

**CITY OF DETROIT  
AMENDMENT AGREEMENT NO. 1  
TO CONTRACT NO. 2890503**

**THIS AMENDMENT AGREEMENT NO. 1** is entered into by and between the City of Detroit, a Michigan municipal corporation, acting by and through its **Human Resources Department ("City")**, and **Health Management Systems of America, a Corporation** with its principal place of business located at **601 Washington Blvd, Detroit, MI 48226** ("Contractor").

**WITNESSETH:**

**WHEREAS**, the City has engaged the Contractor to provide certain services ("Services") to the City; and

**WHEREAS**, the City and the Contractor have entered into a Contract reflecting the terms and conditions governing the subject engagement; and

**WHEREAS**, Article 17 of the Contract permits the parties to amend the Contract by mutual agreement; and

**WHEREAS**, it is the mutual desire of the parties to enter into this Amendment to amend the Contract as set out in detail in the following sections;

**NOW, THEREFORE**, in consideration of the foregoing, and of the benefits to accrue to the parties from this Amendment, the parties agree that this Contract is amended as follows:

**1. AMENDMENT TO SECTION 1  
COMPENSATION**

**1.01** Section 1, which now reads:

Compensation for *Services* provided shall not exceed the amount up to **\$300,960**, inclusive of expenses, and will be paid as provided for in Exhibits A and B. Unless this *Contract* is amended pursuant to Article 17, this amount shall be the entire compensation to which the *Contractor* is entitled for the performance of *Services* under this *Contract*.

Is amended to read:

Compensation for *Services* provided shall not exceed the amount up to **\$362,520**, Inclusive of expenses, and will be paid as provided for in Exhibits A and B. Unless this *Contract* is amended pursuant to Article 17, this amount shall be the entire compensation to which the *Contractor* is entitled for the performance of *Services* under this *Contract*.

## **2. AMENDMENT TO SECTION \_\_\_\_ MISCELLANEOUS**

### **2.01 NO CHANGES TO THE MISCELLANEOUS SECTION**

## **3. AMENDMENT TO EXHIBIT A**

### **3.01 Exhibit A, which now reads:**

Twelve (12) Cases per year where by the Human Resources Department may refer an employee and/or their family for face to face counseling.

Is amended to read:

Twelve (12) Cases per year where by the Human Resources Department may refer an employee and/or their family for face to face counseling.

Eight (8) Cases per year where by the Police Department may refer an employee and/or their family for face to face counseling .

## **4. AMENDMENT TO EXHIBIT B**

### **4.01 NO CHANGES TO EXHIBIT B**

## **5. EFFECT OF AMENDED TERMS ON THE REMAINING PROVISIONS OF THE CONTRACT**

**5.01** With the exception of the provisions of the Contract specifically contained in this Amendment, all other terms, conditions and covenants contained in the Contract shall remain in full force and effect and as set forth in the Contract.

## **6. AMENDMENT AUTHORIZATION**

**6.01** This Amendment to the Contract shall not become effective until:

- (a) The Amendment has been approved by the required City departments;
- (b) The Amendment has been authorized by resolution of the City Council; and
- (c) The Amendment has been signed by the City's Purchasing Director.

Prior to the approvals set forth in this Section, the Finance Director shall not authorize any payments to the Contractor pursuant to this Amendment, nor shall the City incur any liability to pay for any services or to reimburse the Contractor for any expenditure authorized by this Amendment.

IN WITNESS WHEREOF, the City and the Contractor, by and through their duly authorized officers and representatives, have executed this Amendment.

WITNESSES:

1. Nancy L Collins  
(signature)

Nancy L Collins  
(print name)

2. Sidney Ireson  
(signature)

Sidney Ireson  
(print name)

CONTRACTOR:

BY: [Signature]  
(signature)

Dennis G. Rice  
(print name)

ITS: President  
(title)

WITNESSES:

1. [Signature]  
(signature)

Nesha Holland  
(print name)

2. [Signature]  
(signature)

Keeley Walker-Chappell  
(print name)

CITY OF DETROIT Human Resources DEPARTMENT:

BY: Denise Starr  
(signature)

Denise Starr  
(print name)

ITS: Director  
(title)

THIS AMENDMENT WAS APPROVED BY THE CITY COUNCIL ON

APPROVED BY LAW DEPARTMENT PURSUANT TO SECTION 6-406 OF THE CHARTER OF THE CITY OF DETROIT

DocuSigned by:  
Boysie Jackson 10/23/2015  
E7BD9F26E53A4D0...  
Purchasing Director Date

\_\_\_\_\_  
Corporation Counsel Date

THIS AMENDMENT IS NOT VALID OR AUTHORIZED UNTIL APPROVED BY RESOLUTION OF THE CITY COUNCIL AND SIGNED BY THE PURCHASING DIRECTOR.

CITY ACKNOWLEDGMENT

STATE OF Michigan )  
 )SS.  
COUNTY OF Wayne )

The foregoing contract was acknowledged before me the 6th day of August,  
2015, by Denise Storr,  
(name of person who signed the contract)  
the Director,  
(title of person who signed the contract as it appears on the contract)  
of Human Resources,  
(complete name of the corporation)

on behalf of the Corporation.

Erica Y Crawford

Notary Public, County of Wayne

State of Michigan

My commission expires: 2-12-2022

**ERICKA Y CRAWFORD**  
Notary Public, State of Michigan  
County of Wayne  
My Commission Expires 02-12-2022  
Acting in the County of Wayne

**CORPORATE ACKNOWLEDGMENT**

STATE OF Michigan )  
 )SS.  
COUNTY OF Wayne )

The foregoing contract was acknowledged before me the 26<sup>th</sup> day of May,  
20 15, by Dennis G. Rice,  
(name of person who signed the contract)  
the President,  
(title of person who signed the contract as it appears on the contract)  
of Health management Systems of America, Inc.,  
(complete name of the corporation)

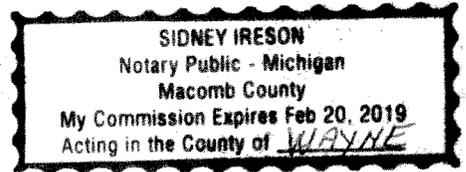
on behalf of the Corporation.

Sidney Ireson

Notary Public, County of Macomb acting in Wayne County

State of Michigan

My commission expires: 02/20/2019



**CORPORATION CERTIFICATE OF AUTHORITY**

I, Dennis Rice, Corporate Secretary of  
(name of corporate secretary)

Health Management Systems Inc., a Michigan  
(complete name of corporation) (state of incorporation)

for profit corporation (the "Corporation"), **DO HEREBY CERTIFY** that the  
(non-profit or for profit)

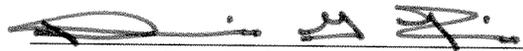
following is a true and correct excerpt from the minutes of the meeting of the Board of Directors  
duly called and held on 5/26/15, and that the same is now in full force and effect  
(date of meeting)

"RESOLVED, that the Chairman, the President, each Vice President, the Treasurer,  
and the Secretary and each of them, is authorized to execute and deliver, in the name  
of and on behalf of the Corporation and under its corporate seal or otherwise, any  
agreement or other instrument or document ('Contract') in connection with any matter  
or transaction that shall have been duly approved; and the execution and delivery of  
any Contract by any of the aforementioned officers shall be conclusive evidence of  
such approval."

FURTHER, I CERTIFY that J. William Sumner is Chairman,  
Dennis G. Rice is President,  
Beth Combs is (are) Vice President(s),  
J. William Sumner is Treasurer,  
Dennis G. Rice is Secretary,  
J. William Sumner is Executive Director, and  
is \_\_\_\_\_.

FURTHER, I CERTIFY that any of the aforementioned officers or employees of the  
Corporation are authorized to execute and commit the Corporation to the conditions, obligations,  
stipulations and undertakings contained in Contract No. 2890503 between the City and the  
above-referenced Corporation and that all necessary corporate approvals have been obtained in  
relationship thereto.

