SEDGWICK COUNTY, KANSAS
FINANCE DEPARTMENT
Purchasing Section
525 N. Main, Suite 823 ~ Wichita, KS 67203
Phone: 316 660-7255 Fax: 316 383-7055
http://sedgwickcounty.org/finance/purchasing.asp

REQUEST FOR PROPOSAL
17-0094
COMPREHENSIVE MEDICAL SERVICES FOR THE JUVENILE DETENTION FACILITY
ADDENDUM 1

April 12, 2018

The following is to ensure that vendors have complete information prior to submitting a proposal. Here are some clarifications regarding the proposal for comprehensive medical services for the juvenile detention facility.

Questions and/or statements of clarification are in **bold** font, and answers to specific questions are *italicized.*

1. **What is the average daily population for each of the facilities, and what is the average length of stay for each of the facilities?**
   In 2017 for JDF it was 52. For JRF it was 16.

2. **What is the address for each facility, and where are they located in conjunction to one another?**
   700 S. Hydraulic & 881 S. Minnesota. Proximity is one block with shared parking lots.

3. **What is the difference between the detention facility and the residential facility?**
   Detention is secure with youth held for court processes. Residential is more of an emergency shelter setting.

4. **How many hours is the current psychiatrist on-site each week, and is that psychiatrist a person the successful bidder will have access to?**
   We currently have approximately 10 hours per month of combined psychiatric/psychiatric APRN services.

5. **How many TB tests are completed each year?**
   Approximately 700.

6. **Please provide a copy of the health assessment form.**
   (See Attachment)

7. **Is the current OB/GYN on-site at the facilities?**
   No.

8. **What type of Mental Health professional is the county looking for?**
   Licensed through BSRB.

9. **Does the County expect 24/7 on-site mental health coverage, or 24/7 mental health coverage by phone?**
   24 hour phone availability with response to facilities as needed if contacted after hours that staff are on site.

10. **Will the physician be sufficient to meet that 24/7 coverage request?**
If in the model presented the physician is the 24 hour point of contact.

11. **The RFP requests our most current annual financial report. Will a letter from our bank representing we are in good financial standing suffice?**
Yes.

12. **The RFP asks for a list of all customers over the last 3 years. Are you instead looking for a list of juvenile facility clients and/or Kansas facility clients?**
References from like facilities would be preferential.

13. **The contract term is intended to be from July 2, 2018 – December 31, 2019. Would the County prefer an annual contract price, or a comprehensive price for the whole 18-month contract?**
Comprehensive price.

14. **How long does the background check take to complete?**
Approximately 2-3 weeks for state return on registry checks.

15. **Can we schedule a site tour?**
Yes.

16. **Please send the payment and invoice provisions referenced on page 7.**
https://www.sedgwickcounty.org/media/39239/payment_and_invoice_provisions.pdf

17. **What is the average number of prescriptions filled per month for the past 12 months?**
This information is not readily available.

18. **What type of medication packaging (blister cards, vials, strips, other) do you currently use? Do you intend to keep the same packaging?**
Blister packs – packaging will be the responsibility of the chosen vendor.

19. **How many days' worth of medication (7, 14, 30 days) is typically dispensed for routine medication orders? Do you intend to keep this the same?**
This varies by prescriber. It will be the vendor's responsibility to determine amount.

20. **V. Scope of Work, x. Ancillary Services, item c on page 4 of the RFP states, "The successful bidder shall provide pharmacy services or contract for those services in the most cost effective manner."**
What company is your current pharmacy services provider?
Dandurand by contract.

21. **What is your total dollar amount spent on pharmacy for the past 12 months? If unknown, can a report be requested from your incumbent provider so that this information is available to all bidders?**
In 2016 it was $32,397.00

22. **Do you currently receive credit for returned medications?**
N/A

23. **Regarding credit on returned medications, not all subcontracted pharmacies apply the same safeguards once medications are returned to them. When a pharmacy reclaims medication for future redispensing (which is standard within the industry where permitted by law), if each individual bubble of the blister pack is not labeled with the medication's name and strength, lot number, and expiration date, tracking this information for a medication subsequently redispensed to your patients (if recalled) would be difficult if not impossible. To avert patient safety issues, will you require the subcontracted pharmacy to dispense medications that are eligible for**

reclamation to be in blister card packaging where each individual bubble of the blister card is labeled with the medication's name and strength, lot number, expiration date, and manufacturer's name?
Yes.

24. Will a bidder's failure to provide proof of compliance (such as a sample blister card from their proposed pharmacy) at the time of proposal submittal deem a bidder who is unable to ensure inmate safety (in the event of a medication recall) as non-responsive and therefore ineligible for an award?
Proposal requests pharmacy services. Please provide in proposal pharmacy best practices, recall processes, etc. as you see fit.

25. Medication utilization data is extremely important for bidders in determining a final and accurate bid rate in their response to your solicitation. Not providing actual utilization data to all bidders would result in an unfair competitive advantage to your incumbent provider who already has this information. All bidders, not just your incumbent provider, need the information to firmly establish their bid rates more accurately and intelligently and in the best interests of your facility and the taxpayers of Sedgwick County. Our understanding is that utilization information is not considered proprietary, and therefore available without the need for a public records or FOIA request, since public money is used to pay for services and medications under the current contract. So no unfair advantage is imparted to your incumbent provider, can you please provide copies of your two most recent monthly pharmacy invoices or a two-month utilization report that includes actual pharmacy utilization data (with patient names redacted) as this information is readily available from recent invoices sent to your incumbent provider or through a report that can be requested of your current pharmacy vendor?
Current billing processes require review and credit when an error is made. Thus, the invoices would not be an actual representation of the final amount paid. Invoices from current contracted pharmacy are attached for February and March 2018. Per 21 above, that is the annual amount. 2015 amount is $66,293 with an ADP of 64 youth for that year.

