MUNICIPALITY OF ANCHORAGE
PURCHASING DEPARTMENT
PHONE (907) 343-4590 - FAX (907) 343-4595

Mailing Address
P.O. Box 196650
Anchorage, AK 99519-6650

Physical Address
632 W. 6th Avenue, Suite 520
Anchorage, AK 99501

REQUEST FOR QUOTATION NO. 2022Q029

RFQ No. **2022Q029 – Provide Upgrades to the WIC Online Application/Enrollment Process** to the Municipality of Anchorage, Anchorage Health Department.

Date of Request	Reply Must Be Received Prior To	Buyer	Buyer Phone Number
08/11/2022	**12:00 P.M. Local Time, August 25, 2022**	**Jared Brunelle**	**907-343-6498**
THIS IS NOT AN ORDER PLEASE QUOTE AT ONCE ON THE FOLLOWING AND SPECIFY YOUR DELIVERY DATE			

Quote must be submitted on Quote Proposal Page 2 along with all required information per attached Specifications.

This Request for Quotation is available electronically (.pdf) at the Municipality of Anchorage, Purchasing Office's website; http://www.muni.org/Departments/purchasing/Pages/bidding.aspx. Should you choose to obtain a copy of this from our website; it is your responsibility to periodically check the website for any addenda.

Questions regarding this RFQ **will** be submitted in writing via email to wwpur@muni.org. Written questions **will** be received no later than **12:00 P.M. Alaska Time, August 16, 2022.** Questions will include the Buyer's name, the RFQ number and RFQ Title, on the subject line.

Quotations will be submitted to the Purchasing Department via one of the following methods. Due to COVID-19 the **preferred** method is email.

1. Email: wwpur@muni.org ***("Subject" line must include Buyer name and RFQ number***)
2. Mail: P.O. Box 196650, Anchorage, AK 99519-6650
3. Hand delivery: 632 W. 6th Avenue, Suite 520, Anchorage, AK 99501.

Municipality of Anchorage
Purchasing Department
632 W. 6th Avenue, Suite 520
Anchorage, AK 99501

Municipality of Anchorage
Purchasing Department
P.O. Box 196650
Anchorage, AK 99519-6650

Phone: 907-343-4590

Office Hours: 8:00 - 5:00 M-F Excluding Municipal Holidays

MUNICIPALITY OF ANCHORAGE

Jared Brunelle

Jared Brunelle
Junior Buyer

QUOTE PROPOSAL

Item	Description	Total Price
1	**Analysis** - In accordance with attached Specifications	$ _____
2	**Design** - In accordance with attached Specifications	$ _____
3	**Implementation** - In accordance with attached Specifications	$ _____
4	**Training** - In accordance with attached Specifications	$ _____
5	**Support and Maintenance** - In accordance with attached Specifications	$ _____
	Total (Lines 1-5)	$ _____

*All project phases through implementation and training must be complete by December 31, 2022.

Addendum Acknowledgement	Prompt Payment Discount - Payment Terms Offered
Number(s) _____is/are hereby acknowledged	_____% _____Days OR Net 30 (default) 1% minimum and 15 days are the minimum amounts allowed (As referenced on page 3 under General Provisions)

The bidder will accept CREDIT CARDS for purchases against this RFQ

☐ Yes
☐ No

By submitting a quote, the quoter acknowledges that he/she have received all documents listed on the cover page. Carefully reviewed and possesses knowledge of all documents listed

_____ _____
Authorized Representative Signature Date

_____ _____
Printed Name Title

_____ _____
Printed Vendor Name Phone Number

_____ _____
Mailing Address Fax Number

_____ _____
City, State, Zip Code Company Email Address

_____
Physical Address of Company (if different from above)

_____
City, State, Zip Code

By signing above the bidder certifies they are an equal opportunity employer and will not discriminate against any employee or applicant for employment because of race, color, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, marital status, or physical or mental disability. The contractor will comply with all laws concerning the prohibition of discrimination including, but not limited to Title 5 and Title 7 of the Anchorage Municipal Code.

GENERAL PROVISIONS

REQUIRED DOCUMENTS: Only the following listed items marked with an "☑" are required to be submitted with your Quote."

- ☑ Quote MUST be submitted on the Quote Proposal Page 2 of this RFQ
- ☑ Shipping is FOB destination (include shipping cost in quote)
- ☑ Quoted prices may not be withdrawn or changed for a period of thirty (30) days
- ☑ Payment terms are Net/30

EVALUATION: Award will be made to the lowest responsive and responsible bidder in accordance with Anchorage Municipal Code Sections 7.15.040, 7.20.020, 7.20.030, and 7.20.040, with preference to local bidders applied in accordance with Section 7.20.040. Evaluation for determining the lowest bid will be made in the **aggregate**. **TO BE CONSIDERED FOR AWARD ALL ITEMS MUST BE BID**. All items must be new and come with manufacturer's warranty, if supplied by the manufacturer. The purchasing officer will have the sole discretion to determine whether the bid submitted meets specifications of the Request for Quote, whether a bidder is responsive, and whether a deviation is material.

DELIVER LOCATION:

Deliver to: Municipality of Anchorage,
Anchorage Health Department
825 L Street
Anchorage, AK 99501

Period of Performance

All project phases through implementation and training must be completed by December 31, 2022.

ANTI-DISCRIMINATION CLAUSE: The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, national origin, ancestry, age, sex, sexual orientation, gender identity, marital status or mental or physical handicap. The Contractor will take affirmative action to ensure that applicants are employed and that employees are treated during employment without regard to the characteristics listed above. Such action will include, without limitation, employment, upgrading, demotion or transfer, recruitment or recruiting advertising, lay-off or termination, rates of pay or other forms of compensation and selection for training including apprenticeship. The Contractor will post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this non-discrimination clause. The contractor will comply with all laws concerning the prohibition of discrimination including, but not limited to Title 5 and Title 7 of the Anchorage Municipal Code

INSURANCE

By submitting a bid, the bidder agrees, if they are the successful bidder, to obtain and maintain the insurance required by this section. The bidder also agrees to provide the Municipality a copy of their Certificate of Liability Insurance prior to signing the contract and prior to commencement of any work under this contract.

GENERAL: The Contractor will not allow any subcontractor to commence work until the subcontractor has obtained insurance as listed in this section. The contractor and each subcontractor will maintain this insurance throughout the life of this contract, including any maintenance and/or guarantee/warranty period. The contractor will obtain separate insurance certificates for each contract.

ADDITIONAL INSURED: The Municipality of Anchorage will be listed as an additional insured on all General and Auto Liability policies required by this contract. All policies will contain a waiver of subrogation against the Municipality, except Professional Liability. All policies will remain in effect during the life of the contract. The Contractors insurance certificate will also indicate the Municipality of Anchorage as a certificate holder of the policy.

WORKERS COMPENSATION: The Contractor will purchase and maintain during the life of this contract, workers compensation insurance for all employees who will work on this project and, if any work is sublet, the Contractor will require the subcontractor similarly to provide such insurance. Employers' Liability with a minimum limit of $500,000 will be maintained and Workers Compensation with minimum limits as required by Alaska State Workers Compensation Statutes. The policy will contain a waiver of subrogation against the Municipality.

NOTICE TO "OUT-OF-STATE" CONTRACTORS WORKING IN ALASKA: The Contractor will provide evidence of Workers Compensation insurance, either State of Alaska Workers Compensation coverage or an endorsement to the Contractor's home state Workers Compensation policy, evidencing coverage for "other states" including Alaska, prior to execution of a contract or, if approved, before commencement of contract performance in Alaska.

GENERAL LIABILITY: The Contractor will purchase and maintain, in force, during the life of this contract such general liability insurance as will protect the Owner and the Contractor against losses which may result from claims for damages for bodily injury, including accidental death, as well as from claims for property damages which may arise from any operations under this contract whether such operations be those of the Contractor, a subcontractor or anyone directly or indirectly employed by either of them.

Commercial General Liability	**Minimum Limits**
Products/Completed Operations	$2,000,000
Personal & Advertising Injury	$1,000,000
Each Occurrence	$1,000,000
General Aggregate	$2,000,000
Medical Payments	$5,000
Commercial Auto Liability	**Minimum Limits**
Combined single limit (Bodily Injury and Property Damage)	$500,000
Including all owned, hired, and non-owned	
Workers Compensation and Employers Liability	**Minimum Limits**
Per Alaska statute	$500,000
Errors and Omissions	**Minimum Limits**
Professional Liability (Not required unless limits appear in space provided)	
Umbrella Liability	**Minimum Limits**
(Not required unless limits appear in space provided)	
$ _____ S.I.R.	

Each insurance policy required by this section will require the insurer to give advance notice to the MOA/Contract Administrator prior to the cancellation of the policy. IF the insurer does not notify the MOA upon policy cancellation, it will be the Contractor's responsibility to notify the MOA of such cancellation.

COMPLIANCE WITH LAWS

The Contractor will observe and abide by all applicable laws, regulations, ordinances and other rules of the State of Alaska and/or any political subdivisions thereof, or any other duly constituted public authority wherein work is done or services performed, and further agrees to indemnify and save the Municipality of Anchorage harmless from any and all liability or penalty which may be imposed or asserted by reason of the Contractor's failure or alleged failure to observe and abide thereby.

(Remainder of Page Initially left Blank)

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

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) will 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	CONTACT NAME:
	PHONE (A/C, No, Ext): / FAX (A/C,
	E-MAIL ADDRESS:

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A :	
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

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 - ☐ LOC							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ☐ NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident)	$
								$
	☐ **UMBRELLA LIAB** ☐ OCCUR						EACH OCCURRENCE	$
	☐ **EXCESS LIAB** ☐ CLAIMS-						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ WC STATU-TORY LIMITS ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE ☐ N / A						E.L. EACH ACCIDENT	$
	OFFICER/MEMBER EXCLUDED? **(Mandatory in NH)** If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA	$
							E.L. DISEASE - POLICY LIMIT	$

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

1. The Municipality of Anchorage is an additional insured on Auto and General Liability policies. All policies, including workers compensation, contain a WAIVER OF SUBROGATION against the Municipality, except Professional Liability, .
2. 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."

CERTIFICATE HOLDER	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

Attachment A: Municipality of Anchorage IT Policy and Procedure 28-9
Business Use and Access Control

MUNICIPALITY OF ANCHORAGE O P E R A T I N G POLICY / PROCEDURE	P&P No. 28-9	Page 1 of 10
	Effective Date: August 27, 2019	
Subject: **Business Use and Access Control**	Supercedes No. 16-3	Dated:
	Approved by:	

1. PURPOSE

To define the appropriate use of MOA information systems, assets, and resources for authorized users. This policy defines the business use and acceptable personal use of MOA devices with the MOA's networks (Wide-area-networks (WAN) or local-area networks (LAN) for employees and contractors.

The objectives of this policy are to:

a. Reduce security risks
b. Protect the integrity of MOA systems and data
c. Comply with regulatory requirements

2. POLICY

It is the policy of the Municipality to establish and maintain Municipal-wide Business Use and Access Control of all MOA owned computer systems and/or networked devices.