IN WITNESS THEREOF, I have set my hand this 26 day of May, 2015.  
CORPORATE SEAL  
(if any)

  
\_\_\_\_\_  
Corporation Secretary

**PLEASE NOTE THAT THE PERSON WHO SIGNS THE CONTRACT ON BEHALF OF  
YOUR CORPORATION MUST BE ONE OF THE INDIVIDUALS LISTED ABOVE AS A  
PERSON AUTHORIZED TO EXECUTE CONTRACTS IN THE NAME OF AND ON  
BEHALF OF THE CORPORATION.**



CITY OF DETROIT  
 FINANCE DEPARTMENT  
 PURCHASING DIVISION  
 1008 COLEMAN A. YOUNG  
 MUNICIPAL CENTER  
 DETROIT, MICHIGAN 48226  
 PHONE 313-224-4600  
 FAX 313-224-4374

IF THIS PURCHASE ORDER  
 DOES NOT AGREE WITH THE  
 BID YOU SUBMITTED,  
 PLEASE CONTACT THE  
 PURCHASING DIVISION.

### Purchase Order

PURCHASE ORDER NO. REVISION PAGE

2890503 0 1

THE ABOVE NUMBER MUST APPEAR ON ALL INVOICES AND SHIPMENTS.

SHIP TO

Coleman A Young Municipal Ce  
 2 Woodward Avenue  
 Ste 316  
 Detroit, MI 48226

United States

Coleman A Young Municipal Ce  
 2 Woodward Avenue  
 Ste 642  
 Detroit, MI 48226  
 United States

SUPPLIER

HEALTH MANAGEMENT SYSTEMS OF  
 601 WASHINGTON BLVD  
 DETROIT, MI 48226

|                                       |  |                            |
|---------------------------------------|--|----------------------------|
| SUPPLIER NO.<br><b>1043088</b>        | DATE OF ORDER/BUYER<br><b>14-MAR-14 B Washington</b> | REVISED DATE/BUYER         |
| PAYMENT TERMS<br><b>Net 30</b>        | SHIP VIA<br><b>Unspecified</b>                       | F.O.B.<br><b>Delivered</b> |
| FREIGHT TERMS<br><b>Your Delivery</b> | REQUESTOR/DELIVER TO                                 | CONFIRM TO / TELEPHONE     |

| LINE | ITEM NUMBER / DESCRIPTION   | DELIVERY DATE | QUANTITY | UNIT | UNIT PRICE | EXTENSION | TAX |
|------|---|---------------|----------|------|------------|-----------|-----|
|      | FURNISH: PROFESSIONAL SERVICES FOR AN EMPLOYEE ASSISTANCE PROGRAM & SUBSTANCE ABUSE FOR CITY OF DETROIT EMPLOYEES FOR THREE (3) YEARS |               |          |      |            |           |     |
|      | OPTION #1 - RATE \$0.95 PER EMPLOYEE PER MONTH  |               |          |      |            |           |     |
|      | - THREE (3) TELEPHONIC COUNSELING SESSIONS PER PROBLEM PER YEAR FOR EMPLOYEES AND FAMILY MEMBERS                                      |               |          |      |            |           |     |



CITY OF DETROIT  
 FINANCE DEPARTMENT  
 PURCHASING DIVISION  
 1008 COLEMAN A. YOUNG  
 MUNICIPAL CENTER  
 DETROIT, MICHIGAN 48226  
 PHONE 313-224-4600  
 FAX 313-224-4374

**IF THIS PURCHASE ORDER  
 DOES NOT AGREE WITH THE  
 BID YOU SUBMITTED,  
 PLEASE CONTACT THE  
 PURCHASING DIVISION.**

| Purchase Order   |          |      |
|--|----------|------|
| PURCHASE ORDER NO.   | REVISION | PAGE |
| 2890503  | 0        | 2    |
| THE ABOVE NUMBER MUST APPEAR ON ALL INVOICES AND SHIPMENTS.  |          |      |
| SHIP TO  |          |      |
| Coleman A Young Municipal Ce<br>2 Woodward Avenue<br>Ste 316<br>Detroit, MI 48226                  |          |      |
| United States  |          |      |
| Coleman A Young Municipal Ce<br>2 Woodward Avenue<br>Ste 642<br>Detroit, MI 48226<br>United States |          |      |

**SUPPLIER**

HEALTH MANAGEMENT SYSTEMS OF  
 601 WASHINGTON BLVD  
 DETROIT, MI 48226

|               |                        |                        |
|---------------|------------------------|------------------------|
| SUPPLIER NO.  | DATE OF ORDER/BUYER    | REVISED DATE/BUYER     |
| 1043088       | 14-MAR-14 B Washington |                        |
| PAYMENT TERMS | SHIP VIA               | F.O.B.                 |
| Net 30        | Unspecified            | Delivered              |
| FREIGHT TERMS | REQUESTOR/DELIVER TO   | CONFIRM TO / TELEPHONE |
| Your Delivery |                        |                        |

| LINE | ITEM NUMBER / DESCRIPTION                       | DELIVERY DATE | QUANTITY | UNIT           | UNIT PRICE | EXTENSION  | TAX |
|------|---|---------------|----------|----------------|------------|------------|-----|
|      | Purchase Agreement<br>Effective From: 17-MAR-14 | To: 16-MAR-17 |          | Amount Agreed: |            | 300,960.00 |     |

Michael Hall  
Director Human Resources and Labor Relations  
Coleman A. Young Municipal Center  
2 Woodward Avenue, Suite 316  
Detroit, Michigan 48226

Mr. Hall:

Thank you for taking the time to meet with me regarding reinstating the City of Detroit Employee Assistance Program (EAP) with Health Management Systems of America (HMSA). As we discussed I have included two program design options and contracts. The fundamental difference between the two options are as follows:

Option 1 – Rate \$0.95 per employee per month (9,600 assumed employee lives):

- Three (3) telephonic counseling sessions per problem per year for employees and family members

Option 2 – Rate \$1.25 per employee per month (9,600 assumed employee lives):

- Three (3) face to face counseling sessions per problem per year for employees and family members
- All Substance Abuse Professional services for employees covered under the U.S. Department of Transportation regulations are included under this rate
- Fifteen (15) hours of onsite standard EAP employee orientation and supervisor training services are included (standard materials)
- Ten (10) hours onsite critical incident stress management services are included

Enclosed are program descriptions for options one and two along with two original contracts for signature. I want to point out specific items in the contract:

- Effective date of March 15, 2014
- Section 7.0 includes a 3.5 percent annual inflation fee increase.

Please contact me if you have any questions and I would like to setup a time to discuss program implementation

**EAP/WORK-LIFE CONTRACT**

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THIS AGREEMENT, as governed under Michigan law entered into by and between **HEALTH MANAGEMENT SYSTEMS INC.**, a Michigan Corporation (hereinafter referred to as "**HMSA**"), whose address is 601 Washington Blvd., Detroit, Michigan 48226, and **City of Detroit** (hereinafter referred to as "Client Organization"), whose address is 2 Woodward Detroit Michigan 48226, on March 15, 2014 (hereinafter referred to as "**Start Date**").

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**WHEREAS**, HMSA provides Employee Assistance Program (EAP) and Work-Life services as defined below and

**WHEREAS**, the Client Organization is seeking to offer an EAP Work-Life program to its eligible employees and dependents;

**NOW THEREFORE**, in consideration of the mutual promises, both parties agree to the following:

**1.0 HMSA SCOPE OF SERVICES**

HMSA agrees to provide the services detailed under the attached program summary sheet which shall be incorporated into this agreement. HMSA is acting as a Business Associate as defined under the Health Insurance Accountability and Portability Act. The Client Organization shall comply with the attached Business Associate Agreement reference herein.

**2.0 PROGRAM PROMOTION**

Both parties agree to publicize the program's existence to employees, managers, supervisors, and union representatives, (as appropriate). HMSA will assist Client Organization in preparing management guides for the EAP and will furnish ideas, copy, suggestions, and other assistance on a continuing basis for use in Client Organization publications, mailings or other media to maintain the awareness of the program. Any included

**EAP/WORK-LIFE CONTRACT**

**4.0 DURATION OF AGREEMENT**

This Agreement shall be for a term of three (3) years (unless otherwise agreed to) commencing on Start Date. Upon expiration, this Agreement shall be automatically renewed provided written notice of termination is not initiated by either party. In the event this Agreement is terminated by Client Organization or HMSA, Client Organization shall continue to make payments, prorated through the effective date of said termination and HMSA shall continue to provide interim services. Following termination, any covered employees caught in treatment on the date of termination may transition or conclude treatment for a maximum of 3 sessions. Client Organization agrees to compensate HMSA at a rate of \$75/ session for any clinical close-out sessions.