26. Do you currently receive inspections of the medication areas at your facility? If so, how frequently?
Yes, weekly, monthly, quarterly and annual – as well as spot checks.

27. Does your facility currently use an electronic prescription order entry and eMAR system that is provided to you at no additional cost? If not, would you consider adding this required to your current solicitation, as electronic med pass will decrease the time required for med pass by up to 50% and that time can be used by your staff to provide other health care services?
There is no current electronic system. We are not considering adding this as a "required" in the RFP.

28. Does your facility currently have access to an online reporting dashboard for you to access meaningful and accurate reporting 24/7/365 that is provided at no cost?
No.

29. If not, would you consider adding this requirement to your current solicitation so your facility-level staff and administrators can analyze prescriber ordering trends and costs to better manage facility operations through accessible reporting?
No.

30. What is the current ADP?
Current ADP – 2017 Averages: JDF 52, JRF 16.

31. What is the maximum capacity at each facility?
JDF 108, JRF 24

32. Please provide the number of patients on Psychotropic medications by month for the last 2 years.
This information is not readily available.

33. Please provide the number of Suicide Watch Placements by month for the last 2 years.

2016: April 34 youth; May 46 youth; June 31 youth; July 30 youth; August 25 youth; September 23 youth; October 24 youth; November 23 youth; December 33 youth

2017: January 29 youth; February 25 youth; March 30 youth; April 26 youth; May 28 youth; June 26 youth; July 26 youth; August 21 youth; September 25 youth; October 30 youth; November 34 youth; December 31 youth

2018: January 11 youth; February 2018 21 youth; March 2018 19 youth

34. Please provide the number of attempted suicides in the past two (2) years.

In calendar years 2015 and 2016 there were 5 Suicide Attempts logged each year. In calendar year 2017, there were 3 suicide attempts documented.

35. Please provide the number completed suicides in the past two (2) years.

0

36. Please provide the current mental health and psychiatric staffing by credential and shift, as provided by the incumbent.

Currently, Mental Health staff are employees of Sedgwick County. There are 4 licensed master level mental health staff positions with one of those being the Program Manager. There is also a case manager but this position does not require licensure. Currently, the contract for medical services is with KU School of Medicine. Current staffing includes a physician, APRN and LPN.

37. Who currently provides Psychiatric services?

Contract with COMCARE of Sedgwick County.

38. Does the incumbent currently provide discharge planning?

No.

39. Does the county prefer 24/7 on-site mental health coverage with this new contract?

Present proposal for coverage that would meet psychiatric care needs.

40. Is basic sick call completed at both facilities (7) days/week including holidays?

Please provide proposal on sick call and meeting resident needs.

41. Please clarify what is required and completed during weekly file audits.

Please provide in proposal best practices for chart file audits.

42. Please provide a recent copy of the weekly audit tool to be used and reported.

Please provide in proposal the best practices for chart file audits and an example of what would be used.

43. Define appropriate referral or follow up requirements when a resident is released from either facility.

Please provide in proposal continuity of care plan.

44. Please provide the current nursing and clinical staffing by credential and shift, as provided by the incumbent.

We are asking for a proposal of staffing to adequately cover the proposal request. We would like the proposal to include a recommended staffing pattern.

45. Does the facility currently have 24/7 nursing coverage? Are you requesting 24/7 nursing coverage?

We require 24/7 medical on call coverage in the facility licensing regulations. Please see #44 response.

46. Will medical and mental health providers be expected to be available on an on-call basis 24 hours a day?

Yes.

47. Is it the expectation that the on-call provider will come in to the units after hours to take care of medical needs?
As needed.

48. Please provide the average number of County new hires annually for the last three years in order to budget for TB screens and health assessments.
Average is 100 per year.

49. Please provide a copy of the health assessment screening tool used for County staff health assessments.
Attached.

50. Who will have financial responsibility for TB serum?
Vendor.

51. Please identify the following current providers:
a. Pharmacy
Dandurand by contract
b. Laboratory
No contract - Multiple
c. Mobile X-Ray Services
No current mobile services
d. Ambulance Service(s)
EMS through Sedgwick County

52. Do you require each new resident to receive all the listed labs/treatments in the RFP upon admission?
No

53. Please provide statistical data for the past two (2) years regarding the following services such as but not necessarily limited to:
a. Intakes
b. Nurse sick call, physician sick call
c. Resident physicals
d. Number of residents evaluated by psychiatric provider
e. Number and volume of chronic care visits by type
f. Number of on-site clinic visits by type (e.g., OB/GYN, orthopedics, ophthalmology, cardiology, etc.)
g. Labs
h. X-rays
i. Telemedicine encounters by specialty (if applicable)
687 Admissions to Detention in 2017 and 934 Admissions to Detention in 2016
All youth are required to have physicals within 10 days of admission but some youth are released prior to that time. The other information is not readily available for reporting.

54. Who bears financial responsibility for off-site services?
Off-site services would be considered for a third-party payer source and if none available county.

55. Immunizations: HPV and meningitis vaccines are currently recommended for this age group, is this required in the new contract?
Please provide plan in proposal.

56. Does the county currently utilize any programs to cover the cost of vaccines?
No.

57. Pharmacy Statistics: Please provide the following information for the past two (2) years:
a. Number of residents on medication(s) per year
b. Number of residents on psychotropic medication(s) per year
c. Number of residents on HIV/AIDS medication(s) per year
d. Number of residents on Hepatitis medication(s) per year
e. Number of residents with diabetes
f. Please provide the number of patients currently on Psychotropic medications.
Not readily available.

