



Department of Management & Budget

PRINTING SERVICES

BID REQUEST

Contact: Kim Sperry

Today's Date: 10/28/09

Phone #: 517-322-1971

Fax #: 517-322-5968

Job Description

Title: CHJ-549 Health Care Request

Quantity: 500,000 sets

COMMENTS

Finish Size: 8 1/2" X 11"

Copy: Electronic File Provided

Sample:

Proof: Required

Pages 1 & 2 print the same

Page 3 contains security/block (see attachment)

Page 2 only, perfed 5/8" from the top

Sides: 1

Stock: 3 part NCR

Bleeds? No

Ink: Black

Total Price: \$ _____

Price per M: \$ _____

Bindery:

Signature: _____

Packing: Shrink wrap 100 sets/pkg., with 1 sheet of chipboard

Company: _____

BIDS MUST BE RECEIVED BY: 10/30/09 @ 4:00PM

The Department of Management and Budget awards bids on best price and value to the state. In some situations, the lowest bidder may not receive an award because the bid does not provide best value. Examples include past quality concerns or inability to meet requirements. Only prequalified vendors will be considered.

– **EFFECTIVE 10/1/05, You MUST be registered to receive payment via Electronic Funds Transfer (EFT). If you are NOT registered for EFT, payment for this purchase order may be delayed. –**

Delivered F.O.B. Lansing, MI 48909

No Overs / No Unders

All printing must be done within the State of Michigan as per Public Act 153 of 1937, as amended.

HEALTH CARE REQUEST

PRISONER: COMPLETE SECTIONS A THROUGH D

A NAME: _____ FACILITY: _____

NUMBER: _____ LOCK: _____ DATE: _____

B. This Health Care Request is for the following (check one or more):
 Health Record Copies Non-urgent
 Dental Medication Refill Medical Optometry Mental Health Urgent

C. I have the following problems/symptoms: _____

D NOTICE TO PRISONER

You will not be denied health care services for lack of personal funds. However, if your account does not have adequate funds, the copayment will be considered an institutional debt and shall be collected as set forth in PD 04.02.105, "Prisoner Funds".

Signing this document formally requests treatment. In addition, it authorizes the DOC to treat or arrange treatment for you and to release any necessary medical information to facilitate that treatment, to review treatment, to respond to a related grievance, or to review any appeal you may make regarding the Department's decision to charge for the care.

I have read Section D above, or it has been read to me and I understand that I will be charged \$5.00 for my health care visit unless it is for one of the reasons listed below in Section F. If I am charged for this visit, I agree that the \$5.00 may be taken from my account.

Prisoner Signature: _____ Date: _____

PRISONER: DO NOT WRITE BELOW THIS LINE

E INSTRUCTIONS TO PRISONER

An appointment has been scheduled for you on: _____ Date: _____

Signature: _____ Title: _____ Provider #: _____ Date: _____

F COPAYMENT (to be filled out by health care):

Note: If none of the exceptions listed below apply, check the box below and a copay will be charged.

- Care that is:
- ◆ requested by a QHP (includes transfer assessments, chronic care clinics, intake and annual screening, and required follow-up care)
 - ◆ for injuries that are work-related as documented by the prisoner's work supervisor
 - ◆ requested for testing for HIV, STD's, infestations, or reportable communicable diseases
 - ◆ requested for evaluation, consultation, or treatment of a mental health need
 - ◆ prompted by a medical emergency (see Section I of the policy, if self-inflicted)

I have reviewed the visit of _____ and certify none of these exceptions apply.

 Date

Signature: _____ Title: _____ Provider #: _____ Date: _____

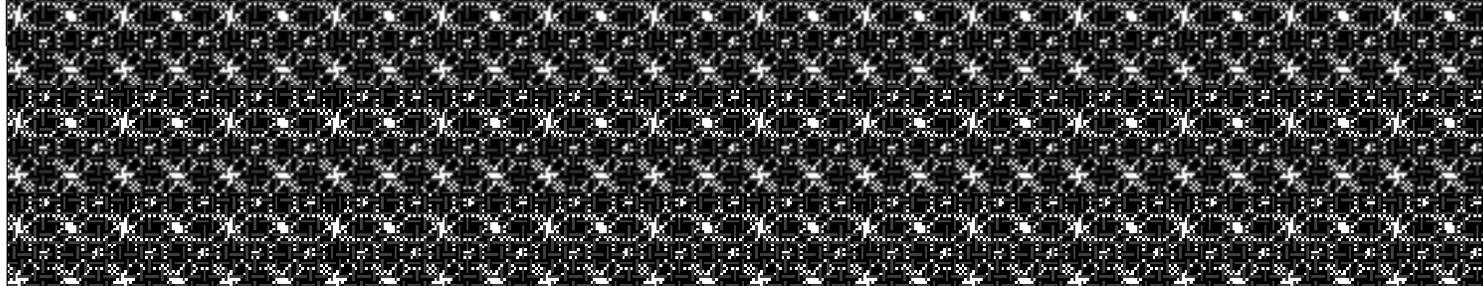
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