Should any statute, regulation or rule be enacted which materially affect the ability of either party to perform, then both parties shall renegotiate the modified area of the service to preserve the overall integrity of the Agreement. This agreement shall be governed by and in accordance with the laws of the state of Michigan.

**5.0 INDEMNIFICATION**

Both parties agree to indemnify and hold each other harmless from any and all liability, loss or damage, including reasonable attorney's fees and expenses, which either party may suffer as a result of claims, demands, costs or judgments against it arising out of either party's failure to perform any of the obligations of this Agreement. In case a claim should be brought or an action filed with respect to the subject of indemnity herein, both parties may employ attorneys of its own selection to appear and defend or settle the claim or action on its own behalf.

**6.0 OWNERSHIP OF RECORDS**

Client Organization agrees that all client records, medical charts, progress charts, and other proprietary documents generated by HMSA in the performance of their services under this Agreement are and shall remain the sole property of HMSA. In the event Client Organization shall terminate this Agreement, HMSA agrees promptly to transfer, in confidence, all statistical records of services rendered and work in progress to a

**EAP/WORK-LIFE CONTRACT**

---

In agreement the parties hereby affix their signatures below:

Client Organization Name:

Health Management Systems, Inc.

Authorized Signer:

Michael G. Hill

Authorized Signer:

[Signature]

Title:

DIRECTOR HUMAN RESOURCES & LABOR RELATIONS

Title:

C.O.O.

Date:

4/2/14 2013

Date:

3/5/ 201~~3~~

**CITY OF DETROIT  
AMENDMENT AGREEMENT NO. 1  
TO CONTRACT NO. 2890503**

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**WITNESSETH:**

**WHEREAS**, the City has engaged the Contractor to provide certain services ("Services") to the City; and

**WHEREAS**, the City and the Contractor have entered into a Contract reflecting the terms and conditions governing the subject engagement; and

**WHEREAS**, Article 17 of the Contract permits the parties to amend the Contract by mutual agreement; and

**WHEREAS**, it is the mutual desire of the parties to enter into this Amendment to amend the Contract as set out in detail in the following sections;

**NOW, THEREFORE**, in consideration of the foregoing, and of the benefits to accrue to the parties from this Amendment, the parties agree that this Contract is amended as follows:

**1. AMENDMENT TO SECTION 1  
COMPENSATION**

**1.01** Section 1, which now reads:

Compensation for *Services* provided shall not exceed the amount up to **\$300,960**, Inclusive of expenses, and will be paid as provided for in Exhibits A and B. Unless this *Contract* is amended pursuant to Article 17, this amount shall be the entire compensation to which the *Contractor* is entitled for the performance of *Services* under this *Contract*.

Is amended to read:

Compensation for *Services* provided shall not exceed the amount up to **\$362,520**, inclusive of expenses, and will be paid as provided for in Exhibits A and B. Unless this *Contract* is amended pursuant to Article 17, this amount shall be the entire compensation to which the *Contractor* is entitled for the performance of *Services* under this *Contract*.

## **2. AMENDMENT TO SECTION \_\_\_\_ MISCELLANEOUS**

### **2.01 NO CHANGES TO THE MISCELLANEOUS SECTION**

## **3. AMENDMENT TO EXHIBIT A**

### **3.01 Exhibit A, which now reads:**

Twelve (12) Cases per year where by the Human Resources Department may refer an employee and/or their family for face to face counseling.

Is amended to read:

Twelve (12) Cases per year where by the Human Resources Department may refer an employee and/or their family for face to face counseling.

Five (8) Cases per year where by the Police Department may refer an employee and/or their family for face to face counseling.

## **4. AMENDMENT TO EXHIBIT B**

### **4.01 NO CHANGES TO EXHIBIT B**

## **5. EFFECT OF AMENDED TERMS ON THE REMAINING PROVISIONS OF THE CONTRACT**

**5.01** With the exception of the provisions of the Contract specifically contained in this Amendment, all other terms, conditions and covenants contained in the Contract shall remain in full force and effect and as set forth in the Contract.

## 6. AMENDMENT AUTHORIZATION

**6.01** This Amendment to the Contract shall not become effective until:

- (a) The Amendment has been approved by the required City departments;
- (b) The Amendment has been authorized by resolution of the City Council; and
- (c) The Amendment has been signed by the City's Purchasing Director.

Prior to the approvals set forth in this Section, the Finance Director shall not authorize any payments to the Contractor pursuant to this Amendment, nor shall the City incur any liability to pay for any services or to reimburse the Contractor for any expenditure authorized by this Amendment.



STATE OF Michigan )  
 )SS.  
COUNTY OF Wayne )

The foregoing contract was acknowledged before me the 6<sup>th</sup> day of August,  
2015, by Denise Stein,  
(name of person who signed the contract)  
the Director,  
(title of person who signed the contract as it appears on the contract)  
of Humax Resources,  
(complete name of the corporation)

on behalf of the Corporation.

Ericka Y Crawford

Notary Public, County of Wayne

State of Michigan

My commission expires: 2-12-2022

**ERICKA Y CRAWFORD**  
Notary Public, State of Michigan  
County of Wayne  
My Commission Expires 02-12-2022  
Acting in the County of Wayne

**CORPORATE ACKNOWLEDGMENT**

STATE OF Michigan )  
 )SS.  
COUNTY OF Wayne )

The foregoing contract was acknowledged before me the 26<sup>th</sup> day of May,  
20 15, by Dennis G. Rice,  
(name of person who signed the contract)  
the President,  
(title of person who signed the contract as it appears on the contract)  
of Health management Systems of America, Inc.,  
(complete name of the corporation)

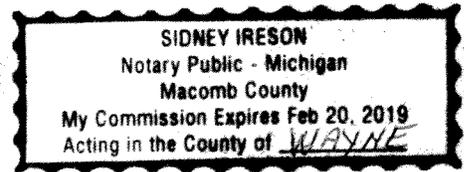
on behalf of the Corporation.

Sidney Ireson

Notary Public, County of Macomb acting in Wayne County

State of Michigan

My commission expires: 02/20/2019



**CORPORATION CERTIFICATE OF AUTHORITY**

I, Dennis Rice, Corporate Secretary of  
(name of corporate secretary)  
Health Management Systems Inc., a Michigan  
(complete name of corporation) (state of incorporation)  
for profit corporation (the "Corporation"), DO HEREBY CERTIFY that the  
(non-profit or for profit)  
following is a true and correct excerpt from the minutes of the meeting of the Board of Directors  
duly called and held on 5/26/15, and that the same is now in full force and effect  
(date of meeting)

"RESOLVED, that the Chairman, the President, each Vice President, the Treasurer, and the Secretary and each of them, is authorized to execute and deliver, in the name of and on behalf of the Corporation and under its corporate seal or otherwise, any agreement or other instrument or document ('Contract') in connection with any matter or transaction that shall have been duly approved; and the execution and delivery of any Contract by any of the aforementioned officers shall be conclusive evidence of such approval."

FURTHER, I CERTIFY that J. William Sumner is Chairman,  
Dennis G. Rice is President,  
Beth Combs is (are) Vice President(s),  
J. William Sumner is Treasurer,  
Dennis G. Rice is Secretary,  
J. William Sumner is Executive Director, and  
is \_\_\_\_\_.

FURTHER, I CERTIFY that any of the aforementioned officers or employees of the Corporation are authorized to execute and commit the Corporation to the conditions, obligations, stipulations and undertakings contained in Contract No. 2890503 between the City and the above-referenced Corporation and that all necessary corporate approvals have been obtained in relationship thereto.