3. ORGANIZATIONS AFFECTED

All Municipal agencies.

4. REFERENCES

NIST SP 800-14 Generally Accepted Principles and Practices for Securing Information Technology Systems, NIST SP 800-53 Access Control, MOA Policy 40-16 against harassment, PP 28-7 Password Management, 17 USC 107 Copyrights.

5. DEFINITIONS

(1) **Access Control**
The principle of limiting access to information assets only to appropriate individuals. See also: *Information Assets.*

(2) **Administrative Account**
A specific category of account on an information system characterized by heightened privilege. See also: *Information System.*

(3) **Authentication**
The process of validating a user's claimed identity using one or more authentication factors. See also: *Identity Management, Authentication Factors.*

(4) **Botnet**
A specific category of malware characterized by remote control of numerous information systems for illicit (and often illegal) purposes. See also: *Malware.*

(5) **Denial of Service**
A cyber-attack in which the perpetrator seeks to make a machine or network resources unavailable to its intended users by disrupting services.

(6) **Encryption**
A technical security control used to protect the confidentiality of an information asset. See also: *Information Asset, Confidentiality, Technical Security Control.*

(7) **Executive Management**
Senior or top-level management, with statutory authority to make business, financial, and operational decisions and changes within an MOA department, corporation or commission. These are generally exempt positions that hold the liability for department functions, service programs or other activity of department staff.

(8) **File Transfer Protocol (FTP) Site**
A site used to transfer files between a client and a server or a computer network.

(9) **Information Asset**
Information owned, held in trust, stewarded or otherwise maintained by the MOA for any purpose. See also: *Information System, Information Owner.*

(10) **Information System**
A discrete set of information resources organized for the collection processing, maintenance, use, sharing, dissemination, or disposition of information.

(11) **Local Area Network (LAN)**
A communications network connecting various hardware devices together within a building by means of a continuous cable or an in-house voice-data telephone system.

(12) **Malicious Software**
Software designed to circumvent one or more security controls and/or create damage that would compromise security

(13) **Malware**
Software designed to interfere with a computer's normal function. See also: *Malicious Software.*

(14) **Network Sniffer**
A software utility or a device used to passively eavesdrop, collect or analyze information packets on a network.

(15) **Password Cracker**
A software utility or a device used for the purpose of obtaining passwords – usually via brute force. See also: *Authentication.*

(16) **Peer-to-Peer Network**
A distributed data sharing network often times used to share copyrighted music, software, and movies.

(17) **Ping Flood**
A simple denial-of-service attack where the attacker overwhelms the victim with ICMP "echo requests" packets.

(18) **Prohibited**
To forbid, by authority, access to any established list, objective or action; such as in reference to forbidden sites – e.g. pornographic, gambling, etc.

(19) **Proxy Server**
A computer within the networks system that acts as an intermediary for requests from users seeking resources from other servers. A user connects to the proxy server, requesting some service, such as a file, connection, web page, or other resource, available from a different server. The proxy server evaluates the request according to its filtering rules. If the request is validated by the filter, the proxy server provides the resource by connecting to the relevant server and requesting the service on behalf of the user.

(20) **Remote Access**
The ability to get access to a computer or a network from a remote distance.

(21) **Trojan Horse**
A specific category of malware disguised as a useful computer program that contains concealed instructions which, when activated, performs an illicit or malicious action (e.g. as destroying data files). See also: *Malware.*

(22) **Usenet**
A worldwide distributed discussion or communication system available on computers.

(23) **Virtual Private Network (VPN)**
A technical security control designed to ensure confidentiality, integrity, and availability of information transmitted between two points across a public network. See also: *Confidentiality, Integrity, and Availability.*

(24) **Virus**
A specific malware category of a computer program that is usually hidden within another seemingly innocuous program which produces copies of itself and inserts them into other programs and usually performs a malicious action such as destroying data. See also: *Malware.*

(25) **Vulnerability Scanner**
A software package or device used for the purpose of enumerating software vulnerabilities on a given host. See also: *Software Vulnerability.*

(26) **WAN**
Wide Area Network.

6. RESPONSIBILITIES

a. The Chief Information Security Officer (CISO) shall be responsible for oversight of all MOA Information security.

b. Records owned by the Departments are subject to oversight as designated by Executive Management under AMC 3.95.

7. PROCEDURE

a. Access for Authorized Purposes

(1) Personnel must use MOA networks and associated systems for authorized purposes only, related to MOA business and their job duties except as authorized in subsection 7.j., "Personal use of MOA equipment".

(2) Personnel must not access MOA information, programs, or systems when such access is not required for an authorized business purpose. This includes system administrators who must have system access right due to their job responsibilities.

(3) No Administrator may view or otherwise access a MOA user's information without the express consent of the user, Executive Management or the Department of Employee Relations.

b. Personal Computing Equipment Prohibited Use

(1) Employees must not connect personal computing equipment (laptops, PC, workstations, servers, cellular devices or other networking equipment) within the internal MOA WAN or LAN other than the exceptions set forth in b.(2)

(2) Cellular or computing equipment approved for stipends are allowed to access MOA associated systems for business use within the guidelines of MOA Policies.

c. Contractors Computing Equipment Authorization

(1) Contractors may use their personal or company owned devices within the MOA WAN or LAN for authorized purposes only, related to MOA business and their job duties.

These devices are subject to all Municipal policies when connecting to the MOA networks and will be monitored, reported and audited for security purposes.

d. Application of Passwords

(1) Authorized users to manage passwords in accordance with P&P 28-7.

e. Use of Issued Credentials

(1) Personnel must use only the user IDs, network addresses, and network connections authorized by the MOA or Office of Information Technology staff to access MOA networks and associated systems.

f. Unauthorized Security Credentials

(1) Personnel must not download, install, or execute any security program or utility (e.g. password cracker, network sniffer, vulnerability scanner) designed to reveal weaknesses in the security of a system without explicit authorization from the CISO. The MOA system is regularly scanned and violation of policy will be immediately acted on.

g. Execution of Electronic Information

(1) Employees must not open files from unrecognized sources without confirming authenticity of message and sender.

(2) When in doubt contact sender through alternate communication method (phone call) to verify message and attachment or call MOA IT helpdesk for additional guidance when opening files that have been sent to, or received by, them either electronically or on removable media, i.e. CD/DVD, USB Flash drive.

a. Examples of such files are email attachments received from unknown senders, files downloaded from the Internet or non-MOA FTP sites.

b. Any and all of these items can contain viruses, e-mail bombs, Trojan-horse code, spyware/ad-ware, BOT net, other malware, or inappropriate material and should be suspected.

c. If contractors with MOA business suspect any of the above listed items they should notify their client supervisor immediately for remediation in all efforts to protect the MOA.

h. Unacceptable Use

(1) Under no circumstances are personnel of the MOA authorized to engage in any activity using MOA technology or devices that is illegal under municipal, state, or federal law.

(2) Prohibited email and communication activities and prohibited system and network activities are listed below and will be strictly enforced.

a. Personnel may be exempted from some of these restrictions during the course of their valid job responsibilities (e.g. systems administration staff may have a need to disable the network access of a host if that host is disrupting production services or the requirement of a law enforcement investigation); however, cautious and meticulous adherence must be followed by all users.

b. Sending unsolicited e-mail messages, including the sending of "junk mail" or other advertising material to individuals who did not specifically request such material.

c. Any form of harassment via email, instant messaging, telephone, paging, or other electronic means, whether through language, frequency, or size of messages.

d. Unauthorized use or forging of email header information.

e. Solicitation of email for any other email address, other than that of the poster's account, with the intent of harass or to collect replies.

f. Creating or forwarding "chain letters", "Ponzi" or other "pyramid" schemes of any type.

g. Use of unsolicited email originating from within MOA networks or other Internet/Intranet/Extranet service providers on behalf of, or to advertise, any service hosted by MOA or connected via the MOA's network.

h. Posting the same or similar non-business-related messages to large numbers of Usenet news groups or web forums.

i. Use for access to or distribution of indecent or obscene material, or child pornography.

j. Use for commercial activities, including advertising, unless specific to charter, mission, or duties of the government agency.

k. Use for political activities, partisan activities, lobbying or outside business.

l. Use of MOA Information technology resources for personal gain.

i. System and Network Prohibited Activities

(1) Violations of the rights of any person or company protected by copyright, trade secret, patent or other intellectual property, or similar laws or regulations, including, but not limited to, the installation or distribution of "pirated" or other software products that are not appropriately licensed for use by the MOA.

(2) Unauthorized copying of Copyright Material including, but not limited to, digitization and distribution of photographs from magazines, books or other copyrighted sources, copyrighted music, and the installation of any copyrighted software for which the MOA or the end user does not have an active license unless such copying constitutes fair use of a copyrighted work pursuant to 17 USC 107.

(3) Exporting software, technical information, encryption software or technology, in violation of federal export control laws. The appropriate management should be consulted prior to export of any material that is in question.

(4) Introduction of malicious programs into MOA information technology resources (e.g., introducing viruses, worms, Trojan horses, e-mail bombs, etc. into the MOA network or individual MOA computing devices).

(5) Revealing account information to others or allowing use of your account by others. This includes family and other household members when work is being done at home.

(6) Using MOA computing assets to actively engage in procuring or transmitting material that is in violation of sexual harassment or hostile workplace laws including MOA Policy 40-16 against harassment.

(7) Making unauthorized offers of products, items, or services originating from any MOA account.

(8) Causing security breaches or disruptions of network communication. Security breaches include, but are not limited to, accessing data of which the employee is not an intended recipient or logging into a server or account that the employee is not expressly authorized to access. For purposes of this section, "disruption" includes, but is not limited to, network sniffing, ping floods, packet spoofing, denial of service, and forging route information for malicious purposes.

(9) Network vulnerability testing, security scanning, virus or trojan horse testing or executing any form of network monitoring, which will intercept data not intended for the employee's host.

(10) Any activity, application or service that circumvents security solutions, services, controls, user authentication, security of any host, network or account, or interfering with or denying service to any authorized user or service is prohibited and strictly enforced. (e.g., URL filtering, network monitoring, remote access requirements through MOA virtual private network, MOA ingress/egress access control requirements, McAfee, and other security solution, service, or control, intentionally creating a denial of service to a user, applications, host, network, or other MOA process.)

(11) Using any program/script/command, or sending messages of any kind, with the intent to interfere with, or disable, another user's terminal session, via any means, locally or via the Internet/intranet/extranet.

(12) Providing information about, or lists of, MOA employees to any outside parties, except as authorized.

(13) Any personal use of private or confidential information of any individual obtained by an employee as a result of performance of job duties or as a result of their employment with the Municipality of Anchorage.

(14) Use of encryption (at rest or in transit) without an approved business case justification and written approval from the Incident Response Team (IRT) and the CISO.