58. Is the intent that a nurse, CMA OR trained detention personnel distribute medications?
Proposal requests plan for vendor to distribute medication.

59. Are there currently any on-site specialty clinics being conducted? If so please identify:
a. Provider name and contact information
b. Frequency and type of clinic
Contracted Psychotropic Medication Clinics occur twice monthly under a contract with COMCARE of Sedgwick County. Current COMCARE providers are Dr. Rex Lear and Nancy Ballinger, APRN.

60. Will the children in state custody/foster care at the facilities also be receiving CCS MH services?
Any youth detained at the Juvenile Detention Facility fall under the licensing requirements. Youth with third party payers that remain active while detained have options outside the facility.

61. Medication Administration:
a. How many med passes are currently conducted daily?
JDF:
A.M. – 1.5 hours
Afternoon – 1 hour
Evening – 2 hours
Bedtime – 1 hour

JRF:
A.M. - 45 minutes
Noon - 10 minutes
Afternoon – 10 minutes
Evening/Bedtime – 45 minutes

b. Which discipline(s) conducts med passes (e.g., CMT, LPN, RN, etc.)?
Proposal requests vendor provide med passes. Please provide input in proposal on discipline/level of staff that would be providing the med pass.

c. How many med carts are utilized per med pass?
Currently 2 carts are used for med passes at JDF.

d. How long does the average med pass take to complete?
See answer to 61. a.

Firms interested in submitting a proposal, must respond with complete information and deliver on or before 1:45 p.m. CDT, May 1, 2018. Late proposals will not be accepted and will not receive consideration for final award.

"PLEASE ACKNOWLEDGE RECEIPT OF THIS ADDENDUM ON THE PROPOSAL RESPONSE PAGE."

Paul Regehr
Purchasing Agent

FCL. 009
Rev. 03/16
3.0309.1

Kansas Department for Children and Families
Foster Care and Residential Facility Licensing Division
555 South Kansas Avenue ● 2nd Floor ● Topeka, KS 66603
Fax: (785) 296-5937
Website: http://FosterLicensing.dcf.ks.gov

Kansas Department for Children and Families
Strong Families Make a Strong Kansas

CERTIFICATE OF HEALTH ASSESSMENT FOR PERSONS 16 YEARS OF AGE OR OLDER

K.A.R. 28-4-126(b)(1) requires each person over 16 years of age regularly caring for children to have a health assessment completed by a licensed physician or by a nurse trained to perform health assessments. All persons over 16 years of age living in a Family Foster Home [K.A.R. 28-4-316(b)(1)] must have a health assessment. A Physician Assistant (PA) may complete the health assessment and must include the signature of the licensed physician authorizing the PA. The Health Assessment must be recorded on this DCF form. Substitute forms are not accepted.

TO BE COMPLETED BY PROVIDER/STAFF (Please print)

Juvenile Detention Facility — Name of the facility (exactly as stated on the license)
3268-004 — License #

700 S. Hydraulic Street — Street Address
Wichita — City
67211 — Zip Code
Sedgwick — County

Check type of child care facility:

- ☐ Attendant Care Facility
- ☒ Detention Center
- ☐ Family Foster Home
- ☐ Group Boarding Home
- ☐ Staff Secure Facility
- ☐ Residential Center
- ☐ Secure Residential Treatment Facility
- ☐ Secure Care Center

Name of Foster Parent/Staff _____ Date of Birth _____
(First) (Middle) (Last) (MM/DD/YYYY)

Please check each question. If answer is yes, please explain.	Yes	No
1. Do you see a physician regularly for any health condition?	☐	☐
2. Are you taking any medication regularly?	☐	☐
3. Have you had any surgery in the past 3 years?	☐	☐
4. Do you have any handicapping conditions which might interfere with the care of children?	☐	☐
5. Do you have any chronic illness conditions such as:		

	Yes	No		Yes	No		Yes	No
Headaches	☐	☐	Cancer	☐	☐	Alcoholism	☐	☐
Heart Disease	☐	☐	Diabetes	☐	☐	Arthritis	☐	☐
High Blood Pressure	☐	☐	Convulsions	☐	☐	Liver Disease	☐	☐
Lung Disease	☐	☐	Mental Illness	☐	☐	Other	☐	☐

If Other, Describe: _____

TO BE COMPLETED BY LICENSED PHYSICIAN, OR NURSE TRAINED TO PERFORM HEALTH ASSESSMENTS:

I have reviewed the above information and have conducted an examination and any tests indicated. Sign one of the statements below: (1 OR 2)

1. **I do not find** evidence of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

_____ _____
Signature of Licensed Physician or Nurse trained to perform health assessments. **Date (MM/DD/YYYY)**

2. **I found evidence** of physical or mental illness that would conflict with the ability to care for the health, safety or welfare of children.

_____ _____
Signature of Licensed Physician or Nurse trained to perform health assessments. **Date (MM/DD/YYYY)**

Record results of TB test or attach results to this form.

Negative tuberculin test ☐ or negative chest x-ray ☐ on _____ (date) (Repeat test not needed unless there is exposure or symptoms.)

