



The following documentation is an electronically-submitted vendor response to an advertised solicitation from the *West Virginia Purchasing Bulletin* within the Vendor Self-Service portal at [wvOASIS.gov](http://wvOASIS.gov). As part of the State of West Virginia's procurement process, and to maintain the transparency of the bid-opening process, this documentation submitted online is publicly posted by the West Virginia Purchasing Division at [WVPurchasing.gov](http://WVPurchasing.gov) with any other vendor responses to this solicitation submitted to the Purchasing Division in hard copy format.

Header @ 4

List View

General Information | Contact | Default Values | Discount | Document Information | Clarification Request

Procurement Folder: 1453834

SO Doc Code: CRFQ

Procurement Type: Central Master Agreement

SO Dept: 0613

Vendor ID: VS0000041736

SO Doc ID: VNF2400000015

Legal Name: INFICARE HEALTH INC

Published Date: 7/2/24

Alias/DBA:

Close Date: 7/16/24

Total Bid: \$85.00

Close Time: 13:30

Response Date: 07/16/2024

Status: Closed

Response Time: 9:16

Solicitation Description: Nurse Practioner

Responded By User ID: Inficare

Total of Header Attachments: 4

First Name: Sumer

Total of All Attachments: 4

Last Name: Mathur

Email: govt@inficare.com

Phone: 7039451800



Department of Administration  
 Purchasing Division  
 2019 Washington Street East  
 Post Office Box 50130  
 Charleston, WV 25305-0130

**State of West Virginia  
 Solicitation Response**

**Proc Folder:** 1453834  
**Solicitation Description:** Nurse Practioner  
**Proc Type:** Central Master Agreement

Solicitation Closes	Solicitation Response	Version
2024-07-16 13:30	SR 0613 ESR07162400000000391	1

**VENDOR**  
 VS0000041736  
 INFICARE HEALTH INC

**Solicitation Number:** CRFQ 0613 VNF2400000015  
**Total Bid:** 85  
**Response Date:** 2024-07-16  
**Response Time:** 09:16:12

**Comments:** InfiCare (www.infiCareHealth.com), incorporated in 2001, is a National Minority Supplier certified by the National Minority Supplier Development Council (NMSDC), a Minority Business Enterprise (MBE), and a Joint Commission Certified with a Gold Seal of Approval. We are an ISO 9001-certified Healthcare Staff Augmentation Services provider headquartered in the Washington, DC, metro region. We have extensive experience providing temporary healthcare staffing services to various Government agencies, Niche Companies, and Fortune 500 Commercial clients across the United States (US).  
 InfiCare has expanded rapidly in terms of temporary healthcare staffing services, and now we support many healthcare clients including various Veterans Home across the US. Our staffing processes are built to be a one-stop shop for our clients. We currently service several clients coast to coast that require a wide range of talent in the healthcare domain. We continue to successfully cater to their per diem healthcare staffing requirements by providing them with skilled personnel on their various assignments on short notice, making them suitable for conditions with fluctuating staffing needs.  
 InfiCare clients include small healthcare facilities, Veterans' Homes and Hospitals, Nursing Homes, Long-Term Care Facilities, global conglomerates, major retailers, insurance firms, hospitals, and health systems. In the last year, we have closed over several hundred positions in the Healthcare domain.

**FOR INFORMATION CONTACT THE BUYER**  
 David H Pauline

304-558-0067  
david.h.pauline@wv.gov

**Vendor**  
**Signature X** **FEIN#** **DATE**

All offers subject to all terms and conditions contained in this solicitation

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Ln Total Or Contract Amount
1	Nursing services				85.00

Comm Code	Manufacturer	Specification	Model #
85101601			

**Commodity Line Comments:** InfiCare has uploaded the duly filled Exhibit A-Pricing on the portal.

**Extended Description:**

Nurse Practioner for the WVVNF

**DESIGNATED CONTACT:** Vendor appoints the individual identified in this Section as the Contract Administrator and the initial point of contact for matters relating to this Contract.

(Printed Name and Title) \_\_\_\_\_

(Address) \_\_\_\_\_

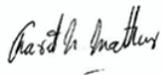
(Phone Number) / (Fax Number) \_\_\_\_\_

(email address) \_\_\_\_\_

**CERTIFICATION AND SIGNATURE:** By signing below, or submitting documentation through wvOASIS, I certify that: I have reviewed this Solicitation/Contract in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation/Contract for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that this bid or offer was made without prior understanding, agreement, or connection with any entity submitting a bid or offer for the same material, supplies, equipment or services; that this bid or offer is in all respects fair and without collusion or fraud; that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; that I am authorized by the Vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on Vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

By signing below, I further certify that I understand this Contract is subject to the provisions of West Virginia Code § 5A-3-62, which automatically voids certain contract clauses that violate State law; and that pursuant to W. Va. Code 5A-3-63, the entity entering into this contract is prohibited from engaging in a boycott against Israel.

(Company) \_\_\_\_\_



(Signature of Authorized Representative) \_\_\_\_\_

(Printed Name and Title of Authorized Representative) (Date) \_\_\_\_\_

(Phone Number) (Fax Number) \_\_\_\_\_

(Email Address) \_\_\_\_\_

**SOLICITATION NUMBER: CRFQ VNF2400000015**  
**Addendum Number: 1**

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The purpose of this addendum is to modify the solicitation identified as CRFQ VNF2400000015 to reflect the change(s) identified and described below.

