

**IFB No.: PSD 24-HCD-01  
LABORATORY DIAGNOSTIC SERVICES  
DEPARTMENT OF PUBLIC SAFETY  
HEALTH CARE DIVISION**

Procurement Officer  
State of Hawaii  
Department of Public Safety  
Administrative Services Office  
Procurement and Contracts Unit  
1177 Alakea Street  
Honolulu, Hawaii 96813

Dear Sir:

The undersigned has carefully read and understands the terms and conditions specified in the Specifications and Special Provisions attached hereto, and in the General Conditions Form AG-008 103D Effective (10/17/2013), by reference made a part hereof and available upon request; and hereby submits the following offer to perform the work specified herein, all in accordance with the true intent and meaning thereof. The undersigned further understands and agrees that by submitting this offer, 1) he/she is declaring his/her offer is not in violation of Chapter 84, Hawaii Revised Statutes, concerning prohibited State contracts, and 2) he/she is certifying that the price(s) submitted was (were) independently arrived at without collusion.

The undersigned represents: **(Check  one only)**

- Hawaii business** incorporated or organized under the laws of the State of Hawaii; **OR**  
 **Compliant Non-Hawaii business** not incorporated or organized under the laws of the State of Hawaii, but registered at the State of Hawaii Department of Commerce and Consumer Affairs Business Registration Division to do business in the State of Hawaii.

State of incorporation: \_\_\_\_\_

Offeror is:

- Sole Proprietor     Partnership     Corporation     Joint Venture  
 Other \_\_\_\_\_

Federal I.D. No.: \_\_\_\_\_

Hawaii General Excise Tax License I.D. No.: \_\_\_\_\_

Payment address (other than street address below): \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Business address (street address): \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Respectfully submitted:

**(x)** \_\_\_\_\_  
Authorized (Original) Signature

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

Telephone No.: \_\_\_\_\_

\_\_\_\_\_  
Name and Title (Please Type or Print)

Fax No.: \_\_\_\_\_

\* \_\_\_\_\_  
**Exact Legal Name of Company (Offeror)**

E-mail Address:  
\_\_\_\_\_

\* If Offeror is a "dba" or a "division" of a corporation, furnish the exact legal name of the corporation under which the awarded contract will be executed:

The following offer is hereby submitted for PSD 24-HCD-01 Laboratory Diagnostic Services for the Department of Public Safety, Health Care Division, as specified herein:

Percentage (%) by which the prevailing Medicaid rate(s) shall be discounted. The Medicaid rate minus the % discount shall represent the all-inclusive cost, including taxes, to the State for the services specified herein:

Oahu	_____	%
Hawaii	_____	%
Maui	_____	%
Kauai	_____	%

Licenses

Medicare Identification Number: \_\_\_\_\_

College of American Pathologists (CAP) or Center for Disease Control (CDC) License Number: \_\_\_\_\_

Name of Laboratory Director: \_\_\_\_\_

Laboratory Director's State of Hawaii License Number: \_\_\_\_\_

Insurance Coverage

Commercial General Liability: \_\_\_\_\_  
Underwriter

Medical Professional Liability: \_\_\_\_\_  
Underwriter

Name of Agent: \_\_\_\_\_ Telephone: \_\_\_\_\_

OFFEROR: \_\_\_\_\_  
COMPANY NAME

References

<u>Hospital/Clinical Institution</u>	<u>Contact Person</u>	<u>Telephone No.</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Subcontractor(s)

Will any part of the specified services be subcontracted? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, list below all subcontractors to be used and what portion of the services the subcontractor(s) will be providing (use additional sheets of paper, if necessary):

Name of subcontractor: \_\_\_\_\_

Portion of services to be provided by subcontractor: \_\_\_\_\_

Medicare Identification Number: \_\_\_\_\_

CAP or CDC License Number: \_\_\_\_\_

Name of Laboratory Director: \_\_\_\_\_

Laboratory Director's State of Hawaii License Number: \_\_\_\_\_

Name of subcontractor: \_\_\_\_\_

Portion of services to be provided by subcontractor: \_\_\_\_\_

Medicare Identification Number: \_\_\_\_\_

CAP or CDC License Number: \_\_\_\_\_

Name of Laboratory Director: \_\_\_\_\_

Laboratory Director's State of Hawaii License Number: \_\_\_\_\_

OFFEROR: \_\_\_\_\_  
COMPANY NAME

For each facility, Offeror shall provide the following laboratory servicing information:

OAHU

Oahu Community Correctional Center (OCCC)

Laboratory Name \_\_\_\_\_

Address \_\_\_\_\_

Point of Contact \_\_\_\_\_

Telephone No. \_\_\_\_\_

Normal Business Hours \_\_\_\_\_

Women's Community Correctional Center (WCCC)

Laboratory Name \_\_\_\_\_

Address \_\_\_\_\_

Point of Contact \_\_\_\_\_

Telephone No. \_\_\_\_\_

Normal Business Hours \_\_\_\_\_

Halawa Correctional Facility (HCF)

Laboratory Name \_\_\_\_\_

Address \_\_\_\_\_

Point of Contact \_\_\_\_\_

Telephone No. \_\_\_\_\_

Normal Business Hours \_\_\_\_\_

Waiawa Correctional Facility (WCF)

Laboratory Name \_\_\_\_\_

Address \_\_\_\_\_

Point of Contact \_\_\_\_\_

Telephone No. \_\_\_\_\_

Normal Business Hours \_\_\_\_\_

OFFEROR: \_\_\_\_\_  
COMPANY NAME

HAWAII

Hawaii Community Correctional Center (HCCC)

Laboratory Name \_\_\_\_\_

Address \_\_\_\_\_

Point of Contact \_\_\_\_\_

Telephone No. \_\_\_\_\_

Normal Business Hours \_\_\_\_\_

Kulani Correctional Facility (KCF)

Laboratory Name \_\_\_\_\_

Address \_\_\_\_\_

Point of Contact \_\_\_\_\_

Telephone No. \_\_\_\_\_

Normal Business Hours \_\_\_\_\_

MAUI

Maui Community Correctional Center (MCCC)

Laboratory Name \_\_\_\_\_

Address \_\_\_\_\_

Point of Contact \_\_\_\_\_

Telephone No. \_\_\_\_\_

Normal Business Hours \_\_\_\_\_

KAUAI

Kauai Community Correctional Center (KCCC)

Laboratory Name \_\_\_\_\_

Address \_\_\_\_\_

Point of Contact \_\_\_\_\_

Telephone No. \_\_\_\_\_

Normal Business Hours \_\_\_\_\_

OFFEROR: \_\_\_\_\_

COMPANY NAME