Test read by _____ _____
Licensed Physician/Nurse Signature or Health Department **Date (MM/DD/YYYY)**

JUVENILE DETENTION FACILITY
HEALTH HISTORY CHECKLIST

RESIDENT:_____ DATE:_____ STAFF:_____

1. Are you having any illness problems at the present time? Yes ☐ No ☐

2. Have you had any of the following in the past 24 hours:

Sore Throat	Yes ☐ No ☐	Vaginal/Penile Discharge	Yes ☐ No ☐
Coughing	Yes ☐ No ☐	Nausea/Vomiting	Yes ☐ No ☐
Swollen Glands	Yes ☐ No ☐	Stomach Pains	Yes ☐ No ☐
Earache	Yes ☐ No ☐	Fever/Chills	Yes ☐ No ☐
Low Back Pain	Yes ☐ No ☐	Pain when urinating	Yes ☐ No ☐
Diarrhea	Yes ☐ No ☐	Headaches	Yes ☐ No ☐
Skin rash	Yes ☐ No ☐		

If YES for skin rash – where located:_____
Date of onset:_____ Describe:_____
_____

Have you been exposed to head lice, crabs or scabies in the past two weeks: Yes ☐ No ☐

3. Do you have any continual medical problems – such as:
Heart Murmur Yes ☐ No ☐ Diabetes Yes ☐ No ☐ Seizures Yes ☐ No ☐
Splint/Cast Yes ☐ No ☐ TYPE:_____
Asthma Yes ☐ No ☐
ALLERGIES Yes ☐ No ☐ TYPE:_____
Other: Yes ☐ No ☐ EXPLAIN:_____

4. Have you been exposed to or do you have a transmittable disease:
Hepatitis Yes ☐ No ☐ STD Yes ☐ No ☐ Other Yes ☐ No ☐
EXPLAIN:_____

5. Are you taking any type of medication or shots? Yes ☐ No ☐ Brought in w/admit? ☐ Yes ☐ No

What type:_____
Physician who ordered it:_____
MEDICATION ALLERGIES:_____

6. Do you use any type of drug? Yes ☐ No ☐ Type:_____
How often:_____ How much:_____
Do you use alcohol? Yes ☐ No ☐ Type:_____
How often:_____ How much:_____

7. Are you having problems with teeth/gums/mouth? Yes ☐ No ☐ Braces Yes ☐ No ☐
Explain:_____
Observed problems:_____

8. Do you think you are in need of medical care? Yes ☐ No ☐
Explain:_____

9. Date of last Menstrual Period:_____ N/A ☐ Pregnant: Yes ☐ No ☐

MEDICAL CARE NEEDED: YES ☐ NO ☐
HEALTH OBSERVATIONS (Appearance, ability to answer questions, mannerisms)
_____

FCL 053
Rev. 03/16

KANSAS DEPARTMENT FOR CHILDREN AND FAMILIES
FOSTER CARE AND RESIDENTIAL FACILITY LICENSING DIVISION
555 SOUTH KANSAS AVENUE, • 2nd FLOOR • TOPEKA, KS 66603
FAX (785) 296-5937

3.1402.4

Kansas Department for Children and Families
Strong Families Make a Strong Kansas

MEDICAL RECORD FOR CHILDREN IN 24 HOUR CARE FACILITIES

(School Health Form or the KAN Be Healthy Form May Be Used)

Name: _____ Birthdate: _____ ☐ Male ☐ /Female

Address: _____ City: _____ Zip: _____

Parent/Guardian: _____ Work Phone: _____ Home: _____

Child lives with: _____ Work Phone: _____ Home: _____

Number in household: _____ Type of family housing: _____

Physician: _____ Date of last examination: _____

Dentist: _____ Date of last examination: _____

Eye Doctor: _____ Community Services:

School: _____ _____

FAMILY HEALTH HISTORY

Response Codes: ***M = Maternal*** ***P = Paternal*** ***S = Sibling*** ***N/A = Not Applicable***

	Code	Comment
1 Are there any chronic illness problems in your family such as heart disease, diabetes,		
2 Does any family member have a vision defect, hearing loss or spinal deformity? Comment.		

CHILD/ADOLESCENT HISTORY

Response Codes: ***Y = Yes*** ***N = No*** ***NA = Not applicable***

1. Birth weight _____ Were there any pre-natal or delivery problems with the child?		
2. Did this child walk, talk and develop at the usual time?		
3. Does this child/adolescent:		
a See a health care provider regularly?		
b Use any medication, drugs or alcohol?		
c Have a history of any hospitalizations, surgeries or emergency room visits?		
d Have a history of any childhood diseases/illnesses?		
e Have a history of other communicable diseases?		
f Age menarche _____ Have a history of menstrual problems?		
g Have a history of vision, speech, hearing or communication problems?		
h Have a problem with being tired or overactive?		
i Have any emotional or behavioral problems?		
j Need any special help in school or day care?		
k Have sexuality concerns?		
l Have any chronic illness or disabling problems with:		

Headache	__	Convulsions	____	Diabetes	____	Earaches	____	Back/spine/	
Colds/sore throat	__	Rheumatic fever	____	Genitalia	____	Oral/dental	____	extremity problems	____
Heart/lung disease	__	Allergies/Asthma	____	Digestive	____	Urinary/bowel	____	Other	____

List present concerns of child/parent/guardian/foster parent:

Immunization:	Record **date** of each dose received (mm/dd/yy)					*Required	**Recommended			
	1st	2nd	3rd	4th	5th		1st	2nd	3rd	4th
DPT (Diphtheria, pertussis, tetanus)*						**MMR** (Measles, Mumps, Rubella) *				
Td/DT *						**HBV** (Hepatitis B) **				
OPV or IPV (Polio) *						**TB** (Skin Test) *	Date	Result		
Immunization:	Record **date** of each dose received (mm/dd/yy)					*Required	**Recommended			

PHYSICAL EXAMINATION: To be completed by health care provider approved to perform health assessments.