(15) Uses of peer-to-peer (P2P) file transfer solutions without an approved business case justification and written approval from the IRT and the CISO.

(16) Use of unauthorized remote-control technologies.

(17) Use of non-operating system standard screen saver or other similar technologies.

(18) Use of any external proxy systems or other similar technologies.

(19)Turning off or tampering with security solutions.

j. Personal Use of MOA Issued Equipment

(1) Under the Municipal Ethics Code, Municipal employees may not divert or permit the diversion of Municipal issued equipment for a purpose unrelated to municipal business. This policy establishes that for, MOA owned computing equipment and systems (cellular devices), in the course of normal business, incidental personal use is acceptable only under the following guidelines:

a. Cell phones, Smartphones, Laptop computers and Tablets when used for voice calls or data – Personal use that does not exceed the greater of 30 minutes or 5% of the minutes allowance under the applicable services plan is presumed insignificant, but any personal use that results in increased cost must be reimbursed to the Municipality in full. (In the case of unlimited use plans, personal use may not exceed the greater of 30 minutes or 5% of total use.)
b. Desktop computers, Laptop computers, Smartphones, and Tablets when used on non-cellular land or wireless based networks that do not require pay by use plans – Personal use is presumed insignificant so long as it does not occur during scheduled work hours and there are no additional costs attributable to personal use.

(2) The employee is required to reimburse the Municipality for all overages that are incurred outside of the approved data plan.

(3) If improper personal use of Municipal equipment is identified, the supervisor may conduct an investigation with guidance from Employee Relations and the employee may be subject to discipline. Serious violations include recurring misuse after direction to stop or misuse resulting in substantial personal benefit may warrant serious discipline up to and including termination.

k. Least Privilege

(1) Personnel tasked with a network administrative account must ensure that network and system access controls are configured to limit the privileges extended to users to the least necessary to accomplish authorized business purposes.

8. ANNUAL REVIEW DATE/LEAD REVIEW AGENCY

The Office of Information Technology will review this document in October of each year for any needed revisions.

Attachment B: Municipality of Anchorage Cloud and/or Offsite Hosting Terms and Conditions

NON-PUBLIC DATA OWNED BY THE MUNICIPALITY OF ANCHORAGE

Municipality of Anchorage Cloud and/or Offsite Hosting Specific Terms and Conditions

Contract # _____, Appendix ____

between Municipality of Anchorage and _____dated _____

This document shall become part of the final contract.

	Terms and Conditions Clauses 1-13 are mandatory for every engagement. Exceptions will be considered non-compliant and non-responsive.
1	**Data Ownership:** The Municipality of Anchorage (MOA) shall own all right, title and interest in its data that is related to the services provided by this contract. The Service Provider shall not access MOA User accounts, or MOA Data, except (i) in the course of data center operations, (ii) response to service or technical issues, (iii) as required by the express terms of this contract, or (iv) at MOA's written request.
2	**Data Protection:** Protection of personal privacy and sensitive data shall be an integral part of the business activities of the Service Provider to ensure that there is no inappropriate or unauthorized use of MOA information at any time. To this end, the Service Provider shall safeguard the confidentiality, integrity, and availability of MOA information and comply with the following conditions: a) All information obtained by the Service Provider under this contract shall become and remain property of the MOA. b) At no time shall any data or processes which either belongs to or are intended for the use of MOA or its officers, agents, or employees, be copied, disclosed, or retained by the Service Provider or any party related to the Service Provider for subsequent use in any transaction that does not include the MOA.
3	**Data Location**: The Service Provider shall not store or transfer non-public MOA data outside of the United States. This includes backup data and Disaster Recovery locations. The Service Provider will permit its personnel and contractors to access MOA data remotely only as required to provide technical support and must notify the MOA about this requirement.
4	**Encryption:** a) The Service Provider shall encrypt all non-public **data in transit** regardless of the transit mechanism. b) For engagements where the Service Provider stores sensitive personally identifiable or otherwise confidential information, this data shall be **encrypted at rest.** Examples are social security number, date of birth, driver's license number, financial data, federal/state tax information, and hashed passwords. The Service Provider's encryption shall be consistent with validated cryptography standards as specified in National Institute of Standards and Technology FIPS140-2, Security Requirements. The key location and other key management details will be discussed and negotiated by both parties. When the Service Provider cannot offer encryption at rest, they must maintain, for the duration of the contract, cyber security liability insurance coverage for any loss resulting from a data breach in accordance with the MOA Cloud and Offsite Hosting Policy. Additionally, where encryption of data at rest is not possible, vendor must describe existing security measures that provide a similar level of protection.

NON-PUBLIC DATA OWNED BY THE MUNICIPALITY OF ANCHORAGE

Municipality of Anchorage Cloud and/or Offsite Hosting Specific Terms and Conditions

Contract # _____, Appendix ____

between Municipality of Anchorage and _____dated _____

This document shall become part of the final contract.

	Terms and Conditions Clauses 1-13 are mandatory for every engagement. Exceptions will be considered non-compliant and non-responsive.
5	**Breach Notification and Recovery**: Alaska law (Chapter 45.48 Personal Information Protection Act) requires that an agency who owns or licenses personal information in any form that included personal information on a state resident, and a breach of the security of the information system that contains personal information occurs then that agency shall, after discovering or being notified of the breach, disclose the breach to each state resident whose personal information was subject to the breach and do so in the most expeditious time possible and without unreasonable delay, except as provided in Section 45.48.020 of the same chapter. Additionally, unauthorized access or disclosure of non-public data is considered to be a breach. The Service Provider will provide notification without unreasonable delay and all communication shall be coordinated with the MOA. When the Service Provider or their sub-contractors are liable for the loss, the Service Provider shall assume all costs associated with the investigation, response and recovery from the breach, for example: 3-year credit monitoring services, mailing costs, website, and toll free telephone call center services. The MOA shall not agree to any limitation on liability that relieves a Contractor from its own negligence or to the extent that it creates an obligation on the part of the MOA to hold a Contractor harmless.
6	**Notification of Legal Requests**: The Service Provider shall contact the MOA upon receipt of any electronic discovery, litigation holds, discovery searches, and expert testimonies related to, or which in any way might reasonably require access to the data of the MOA. The Service Provider shall not respond to subpoenas, service of process, and other legal requests related to the MOA without first notifying the MOA unless prohibited by law from providing such notice.
7	**Termination and Suspension of Service:** In the event of termination of the contract, the Service Provider shall implement an orderly return of MOA data in mutually agreeable format. The Service Provider shall guarantee the subsequent secure disposal of MOA data. a) Suspension of services: During any period of suspension or contract negotiation or disputes, the Service Provider shall not take any action to intentionally erase any MOA data. b) Termination of any services or agreement in entirety: In the event of termination of any services or agreement in entirety, the Service Provider shall not take any action to intentionally erase any MOA data for a period of 90 days after the effective date of the termination. After such 90 day period, the Service Provider shall have no obligation to maintain or provide any MOA data and shall thereafter, unless legally prohibited, dispose of all MOA data in its systems or otherwise in its possession or under its control as specified in section 7d) below. Within this 90 day timeframe, vendor will continue to secure and back up MOA data covered under the contract. c) Post-Termination Assistance: The MOA shall be entitled to any post-termination assistance generally made available with respect to the Services unless a unique data retrieval arrangement has been established as part of the Service Level Agreement. d) Secure Data Disposal: When requested by the MOA, the provider shall destroy all requested data in all of its forms, for example: disk, CD/DVD, backup tape, and paper. Data shall be permanently deleted and shall not be recoverable, according to National Institute of Standards and Technology (NIST) approved methods and certificates of destruction shall be provided to the MOA.

NON-PUBLIC DATA OWNED BY THE MUNICIPALITY OF ANCHORAGE

Municipality of Anchorage Cloud and/or Offsite Hosting Specific Terms and Conditions

Contract # _____, Appendix ____

between Municipality of Anchorage and _____dated _____

This document shall become part of the final contract.

	Terms and Conditions Clauses 1-13 are mandatory for every engagement. Exceptions will be considered non-compliant and non-responsive.
8	**Background Checks:** The Service Provider shall conduct criminal background checks and not utilize any staff, including sub-contractors, to fulfill the obligations of the contract who has been convicted of any crime of dishonesty, including but not limited to criminal fraud, or otherwise convicted of any felony or any misdemeanor offense for which incarceration for a minimum of 1 year is an authorized penalty. The Service Provider shall promote and maintain an awareness of the importance of securing the MOA's information among the Service Provider's employees and agents.
9	**Data Dictionary:** Prior to go-live, the Service Provider shall provide a data dictionary in accordance with the MOA's Data Modeling Standard.
10	**Security Logs and Reports:** The Service Provider shall allow the MOA access to system security logs that affect this engagement, its data and or processes. This includes the ability for the MOA to request a report of the records that a specific user accessed over a specified period of time.
11	**Contract Audit:** The Service Provider shall allow the MOA to audit conformance including contract terms, system security and data centers as appropriate. The MOA may perform this audit or contract with a third party at its discretion at the MOA's expense. Such reviews shall be conducted with at least 30 days advance written notice and shall not unreasonably interfere with the Service Provider's business.
12	**Sub-contractor Disclosure:** The Service Provider shall identify all of its strategic business partners related to services provided under this contract, including but not limited to, all subcontractors or other entities or individuals who may be a party to a joint venture or similar agreement with the Service Provider, who will be involved in any application development and/or operations.
13	**Operational Metrics:** The Service Provider and the MOA shall reach agreement on operational metrics and document said metrics in the Service Level Agreement. Examples include but are not limited to: a) Advance notice and change control for major upgrades and system changes b) System availability/uptime guarantee/agreed-upon maintenance downtime c) Recovery Time Objective/Recovery Point Objective d) Security Vulnerability Scanning

By signing this Agreement, the Service Provider agrees to abide by all of the above Terms and Conditions.

Service Provider Name/Address (print): _____

_____

_____

Service Provider Authorizing Official Name (print): _____

Service Provider Authorizing Official Signature: _____

Date: _____

Form Revision Date: 01/13/2016

Attachment C
HIPAA Business Associate Agreement

BUSINESS ASSOCIATE NAME

This Business Associate Agreement ("**BAA**") is entered into and effective on this day of _____20__ ("**Effective Date**") by and between Anchorage Health Department ("**Covered Entity**") and BA NAME (**"Business Associate"**) (each a "**Party"** and collectively, the "**Parties**").

RECITALS

WHEREAS, Covered Entity is a "Covered Entity" as that term is defined under the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-91), as amended, ("HIPAA"), and the regulations promulgated thereunder by the Secretary of the U.S. Department of Health and Human Services ("Secretary"), including, without limitation, the regulations codified at 45 C.F.R. Parts 160 and 164 ("HIPAA Regulations");

WHEREAS, Business Associate seeks to perform Services for or on behalf of Covered Entity, and in performing said Services, Business Associate will create, receive, maintain, or transmit Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI"); and

WHEREAS, the parties intend to protect the privacy and provide for the security of PHI and ePHI disclosed by Covered Entity to Business Associate, or received or created by Business Associate, when providing Services in compliance with the HIPAA Act, the HIPAA regulations, the Health Information Technology for Economic and Clinical Health Act ("the HITECH Act"), and all other applicable state and federal laws, all as amended from time to time.