IN WITNESS THEREOF, I have set my hand this 26 day of May, 2015.  
CORPORATE SEAL  
(if any)

  
\_\_\_\_\_  
Corporation Secretary

**PLEASE NOTE THAT THE PERSON WHO SIGNS THE CONTRACT ON BEHALF OF YOUR CORPORATION MUST BE ONE OF THE INDIVIDUALS LISTED ABOVE AS A PERSON AUTHORIZED TO EXECUTE CONTRACTS IN THE NAME OF AND ON BEHALF OF THE CORPORATION.**

**Budget Dollars for HMSA AMENDMENT (2890503) Fiscal Year 2015-16**

Agency

Vendor :  
Charge Account

FUTURENET

Amount

|                   |  |                      |
|-------------------|--|----------------------|
| POLICE DEPARTMENT | 1000-370677-000165-617900-00119-000000-A1081 | \$ 61,560.00         |
| HUMAN RESOURCES   | 1002-282050-000000-628500-13976-000000-00000 | \$ 234,150.40        |
| <b>Total</b>      |  | <u>\$ 295,710.40</u> |

Prepared by Olga Johnson on July 27, 2015

Previous funding on C.P.O.

|                      |    |            |
|----------------------|----|------------|
|                      | \$ | 66,809.60  |
| Total C.P.O. funding | \$ | 362,520.00 |



Funds Available Inquiry (GLD)

**Selection Criteria**

Budget: **CODAMENDED** Amount Type: **Year To Date Extended**

Period: **JUN-16** Encumbrance Type: **ALL**

Account Level: **All**

**Funds Available (USD)**

Summary

| Account  | Budget     | Encumbrance | Actual     | Funds Available |
|--|------------|-------------|------------|-----------------|
| <input type="checkbox"/> 1000-370675-000165-617903-0011            | 0.00       | 0.00        | 0.00       | 0.00            |
| <input type="checkbox"/> 1000-370675-000165-617906-0011            | 0.00       | 0.00        | 0.00       | 0.00            |
| <input type="checkbox"/> 1000-370677-000000-617900-0011            | 0.00       | 0.00        | (3,018.50) | 3,018.50        |
| <input checked="" type="checkbox"/> 1000-370677-000165-617900-0011 | 718,579.00 | 0.00        | 0.00       | 718,579.00      |
| <input type="checkbox"/> 1000-370678-000165-617903-0011            | 0.00       | 0.00        | 0.00       | 0.00            |
| <input type="checkbox"/> 1000-370685-000000-617903-0011            | 0.00       | 0.00        | 0.00       | 0.00            |
| <input type="checkbox"/> 1000-370685-000165-617903-0011            | 36,050.00  | 0.00        | 0.00       | 0.00            |
| <input type="checkbox"/> 1000-370686-000000-617900-0011            | 0.00       | 0.00        | 0.00       | 0.00            |

**Encumbrance Amounts**

Requisition: **0.00** Purchase Order: **0.00**

**Account Description**  
 General Fund-Facilities Unit-Police Management Se-Contract Svcs-Other--Support Services Bur-Under

**Accounting Flexfield**

FUND: **1000**

COST CENTER: **370677**

PROJECTS: **000165**

OBJECT: **617900**

APPROPRIATION: **00119**

UTILITY: **000000**

FUNCTION: **A1081**



HMSA FUNDING \$300,960.00 FY-15-16

Oracle Applications - DRMPRO1 - DRMS Taking the Right Path

File Edit View Forms Tools Window Help

Selection Criteria

Budget: **CODAMENDED** Amount Type: **Year To Date Extended**

Period: **JUN-16** Encumbrance Type: **ALL**

Account Level: **All**

Funds Available (USD)

| Account                        | Budget       | Encumbrance | Actual | Funds Available |
|--------------------------------|--------------|-------------|--------|-----------------|
| 1002-282050-000000-628500-1397 | 1,000,000.00 | 0.00        | 0.00   | 1,000,000.00    |
|                                |              |             |        |                 |
|                                |              |             |        |                 |
|                                |              |             |        |                 |
|                                |              |             |        |                 |
|                                |              |             |        |                 |

Encumbrance Amounts

Requisition: **0.00** Purchase Order: **0.00**

Account Description

**Quality of Life Fund-Human Resources \- Re-DUMMY PROJECT FOR GL-Miscellaneous Expen-Human F**

Accounting Flexfield

FUND: **1002** Quality of Life Fund

COST CENTER: **282050** Human Resources - Reorgan

PROJECTS: **000000** DUMMY PROJECT FOR GL

OBJECT: **628500** Miscellaneous Expense

APPROPRIATION: **13976** Human Resources Restructur

UTILITY: **000000** Undefined Utility Account

FUNCTION: **00000** Undefined Function

OK Cancel

# City Council Contract Agenda Items Review Checklist

Reviewer: [Signature] (Contracting and Procurement Specialist signs here)

Date Received: 6/15/15  
00/00/2015

Date: 6/3/15 Department POLICE Division: BUDGET OPERATIONS

Dept Head/Contact Person: TINA TOLLIVER Telephone No: 596-5494

Description: Professional Services for an Employee Assistance Program & Substance Abuse for City of Detroit Employees (three (3)

years). Police for the last 2 years.

Brief explanation-function of or need for the goods/service

Contract No.: 2890503 PO Type: Prof Svc Est. Value: \$ 61,560 (2 years)

Contract Term (if applicable): 3/17/14 to 3/16/17

Funding Source: City: 100% State:     %  
Federal:     % Other:     %

(Documentation must be furnished by the Dept. if anything other than City funding)

Recommended Supplier: HEALTH MANAGEMENT SYSTEMS Required Date: ASAP  
3/17/14 - 3/16/17

ADDING POLICE TO CONTRACT / INCREASE OF FUNDS

1. The business being awarded is NEW / RENEWAL If a renewal, provide justification for renewal: Employee substance abuse assistance is important to the City of Detroit.

2. Was the product or service competitively bid?  Yes  No UNDER EMERGENCY MGR.  
Attach Copy of Bid Tabulation/Evaluation score sheets as needed

If the answer to #2 is "NO" explain why there was no competition: \_\_\_\_\_

3. Was a Co-Operative Agreement Considered?  Yes  No Co-Operative Name: N/A  
If answer to #3 is "No" explain why a Co-Op was not considered: \_\_\_\_\_

4. Were savings achieved?

Yes Amount \$ \_\_\_\_\_

No

5. Does this agreement represent an increase?  
 Variance in unit price only (Current unit price \$0.00 Proposed Unit Price \$0.00)  
 Change in amount/volume of the good or service to be used. \$61,560 POLICE BEING ADDED TO EXISTING CONTRACT.
6. Does the supplier currently provide other goods and services to the City?  Yes  No  
 If yes please list: \_\_\_\_\_
7. Is this good/service used by other departments?  Yes  No  
 If "yes" can this REQ/PAR be combined other department requirements?  Yes  No
8. Is this a service that can be performed by City employees?  Yes  No  
 Is this a service that City employees can be trained to do?  Yes  No

NOTES:

Buyer: 

a. Excluded Parties List / Supplier Award Management Website Reviewed? Yes  No

PLACE ON FINANCIAL REVIEW COMMISSION AGENDA

PLACE ON CITY COUNCIL AGENDA

REJECT AND NOTIFY DEPARTMENT DIRECTOR:

SIGNED:  DATE: 6/5/15  
 (Department)

INFORMATION PROVIDED BY: Otis Milhouse

TITLE: Police Assistant

PHONE: 596-1922

*[Handwritten Signature]*  
6/3/15

### CONTRACT INCREASE FORM DEPARTMENT REQUEST

Original C.C. Res.\* \_\_\_\_\_ To Council By:\* \_\_\_\_\_  
C.C. Res.\* \_\_\_\_\_

AGENCY SPECIFIC       CITY WIDE

Oracle Purchase Order No. 2890503      File No. \_\_\_\_\_

Description of Commodity Employee Assistance Program

Contract Period:      FROM: March 17, 2014      TO: March 16, 2017

Original Department Estimate      \$ 300,960.00

Prev. Approved Dept. Increase(s): \$ \_\_\_\_\_

Requested Dept. Increase: \$ 30,780.00/Year for 2 years -      \$ 61,560 total  
New Dept. Total: \$ 362,520.00

Increase in Estimated Expenditure to: \$ \_\_\_\_\_ Total Expended on Contract:\* \$ \_\_\_\_\_

Detailed Reason for Increase Adding Detroit Police Department employees to existing contract

Vendor Health Management Systems of America

Vendor's Address: 601 Washington Blvd.