Height _____ Weight _____ Hgb or Hct _____
Pulse _____ Blood Pressure _____ Lead _____
Urinalysis _____ Sickle Cell _____ Other _____
Tuberculosis _____ Head Circumference _____

Code Each Item as Follows: 0 = No significant findings 1 = Significant findings	Code	Description of Findings
General Appearance Integument Head - Neck EENT Oral - Dental Thorax Breasts Cardiovascular Abdomen Musculoskeletal Genitourinary Neurological		

SCREENING

1. Nutritional Evaluation (all ages - each screen) (✓ if applicable)
☐ Enrolled in WIC ☐ Receiving Vitamin Supplement with iron ☐ Without iron ☐ Fluoride Supplement

Nutrition/WIC Questionnaires available from (785) 296-0092.

Food intake review. Results:
milk/milk products (breast-fed/type of formula) _____
fruit/vegetables _____
meat, beans, eggs _____
breads, cereals _____

Type of screen

2. Developmen _____ Result _____
3. Speech _____ Result _____
4. Hearing _____ Result _____ Date of last screen _____
5. Vision _____ Result _____ Date of last screen _____

Significant Assessment Findings:

Recommendations: (include referrals)

Follow Up:

Anticipatory Guidance: (circle those discussed)

1. Safety/poisons
2. Nutrition
3. Parenting
4. Family Planning
5. Discipline
6. Immunizations
7. Hygiene
8. Lifestyle
9. Development
10. Behavior
11. Sexuality
12. Dental
13. Other

Comments:

Additional Information may be attached

_____ _____

Signature of Licensed Physician or Nurse approved to perform health assessments Date

Remit To:
DANDURAND PHARMACY
7732 E Central Street
Ste 102A
Wichita, KS 67206

Ph. (316) 685-2353

S T A T E M E N T

J2
881 S. MINNESOTA
WICHITA, KS 67211

Account Number: 108185-006903
Statement thru: 02/28/18

Date	Ticket	Description	Tax	Charges	Payments
********	Patient	EVANS, DAMIEN			
		881 S MINNESOTA			
02/10/18	2005633400	Qty=0001 PROVENTIL HFA AER		120.68	
02/10/18	2005633500	Qty=0001 OPTICHAMBER DIAMON DIAMOND		45.20	
02/14/18	2005669200	Qty=0018 VENTOLIN HFA 90MCG AER		74.13	
02/19/18	2005737700	Qty=0014 OMEPRAZOLE 20MG CAP		14.55	
########	Patient	Total $ 254.56			
********	Patient	[redacted]			
		881 S. MINNESOTA			
02/09/18	2005149301	Rf#01 Qty=0016 FLUTICASONE PROPIO 50MCG/AC		20.76	
########	Patient	Total $ 20.76			
********	Patient	[redacted]			
		881 S. MINNESOTA			
02/21/18	2005770100	Qty=0030 LATUDA 40MG TAB		1155.74	
02/22/18	2005784500	Qty=0030 MELATONIN 5MG TAB		4.00	
########	Patient	Total $ 1159.74			
********	Patient	[redacted]			
		881 S. MINNESOTA			
02/09/18	2005630200	Qty=0018 VENTOLIN HFA 90MCG AER		74.13	
########	Patient	Total $ 74.13			
********	Patient	[redacted]			
		881 S. MINNESOTA			
02/01/18	2005527800	Qty=0007 OMEPRAZOLE 40MG CAP		8.00	
########	Patient	Total $ 8.00			
********	Patient	[redacted]			
		881 S. MINNESOTA			
02/12/18	2004916703	Rf#03 Qty=0030 MONTELUKAST SODIUM 10MG TAB		19.49	
########	Patient	Total $ 19.49			
********	Patient	[redacted]			
		881 S. MINNESOTA			
02/09/18	2005627400	Qty=0021 IBUPROFEN 600 MG TABLET		8.00	
########	Patient	Total $ 8.00			
********	Patient	[redacted]			
		700 S HYDRAULIC			
02/05/18	2005331201	Rf#01 Qty=0060 TRAZODONE 100MG TAB		3.00	
02/05/18	2005562000	Qty=0020 SULFAMETH/TRIMETH 800-160 T		3.00	

Continued on next page

Ph. (316) 685-2353

S T A T E M E N T

J2
881 S. MINNESOTA
WICHITA, KS 67211

Account Number: 108185-006903
Statement thru: 02/28/18

Date	Ticket	Description	Tax	Charges	Payments
02/06/18	2005573800	Qty=0022 MUPIROCIN 2% OIN		10.00	
02/12/18	2005640900	Qty=0030 ADZENYS XR-ODT 9.4MG TBE		70.00	
########	Patient	Total $ 86.00			
********	Patient	J2			
		881 S. MINNESOTA			
02/07/18	2005583300	Qty=0472 EXPECTORANT 100-10/5 SYR		8.13	
02/07/18	2005583700	Qty=0060 HALLS COUGH DROPS CHERRY LO		4.57	
02/07/18	2005584700	Qty=0003 SM INSTANT COLD PACK		11.61	
########	Patient	Total $ 24.31			
		Amount Financed $4,111.19			
		Days Financed 28			
02/28/18	9000000820	Finance Charge $56.76		56.76	

A Monthly Finance Charge of 1.50% (18.00% APR) is charged on any unpaid previous balance.