WHEREAS, Covered Entity is required under HIPAA to enter into a Business Associate Agreement (BAA) with Business Associate that meets certain requirements with respect to the use and disclosure of PHI.

AGREEMENT

In consideration of the above Recitals and for other good and valuable consideration, the receipt and adequacy of which is hereby acknowledged, the Parties agree as follows:

ARTICLE I
DEFINITIONS

The following terms shall have the meanings set forth below. Capitalized terms used in this BAA and not otherwise defined shall have the meanings ascribed to them in HIPAA, the HIPAA Regulations, or the HITECH Act, as applicable.

1.1. "**Breach**" shall have the meaning given under 42 U.S.C. § 17921(1) and 45 C.F.R. § 164.402.

1.2. "**Data Aggregation**" shall have the meaning given under 45 C.F.R. § 164.501.

1.3. "**Designated Record Set**" shall have the meaning given such term under 45 C.F.R. § 164.501.

1.4. "**Disclose**" and "**Disclosure**" mean, with respect to PHI, the release, transfer, provision of access to, or divulging in any other manner of PHI outside of Business Associate or to other than members of its Workforce, as set forth in 45 C.F.R. § 160.103.

1.5. "**Electronic PHI**" or "**ePHI**" means PHI that is transmitted or maintained in electronic media, as set forth in 45 C.F.R. § 160.103.

1.6. "**Protected Health Information**" and "**PHI**" mean any information, whether oral or recorded in any form or medium, that: (a) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that (b) identifies the individual, or for which there is a reasonable basis for believing that the information can be used to identify the individual. "Protected Health Information" shall have the meaning given to such term under 45 C.F.R. § 160.103. Under 45 C.F.R. § 160.103, Protected Health Information includes Electronic Protected Health Information (ePHI).

1.7. "**Security Incident**" shall have the meaning given to such term under 45 C.F.R. § 164.304.

1.8. "**Services**" shall mean the services for or functions performed by Business Associate on behalf of Covered Entity pursuant to any service agreement(s) between Covered Entity and Business Associates which may be in effect now or from time to time ("**Underlying Agreement**"), or, if no such agreement is in effect, the services or functions performed by Business Associate that constitute a Business Associate relationship, as set forth in 45 C.F.R. § 160.103, *Definition of "Business Associate."*

1.9. "**Subcontractor**" A subcontractor means a person or entity to whom a Business Associate delegates a function, activity, or service, other than in the capacity of a member of the Workforce of such Business Associate.

1.10. "**Unsecured PHI**" shall have the meaning given to such term under 42 U.S.C. § 17932(h), 45 C.F.R. § 164.402, and Federal Register documents, including, but not limited to, Federal Register document 74; Federal Register 19006 (April 27, 2009); and 78 Federal Register 5565 (January 25, 2013).

1.11. "**Use**" or "**Uses**" mean, with respect to PHI, the sharing, employment, application, utilization, examination, or analysis of such PHI within Business Associate's internal operations, as set forth in 45 C.F.R. § 160.103.

1.12. "**Workforce**" shall have the meaning given to such term under 45 C.F.R. § 160.103.

ARTICLE II
OBLIGATIONS OF BUSINESS ASSOCIATE

2.1. Permitted Uses and Disclosures of Protected Health Information: Business Associate shall not use or disclose PHI other than for the purposes of performing the Services, as permitted or required by this BAA, or as required by law. Business Associate shall not use or disclose PHI in any manner that would constitute a violation of Subpart E of 45 C.F.R. Part 164 if so used or disclosed by Covered Entity. However, Business Associate may use or disclose PHI (i) for the proper management and administration of Business Associate; (ii) to carry out the legal responsibilities of Business Associate, provided that with respect to any such disclosure either: (a) the disclosure is required by law; or (b) Business Associate obtains a written agreement from the person to whom the PHI is to be disclosed that such person will hold the PHI in confidence and will not use or further disclose such PHI except as required by law and for the purpose(s) for which it was disclosed by Business Associate to such person, and that such person will notify Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached; and (iii) pursuant to 45 C.F.R. § 164.501, for Data Aggregation purposes for the healthcare operations of Covered Entity. To the extent that Business Associate carries out one or more of Covered Entity's obligations under Subpart E of 45 C.F.R. Part 164, Business Associate must comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligations.

2.2. Prohibited Marketing and Sale of PHI: Notwithstanding any other provision in this BAA, Business Associate shall comply with the following requirements: (i) Business Associate shall not use or disclose PHI for fundraising or marketing purposes, except to the extent expressly authorized or permitted by this BAA and consistent with the requirements of 42 U.S.C. § 17936, 45 C.F.R. § 164.514(f), and 45 C.F.R. § 164.508(a)(3)(ii); and (ii) Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of Covered Entity and as permitted by the HITECH Act, 42 U.S.C. § 17935(d)(2), and 45 C.F.R. § 164.502(a)(5)(ii).

2.3. Adequate Safeguards of PHI: Business Associate shall implement and maintain appropriate safeguards to prevent use or disclosure of PHI other than as provided for by this BAA. Business Associate shall reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI that it creates, receives, maintains, or transmits on behalf of Covered Entity in compliance with Subpart C of 45 C.F.R. Part 164 to prevent use or disclosure of PHI other than as provided for by this BAA.

2.4 Mitigation: Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this BAA.

2.5. Reporting Non-Permitted Use or Disclosure:

2.5.1 Reporting Security Incidents and Non-Permitted Use or Disclosure: Business Associate shall report to Covered Entity in writing each security incident or use or disclosure

that is made by Business Associate, members of its workforce, or subcontractors that is not specifically permitted by this BAA, no later than three (3) business days after becoming aware of such security incident or non-permitted use or disclosure, in accordance with the notice provisions set forth herein. Business Associate shall investigate each security incident or non-permitted use or disclosure of Covered Entity's PHI that it discovers, to determine whether such security incident or non-permitted use or disclosure constitutes a reportable breach of unsecured PHI. Business Associate shall document and retain records of its investigation of any breach, including its reports to Covered Entity under this Section 2.5.1. Upon request of Covered Entity, Business Associate shall furnish to Covered Entity the documentation of its investigation and an assessment of whether such security incident or non-permitted use or disclosure constitutes a reportable breach. If such security incident or non-permitted use or disclosure constitutes a reportable breach of unsecured PHI, then Business Associate shall comply with the additional requirements of Section 2.5.2 below.

2.5.2 Breach of Unsecured PHI: If Business Associate determines that a reportable breach of unsecured PHI has occurred, Business Associate shall provide a written report to Covered Entity without unreasonable delay, but no later than thirty (30) calendar days after discovery of the breach. To the extent that information is available to Business Associate, Business Associate's written report to Covered Entity shall be in accordance with 45 C.F.R. §164.410(c). Business Associate shall cooperate with Covered Entity in meeting Covered Entity's obligations under HIPAA and the HITECH Act with respect to such breach. Covered Entity shall have sole control over the timing and method of providing notification of such breach to the affected individual(s), the HHS Secretary and, if applicable, the media, as required by HIPAA and the HITECH Act. Business Associate shall reimburse Covered Entity for its reasonable costs and expenses in providing the notification, including, but not limited to, any administrative costs associated with providing notice, printing and mailing costs, and costs of mitigating the harm (which may include the costs of obtaining credit monitoring services and identity theft insurance) for affected individuals whose PHI has or may have been compromised as a result of the breach.

2.6. Availability of Internal Practices, Books, and Records to Government: Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, created, or received by the Business Associate on behalf of Covered Entity available to the Secretary for purposes of determining Covered Entity's compliance with HIPAA, the HIPAA Regulations, and the HITECH Act. Except to the extent prohibited by law, Business Associate shall notify Covered Entity of all requests served upon Business Associate for information or documentation by or on behalf of the Secretary. Business Associate agrees to provide to Covered Entity proof of its compliance with the HIPAA Security Standards.

2.7. Access to and Amendment of Protected Health Information: To the extent that Business Associate maintains a Designated Record Set on behalf of Covered Entity and within fifteen (15) days of a request by Covered Entity, Business Associate shall (a) make the PHI it maintains (or which is maintained by its Subcontractors) in Designated Record Sets available to

Covered Entity for inspection and copying, or to an individual to enable Covered Entity to fulfill its obligations under 45 C.F.R. § 164.524, or (b) amend the PHI it maintains (or which is maintained by its Subcontractors) in Designated Record Sets to enable the Covered Entity to fulfill its obligations under 45 C.F.R. § 164.526. Business Associate shall not Disclose PHI to a health plan for payment or Health Care Operations purposes if and to the extent that Covered Entity has informed Business Associate that the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates, consistent with 42 U.S.C. § 17935(a) and 42 C.F.R. § 164.522(a)(1)(vi). If Business Associate maintains PHI in a Designated Record Set electronically, Business Associate shall provide such information in the electronic form and format requested by the Covered Entity if it is readily reproducible in such form and format, and, if not, in such other form and format agreed to by Covered Entity to enable Covered Entity to fulfill its obligations under 42 U.S.C. § 17935(e) and 45 C.F.R. § 164.524(c)(2). Business Associate shall notify Covered Entity within fifteen (15) days of receipt of a request for access to PHI.

2.8. **Accounting:** To the extent that Business Associate maintains a Designated Record Set on behalf of Covered Entity, within thirty (30) days of receipt of a request from Covered Entity or an individual for an accounting of disclosures of PHI, Business Associate and its Subcontractors shall make available to Covered Entity the information required to provide an accounting of disclosures to enable Covered Entity to fulfill its obligations under 45 C.F.R. § 164.528 and its obligations under 42 U.S.C. § 17935(c). Business Associate shall notify Covered Entity within fifteen (15) days of receipt of a request by an individual or other requesting party for an accounting of disclosures of PHI.

2.9. **Use of Subcontractors:** Business Associate shall require each of its Subcontractors that creates, maintains, receives, or transmits PHI on behalf of Business Associate, to execute a Business Associate Agreement that imposes on such Subcontractors the same restrictions, conditions, and requirements that apply to Business Associate under this BAA with respect to PHI.

2.10. **Minimum Necessary:** Business Associate (and its Subcontractors) shall, to the extent practicable, limit its request, use, or disclosure of PHI to the minimum amount of PHI necessary to accomplish the purpose of the request, use, or disclosure, in accordance with 42 U.S.C. § 17935(b) and 45 C.F.R. § 164.502(b)(1) or any other guidance issued thereunder.

ARTICLE III
TERM AND TERMINATION

3.1. **Term:** The term of this Agreement shall be effective as of the Effective Date and shall terminate as of the date that all of the PHI provided by Covered Entity to Business Associate, created, or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy the PHI, protections are extended to such information, in accordance with Section 3.3, or on the date that Covered Entity terminates for cause as authorized in Section 3.2, whichever is sooner.

