | [X] HIRED AUTOS | | | | | |
| | | [X] NON-OWNED AUTOS | | | | PROPERTY DAMAGE (Per accident) | $ |
| | | | | | | | |
| | | GARAGE LIABILITY | | | | AUTO ONLY - EA ACCIDENT | $ |
| | | [ ] ANY AUTO | | | | OTHER THAN AUTO ONLY: EA ACC | $ |
| | | | | | | AGG | $ |
| A | | EXCESS/UMBRELLA LIABILITY | PAS002711457 | 12/06/09 | 12/06/10 | EACH OCCURRENCE | $2,000,000 |
| | | [X] OCCUR [ ] CLAIMS MADE | | | | AGGREGATE | $2,000,000 |
| | | | | | | | $ |
| | | [ ] DEDUCTIBLE | | | | | $ |
| | | [ ] RETENTION $ | | | | | $ |
| | | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | | | | [ ] WC STATU-TORY LIMITS [ ] OTH-ER | |
| | | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? | | | | E.L. EACH ACCIDENT | $ |
| | | If yes, describe under SPECIAL PROVISIONS below | | | | E.L. DISEASE - EA EMPLOYEE | $ |
| | | | | | | E.L. DISEASE - POLICY LIMIT | $ |
| | | OTHER | | | | | |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

CERTIFICATE HOLDER

Hidalgo County Headstart Program
P O Box 0117
Edinburg, TX 78540-0117

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL 10 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

James R Lo D

KRZ

May. 26. 2010 12:00PM SWK Ins Group No. 8300 P. 1

# ACORD CERTIFICATE OF LIABILITY INSURANCE

OP ID BQ | DATE (MM/DD/YYYY) 05/26/10

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

**PRODUCER**
Shepard Walton King Ins Group*
1906B E. Tyler
P. O. Box 1830
Harlingen TX 78551-1830
Phone: 956-423-8755 Fax: 956-428-0730

CONTACT NAME:
PHONE (A/C, No, Ext): FAX (A/C, No):
E-MAIL ADDRESS:
PRODUCER CUSTOMER ID #: CHILD-2

**INSURED**
The Children's Dentist
George M Angelos DDS PA dba
1717 E Harrison St
Harlingen TX 78550

| INSURER(S) AFFORDING COVERAGE | NAIC # |
|---|---|
| INSURER A: Texas Mutual Insurance Co. | 22945 |
| INSURER B: | |
| INSURER C: | |
| INSURER D: | |
| INSURER E: | |
| INSURER F: | |

**COVERAGES** CERTIFICATE NUMBER: REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

| INSR LTR | TYPE OF INSURANCE | ADDL INSR | SUBR WVD | POLICY NUMBER | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS | |
|---|---|---|---|---|---|---|---|---|
| | GENERAL LIABILITY | | | | | | EACH OCCURRENCE | $ |
| | COMMERCIAL GENERAL LIABILITY | | | | | | DAMAGE TO RENTED PREMISES (Ea occurrence) | $ |
| | CLAIMS-MADE OCCUR | | | | | | MED EXP (Any one person) | $ |
| | | | | | | | PERSONAL & ADV INJURY | $ |
| | | | | | | | GENERAL AGGREGATE | $ |
| | GEN'L AGGREGATE LIMIT APPLIES PER: | | | | | | PRODUCTS - COMP/OP AGG | $ |
| | POLICY PRO-JECT LOC | | | | | | | $ |
| | AUTOMOBILE LIABILITY | | | | | | COMBINED SINGLE LIMIT (Ea accident) | $ |
| | ANY AUTO | | | | | | BODILY INJURY (Per person) | $ |
| | ALL OWNED AUTOS | | | | | | BODILY INJURY (Per accident) | $ |
| | SCHEDULED AUTOS | | | | | | PROPERTY DAMAGE (Per accident) | $ |
| | HIRED AUTOS | | | | | | | $ |
| | NON-OWNED AUTOS | | | | | | | $ |
| | UMBRELLA LIAB OCCUR | | | | | | EACH OCCURRENCE | $ |
| | EXCESS LIAB CLAIMS-MADE | | | | | | AGGREGATE | $ |
| | DEDUCTIBLE | | | | | | | $ |
| | RETENTION $ | | | | | | | $ |
| A | WORKERS COMPENSATION AND EMPLOYERS' LIABILITY | | | TSF0001116276 | 06/01/10 | 06/01/11 | WC STATU-TORY LIMITS OTH-ER | |
| | ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? Y/N (Mandatory in NH) | N/A | | | | | E.L. EACH ACCIDENT | $ 1000000 |
| | If yes, describe under DESCRIPTION OF OPERATIONS below | | | | | | E.L. DISEASE - EA EMPLOYEE | $ 1000000 |
| | | | | | | | E.L. DISEASE - POLICY LIMIT | $ 1000000 |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)
Dentist Office - 1717 East Harrison Ave, Harlingen, Tx 78550