**Applicable Addendum Category:**

- Modify bid opening date and time
- Modify specifications of product or service being sought.
- To respond to technical questions
- Attachment of pre-bid sign-in sheet
- Correction of error
- Other

**Additional Documentation:**

- 1. To respond to vendor technical questions, see attached.**
- 2. Bid opening date and time remains July 16, 2024, at 1:30 pm., est.**
- 3. No other changes.**

**Terms and Conditions:**

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.
2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

**ADDENDUM ACKNOWLEDGEMENT FORM**  
**SOLICITATION NO.: CRFQ VNF240000015**

**Instructions:** Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

**Acknowledgment:** I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

**Addendum Numbers Received:**

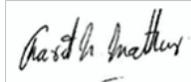
(Check the box next to each addendum received)

- |                                     |                |                          |                 |
|-------------------------------------|----------------|--------------------------|-----------------|
| <input checked="" type="checkbox"/> | Addendum No. 1 | <input type="checkbox"/> | Addendum No. 6  |
| <input type="checkbox"/>            | Addendum No. 2 | <input type="checkbox"/> | Addendum No. 7  |
| <input type="checkbox"/>            | Addendum No. 3 | <input type="checkbox"/> | Addendum No. 8  |
| <input type="checkbox"/>            | Addendum No. 4 | <input type="checkbox"/> | Addendum No. 9  |
| <input type="checkbox"/>            | Addendum No. 5 | <input type="checkbox"/> | Addendum No. 10 |

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

InfiCare Health Inc.

\_\_\_\_\_  
Company



\_\_\_\_\_  
Authorized Signature

July 16, 2024

\_\_\_\_\_  
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

2/15/2024

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 have **ADDITIONAL INSURED** provisions or 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> Marsh & McLennan Agency LLC 20 North Martingale Road Schaumburg IL 60173	<b>CONTACT NAME:</b> Joe Flaherty <b>PHONE (A/C, No, Ext):</b> (847) 908-8719 <b>FAX (A/C, No):</b> (847) 440-9126 <b>E-MAIL ADDRESS:</b> Joe.Flaherty@MarshMMA.com	
	<b>INSURER(S) AFFORDING COVERAGE</b>	
<b>INSURED</b> Inficare Health, Inc. 22375 Broderick Dr. Sterling VA 20166	<b>INSURER A:</b> Philadelphia Indemnity Insuran	<b>NAIC #</b> 18058
	<b>INSURER B:</b> Carolina Casualty	10510
	<b>INSURER C:</b> Beazley Insurance Company	37540
	<b>INSURER D:</b>	
	<b>INSURER E:</b>	
<b>INSURER F:</b>		

**COVERAGES**

CERTIFICATE NUMBER: 913975602

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 <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input checked="" type="checkbox"/> PRO-JECT <input checked="" type="checkbox"/> LOC OTHER:			PHPK2614630	10/16/2023	10/16/2024	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 3,000,000 \$
A	<b>AUTOMOBILE LIABILITY</b> <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			PHPK2614630	10/16/2023	10/16/2024	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE <input type="checkbox"/> DED <input checked="" type="checkbox"/> RETENTION \$ 10,000			PHUB885864	10/16/2023	10/16/2024	EACH OCCURRENCE \$ 5,000,000 AGGREGATE \$ 5,000,000 \$
B	<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b> ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below		N/A	KEY0162416	1/1/2024	1/1/2025	<input checked="" type="checkbox"/> PER STATUTE <input type="checkbox"/> OTH-ER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000
A A C	Crime (incl. 3rd Party) Professional Liability Cyber Liability			PHPK2614630 PHPK2614630 V36517230101	10/16/2023 10/16/2023 12/15/2023	10/16/2024 10/16/2024 12/15/2024	Limit: \$100,000 Claim: \$2,000,000 Limit: \$5,000,000 Agg: \$4,000,000

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

Proof of Insurance

Healthcare Liability applies per the Allied Healthcare Endorsement on the Professional Liability Policy.

**CERTIFICATE HOLDER****CANCELLATION**

Sample COI

\*  
\*

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

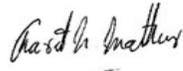
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**Exhibit A - Pricing Page - CRFQ VNF24\*15  
Nurse Practitioner**

Item No.	Description Of Services	Estimated Hours*	Hourly Rate	Total
1	Nurse Practitioner Hourly Rate	1,250	\$85.00	\$ 106,250.00
			<b>Grand Total</b>	<b>\$ 106,250.00</b>

\*Estimated number of hours is not guaranteed.

\*Time for calls during non-working hours must be allocated for in the vendors total bid. Specifications 4.28

<b>Vendor Information</b>	
Vendor: InfiCare Health Inc.	Printed Name: Charit Mathur
Address: 22375 Broderick Drive, #225, Dulles, VA 20166 - 9347	Title: Vice President
Office Phone: (703) 945-1800	*Signature 
Cell Phone: (571) 246-3799	*I hereby certify I am authorized by the Vendor to sign this document.
Fax: (703) 260-6465	Email: <a href="mailto:charit@inficare.com">charit@inficare.com</a>