3.2. **Termination for Cause:** Upon Covered Entity's knowledge of a material breach or violation of this BAA by Business Associate, Covered Entity shall either:

1. Notify Business Associate of the breach in writing, and provide an opportunity for Business Associate to cure the breach or end the violation within ten (10) business days of such notification; provided that if Business Associate fails to cure the breach or end the violation within such time period to the satisfaction of Covered Entity, Covered Entity may immediately terminate this BAA upon written notice to Business Associate; or

2. Upon written notice to Business Associate, immediately terminate this BAA if Covered Entity determines that such breach cannot be cured.

3.3. **Disposition of Protected Health Information Upon Termination or Expiration:**

3.3.1. Upon termination or expiration of this BAA, Business Associate shall either return or destroy all PHI received from, created, or received by Business Associate on behalf of Covered Entity, that Business Associate still maintains in any form and retain no copies of such PHI. If Covered Entity requests that Business Associate return PHI, PHI shall be returned in a mutually agreed upon format and timeframe, at no additional charge to Covered Entity.

3.3.2. If return or destruction is not feasible, Business Associate shall (a) retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities; (b) return to Covered Entity the remaining PHI that Business Associate still maintains in any form; (c) continue to extend the protections of this BAA to the PHI for as long as Business Associate retains the PHI; (d) limit further Uses and Disclosures of such PHI to those purposes that make the return or destruction of the PHI infeasible and subject to the same conditions set out in Section 2.1 and 2.2 above, which applied prior to termination; and (e) return to Covered Entity the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

ARTICLE IV
MISCELLANEOUS

4.1. **Amendment to Comply with Law:** This BAA shall be deemed amended to incorporate any mandatory obligations of Covered Entity or Business Associate under the HITECH Act and its implementing HIPAA Regulations. Additionally, the Parties agree to take such action as is necessary to amend this BAA from time to time as necessary for Covered Entity to implement its obligations pursuant to HIPAA, the HIPAA Regulations, or the HITECH Act.

4.2. **Indemnification:** Both companies/organizations (Covered Entity and/or Business Associate(s)) hereby agree to indemnify and hold harmless the other, its affiliates, and their respective officers, directors, managers, members, shareholders, employees, and agents from

and against any and all fines, penalties, damage, claims, or causes of action and expenses (including, without limitation, court costs, and attorney's fees) the companies/organizations incur, arising from violations of the HIPAA Act, the HIPAA Regulations, the HITECH Act, or from any negligence or wrongful acts or omissions, including, but not limited to, failure to perform its obligations that results in a violation of the HIPAA Act , the HIPAA Regulations, or the HITECH Act, by either company/organization or its employees, directors, officers, subcontractors, agents, or members of its Workforce.

4.3. Notices: Any notices required or permitted to be given hereunder by either Party to the other shall be given in writing: (1) by personal delivery; (2) by electronic mail or facsimile with confirmation sent by United States first class registered or certified mail, postage prepaid, return receipt requested; (3) by bonded courier or by a nationally recognized overnight delivery service; or (4) by United States first class registered or certified mail, postage prepaid, return receipt, in each case, addressed to a Party on the signature page(s) to this Agreement or to such other addresses as the Parties may request in writing by notice given pursuant to this Section 4.3. Notices shall be deemed received on the earliest of personal delivery; upon delivery by electronic facsimile with confirmation from the transmitting machine that the transmission was completed; twenty-four (24) hours following deposit with a bonded courier or overnight delivery service; or seventy-two (72) hours following deposit in the U.S. mail as required herein.

4.4. Relationship of Parties: Business Associate is an independent contractor and not an agent of Covered Entity under this BAA. Business Associate has the sole right and obligation to supervise, manage, contract, direct, procure, perform, or cause to be performed, all Business Associate obligations under this BAA.

4.5. Survival: The respective rights and obligations of the Parties under Sections 3.3 and 4.2 of this BAA shall survive the termination of this BAA.

4.6 Applicable Law and Venue: This Agreement shall be governed by and construed in accordance with the laws of the state of Alaska (without regards to conflict of laws principles). The Parties agree that all actions or proceedings arising in connection with this BAA shall be tried and litigated exclusively in the state or federal (if permitted by law and if a Party elects to file an action in federal court) courts located in the county of Anchorage.

The Parties hereto have duly executed this agreement as of the Effective Date.

FOR BUSINESS ASSOCIATE:

Organization Name:

_____

By:

_____

Print Name:

_____

Title:

_____

Dated:

_____

Notice Address:

_____
_____
_____
attn: _____

FOR COVERED ENTITY:

Organization Name:

Anchorage Health Department

By:

_____

Print Name:

TBD

Title:

Director

Dated:

_____

Notice Address:
Municipality of Anchorage
Department of Law
632 W. 6th Avenue, Suite 730
Anchorage, AK 99501

ANCHORAGE (907) 343-4668 muni.org/WIC

Attachment D - Sample of Forms

State of Alaska
Department of Health & Social Services/Public Assistance Please Fax to (907) 249-8080

ANCHORAGE HEALTH DEPARTMENT

Client Name _____ DOB _____ WIC HH#_____
Parent's/Caregivers Name_____ Phone:_____
Address:_____
Medicaid Eligible? ☐ No ☐ Yes Medicaid # _____ End date _____
Current Measurements (if available): Medical date _____ Ht =_____ in/cm Wt= _____lbs/kg

ALASKA WIC STANDARD CONTRACT FORMULAS:

The following contract formulas DO NOT REQUIRE MEDICAL DOCUMENTATION for infants younger than 12 months, except when an increased formula amount is requested for infants 6-11 months:

Similac Advance (milk based) 20 Cal/oz
Similac Soy Isomil (soy based) 20 Cal/oz
Similac Sensitive (milk based) 20 Cal/oz
Similac Total Comfort (milk based) 20 kcal/oz

Note: WIC cannot provide Similac Pro or Similac Sensitive Pro

Directions: Please complete the Enteral Nutrition Prescription Request (ENPR) form so that WIC can provide a Non-Contract formula for your patient. This form can be provided to the WIC client or faxed to the WIC office. If the ENPR form is approved by the Local Agency Registered Dietitian, WIC will provide the Non-Contract formula.

Infant

Formula:
☐ Similac for Spit Up ☐ Similac Neosure
☐ Similac Alimentum
☐ Enfamil Nutramigen ☐ Nutricia Neocate Infant
☐ Enfamil Enfacare ☐ Elecare
Prescribed amount of formula:
☐ Maximum allowable OR ☐ _____ ounces

Duration: ☐ up to age 1 **OR** ☐ _____ months

Infants 6-11 months who are not developmentally able to begin foods may receive more formula

Check foods to avoid:
☐ Infant Cereal
☐ Infant Fruits/Vegetables
☐ Provide no infant foods, and increase formula amount

Child/ Woman

Formula:
☐ _____
☐ Pediasure
☐ Ensure
☐ Neocate Jr.

Prescribed amount of formula:
☐ Maximum allowable OR ☐ _____ ounces

Milk in addition to formula for children and women
Specify: ☐ Whole ☐ 2% ☐ 1% or skim

Food Prescription (check one)
☐ Infant cereal for children or women
☐ Infant fruits and vegetables for children or women

Duration: ☐ 12 months or ☐ _____months

The prescription must be completed by a Health Care Provider eligible to write prescriptions in Alaska. Please include your Alaska License number or Medicaid Provider number.

Please fill in Medical Diagnosis and ICD-10 Code

(Both must be completed in order to process the request for therapeutic formulas)

Medical Diagnosis:_____
ICD-10 Code:_____

Signature:_____Date:_____
Medical Provider Phone_____

Medical Provider Name_____
Provider Medicaid ID #_____

Some conditions may not qualify for special formula through WIC

The program does NOT authorize issuance of therapeutic formulas for:

- Nonspecific symptoms such as intolerance, fussiness, gas, spitting up, constipation or colic OR
- Enhancing nutrient intake or managing body weight without an underlying medical condition

WIC REGISTERED DIETITIAN OR LICENSED NUTRITIONIST & MEDICAID USE ONLY

Date _____ RD Approved _____ Denied _____ Date Range approved: _____
Formula average daily calorie needs for _____ months = _____

ANCHORAGE
(907) 343-4668
muni.org/WIC

Cheat Sheet for ENPRs

Therapeutic Formulas and Medical Foods that May be Provided with Medical Documentation

WIC is a supplemental Food Program. Infants who are not breastfed may require more formula than WIC is able to provide

Hydrolyzed Protein

Similac Expert Care Alimentum
Nutramigen with Enflora

Amino Acid Based

Neocate Infant
Elecare

WIC-eligible Nutritionals for Children/Women

Pediasure and Pediasure with Fiber
Ensure or Ensure with Fiber
Neocate Jr.

Premature Infant Post Discharge

Enfamil Enfacare
Similac Neosure

	Age in Years	RDA Energy (kcals/kg)	Protein (g/kg/day)		Velocity of Weight Gain (gm/day)	
					Females	*Male*
Infants	Premature	120	2.2	Birth-3 month	24	28
	0-6months	108	2.2	3-6 months	19	21
	6-12 months	98	1.6	6-9 months	14	15
				9-12 months	11	11
Children	1-3 years	102	1.2	12-18 months	8	8
	4-6 years	90	1.1	18-36 months	5	5
				3-4 years	5	5
				4-5 years	6	6

Breastfeeding/Postpartum Women Application

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date _____

1. Name (First, Middle, Last)	2. Birth Date	331 332 333

3. If receiving Medicaid, please provide Medicaid number:

4. Is this person Hispanic or Latino? ☐ Yes ☐ No

5. Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Current History

6. How are you doing after having your baby? Please tell us if you have any concerns?

7. What was the actual date your baby was born?

8. What was your baby's weight at birth? What was the baby's length at birth?

9. At what Birthing Facility was the child born?

10. How many weeks did your pregnancy last?

11. When did your Prenatal care begin? (Month, Year)

12. How far apart were your last two pregnancies? 332

13. How many babies did you have during your last pregnancy? 335

14. How many times have you been pregnant? (Do not count this pregnancy)

15. How old are your children? 333

16. How much did you weigh before pregnancy?

17. Check it you had any of the problems during your recent pregnancy?

☐ Miscarried - How many? _____	321	☐ Baby born 3 or more weeks early	311	☐ Genetic or birth defects	339
☐ Stillbirth - How many? _____	321	☐ Baby, less than 5 pounds 9 oz at birth	312	☐ C-section	359
☐ More than one baby How many? _____	335	☐ Baby, 9 pounds or more at birth	337	☐ History of Gestational Diabetes	303
		☐ Baby died before 1 month old	321	☐ History of Preeclampsia	304

18. List any medication, vitamin, prenatal vitamins, mineral or herbal supplement you are taking. If not daily, how often? 357
427.01
427.04