**CERTIFICATE HOLDER**

HIDCHED

Hidalgo County Headstart
Program
P O Box 0117
Edinburg TX 78540-0117

**CANCELLATION**

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Request for Qualification

"MEDICAL & DENTAL PROVIDERS"
RFQ No: 2010-014-03-30

March 30, 2010

To: Hidalgo County Head Start Program
Ambrosio Tovar, Procurement Director
P.O. Box 0117
Edinburg, Texas 78540-0117

In accordance with the requirements, and subject to all laws and regulations of the United States and state and local laws, the undersigned respondent proposes and commits to furnish all labor, equipment, material, software and services as set forth in the documents hereinbefore mentioned. The undersigned respondent further agrees, upon acceptance of its RFQ, to execute a contract and/or Purchase Order issued by Hidalgo County Head Start Program for performing and completing the work described in the requirements within the time stated and for the prices proposed in the documents attached hereto and made a part hereof.

Participant acknowledges receipt of all of the pages of the documents referenced in the Request for Qualifications Checklist presented in connection with this procurement. Participant understands that Hidalgo County Head Start Program reserves the right to reject any or all of the RFQ and further reserves the right to design the evaluation criteria to be used in selecting the lowest and best RFQ.

Participant agrees that this RFQ shall be good and may not be withdrawn for a period of ninety (90) calendar days after the scheduled closing time for accepting the RFQ, as contained in the requirements.

Respectfully submitted,

Respondent: GEORGE M. ANGELOS, DMD

Address: 1717 E. HARRISON ST, HARLINGEN, TX 78550

By: [signature]

Printed Name: GEORGE M. ANGELOS, DMD

Title: PRESIDENT

# ACKNOWLEDGMENT FORM

**STATEMENT OF QUALIFICATIONS**
**FOR**
**HIDALGO COUNTY HEAD START PROGRAM**
**"MEDICAL & DENTAL PROVIDERS"**
**RFQ 2010-014-03-30**

We, as an interested party, agree to the criteria and the requirements of the RFQ and have submitted our statement of qualifications as requested.

All costs involved in submitting this statement to Hidalgo County Head Start Program shall be borne in full by the RFQ Company.

COMPANY: THE CHILDREN'S DENTIST, GEORGE M. ANGELOS, DMD, PA

ADDRESS: 1717 E. HARRISON ST, HARLINGEN, TX

AUTHORIZED REPRESENTATIVE: GEORGE M. ANGELOS, DMD

SIGNATURE: [signature]

TITLE: PRESIDENT

TELEPHONE: 956-428-2221 FAX NO. 956-423-4492

E-MAIL: childrensdentist@gmail.com

DATE: 4/29/10

## CERTIFICATION
## Regarding Debarment, Suspension Ineligibility

As is required by the Federal Regulations Implementing Executive Order 12549, Debarment and Suspension, 45 CFR Part 76, Government-wide Debarment and Suspension, in the applicant certifies, to the best of his or her knowledge and belief, that both it and its principals:

a. Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any federal department or agency;

b. Have not within a three-year period preceding this bid/proposal and/or application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, state or local) transaction or contract under a public transaction, violation of federal or state antitrust statutes or commission of embezzlement, theft, theory, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

c. Are not presently indicted for or otherwise criminally or civilly charged by a government entity with commission of any of the offenses enumerated herein; and

d. Have not within a three-year period preceding this bid/proposal and/or application had one or more public transactions terminated of cause or default

Signature: _____

Print Name: GEORGE M. ANGELOS, DMD

Title: PRESIDENT

Telephone Number: 956-428-2221

Date: 4/28/10

If the proposer is unable to certify to all of the statements in this Certification, such proposer should attach an explanation to this proposal.