Past Due	
Last Per	1961.76
30-Days	2149.43
60-Days	0.00
90-Days	0.00

Previous Balance	- Credits	- Payments	+ Current Charges	+ Account Charges	= Total Amount Due
4111.19	0.00	0.00	1654.99	56.76	$5,822.94

---------- (Please return portion below with payment) ----------

J2
881 S. MINNESOTA
WICHITA, KS 67211

Account Number: 108185-006903
Statement thru: 02/28/18
Amount Due: $5,822.94 by 03/30/18

Please indicate amount paid [.]

Remit To: DANDURAND PHARMACY
7732 E Central Street
Ste 102A
Wichita, KS 67206

Ph. (316) 685-2353

S T A T E M E N T

J-1
700 S. HYDRAULIC
WICHITA, KS 67211

Account Number: 108185-006901
Statement thru: 02/28/18

Date	Ticket	Description	Tax	Charges	Payments
********	Patient	[redacted]			
		700 S. HYDRAULIC			
01/08/18	2005306200	Rx Void Adjustment		-14.72	
########	Patient	Total $ -14.72			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/26/18	2005812600	Qty=0030 ARIPIPRAZOLE 5 MG TAB		24.39	
########	Patient	Total $ 24.39			
********	Patient	[redacted]			
		700 S HYDRAULIC			
02/14/18	2005668600	Qty=0002 AZITHROMYCIN 500MG TAB		20.85	
########	Patient	Total $ 20.85			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
01/19/18	2005419700	Rx Void Adjustment		-32.17	
02/12/18	2005640100	Qty=0030 ARIPIPRAZOLE 10 MG TABLET		26.88	
02/12/18	2005640200	Qty=0015 MIRTAZAPINE 15MG TAB		15.31	
02/12/18	2005640300	Qty=0060 MELATONIN 3MG TAB		8.00	
02/26/18	2005816300	Qty=0060 GUANFACINE 1MG TAB		19.18	
02/26/18	2005816400	Qty=0060 MELATONIN 3MG TAB		8.00	
02/26/18	2005816500	Qty=0015 MIRTAZAPINE 15MG TAB		15.31	
02/26/18	2005816600	Qty=0030 ARIPIPRAZOLE 10 MG TABLET		26.88	
########	Patient	Total $ 87.39			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/19/18	2005745200	Qty=0018 VENTOLIN HFA 90MCG AER		74.13	
########	Patient	Total $ 74.13			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/26/18	2005812500	Qty=0045 QUETIAPINE 400MG TAB		29.80	
########	Patient	Total $ 29.80			
********	Patient	[redacted]			
		700 S HYDRAULIC			
02/01/18	2005524800	Qty=0007 CETIRIZINE 10MG TAB		4.00	
02/01/18	2005524900	Qty=0016 FLUTICASONE PROPIO 50MCG/AC		14.22	
########	Patient	Total $ 18.22			
********	Patient	[redacted]			
		700 S. HYDRAULIC			

Continued on next page

Ph. (316) 685-2353

S T A T E M E N T

J-1
700 S. HYDRAULIC
WICHITA, KS 67211

Account Number: 108185-006901
Statement thru: 02/28/18

Date	Ticket	Description	Tax	Charges	Payments
02/09/18	2004716001	Rf#01 Qty=0018 VENTOLIN HFA 90MCG AER		72.28	
02/12/18	2004716002	Rf#02 Qty=0018 VENTOLIN HFA 90MCG AER		72.28	
########	Patient	Total $ 144.56			
********	Patient	[redacted]			
		881 S. MINNESOTA			
02/16/18	2005190602	Rf#02 Qty=0030 CETIRIZINE 10MG TAB		8.00	
########	Patient	Total $ 8.00			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/26/18	2005198502	Rf#02 Qty=0015 RANITIDINE 150MG TAB		15.53	
########	Patient	Total $ 15.53			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/07/18	2005387101	Rf#01 Qty=0030 BUPROPION XL 150MG TAB		27.25	
########	Patient	Total $ 27.25			
********	Patient	[redacted]			
		700 S HYDRAULIC			
02/09/18	2005631600	Qty=0015 AFRIN NASAL SPRAY 0.05% SPR		9.99	
########	Patient	Total $ 9.99			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/16/18	2005710500	Qty=0060 RISPERIDONE 0.25 MG TAB		20.06	
02/26/18	2005812700	Qty=0060 RISPERIDONE 0.25 MG TAB		18.73	
########	Patient	Total $ 38.79			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/09/18	2005630100	Qty=0018 VENTOLIN HFA 90MCG AER		74.13	
02/19/18	2005737800	Qty=0018 VENTOLIN HFA 90MCG AER		74.13	
02/19/18	2005737900	Qty=0020 AMOXICILLIN 875MG TAB		17.50	
########	Patient	Total $ 165.76			
********	Patient	[redacted]			
		700 S HYDRAULIC			
02/12/18	2005640400	Qty=0030 CLONIDINE 0.1MG TAB		15.00	
02/12/18	2005640600	Qty=0030 SERTRALINE 50MG TAB		15.50	
02/26/18	2005812200	Qty=0030 MELATONIN 5MG CAP		8.00	
02/26/18	2005812300	Qty=0030 CLONIDINE 0.2MG TAB		15.65	
02/26/18	2005812400	Qty=0030 SERTRALINE 50MG TAB		16.27	
02/28/18	2005835700	Qty=0018 VENTOLIN HFA 90MCG AER		74.13	