City, State & Zip Code: Detroit, MI 48226

User Agency: \_\_\_\_\_

[Handwritten Signature]  
Authorized Department Signature/Title/Phone No.

Date: 6/3/15

Purchasing Approval \_\_\_\_\_ Date: \_\_\_\_\_

1000-370210-000159-617900-00115-000000-A1075

APR 30 2015



# REQUEST FOR INCOME TAX CLEARANCE

REQUESTING DEPARTMENT/DIVISION: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

CONTACT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Type of Clearance:  New  Renewal (Please submit 30 days prior to submitting bid or expiration date)

To: **A. City of Detroit**  
 Income Tax Division  
 Coleman A. Young Municipal Center  
 2 Woodward Avenue, Ste. 1220  
 Detroit, MI 48226

For: Individual or  
 Company Name Health Management Systems  
 Address 601 Washington

Phone: (313) 224-3328 or 224-3329  
Fax: (313) 224-4588

City Detroit

State MI Zip Code 48226

Telephone (313) 964-3100 Fax # (313) 964-3161

E-mail Address Dennis.Rice@HMSADenet.com

|   |                                   |
|---|-----------------------------------|
| B. Name of Chief Financial Officer/Authorized Contact Person<br>(include address if different from above) | Telephone # <u>(313) 964-3100</u> |
| <u>Dennis Rice</u>  | Fax # <u>(313) 964-3161</u>       |

|  |                               |
|--|-------------------------------|
| Employer Identification or Social Security Number<br><u>38-2686158</u> | Spouse Social Security Number |
|--|-------------------------------|

Nature of Contract Employee Assistance Program BID CONTRACT AMOUNT (if known):  
 Labor: \$ \_\_\_\_\_ Material: \$ \_\_\_\_\_  
 Contract # (if known) \_\_\_\_\_

C. ALL QUESTIONS MUST BE ANSWERED TO EXPEDITE APPROVAL PROCESS. ANY QUESTION NOT ANSWERED MAY RESULT IN A DENIAL OF INCOME TAX CLEARANCE.

Check One:  Individual  Corporation  Partnership  Estate & Trust

### INDIVIDUALS ANSWER QUESTIONS 1,2,3,4.

- Have you filed joint returns with spouse during the last seven (7) years? (If yes, include spouse SSN above)  Yes  No
- Are you a student, and/or claimed as a dependent on someone else's tax return?  Yes  No
- Were you employed in the City of Detroit during the last seven (7) years?  Yes  No
- Were you a resident of Detroit during the last seven (7) years?  Yes  No

### CORPORATIONS AND PARTNERSHIPS ANSWER QUESTIONS 5,6,7.

- Is the company a new business in Detroit? If yes, attach Employer Registration (Form DSS-4).  Yes  No
- Will the company have employees working in Detroit?  Yes  No
- Will the company use sub-contractors or independent contractors in Detroit?  Yes  No

### D. FOR INCOME TAX USE ONLY

Has the contractor complied with the provisions of the City Income Tax Ordinance?

- Yes  No  
 Yes  No  
 Yes  No

Signature LUCHETIA JENNINGS Date MAY 02 2015 Expires MAY 02 2016  
 Signature \_\_\_\_\_ Date \_\_\_\_\_ Expires \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_ Expires \_\_\_\_\_

VISIT OUR WEBSITE FOR INFORMATION AND TAX FORMS AT: [www.detroitmi.gov](http://www.detroitmi.gov)

NOTE: An approved Income Tax Certificate may be used in multiple city wide departments that require a bid. Please e-mail your completed request form (preferably in pdf format) to: [IncomeTaxClearance@detroitmi.gov](mailto:IncomeTaxClearance@detroitmi.gov)

CITY OF DETROIT

ACCOUNTS RECEIVABLE CLEARANCE APPLICATION  
2 WOODWARD AVENUE, SUITE 105, COLEMAN A YOUNG MUNICIPAL CENTER  
REVENUE COLLECTIONS UNIT (313) 224-4087 / FAX: 224-4238 / RevenueCollections@DetroitMi.gov

SECTION A BUSINESS LICENSE BUDGET CITY COUNCIL DDOT DPW FINANCE FIRE HEALTH  
HUMAN RIGHTS LAW MAYOR OMBUDSMAN PLANNING & DEVELOPMENT POLICE PURCHASING  
RECREATION WATER & SEWAGE OTHER

ADDRESS OF DEPARTMENT 1008 CASMC  
DATE SENT 5-1-15 CONTACT PERSON V. Gaines  
PHONE NUMBER 313-224-4422 FAX NUMBER 313-628-1160 EMAIL Gainesye@detroitmi.gov  
CONTRACT AMOUNT \$ 358,400

SECTION B: CORPORATION LICENSE TYPE  
CORPORATION NAME Health Management Systems, Inc. ADDRESS 601 Washington CITY/STATE/ZIP Detroit MI 48226  
 OWN LEASE  
CITY PERSONAL PROPERTY NUMBER 02990073.00 FID / EIN NUMBER 38-2686158 OTHER CITY OWNED PROPERTY None  
CONTACT PERSON Dennis Rice PHONE NUMBER (313) 964-3100 EMAIL ADDRESS Dennis.Rice@HMSANET.com

SECTION C: PARTNERSHIP LICENSE TYPE  
BUSINESS NAME  
BUSINESS ADDRESS CITY/STATE/ZIP OWN LEASE  
CITY PERSONAL PROPERTY NUMBER FID / EIN NUMBER  
A: PARTNER'S NAME PHONE NUMBER  
HOME ADDRESS CITY/STATE/ZIP OWN LEASE  
DRIVER'S LICENSE # OTHER CITY-OWNED PROPERTY PARCELS  
B. PARTNER'S NAME PHONE NUMBER  
HOME ADDRESS CITY/STATE/ZIP OWN LEASE  
DRIVER'S LICENSE # OTHER CITY-OWNED PROPERTY PARCELS  
CONTACT PERSON PHONE NUMBER EMAIL ADDRESS

SECTION D: SOLE PROPRIETORSHIP LICENSE TYPE  
BUSINESS NAME  
BUSINESS ADDRESS CITY/STATE/ZIP OWN LEASE  
CITY PERSONAL PROPERTY NUMBER FID / EIN NUMBER  
OWNER'S NAME DRIVER'S LICENSE # PHONE NUMBER  
HOME ADDRESS CITY/STATE/ZIP OWN LEASE  
OTHER CITY-OWNED PROPERTY PARCELS  
EMAIL ADDRESS

SECTION E: PERSONAL SERVICES LEASE  
NAME ADDRESS  
CITY/STATE/ZIP  
PHONE NUMBER DRIVER LICENSE #  
OTHER PROPERTY ADDRESSES OWNED IN WITHIN DETROIT  
SOCIAL SECURITY NUMBER EMAIL ADDRESS

REVENUE COLLECTIONS  
APPROVED  
CONTRACT CLEARANCES

FOR TREASURY COLLECTION USE ONLY:  
APPROVED DENIED DENIED WITH ATTACHMENTS  
Annette Smith MAY 06 2015 AUG 31 2015  
DATE CLEARANCE VALID UNTIL

**REVISED 7-12-2012**  
**COVENANT OF EQUAL OPPORTUNITY**  
**(Application for Clearance – Terms Enforced After Contract is Awarded)**

I, being a duly authorized representative of Health Management Inc. - DBA Health Management Systems of America, (hereinafter "Contractor"), am hereby authorized to enter into a Covenant of Equal Opportunity, (hereinafter "Covenant") with the City of Detroit, ("hereinafter" City); obligating the Contractor and all sub-contractors, not to discriminate against any employee or applicant for employment, training, education, or apprenticeship connected directly or indirectly with the performance of the contract, with respect to his/her hire, promotion, job assignment, tenure, terms, conditions or privileges of employment because of race, color, religious beliefs, public benefit status, national origin, age, marital status, disability, sex, sexual orientation, or gender identity or expression; except as otherwise exempted under City Code, Ordinance No. 27-2-12.