19. Please, tell us if you see a doctor, dietitian or health care provider for medical or emotional reason(s) ex: hypertension, pre-hypertension, pre-diabetes, diabetes, anemia or gastrointestinal disorders. 201
302-304
341-349
351-363

Describe:

20. If you were in the hospital in the last 3 months, please tell us why. 359

Cigarette, Alcohol, Drug Usage

21. Do you smoke cigarettes, pipes or cigars?	☐ Yes	☐ No	If yes, How much a day?	371
22. Did you smoke in the last 3 months of your pregnancy?	☐ Yes	☐ No	If yes, How many a day?	
23. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home?	☐ Yes	☐ No		904
24. Do you use smokeless, chewing tobacco or iqmik?	☐ Yes	☐ No	If yes, How much a day?	
25. Did you drink alcohol in the last 3 months of your pregnancy?	☐ Yes	☐ No	If yes, How many a week?	371
26. Do you drink, wine, beer, or other alcoholic beverages?	☐ Yes	☐ No	If yes, How many a day? If yes, How many a week?	372

To Be Completed by Health Care Provider (HCP)

Medical date_____Ht_____ Pre-Pregnancy Wt_____(101,111) Weight Before Delivery_____Current Wt_____(133) Hgb/Hct_____(201)

Name of HCP verifying applicant lives in Alaska_____**ID Verified by:** Visual Recognition_____/Other_____WIC

Name of CPA reviewing WIC application_____Certification Date_____

27. Check any drugs you are using during this pregnancy:

☐ Cocaine ☐ Crack Methamphetamine ☐ Marijuana ☐ Speed ☐ Other _____
☐ Crank ☐ Heroin ☐ Methadone ☐ None ☐ Stopped Using When? _____

Eating & Feeding

28. What concerns, if any, do you have about having enough food to feed your family?

29. How are you feeding your baby? ☐ Breastmilk ☐ Breastmilk+Formula ☐ Formula Only

30. **If breastfeeding**, what date did it begin? When did breastfeeding end?

31. What was the reason that breastfeeding was stopped?

32. On a scale of 0 to 10,
How confident are you about breastfeeding your baby? Not Confident ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Confident

601

a. How long do you plan to breastfeed?_____

601,602

b. I breastfeed_____ times in 24 hours and each feeding lasts _____ minutes.

602

33. **If formula only**, did you ever breastfeed? ☐ Yes ☐ No If yes, how long? (i.e. days or weeks)

34. When did you introduce formula?

35. On a scale of 0 to 10,
How well do you think you are eating? Not Well ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Well

a. I usually eat _____ meals/day and _____ snacks/day.
b. I usually eat fruits: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more
c. I usually eat vegetables: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more

36. Check if you crave or eat

427.03

☐ Ashes ☐ Carpet Fibers ☐ Clay ☐ Soil
☐ Baking Soda ☐ Chalk ☐ Dust ☐ Starch (laundry or corn starch
☐ Burnt Matches ☐ Cigarettes ☐ Paint Chips ☐ Large quantities of ice and/or freezer frost

37. Do you fast, binge, vomit to control your weight or follow a specific diet? ☐ Yes ☐ No

358
427.02

Describe:

38. Do you have any problems eating any type of food for any reason such as dental problems, food intolerances, food allergies or others?

353-355
381

Additional

39. Have you been screened or referred for lead poisoning? ☐ Yes ☐ No 211

40. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping? ☐ Yes ☐ No 801

41. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals? ☐ Yes ☐ No 801

42. Did a family member have a seasonal farming job with a temporary home in the last 24 months? ☐ Yes ☐ No 802

43. Are you in a relationship with anyone who pushes, hits or threatens you in any way? ☐ Yes ☐ No 901

44. How often do you feel down, depressed or hopeless? ☐ Never ☐ Sometimes ☐ Often ☐ Always 361

45. What type of milk you would like on your WIC check?

☐ Fresh/Refrigerated ☐ Boxed (UHT) ☐ Soy ☐ Dry ☐ Evaporated ☐ Lactose Reduced 355

46. What problems, if any do you have caring for yourself or your baby/children? 902

47. Write the date of you last dental check-up: (Month, Year) 381

48. What does your family do for fun?

49. How can WIC help your family today?

Thank You!

Child Application

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date _____

1. Child's Name (First, Middle, Last)	2. Child's Birth Date ☐ Boy ☐ Girl
3. Your Name (First, Middle, Last)	4. Relationship to Child

5. If receiving Medicaid, please provide Medicaid number:

6. Is this child Hispanic or Latino? ☐ Yes ☐ No

7. Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Current History

8. What concerns, if any, do you have about your child's eating behaviors or growth?

9. What was the child's Birth Weight? Birth Length?

10. At what Birthing Facility was the child born?

11. How many weeks did your pregnancy last?

12. Please Answer if your child is under 2:

Child's birth weight was less than 5 lbs. 9 oz ☐ Yes ☐ No 141 My child's immunizations are up to date ☐ Yes ☐ No

My child was born at 37 weeks or less ☐ Yes ☐ No 142

13. Check the box if you have any of the following concerns about your child: 342

☐ Chewing/Swallowing ☐ Choking/Gagging ☐ Constipation ☐ Diarrhea ☐ Vomiting ☐ Other

14. List any medication, vitamin, mineral or herbal supplement your child takes. 357 425.07 425.08

15. Please, tell us if your child sees a doctor, dietitian or health care provider for medical or emotional reason(s) ex: hypertension, pre-hypertension, diabetes, fetal alcohol syndrome, gastrointestinal disorders or anemia. 151 201 341-357 359 360,362 382

Describe:

16. If your child was in the hospital in the last 3 months, please tell us why. 359

Eating & Feeding

17. What concerns, if any, do you have about having enough food to feed your family?

18. I am breastfeeding my child. ☐ Yes ☐ No

19. If breastfed, what date did it begin? When did breastfeeding end?

20. What was the reason that breastfeeding was stopped?

21. If your child used(s) formula, at what age (weeks or months) did you first offer?

22. On a scale of 0 to 10,
How well do you think you think your child is eating? Not Well ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Well

a. He/she usually eats_____ meals/day and _____ snacks/day.

b. He/she usually eat fruits: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more

c. He/she usually eat vegetables: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more

23. My child eats: ☐ Liquid Foods ☐ Finger Foods ☐ Table Foods ☐ Mashed, Pureed / Baby Foods 425.04 428

To Be Completed by Health Care Provider (HCP)

Medical date_____ Current Wt_____(103,113,134,135) Ht_____(121) Hgb/Hct_____(201)

Name of HCP verifying applicant lives in Alaska_____ID Verified by: Visual Recognition_____/Other_____WIC

Name of CPA reviewing WIC application_____Certification Date_____

24. Check the box if your child eats any these foods. 425.05

- ☐ **Raw sprouts:** alfalfa, clover and radish
- ☐ **Raw or undercooked:** meat, chicken, turkey, fish, eggs
- ☐ **Uncooked** refrigerated smoked seafood
- ☐ **Unheated meats:** lunch meats, deli-style meat or chicken, fermented and dry sausage, raw hot dogs
- ☐ **Food with raw or undercooked eggs:** salad dressing, cookie and cake batter, sauces
- ☐ **Soft cheese made with unpasteurized milk:** feta, mexican-style (queso blanco fresco), brie, blue
- ☐ **Unpasteurized** milk or foods made with unpasteurized milk
- ☐ **Unpasteurized** fruit or vegetable juice

25. My child drinks from (Check all that apply): ☐ Sippy Cup ☐ Cup ☐ Baby Bottle 425.03

a. If your child drinks from a baby bottle, how many in 24 hours? _____

b. What's in the baby bottle?

26. When does your child get a baby bottle? ☐ Bedtime/Naptime ☐ Mealtime ☐ All day ☐ Other: 425.03

27. When do you want your child to only use a cup?

28. Check if your child drinks regularly 425.01 425.02

☐ Water	☐ Dry milk	☐ Whole milk	☐ Sweet tea	☐ 100% Pasteurized juice	☐ Cereal/Solid foods in a baby bottle
☐ Pedialyte	☐ Raw milk	☐ 1% or 2% milk	☐ Coffee/tea	☐ Fruit drink (not 100% juice)	
☐ Soy milk	☐ Breastmilk	☐ Evaporated milk	☐ Tang/Kool-aid	☐ Raw juice	☐ Other _____
☐ Skim milk	☐ Rice milk	☐ Formula	☐ Pop/Soda	☐ Sports Drinks	

29. Check if your child craves or eats: 425.09

☐ Ashes	☐ Carpet Fibers	☐ Clay	☐ Soil
☐ Baking Soda	☐ Chalk	☐ Dust	☐ Starch (laundry or corn starch
☐ Burnt Matches	☐ Cigarettes	☐ Paint Chips	☐ Large quantities of ice and/or freezer frost

30. Does your child eat meals with the family?

31. Is your child on a special diet? 425.06

32. Does your child have any problems eating any type of food for any reason such as dental problems, food intolerances, or others? 354 355 381

33. List any food allergies your child may have. 353

Additional

34. Has your child been screened or referred for lead poisoning?	☐ Yes	☐ No	211
35. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home?	☐ Yes	☐ No	904
36. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping?	☐ Yes	☐ No	801
37. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals?	☐ Yes	☐ No	801
38. Did a family member have a seasonal farming job with a temporary home in the last 24 months?	☐ Yes	☐ No	802
39. Do you have any concerns about anyone hurting your child?	☐ Yes	☐ No	901
40. Has your child been in foster care or moved to a new foster home within the last 6 months?	☐ Yes	☐ No	

41. What type of milk you would like with your WIC benefits?

☐ Fresh/Refrigerated ☐ Boxed (UHT) ☐ Soy ☐ Dry ☐ Evaporated ☐ Lactose Reduced 355

42. In a typical day, how much time does your child watch TV, play video games and or play computer games?

☐ Less than 1 hour ☐ 1-2 hours ☐ More than 2 hours

43. Do you have problems taking care of your child? 902

44. Write the date of you last child's last dental check-up: (Month, Year) 381

45. For dads, please tell us your weight: height:

46. What does your family do for fun?

47. How can WIC help your family today?

Thank You!