# PROJECT REQUIREMENTS ACKNOWLEDGMENT

This is to certify that I, GEORGE M. ANGELOS, DMD possess all of the APPLICABLE;

1. Licenses: TX DENTAL LICENSE # 17313
2. Bonds: DEA # BA3328332 DPS # B00826660
3. Certificates: _____
4. Permits: _____
5. Other: _____

necessary to carry out the required project. Furthermore, I am providing copies of the required documentation so that, if my company is awarded this bid, I may be eligible to enter into a contract with Hidalgo County Head Start Program and proceed to complete the project in a timely manner.

Any licenses, bonds, certificates, and permits, etc. which are required must be presented as part of the bid packet in order to expedite the bid evaluation process. Failure to provide said documentation will result in the disqualification of your bid.

Authorized Signature

4/29/10
Date

GEORGE M. ANGELOS, DMD, PA
THE CHILDREN'S DENTIST
Company

1717 E. HARRISON ST
Address

HARLINGEN, TX 78550
City, State, Zip

**EXHIBIT D**

# CONFLICT OF INTEREST QUESTIONNAIRE

FORM CIQ

For vendor or other person doing business with local governmental entity

This questionnaire is being filed in accordance with chapter 176 of the Local Government Code by a person doing business with the governmental entity.

By law this questionnaire must be filed with the records administrator of the local government not later than the 7th business day after the date the person Becomes aware of facts that require the statement to be filed. See Section 176.006, Local Government Code.

A person commits an offense if the person violates Section 176.006 Local Government Code. An Offense under this section is a Class C misdemeanor.

| OFFICE USE ONLY |
| --- |
| Date Received |

1 Name of person doing business with local governmental entity.

George M. Angelos, DMD

2 ☐ Check this box if you are filling an update to a previously filed questionnaire.

(The law requires that you file an updated completed questionnaire with the appropriate filing authority not later than the 7th business day after the date the originally filed questionnaire becomes incomplete or inaccurate.)

3 Name of local government officer with whom filer has employment or business relationship.

N/A

Name of Officer

This section (item 3 including subparts A,B, C & D) must be completed for each officer with whom the filer has an employment or other business relationship as defined by Section 176.001 (1-a), Local Government Code. Attach additonal pages to this Form CIQ as necessary.

A. Is the local government officer named in this section receiving or likely to receive taxable income other than investment income from the filer of the questionnaire?

☐ Yes ☐ No

B. Is the filer of the questionnaire receiving or likely to receive taxable income, other than investment income, from or at the direction of the local government officer named in this section AND the taxable income is not received from the local government entity?

☐ Yes ☐ No

C. Is the filer of the questionnaire employed by a corporation or other business entity with respect to which the local government officer serves as an officer or director, or holds an ownership of 10 percent or more?

☐ Yes ☐ No

D. Describe each employment or business relationship with the local government officer named in this section.

4

Signature of person doing business with the governmental entity

Date

**EXHIBIT "E"**
**PROPOSER'S AFFIDAVIT**

**PROPOSER'S AFFIDAVIT OF NON-COLLUSION**
**NON-CONFILICT OF INTREST, AND ANTI-LOBBYING**
**FOR "MEDICAL & DENTAL SERVICE PROVIDERS"**

STATE OF TEXAS
COUNTY OF HIDALGO

Affiant, George M. Angelos, DMD, being first duly sworn, deposes that:

(1) Affiant does hereby state neither the Proposer nor any of the Proposer's officers, partners, owners, agents, representatives, employees, or parties in interest, has in any way colluded, conspired, agreed, directly or indirectly with any person, firm, corporation, or other proposer, or potential proposer, to provide any money or other valuable consideration for assistance in procuring or attempting to procure a contract or fix the prices in the attached proposed or the proposal of any other proposer, and further states that no such money or other reward will be hereinafter paid.

(2) Affiant further states they have neither recommended or suggested to Hidalgo County or any of its officials or employees, any of the terms or provisions set forth in their Request for Proposal and subsequent agreement, except at a meeting open to all interested proposers, of which proper notice was given.

(3) Affiant, further states their officers, employees, or agents have not, and will not attempt to lobby, directly or indirectly, the Hidalgo County Commissioner's Court between proposal submission date and award by the Hidalgo County Commissioner's Court.

(4) Affiant further States no officer, or stockholder of the Proposer is a member of the staff, or related to any employee of the Hidalgo County except as noted herein below:

Signature/ Title: DDS

Subscribed and sworn to before me this 30th day of April, 2010.