Contractor will ensure that the City of Detroit Human Rights Department shall receive notification of all potential sub-contractors and a copy of their Covenant prior to the commencement of work on any City of Detroit contract. Contractor further agrees that the City of Detroit reserves the right to require additional information prior to, during, and at any time after the Covenant is fully executed.

Furthermore, Contractor agrees that this Covenant is valid for the life of the contract and/or for a specified period of time as indicated below and that a breach of this Covenant shall be deemed a material breach of contract and be subject to damages pursuant to City Code, Ordinance No. 27-3-2, Section (e).

RFQ / PO No.: (if applicable) 49683

Duration of Covenant Life of the Contract to \_\_\_\_\_

Printed Name of Contractor/Organization Health Management Inc. DBA- Health Management Systems of America  
(Type or Print Legibly)

Contractor Address 601 Washington Blvd. Detroit, Michigan, 48226-3130  
(City) (State) (Zip)

Contractor Phone/E-mail (313) 964-3100 / dennis.rice@hmsanet.com  
(Phone) (E-mail)

Printed Name & Title of Authorized Representative Dennis Rice, President

Signature of Authorized Representative: [Signature]

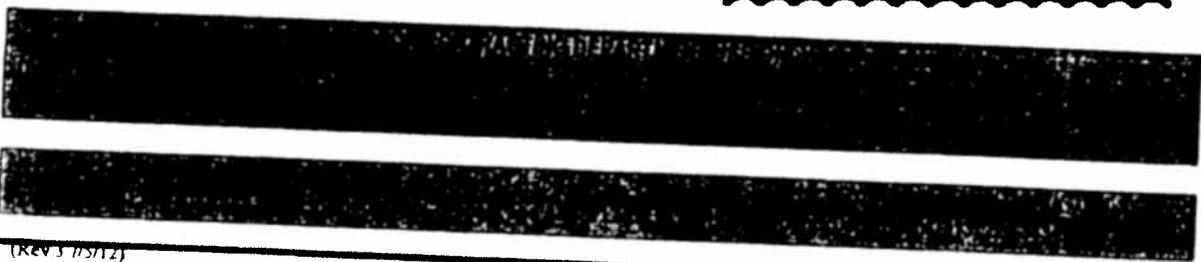
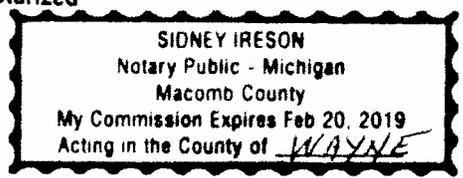
Date: 1/5/15

\*\*\* This document MUST be notarized \*\*\*

Signature of Notary: [Signature]

Printed Name of Seal of Notary: Sidney Ireson

My Commission Expires: 02/20/2019







# HMSA HEALTH MANAGEMENT SYSTEMS OF AMERICA

## Application for Employment Health Management Systems of America, Inc.

| To be filled out by Human Resources |        |                  |                |           |                |           |
|-------------------------------------|--------|------------------|----------------|-----------|----------------|-----------|
| Location                            | _____  | First Pay Date   | ____/____/____ |           |                |           |
| Department                          | _____  | Job Function     | _____          | Hire Date | ____/____/____ |           |
| Pay Rate                            | _____  | First Day Worked | ____/____/____ |           |                |           |
| Pay Type                            | Hourly | Salary           | Commission     | Full-Time | Part-Time      | Temporary |

Position Applied for \_\_\_\_\_ Date of Application \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Telephone No. (\_\_\_\_) \_\_\_\_\_  
 Last First MI

Street Address \_\_\_\_\_  
 City State Zip code

If you are under the age of 18, can you furnish a work permit? Yes No

Have you ever been employed here before? Yes No

Are you legally eligible for employment in the United States? Yes No

Date available for work: \_\_\_\_/\_\_\_\_/\_\_\_\_

Driver's license number if driving is an essential job function \_\_\_\_\_ State \_\_\_\_\_

## Employment History

PROVIDE THE FOLLOWING INFORMATION FOR YOUR LAST THREE(3) PAST EMPLOYERS STARTING WITH THE MOST RECENT

|                    |  |                  |
|--------------------|--|------------------|
| Dates Employed     | Employer                                     | Telephone Number |
| Job Title          | Employer's Address, City, State, Zip Code    |                  |
| Supervisor         | Nature of Work and Job Responsibilities      |                  |
| Reason for Leaving | May we contact for reference<br>Yes No Later |                  |
| Starting Rate      | Final Rate                                   | Comments         |
|                    |  |                  |
| Dates Employed     | Employer                                     | Telephone Number |
| Job Title          | Employer's Address, City, State, Zip Code    |                  |
| Supervisor         | Nature of Work and Job Responsibilities      |                  |
| Reason for Leaving | May we contact for reference<br>Yes No Later |                  |
| Starting Rate      | Final Rate                                   | Comments         |
|                    |  |                  |
| Dates Employed     | Employer                                     | Telephone Number |
| Job Title          | Employer's Address, City, State, Zip Code    |                  |
| Supervisor         | Nature of Work and Job Responsibilities      |                  |
| Reason for Leaving | May we contact for reference<br>Yes No Later |                  |
| Starting Rate      | Final Rate                                   | Comments         |

## Educational Background

| Name and Location | Number of Years Completed | Did you Graduate? |
|-------------------|---------------------------|-------------------|
| High School       |                           |                   |
| College           |                           |                   |
| Other             |                           |                   |

## Additional Skills and Qualifications

Summarize any training, skills, licenses, and/or certifications that you have received in addition to your education

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## References

| Name | Telephone Number | # of Years known |
|------|------------------|------------------|
|      | (     ) -        |                  |
|      | (     ) -        |                  |
|      | (     ) -        |                  |

## Applicant Statement

I certify the information provided in this application is true and correct to the best of my knowledge. If employed, any misstatement or omission of fact on this application may result in my dismissal.

I understand acceptance of an offer of employment does not create a contractual obligation or contract to continue my employment in the future.

I understand if Health Management Systems of America, Inc. decides to engage an investigative consumer reporting agency on my credit and personal history, I hereby authorize this engagement. If a report is obtained, HMSA must provide, at my request, the name of the reporting agency. I may obtain from the reporting agency, the nature and substance of the information contained in the report.

I acknowledge, if at any time during my employment I am subjected to any type of harassment, including sexual harassment, I agree to immediately contact the Human Resource Department or my supervisor in order to obtain assistance in the resolution of such matters.

I understand that I am employed at the mutual consent of myself and HMSA. Consequently, I have the right to terminate my employment at any time, for any reason, with or without cause, and HMSA reserves the same right. The relationship is defined as "Employment At Will."

I shall report all work-related injuries and/or sicknesses that occur while on my work assignment to HMSA within 24 hours of the incident. I understand all administration and/or payment of any claims will be provided by HMSA's Workers' Compensation carrier. I also hold harmless HMSA from any claim that may arise. I voluntarily acknowledge the exclusive remedy will be under HMSA's Workers' Compensation policy.

I understand this agreement is for the benefit of Health Management Systems of America, Inc. (HMSA)

### **DO NOT SIGN UNTIL YOU HAVE READ THE ABOVE STATEMENT**

I certify I have read the agreement statement of this application.

Applicant Signature \_\_\_\_\_

Date     \_\_\_\_/\_\_\_\_/\_\_\_\_

**CITY OF DETROIT**  
**SLAVERY ERA RECORDS AND INSURANCE DISCLOSURE AFFIDAVIT**

1. Name of Contractor: Health Management Inc. DBA- Health Management Systems of America  
2. Address of Contractor: 601 Washington Blvd.  
Detroit, MI 48226-3130

3. Name of Predecessor Entities (if any): None

4. Prior Affidavit submission? \_\_\_ No  Yes, on: Uncertain  
(Date of prior submission)

If "No", complete Items 5 and 6.