Continued on next page

Ph. (316) 685-2353

S T A T E M E N T

J-1
700 S. HYDRAULIC
WICHITA, KS 67211

Account Number: 108185-006901
Statement thru: 02/28/18

Date	Ticket	Description	Tax	Charges	Payments
########	Patient	Total $ 144.55			
********	Patient	KEMP, TYREE			
		700 S. HYDRAULIC			
02/05/18	2005561900	Qty=0020 AMOXICILLIN 875MG TAB		17.31	
########	Patient	Total $ 17.31			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/05/18	2005561700	Qty=0010 CETIRIZINE 10MG TAB		8.00	
02/05/18	2005561800	Qty=0003 PREDNISONE 5MG TAB		14.43	
02/12/18	2005640800	Qty=0054 QUETIAPINE FUMARATE 300 MG		25.95	
02/19/18	2005561701	Rf#01 Qty=0010 CETIRIZINE 10MG TAB		14.44	
02/26/18	2005813100	Qty=0030 BUPROPION XL 150MG TAB		27.25	
02/26/18	2005814100	Qty=0030 QUETIAPINE FUMARATE 300 MG		20.64	
########	Patient	Total $ 110.71			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/19/18	2005745100	Qty=0010 OMEPRAZOLE 20MG CAP		14.39	
########	Patient	Total $ 14.39			
********	Patient	[redacted]			
		700 S HYDRAULIC			
02/12/18	2005640700	Qty=0030 CLONIDINE 0.1MG TAB		15.00	
02/26/18	2005812100	Qty=0030 MELATONIN 5MG CAP		8.00	
02/26/18	2005812800	Qty=0045 ARIPIPRAZOLE 5 MG TAB		29.59	
02/26/18	2005812900	Qty=0030 CLONIDINE 0.1MG TAB		15.00	
########	Patient	Total $ 67.59			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/02/18	2005496701	Rf#01 Qty=0005 MEDROXYPROG 5MG TAB		14.94	
########	Patient	Total $ 14.94			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/05/18	2005561600	Qty=0020 AMOXICILLIN 875MG TAB		17.31	
########	Patient	Total $ 17.31			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/13/18	2005658400	Qty=0100 PREVDNT 5000PST1.1PCT		32.13	
########	Patient	Total $ 32.13			
********	Patient	[redacted]			

Continued on next page

Ph. (316) 685-2353

S T A T E M E N T

J-1
700 S. HYDRAULIC
WICHITA, KS 67211

Account Number: 108185-006901
Statement thru: 02/28/18

Date	Ticket	Description	Tax	Charges	Payments
		700 S. HYDRAULIC			
02/12/18	2005648000	Qty=0030 ARIPIPRAZOLE 5 MG TAB		24.38	
########	Patient	Total $ 24.38			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
02/19/18	2005742800	Qty=0030 CETIRIZINE 10MG TAB		8.00	
02/19/18	2005742900	Qty=0030 MONTELUKAST SODIUM 10MG TAB		19.49	
########	Patient	Total $ 27.49			
********	Patient	J-1			
		700 S. HYDRAULIC			
02/01/18	2005524600	Qty=0032 FLUTICASONE PROPIO 50MCG/AC		11.71	
02/01/18	2005524700	Qty=0050 KETOSTIX STRIP TES		11.07	
02/07/18	2004907804	Rf#04 Qty=0006 HEAD & SHOULDERS 1% SHA		44.31	
02/07/18	2005583100	Qty=0100 IBUPROFEN 200 MG TABLET		8.00	
02/07/18	2005584300	Qty=0003 SM INSTANT COLD PACK		11.61	
02/19/18	2005742700	Qty=0339 SENSODYNE FRESH IMPACT		18.81	
02/21/18	2004310904	Rf#04 Qty=1152 CLEARASIL FACE WASH		34.55	
02/21/18	2004907805	Rf#05 Qty=0004 HEAD & SHOULDERS 1% SHA		29.54	
02/22/18	2004542705	Rf#05 Qty=2838 CETAPHIL CLEANSER LOT		81.08	
02/27/18	0000001677	ELECTRONIC PAYMENT			2787.66
########	Patient	Total $ 250.68			
		Amount Financed $2,968.85			
		Days Financed 28			
02/28/18	9000000819	Finance Charge $40.99		40.99	

Continued on next page

Ph. (316) 685-2353

S T A T E M E N T

J-1
700 S. HYDRAULIC
WICHITA, KS 67211

Account Number: 108185-006901
Statement thru: 02/28/18

A Monthly Finance Charge of 1.50% (18.00% APR) is charged on any unpaid previous balance.

Past Due	
Last Per	2968.85
30-Days	0.00
60-Days	0.00
90-Days	0.00

Previous Balance	- Credits	- Payments	+ Current Charges	+ Account Charges	= Total Amount Due
5803.40	46.89	2787.66	1418.31	40.99	$4,428.15

---------- (Please return portion below with payment) ----------

J-1
700 S. HYDRAULIC
WICHITA, KS 67211

Account Number: 108185-006901
Statement thru: 02/28/18
Amount Due: $4,428.15 by 03/30/18

Please indicate amount paid [.]