Family Information Form

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date _____

1. Are you currently on WIC? ☐ Yes ☐ No **If yes**, where?

2. Have you been on WIC before? ☐ Yes ☐ No **If yes**, where?

3. How did you hear about WIC?

Applicant or Parent / Guardian for applicants under age 5 (Please print and use legal names)

4. Name (First, Middle, Last)	5. Maiden Name	6. Birth Date

7. Home address	8. Apartment or suite number

9. City	10. State	11. ZIP Code

12. Mailing Address (If different from Home address)	13. Apartment or suite number

14. City	15. State	16. ZIP Code

17. Cell phone number	18. Home phone number	19. Other phone number

20. May we call or leave a message? ☐ Yes ☐ No

21. May we send texts to your cell phone? ☐ Yes ☐ No

22. May we send mail for appointment reminders? ☐ Yes ☐ No

23. Email address:

24. Are you Hispanic or Latino? ☐ Yes ☐ No

25. Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Household Information (Please provide proof of income and identification)

26. Are you applying for your own WIC benefits today? ☐ Yes ☐ No

27. Are **you** currently working? ☐ Yes ☐ No Pay per hour? Hours worked per week?

28. Is **anyone else** in the household working? ☐ Yes ☐ No Pay per hour? Hours worked per week?

29. Are you pregnant? ☐ Yes ☐ No

30. How many people are living in your household?

31. How many members of your household received last year's Permanent Fund Dividend? (Include even if garnished)

32. Check any of the following programs you or any family member is currently receiving:

☐ Food Stamps/SNAP ☐ Applied for Denali Kid Care, Medicaid, ATAP - "Application Pending" ☐ Medicaid

☐ Denali Kid Care ☐ Alaska Temporary Assistance Program - Amount: _____ ☐ Head Start/School Lunch

33. Check any other money received by you or anyone in your household. (Include monthly amount)

☐ Supplemental Security Income/Disability _____ ☐ Self Employment _____ ☐ Unemployment _____

☐ Native Corporation Dividends _____ ☐ Commissions _____ ☐ Other _____

34. Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Living with a partner / significant other

35. What is the highest grade in school you completed?

36. If you are a U.S. Citizen, do you want to register to vote here at the WIC office? ☐ Yes ☐ Already registered ☐ Not interested

37. Would you like someone else's name on your checks, who can pick up and use your checks for you? ☐ Yes ☐ No

If yes, please print name: _____ Relationship: _____ **Please sign on the back.** →

Alaska WIC Rights and Responsibilities

You have rights and responsibilities as a WIC participant. The names and addresses of you and your child may be given to agencies such as Medicaid, Denali Kid Care, Supplemental Nutrition Assistance Program (SNAP), Heating Assistance, Temporary Assistance, Child Care, Infant Learning, Head Start and Public Health Nursing Programs for referral and outreach. Programs listed above may give the WIC program name(s), address, income, identification and residency for you and your child to help check if you qualify for WIC.

Other WIC information may also be shared with health programs to see if you qualify for their program's services, to share needed health information with programs you are already participating in, and to help assess the overall health of Alaskan families through reports and studies. These same programs listed below may also share their information with WIC for the same purposes. You may ask WIC staff for more information about these programs. These programs include: Medicaid, Denali Kid Care, Pro Care, Head Start, Supplemental Nutrition Assistance Program (Formally known as the Food Stamp Program), Immunizations Program, Public Health Nursing, State Epidemiology and Infant Learning Program.

I understand my Rights and Responsibilities

Responsibilities:

- I will treat WIC and store staff with courtesy and respect.
- All the information I give WIC is true and accurate. WIC staff can check this information.
- I will immediately report any changes in my income, family size, address, phone number or eligibility for Medicaid/Denali Kid Care, or the SNAP Program. I will also notify the WIC office if my card is lost or stolen, or if I am no longer breastfeeding.
- I will get WIC benefits from only one clinic at a time. If I move out of Alaska, I will ask for a transfer.
- I will not sell, or try to sell my eWIC card, trade or give away formula or other WIC food benefits and breast pumps. This includes sell of such items in person, in print, or online.
- I will be removed from the WIC program if my benefits are not issued or I do not use my benefits, for two months in a row.
- I will allow WIC staff to take my or my child's height and weight and take a small amount of blood to check my or my child's iron level. I understand this information is needed to check nutrition needs and determine eligibility for WIC.
- I will come to my appointments or call ahead when I need to reschedule.
- I will reapply for benefits as needed. I understand that WIC benefits are for participant use only.
- I will follow the WIC program and shopping rules that are on my WIC food list.
- WIC is a Federal program. If I break the rules, make false statements, intentionally misrepresent, conceal, or withhold facts about my eligibility for the WIC Program, I understand that:
    - I or my child can be taken off WIC.
    - I will have to pay money back to WIC for foods, formula or breast pumps I should not have received. If I do not pay back the WIC program for foods and/or formula that I accepted or return loaned breast pumps that I was not eligible to receive, the state may use other types of legal options to collect payment, including small claims court, which could result in **Permanent Fund Dividend (PFD) garnishment.**
    - I can face civil or criminal prosecution under State and Federal law.

Rights:

- If I qualify for WIC, I will get benefits to buy healthy foods. **I understand that WIC does not give all the food or formula needed in a month.** WIC foods help promote and support the nutrition and well-being and help meet the needed intake of important nutrients or foods for myself and / or my child(ren).
- WIC will give me information for healthy eating and active living. WIC will provide me with breastfeeding support.
- WIC will give me information to find a doctor and get immunizations for my child. I will be referred to other services.
- WIC staff will treat me with courtesy and respect.
- WIC will keep information about me and / or my child(ren) confidential and share only needed information to determine eligibility and for referral to other services.
- The rules for getting on WIC are the same for everyone. I can ask for a Fair Hearing if I do not agree with a decision about my WIC eligibility. WIC will tell me why my child or I qualify for the WIC Program.

By signing this form I agree that:

- **I have read the Rights and Responsibilities form or a WIC staff has read it to me.**
- **I agree to the above.**

Client/Guardian Signature Required for WIC Enrollment **Date**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. mail: U.S. Department of Agriculture
   Office of the Assistant Secretary for Civil Rights
   1400 Independence Avenue, SW
   Washington, D. C. 20250-9410;
2. fax (202) 690-7442; or
3. email: program.intake@usda.gov.

This institution is an equal opportunity provider.

Infant Application

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date _____

1. Child's Name (First, Middle, Last)	2. Child's Birth Date ☐ Boy ☐ Girl
3. Your Name (First, Middle, Last)	4. Relationship to Child

5. If baby is on Medicaid, please provide Medicaid number:

6. Is this baby Hispanic or Latino? ☐ Yes ☐ No

7. Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Current History

8. What concerns, if any, do you have about what, how or how much your baby eats? 342 411.04

9. What was the child's Birth Weight? Birth Length?

10. At what Birthing Facility was the child born? How many weeks did your pregnancy last?

11. Are you breastfeeding another child? ☐ Yes ☐ No

12. Please answer about your baby:

My baby's birth weight was less than 5 lbs. 9 oz ☐ Yes ☐ No 141 My baby weighed more than 9 pounds at birth ☐ Yes ☐ No 153

My baby was born at 37 weeks or less ☐ Yes ☐ No 142 My baby's immunizations are up to date ☐ Yes ☐ No

13. List any medication your baby may be taking: 357

14. Please, tell us if your baby sees a doctor, dietician or health care provider for medical reasons: 151,152 201 341-357 359,360 362,382
ex: hypertension, prehypertension, diabetes, fetal alcohol syndrome, small for gestational age, gastrointestinal disorders, or anemia.
Describe:

15. If your baby was in the hospital in the last 3 months, please tell us why. 359

Eating & Feeding

16. What concerns, if any, do you have about having enough food to feed your family?

17. How are you feeding your baby? ☐ Breastmilk ☐ Breastmilk + Formula ☐ Formula Only

18. If breastfed, what date did it begin? When did breastfeeding end?

19. What was the reason that breastfeeding was stopped?

20. On a scale of 0 to 10,
How well do you think you think breastfeeding is going? Not Well ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Well

a. I breastfeed_____ times in 24 hours and each feeding lasts _____ minutes. 411.7 603

b. My baby has_____ (#) stools a day and _____ (#) wet diapers a day. 703 411.7

21. How do you store breastmilk? (i.e. freeze, refrigerate, store on counter, in cabinet, etc.) 411.9

22. What do you usually do, if there is leftover breastmilk or formula in the bottle after feeding? 411.9

☐ Throw it out ☐ Put it in the refrigerator ☐ Leave near baby

23. At what age did you start your baby on formula? 701 What formula are you feeding your baby?

24. On a scale of 0 to 10,
How well do you think formula feeding is going? Not Well ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Well

25. How often do you feed your baby formula?

26. How much formula does your baby eat at feeding?

To Be Completed by Health Care Provider (HCP)

Medical date_____ Current Wt_____(103,113,134,135) Ht_____(121) Hgb/Hct_____(201)

Name of HCP verifying applicant lives in Alaska_____ID Verified by: Visual Recognition_____/Other_____WIC

Name of CPA reviewing WIC application_____Certification Date_____

27. How do you prepare your baby's formula? 411.5 411.6

☐ Powdered formula I add _____ scoops of powder to _____ ounces of water
☐ Concentrated formula I add _____ ounces of formula to _____ ounces of water
☐ Ready-to-feed formula Do you add water? ☐ Yes ☐ No If yes, how many ounces of water? _____

28. Does your baby drink juice, sweetened drinks, soda, sweet tea, Tang/Koolaid or Hi-C in a bottle or cup? 412.2 411.3

☐ Yes ☐ No ☐ Sometimes

29. Do you add sugar, honey or syrup to your baby's pacifier or foods? 411.3

☐ Yes ☐ No ☐ Sometimes If yes, tell us more about the reasons:

30. How old was your baby the first time he or she drank liquids other than breastmilk or formula? List what he or she drank: 411.1

31. How old was your baby the first time he or she ate food such as cereal, baby food, or any other food? List what he or she ate: 411.3

32. Is your baby held when bottle fed? ☐ Never ☐ Rarely ☐ Sometimes ☐ Always 381 411.2

33. Where else do you give your baby a bottle? ☐ Crib/Bed ☐ Car Seat ☐ High-chair ☐ Stroller ☐ Other _____ 411.2

34. How do you feed your baby solid food? 411.2 411.4

☐ No solid foods, only breastmilk/formula ☐ By Spoon ☐ In Baby Bottle
☐ By Infant Feeder ☐ Baby Foods ☐ Finger Foods ☐ Other _____

35. Check the box if you are eating any these foods. 411.4 411.5 411.8

☐ **Raw sprouts:** alfalfa, clover and radish
☐ **Raw or undercooked:** meat, chicken, turkey, fish, eggs
☐ **Uncooked** refrigerated smoked seafood
☐ **Unheated meats:** lunch meats, deli-style meat or chicken, fermented and dry sausage, raw hot dogs
☐ **Strained:** meat,egg yolk, yogurt, cottage cheese, tuna
☐ **Strained or mashed:** vegetables or fruits
☐ **Chopped** fruits/vegetables or fruits
☐ Homemade baby food
☐ Bread
☐ **Food with raw or undercooked eggs:** salad dressing, cookie and cake batter, sauces
☐ **Soft cheese made with unpasteurized milk:** feta, mexican-style (queso blanco fresco), brie, blue
☐ **Unpasteurized** milk or foods made with unpasteurized milk
☐ **Unpasteurized** fruit or vegetable juice
☐ **Cooked soft pieces of:** beans, chicken, turkey, beef, pork
☐ **No solid foods** only breastmilk/formula
☐ Infant Cereal in the bottle
☐ Infant Cereal
☐ Crackers

36. How do you know your baby is done eating? (Check all that apply) 411.4

☐ Turns head away ☐ Won't open his/her mouth ☐ Eats all food ☐ Bottle is empty ☐ Spits out food

37. Please describe any teething problems your baby maybe having.

38. Please describe any food intolerances or food allergies your baby may have.

Additional

39. Has your baby been screened or referred for lead poisoning? ☐ Yes ☐ No 211

40. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home? ☐ Yes ☐ No 904

41. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping? ☐ Yes ☐ No 801

42. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals? ☐ Yes ☐ No 801

43. Did a family member have a seasonal farming job with a temporary home in the last 24 months? ☐ Yes ☐ No 802

44. Do you have any concerns about anyone hurting your baby? ☐ Yes ☐ No 901

45. Has your child been in foster care or moved to a new foster home within the last 6 months? ☐ Yes ☐ No 903

46. Do you have any problems taking care of you baby?

47. For dads, please tell us your weight: height:

48. What does your family do for fun?

49. How can WIC help your family today?

Thank You!