If "Yes", list date of prior submission above, go to Item 6 and execute this Affidavit.

5.  Contractor was established in 1986 (year) and did not exist during the slavery era in the United States, is not a successor in interest to any entity that existed during such time, and therefore has no relevant records to search, or any pertinent information to disclose.

\_\_\_ Contractor has searched their records and those of any predecessor entity, and has found no records that they or any predecessor(s) made any investments in, or derived profits from the slave industry or from slave holder insurance policies.

\_\_\_ Contractor has found records that they or their predecessor(s) made investments in, or derived profits from, the slave industry or slave holder insurance policies. The nature of the investment, profits, or insurance policies, including the names of any slaves or slave holders, is disclosed in the attached document(s).

6. I declare that the representations made in this Affidavit are accurate to the best of my knowledge and are based upon a diligent search of records in the Contractor's possession or knowledge. All documentation attached to this Affidavit reflects full disclosure of all records that are required to be disclosed to the City of Detroit. I also acknowledge that any failure to conduct a diligent search, or to make a full and complete disclosure, shall render this contract voidable by the City of Detroit.

Dennis Rice (Printed Name) President (Title)  
[Signature] (Signature) 1/3/15 (Date)

Subscribed and sworn to before me  
this 5 day of January 2015

[Signature]  
Notary Public, Wayne County, Michigan  
My Commission expires: 02-20-2019  
Acting in the county of Wayne

[View assistance for Search Results](#)

# Search Results

**Current Search Terms: health\* management\* systems\* OF america\***

**Notice:** This printed document represents only the first page of your SAM search results. More results may be available. To print your complete search results, you can download the PDF and print it.  
No records found for current search.

## Glossary

**Search Results**

Entity  
Exclusion

**Search Filters**

By Record Status

By Functional Area - Entity Management

By Functional Area - Performance Information

SAM | System for Award Management 1.0

IBM v1.P.27.20150327-1711

**Note to all Users:** This is a Federal Government computer system. Use of this system constitutes consent to monitoring at all times.



## Workflow Profile

## Workflows

[Active Workflows](#)
[Completed Workflows](#)
[Documents](#)

[Browse Workflows](#)

[Documents](#)

[Close Workflow](#)

Workflow : Contract Workflow for < \$25,000 - Workflow Owner : Gaines, Yolanda

| Step | Step Name  | C   | Completed On        | Completed By    | Duration                  | Owner           |   |
|------|--|-----|---------------------|-----------------|---------------------------|-----------------|---|
| 1    | Is this an emergency purchase?                     | ... | 08/11/2015 08:44:57 | Gaines, Yolanda | Less than 1 minute        | Gaines, Yolanda |   |
| 2    | Upload emergency purchase documents                | ... | -                   | -               | -                         | Gaines, Yolanda | - |
| 3    | Is this a sole source purchase?                    | ... | 08/11/2015 08:45:09 | Gaines, Yolanda | Less than 1 minute        | Gaines, Yolanda |   |
| 4    | Confirm upload of signed sole source justification | ... | -                   | -               | -                         | Gaines, Yolanda | - |
| 5    | Confirm Vendor Signature                           | ... | 08/11/2015 08:45:19 | Gaines, Yolanda | Less than 1 minute        | Gaines, Yolanda |   |
| 6    | Did this contract originate as a RFQ?              | ... | 08/11/2015 08:45:38 | Gaines, Yolanda | Less than 1 minute        | Gaines, Yolanda |   |
| 7    | Confirm Requesting Department Signature            | ... | 08/11/2015 08:46:00 | Gaines, Yolanda | Less than 1 minute        | Gaines, Yolanda |   |
| 8    | Does Budget need to approve?                       | ... | 08/11/2015 08:46:10 | Gaines, Yolanda | Less than 1 minute        | Gaines, Yolanda |   |
| 9    | Budget admin initiates workflow                    | ... | 08/11/2015 11:02:22 | Johnson, Alicia | 2 hours 16 minutes        | Johnson, Alicia |   |
| 10   | Budget completes workflow                          | ... | 08/13/2015 07:57:39 | Johnson, Alicia | 1 day 20 hours 55 minu... | Johnson, Alicia |   |
| 11   | Grant Funded?                                      | ... | 08/14/2015 15:26:47 | Gaines, Yolanda | 1 day 7 hours 29 minutes  | Gaines, Yolanda |   |
| 12   | OGM-AD-Reviews                                     | ... | -                   | -               | -                         | Russell, Kellie | - |
| 13   | OGM-Director-Approves                              | ... | -                   | -               | -                         | Russell, Kellie | - |

APR 30 2015



# REQUEST FOR INCOME TAX CLEARANCE

REQUESTING DEPARTMENT/DIVISION: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

CONTACT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

Type of Clearance:  New  Renewal (Please submit 30 days prior to submitting bid or expiration date)

To: **A. City of Detroit**  
 Income Tax Division  
 Coleman A. Young Municipal Center  
 2 Woodward Avenue, Ste. 1220  
 Detroit, MI 48226

For: Individual or  
 Company Name Health Management Systems  
 Address 601 Washington

Phone: (313) 224-3328 or 224-3329  
Fax: (313) 224-4588

City Detroit

State MI Zip Code 48226

Telephone (313) 964-3100 Fax # (313) 964-3161

E-mail Address Dennis.Rice@HMSADenet.com

|   |                                   |
|---|-----------------------------------|
| B. Name of Chief Financial Officer/Authorized Contact Person<br>(Include address if different from above)<br><b>Dennis Rice</b> | Telephone # <u>(313) 964-3100</u> |
|   | Fax # <u>(313) 964-3161</u>       |

|  |                               |
|--|-------------------------------|
| Employer Identification or Social Security Number<br><b>38-2686158</b> | Spouse Social Security Number |
|--|-------------------------------|

Nature of Contract Employee Assistance Program BID CONTRACT AMOUNT (if known):  
 Labor: \$ \_\_\_\_\_ Material: \$ \_\_\_\_\_  
 Contract # (if known) \_\_\_\_\_

C. ALL QUESTIONS MUST BE ANSWERED TO EXPEDITE APPROVAL PROCESS. ANY QUESTION NOT ANSWERED MAY RESULT IN A DENIAL OF INCOME TAX CLEARANCE.

Check One:  Individual  Corporation  Partnership  Estate & Trust

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- Will the company have employees working in Detroit?  Yes  No
- Will the company use sub-contractors or independent contractors in Detroit?  Yes  No

### D. FOR INCOME TAX USE ONLY

Has the contractor complied with the provisions of the City Income Tax Ordinance?

- Yes  No  
 Yes  No  
 Yes  No

Signature LUCHETIA JENNINGS Date MAY 02 2015 Expires MAY 02 2016  
 Signature \_\_\_\_\_ Date \_\_\_\_\_ Expires \_\_\_\_\_  
 Signature \_\_\_\_\_ Date \_\_\_\_\_ Expires \_\_\_\_\_

VISIT OUR WEBSITE FOR INFORMATION AND TAX FORMS AT: [www.detroitmi.gov](http://www.detroitmi.gov)

NOTE: An approved Income Tax Certificate may be used in multiple city wide departments that require a bid. Please e-mail your completed request form (preferably in pdf format) to: [IncomeTaxClearance@detroitmi.gov](mailto:IncomeTaxClearance@detroitmi.gov)

CITY OF DETROIT

ACCOUNTS RECEIVABLE CLEARANCE APPLICATION
2 WOODWARD AVENUE, SUITE 105, COLEMAN A YOUNG MUNICIPAL CENTER
REVENUE COLLECTIONS UNIT (313) 224-4087 / FAX: 224-4238 / RevenueCollections@DetroitMi.gov

SECTION A: BUSINESS LICENSE BUDGET CITY COUNCIL DDOT DPW FINANCE FIRE HEALTH HUMAN RIGHTS LAW MAYOR OMBUDSMAN PLANNING & DEVELOPMENT POLICE PURCHASING RECREATION WATER & SEWAGE OTHER
ADDRESS OF DEPARTMENT OCP
DATE SENT 8/21/15 CONTACT PERSON J. Guiney
PHONE NUMBER 224-4612 FAX NUMBER 228-1160 EMAIL jguiney@detroitmi.gov
CONTRACT AMOUNT \$ 350,400