Rose M. Cornejo.

Notary Public

My Commission expires: 2-22-2014, 2010

ROSE M CORNEJO
Notary Public
STATE OF TEXAS
My Comm. Exp. 02-22-2014

# HIDALGO COUNTY
# Respondent/Vendor Application

Complete in print or type. Please return this application to the Hidalgo County Head Start Program – Procurement Department thru Facsimile: (956) 381-0439, in person: 1901 West State Highway 107, McAllen, TX 78504 or mailed: P. O. Box 0117, Edinburg, TX 78540

**Company Name:** George M. Angelos, DMD, PA **Telephone Name:** ( ) (956) 428-2221

**dba Name:** The Children's Dentist

**Legal Name:** GEORGE M. ANGELOS, DMD, PA

**Mailing Address:** 1717 E. Harrison St. **Fax Name:** ( ) (956) 423-4492

**Physical Address:** 1717 E. Harrison St.

**City, State, Zip:** Harlingen, TX 78550 **Tax I.D. №** 74-2913865

**Remit to Address:** 1717 E. Harrison St. **City, State, Zip** Harlingen, TX 78550

**E-Mail Address:** childrensdentist@gmail.com

**Representative(s) Name(s) & Title(s)**
SUE EBERSOLE, ADMINISTRATOR

**Type of Organization(check one):** ___Individual ___Partnership ___Corporation ___Non-Profit ___ LLC ___ Sole Proprietor ✓Other, Specify P.A.

**State Identification №:**_____ **(Please attached completed W-9 form with this application)**

**Federal Identification № or (if individual) SS №** 74-2913865

**Type of Business (check one):** ___Manufacturer ___Wholesaler ___Retailer ___Broker ___ Distributor ___Service Organization ✓Other, Specify DENTAL PROVIDER

**Name & Title of Person(s) Authorized to Sign Bids, Proposals, and/or Contracts:**
GEORGE M. ANGELOS, DMD, PRESIDENT

**Small and/or Disadvantaged Business Information (check application criteria)**

**Small Business:**

Less than 125,000 annual gross receipt ___
Less than 250,000 annual gross receipt ___
Less than 499,000 annual gross receipt ___

**Disadvantaged Business (At Least 51% Ownership)**

Black American ___
Hispanic American ___
Asian Pacific American ___
Native American ___
Women ___
Other ___

**Have you been certified as a HUB or an MBE/WBE source?:** YES__ NO✓

**Indicate Certification №(s):** N/A **or are Certificate(s) attached?:** YES__ NO__

**What type of product(s) is/are solicited by your company?:** DENTAL SERVICES
**Would you like to be provided with specifications for procurements of such products ?:** YES___ NO✓

**To Be Completed by Head Start:** **Rec'd by (Procurement):**_____ **Date Rec'd by (Procurement):**_____

**Date Forwarded Information to Finance Office:**_____ **Entry Date:**_____ **Vendor №:**_____

## Certification For
## Primary Covered Transactions

1. The CHILDREN'S DENTIST (Vendor Name) certifies to the best of its knowledge and belief, that it and its principals:

   a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

   b) Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

   c) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and

   d) Have not within a three-year period preceding this request for qualifications had one or more public transactions (Federal, State or local) terminated for cause or default.

2. Where the CHILDREN'S DENTIST (Vendor Name) is unable to certify to any of the statements in this certification, such prospective vendor shall attach an explanation to this RFQ.

Signature: _____

Print Name: GEORGE M. ANGELOS, DMD

Title: PRESIDENT

Telephone No.: 956-428-2221 Date: 4/29/10

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

# Request for Taxpayer Identification Number and Certification

**Give form to the requester. Do not send to the IRS.**

Print or type See Specific Instructions on page 2

Name (as shown on your income tax return)
George M. Angelos, DMD, PA

Business name, if different from above
The Children's Dentist

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ .....
☑ Other (see instructions) ▶ D.A

☐ Exempt payee

Address (number, street, and apt. or suite no.)
1717 E. Harrison Street

Requester's name and address (optional)

City, state, and ZIP code
Harlingen, TX 78550

List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

**Note.** If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
: :

or

Employer identification number
74 : 2913865

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

**Sign Here** Signature of U.S. person ▶ [signature] Date ▶ 4/29/10

## General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

## Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

**Note.** If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

**Definition of a U.S. person.** For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

**Special rules for partnerships.** Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,