Pregnant Women Application

Women, Infants, Children (WIC) Program, Alaska Department of Health & Social Services

Today's Date _____

1. Name (First, Middle, Last)	2. Birth Date 331 332 333	3. Due Date

4. If receiving Medicaid, please provide Medicaid number:

5. Is this person Hispanic or Latino? ☐ Yes ☐ No

6. Race (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Pacific Islander ☐ White

Current History

7. How is your pregnancy going? Please tell us if you have any concerns.

8. The date I started seeing a doctor for this pregnancy was? ☐ I have not started seeing a doctor for this pregnancy. 334 503

9. When was your last pregnancy? (Month, Year)

10. How many babies are you expecting? 332 335

11. How many times have you been pregnant? (Do not count this pregnancy)

12. How old are your children? 333

13. How much did you weigh before pregnancy?

14. Are you breastfeeding another child? ☐ Yes ☐ No 338

15. Check any problems you had with any of your pregnancies?

☐ Never pregnant before or didn't have problems	☐ Baby born 3 or more weeks early 311	☐ Genetic or birth defects 339
☐ Miscarried - How many? _____ 321	☐ Baby, less than 5 pounds 9 oz at birth 312	☐ C-section 359
☐ Stillbirth - How many? _____ 321	☐ Baby, 9 pounds or more at birth 337	☐ History of Gestational Diabetes 303
☐ Abortions - How many? _____	☐ Baby died before 1 month old 321	☐ History of Preeclampsia 304

16. Check if you are having any of the following problems with this pregnancy: 301 342

☐ Constipation ☐ Heartburn ☐ Nausea ☐ Vomiting

17. Did you take vitamins before your pregnancy? ☐ Yes ☐ No If yes, how often?

18. List any medication, vitamin, prenatal vitamins, mineral or herbal supplement you are taking. If not daily, how often? 357 427.01 427.04

19. Please, tell us if you see a doctor, dietitian or health care provider for medical or emotional reason(s) 201, 211 302 336 341-349 351-362
ex: fetal growth restriction, hypertension, prehypertension, gestational diabetes, diabetes, anemia or gastrointestinal disorders.

Describe:

20. If you were in the hospital in the last 3 months, please tell us why. 359

Cigarette, Alcohol, Drug Usage

21. Do you smoke cigarettes, pipes or cigars? ☐ Yes ☐ No If yes, How much a day? 371

22. Did you smoke before your pregnancy? ☐ Yes ☐ No If yes, How many a day?

23. Did you smoke cigarettes, pipes or cigars at any time during this pregnancy? ☐ Yes ☐ No 371

24. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home? ☐ Yes ☐ No 904

25. Do you use smokeless, chewing tobacco or iqmik? ☐ Yes ☐ No If yes, How much a day?

26. Did you drink alcohol before your pregnancy? ☐ Yes ☐ No If yes, How many a week?

27. Did you drink wine, beer or other alcoholic beverages during this pregnancy? ☐ Yes ☐ No If yes, How many a day? If yes, How many a week? 372

To Be Completed by Health Care Provider (HCP)

Medical date_____Ht_____ Pre-Pregnancy Wt_____(101,111) Weight Before Delivery_____Current Wt_____(133) Hgb/Hct_____(201)

Name of HCP verifying applicant lives in Alaska_____**ID Verified by:** Visual Recognition_____/Other_____WIC

Name of CPA reviewing WIC application_____Certification Date_____

28. Check any drugs you are using during this pregnancy: 372

☐ Cocaine ☐ Crack Methamphetamine ☐ Marijuana ☐ Speed ☐ Other _____
☐ Crank ☐ Heroin ☐ Methadone ☐ None ☐ Stopped Using When? _____

Eating & Feeding

29. What concerns, if any, do you have about having enough food to feed your family?

30. How do you plan to feed your baby? ☐ Breastmilk ☐ Breastmilk/Formula ☐ Formula ☐ Unsure

a. Have you breastfeed before? ☐ Yes ☐ No

31. On a scale of 0 to 10,
How ready do you feel about breastfeeding your baby? Not Ready ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Ready

32. On a scale of 0 to 10,
How well do you think you are eating? Not Well ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Very Well

a. I usually eat _____ meals/day and _____ snacks/day.

b. I usually eat fruits: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more

c. I usually eat vegetables: ☐ 1 cup/day or less ☐ 2 cups/day ☐ 3 cups/day or more

33. Check the box if you are eating any these foods. 427.05

☐ **Raw sprouts:** alfalfa, clover and radish

☐ **Raw or undercooked:** meat, chicken, turkey, fish, eggs

☐ **Uncooked** refrigerated smoked seafood

☐ **Unheated meats:**
lunch meats, deli-style meat or chicken, fermented and dry sausage, raw hot dogs

☐ **Food with raw or undercooked eggs:**
salad dressing, cookie and cake batter, sauces

☐ **Soft cheese made with unpasteurized milk:**
feta, mexican-style (queso blanco fresco), brie, blue

☐ **Unpasteurized** milk or foods made with unpasteurized milk

☐ **Unpasteurized** fruit or vegetable juice

34. Check if you crave or eat any of the following: 427.03

☐ Ashes ☐ Carpet Fibers ☐ Clay ☐ Soil
☐ Baking Soda ☐ Chalk ☐ Dust ☐ Starch (laundry or cornstarch)
☐ Burnt Matches ☐ Cigarettes ☐ Paint Chips ☐ Large quantities of ice and/or freezer frost

35. Do you fast, binge, vomit to control your weight or follow a specific diet? ☐ Yes ☐ No 358 427.02

Describe:

36. Do you have any problems eating any type of food for any reason such as dental problems, food intolerances, food allergies or others? 353-355 381

Additional

37. Have you been screened or referred for lead poisoning? ☐ Yes ☐ No 211

38. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping? ☐ Yes ☐ No 801

39. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals? ☐ Yes ☐ No 801

40. Did a family member have a seasonal farming job with a temporary home in the last 24 months? ☐ Yes ☐ No 802

41. Are you in a relationship with anyone who pushes, hits or threatens you in any way? ☐ Yes ☐ No 901

42. How often do you feel down, depressed or hopeless? ☐ Never ☐ Sometimes ☐ Often ☐ Always 361

43. What type of milk you would like on your WIC check?

☐ Fresh/Refrigerated ☐ Boxed (UHT) ☐ Soy ☐ Dry ☐ Evaporated ☐ Lactose Reduced 355

44. What problems, if any do you have caring for yourself or your baby/children? 902

45. Write the date of you last dental check-up: (Month, Year) 381

46. What does your family do for fun?

47. How can WIC help your family today?

Thank You!

Revised: 5/24/19

SPECIFICATIONS

WIC Online Application / Enrollment Process Upgrade

1. Overview

The Municipality of Anchorage (MOA) Anchorage Health Department (AHD) Women, Infants and Children Supplemental Nutrition Program (WIC) proposes to upgrade the WIC application and enrollment process. This will be a project making the forms and documents required to enroll in the WIC program available in an online, user-friendly format.

Currently the online application process that MOA WIC has available is cumbersome and difficult for participants, requiring them to use a computer or download an app to allow them to complete the forms on their phone. Often a WIC staff member must assist participants with the application and enrollment process over the phone which is time consuming for staff.

2. Scope of Work

The Vendor's scope of work consists of Analysis of WIC Enrollment Process & WIC Enrollment Workflow, Review of Requirements, Solution Recommendation, Implementation of Solution, Maintenance of Solution.

3. Period of Performance

All project phases through implementation and training must be complete by December 31, 2022.

4. Requirements

- Offer web-based forms to participants for enrollment.
- Provide secure, efficient, and user-friendly solution for electronic submission of required forms.
- Provide a software that improves the user experience yet maintains the State of Alaska required format.
- For the purposes of this RFQ, vendor should expect approximately 10,000 applicants per year, the number of forms generated per applicant will vary depending on answers to the pre-screening questionnaire.

Requirement	Description
Compatibility	
Smartphone	Apple Compatible
Smartphone	Android Compatible
PC	Windows Compatible
PC	Mac Compatible
Browser	Any browser-based elements must work with Chrome and IE.
WordPress	WordPress compatible
SharePoint	SharePoint compatible
Email Integration	Full integration with email, allowing sending of notification emails etc.
User Interface	
Smartphone	User-friendly on a Smartphone
PC	User-friendly on a PC
Web	User-friendly on the web
Application	
AHD WIC Forms	ALL AHD forms associated with the WIC application and enrollment process must match the State of Alaska WIC forms
Questionnaire	Questionnaire to be made available to applicants to help them understand what forms need to be filled out
Pre-screening	Pre-screening to be provided as part of the application process for language barriers E.g. Interpreter
Preferred Language	Ability to read the application forms in the applicant's preferred language
Quick Chat	Ability for quick chat feature to be provided to applicants to assist with common questions
Form Fields	Ability to make certain fields required on forms in order to submit application
Review	Ability to review the application before submitting
Receipts	Ability to send confirmation receipts to applicants as part of the application process
Electronic Signatures	Ability for Family Application Form to be electronically signed
Incomplete Applications	Ability to allow applicants to submit incomplete applications
Vendor	

Demo	Vendor will be required to provide a demo of proposed solution to prove they can meet the listed requirements
BAA	Vendor will be required to sign a BAA as part of the purchase
Vendor Support	
Vendor Support	Vendor must provide full version updates, specify how often those updates are available, and what those updates will require from client
Security	
Cloud-based	Cloud-based software must be FedRAMP certified
On-Prem	On-Prem software must be HIPAA compliant
ADA	
ADA	Text to speech is available to assist applicants

5. **Additional Information**

   The anticipated budget for this project is NTE $30,000.

6. **Attachments**
   - Attachment A: Municipality of Anchorage IT Policy and Procedure 28-9 Business Use and Access Control
   - Attachment B: Municipality of Anchorage Cloud and/or Offsite Hosting Terms and Conditions
   - Attachment C: HIPAA Business Associate Agreement
   - Attachment D: Sample of State of Alaska Required WIC Forms