SECTION B: CORPORATION LICENSE TYPE
CORPORATION NAME Health Management Systems Inc.
ADDRESS 601 Washington CITY/STATE/ZIP DET MI 48226 OWN LEASE
CITY PERSONAL PROPERTY NUMBER 02990078.00 FID/EIN NUMBER 38-2896158
OTHER CITY-OWNED PROPERTY PARCELS 02990078.00
CONTACT PERSON Dennis Rice PHONE NUMBER 964-3100 EMAIL ADDRESS dennis.rice@hmsamerica.com

SECTION C: PARTNERSHIP LICENSE TYPE
BUSINESS NAME
BUSINESS ADDRESS CITY/STATE/ZIP OWN LEASE
CITY PERSONAL PROPERTY NUMBER FID/EIN NUMBER
A. PARTNER'S NAME PHONE NUMBER
HOME ADDRESS CITY/STATE/ZIP OWN LEASE
DRIVER'S LICENSE # OTHER CITY-OWNED PROPERTY PARCELS
B. PARTNER'S NAME PHONE NUMBER
HOME ADDRESS CITY/STATE/ZIP OWN LEASE
DRIVER'S LICENSE # OTHER CITY-OWNED PROPERTY PARCELS
CONTACT PERSON PHONE NUMBER EMAIL ADDRESS

SECTION D: SOLE PROPRIETORSHIP LICENSE TYPE
BUSINESS NAME
BUSINESS ADDRESS CITY/STATE/ZIP OWN LEASE
CITY PERSONAL PROPERTY NUMBER FID/EIN NUMBER
OWNER'S NAME DRIVER'S LICENSE # PHONE NUMBER
HOME ADDRESS CITY/STATE/ZIP OWN LEASE
OTHER CITY-OWNED PROPERTY PARCELS
EMAIL ADDRESS

SECTION E: PERSONAL SERVICES
NAME ADDRESS OWN LEASE
CITY/STATE/ZIP
PHONE NUMBER DRIVER LICENSE #
OTHER PROPERTY ADDRESSES OWNED IN WITHIN DETROIT
SOCIAL SECURITY NUMBER EMAIL ADDRESS

REVENUE COLLECTIONS APPROVED CONTRACT CLEARANCES

FOR TREASURY COLLECTION USE ONLY:
APPROVED DENIED
Signature: Annette Am... DATE: SEP 17 2015 DENIED WITH ATTACHMENTS
CLEARANCE VALID UNTIL: JAN 15 2016



# CERTIFICATE OF LIABILITY INSURANCE

HEAL782

OP ID: DC

DATE (MM/DD/YYYY)

08/24/2015

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).

|   |   |                                    |
|---|---|------------------------------------|
| <b>PRODUCER</b><br>George B. Ford Agency, Inc.<br>39500 High Pointe Blvd #400<br>Novi, MI 48375<br>Mark Churella, Jr. | <b>CONTACT NAME:</b> Debbie Floyd-Snoek   |                                    |
|   | <b>PHONE (A/C, No, Ext):</b> 248-348-8200 | <b>FAX (A/C, No):</b> 248-675-2218 |
| <b>E-MAIL ADDRESS:</b> certificates@fdigroup.com  |   |                                    |
| <b>INSURER(S) AFFORDING COVERAGE</b>  |   | <b>NAIC #</b>                      |
| <b>INSURER A:</b> Citizens Insurance Company  |   | <b>31534</b>                       |
| <b>INSURER B:</b> The Travelers Indemnity Co.   |   | <b>25658</b>                       |
| <b>INSURER C:</b> Lloyds of London  |   |                                    |
| <b>INSURER D:</b>   |   |                                    |
| <b>INSURER E:</b>   |   |                                    |
| <b>INSURER F:</b>   |   |                                    |

**INSURED**  
 Health Mgt. Systems of America  
 601 Washington Blvd.  
 Detroit, MI 48226

**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 INSD | SUBR WVD | POLICY NUMBER   | POLICY EFF (MM/DD/YYYY) | POLICY EXP (MM/DD/YYYY) | LIMITS   |
|----------|--|-----------|----------|-----------------|-------------------------|-------------------------|--|
| A        | <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY<br><input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR   |           |          | RHB9195129 04   | 06/30/2015              | 06/30/2016              | EACH OCCURRENCE \$ 1,000,000   |
| A        | <input checked="" type="checkbox"/> Prof Liability   |           |          | RHB9195129 04   | 06/30/2015              | 06/30/2016              | DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000                               |
| C        | <input checked="" type="checkbox"/> Cyber Liability  |           |          | ESD01103531     | 12/30/2014              | 12/30/2015              | MED EXP (Any one person) \$ 10,000   |
|          | GEN'L AGGREGATE LIMIT APPLIES PER:<br><input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC<br>OTHER:   |           |          |                 |                         |                         | PERSONAL & ADV INJURY \$ 1,000,000   |
|          |  |           |          |                 |                         |                         | GENERAL AGGREGATE \$ 3,000,000   |
|          |  |           |          |                 |                         |                         | PRODUCTS - COMP/OP AGG \$ 3,000,000  |
|          |  |           |          |                 |                         |                         | <b>Cyber Cov</b> \$ 5,000,000  |
| A        | <b>AUTOMOBILE LIABILITY</b><br><input type="checkbox"/> ANY AUTO<br><input type="checkbox"/> ALL OWNED AUTOS<br><input checked="" type="checkbox"/> HIRED AUTOS<br><input type="checkbox"/> SCHEDULED AUTOS<br><input checked="" type="checkbox"/> NON-OWNED AUTOS |           |          | RHB9195129 04   | 06/30/2015              | 06/30/2016              | COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000                                   |
|          |  |           |          |                 |                         |                         | BODILY INJURY (Per person) \$  |
|          |  |           |          |                 |                         |                         | BODILY INJURY (Per accident) \$  |
|          |  |           |          |                 |                         |                         | PROPERTY DAMAGE (Per accident) \$  |
|          |  |           |          |                 |                         |                         | \$   |
| A        | <input type="checkbox"/> UMBRELLA LIAB<br><input type="checkbox"/> EXCESS LIAB<br><input checked="" type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 0   |           |          | UHB9195178 04   | 06/30/2015              | 06/30/2016              | EACH OCCURRENCE \$ 10,000,000  |
|          |  |           |          |                 |                         |                         | AGGREGATE \$ 10,000,000  |
|          |  |           |          |                 |                         |                         | \$   |
| B        | <b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b><br>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)<br>If yes, describe under DESCRIPTION OF OPERATIONS below  | Y/N       | N/A      | ITMUB1B23744615 | 06/30/2015              | 06/30/2016              | <input checked="" type="checkbox"/> PER STATUTE<br><input type="checkbox"/> OTH-ER |
|          |  |           |          |                 |                         |                         | E.L. EACH ACCIDENT \$ 500,000  |
|          |  |           |          |                 |                         |                         | E.L. DISEASE - EA EMPLOYEE \$ 500,000  |
|          |  |           |          |                 |                         |                         | E.L. DISEASE - POLICY LIMIT \$ 500,000   |
| B        | <b>Crime/Fidelity</b>  |           |          | 105575811       | 06/30/2015              | 06/30/2016              | <b>Emp Theft</b> 1,000,000   |
| B        | <b>Fiduciary/ERISA</b>   |           |          | 105575811       | 06/30/2015              | 06/30/2016              | <b>ERISA/Fid</b> 1,000,000   |

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

City of Detroit is Additional Insured with respect to General Liability for named insured.

**CERTIFICATE HOLDER****CANCELLATION**

|   |   |
|---|---|
| <b>CITYDPL</b><br><br>City of Detroit<br>65 Cadillac Square Ste.1700<br>Detroit, MI 48226 | SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.<br><br>AUTHORIZED REPRESENTATIVE<br> |
|---|---|

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