Remit To: DANDURAND PHARMACY
7732 E Central Street
Ste 102A
Wichita, KS 67206

Ph. (316) 685-2353

S T A T E M E N T

J-1
700 S. HYDRAULIC
WICHITA, KS 67211

Account Number: 108185-006901
Statement thru: 03/31/18

Date	Ticket	Description	Tax	Charges	Payments
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/15/18	2005983400	Qty=0030 PRENATAL 27-0.8MG TAB		4.00	
########	Patient	Total $ 4.00			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
03/12/18	2005941700	Qty=0045 ARIPIPRAZOLE 5 MG TAB		29.59	
03/26/18	2006060700	Qty=0045 ARIPIPRAZOLE 5 MG TAB		29.59	
03/26/18	2006062000	Qty=0060 GUANFACINE 1MG TAB		19.18	
03/27/18	2006061900	Qty=0030 ARIPIPRAZOLE 5 MG TAB		24.39	
03/28/18	2006086100	Qty=0010 NEO/POLYB/HYDROCOR 1% OTIC		98.54	
########	Patient	Total $ 201.29			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/09/18	2005923800	Qty=0020 AMOXICILLIN 875MG TAB		17.50	
03/09/18	2005927600	Qty=0010 NEO/POLYB/HYDROCOR 1% OTIC		70.91	
03/19/18	2006009700	Qty=0016 FLUTICASONE PROPIO 50MCG/AC		19.86	
########	Patient	Total $ 108.27			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
03/12/18	2005939700	Qty=0045 QUETIAPINE 400MG TAB		29.80	
########	Patient	Total $ 29.80			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/01/18	2005852100	Qty=0014 AMOX/CLAV 875-125MG TAB		23.78	
########	Patient	Total $ 23.78			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/12/18	2005948700	Qty=0004 AZITHROMYCIN 250MG TAB		17.89	
########	Patient	Total $ 17.89			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/26/18	2006065800	Qty=0018 VENTOLIN HFA 90MCG AER		74.13	
########	Patient	Total $ 74.13			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
03/01/18	2005852000	Qty=0018 VENTOLIN HFA 90MCG AER		74.13	
########	Patient	Total $ 74.13			

Continued on next page

Ph. (316) 685-2353

S T A T E M E N T

J-1
700 S. HYDRAULIC
WICHITA, KS 67211

Account Number: 108185-006901
Statement thru: 03/31/18

Date	Ticket	Description	Tax	Charges	Payments
********	Patient	[redacted]			
		700 S. HYDRAULIC			
03/19/18	2006009600	Qty=0018 VENTOLIN HFA 90MCG AER		74.13	
########	Patient	Total $ 74.13			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/26/18	2006061400	Qty=0030 BUPROPION SR 150MG SR TAB		31.49	
03/26/18	2006061500	Qty=0060 MELATONIN 5MG TAB		8.00	
03/26/18	2006061600	Qty=0030 LATUDA 40MG TAB		1270.64	
########	Patient	Total $ 1310.13			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
03/30/18	2006106300	Qty=0060 SM MIGRAINE RELIEF RELIEF T		8.00	
########	Patient	Total $ 8.00			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/12/18	2005940300	Qty=0030 MELATONIN 5MG TAB		5.00	
03/12/18	2005940400	Qty=0030 CLONIDINE 0.2MG TAB		15.65	
03/12/18	2005940500	Qty=0030 CITALOPRAM 20MG TAB		15.43	
03/26/18	2006061700	Qty=0030 CITALOPRAM 20MG TAB		15.43	
########	Patient	Total $ 51.51			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/12/18	2005940200	Qty=0030 QUETIAPINE 300MG TAB		27.04	
03/12/18	2005941600	Qty=0060 DIVALPROEX ER 500MG TAB		45.96	
########	Patient	Total $ 73.00			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
03/09/18	2004956701	Rf#01 Qty=0018 VENTOLIN HFA 90MCG AER		72.28	
03/19/18	2006014800	Qty=0020 AMOX/CLAV 875-125MG TAB		27.97	
########	Patient	Total $ 100.25			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
03/02/18	2005864400	Qty=0030 CEPHALEXIN 500MG CAP		18.04	
03/02/18	2005864500	Qty=0022 MUPIROCIN 2% OIN		25.41	
03/12/18	2005940000	Qty=0015 QUETIAPINE 300MG TAB		20.52	
03/12/18	2005940100	Qty=0030 BUPROPION XL 150MG TAB		33.44	
########	Patient	Total $ 97.41			

Continued on next page

Ph. (316) 685-2353

S T A T E M E N T

J-1
700 S. HYDRAULIC
WICHITA, KS 67211

Account Number: 108185-006901
Statement thru: 03/31/18

Date	Ticket	Description	Tax	Charges	Payments
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/02/18	2005864200	Qty=0001 FLOVENT HFA 44MCG AER		211.20	
03/12/18	2005939900	Qty=0030 METHYLPHENIDATE HC 27MG ER		133.82	
03/26/18	2006060800	Qty=0030 METHYLPHENIDATE HC 27MG ER		164.21	
03/26/18	2006062100	Qty=0045 ARIPIPRAZOLE 5 MG TAB		29.59	
03/26/18	2006062200	Qty=0030 MELATONIN 5MG TAB		4.00	
########	Patient	Total $ 542.82			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
03/07/18	2005898800	Qty=0018 VENTOLIN HFA 90MCG AER		74.13	
########	Patient	Total $ 74.13			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
03/02/18	2005864300	Qty=0020 AMOXICILLIN 875MG TAB		17.50	
03/26/18	2006061800	Qty=0030 FLUOXETINE HCL 10 MG CAP		14.69	
########	Patient	Total $ 32.19			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/08/18	2005918200	Qty=0060 BENZTROPINE 0.5MG TAB		22.15	
03/08/18	2005918300	Qty=0060 BANOPHEN 25 MG CAPSULE		8.00	
03/08/18	2005918400	Qty=0030 TRAZODONE 50MG TAB		15.89	
########	Patient	Total $ 46.04			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
03/07/18	2005905900	Qty=0002 AZITHROMYCIN 500MG TAB		20.85	
03/19/18	2006013900	Qty=0030 MELATONIN 10MG CAP		8.00	
########	Patient	Total $ 28.85			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/15/18	2005984200	Qty=0030 TRAZODONE 50MG TAB		15.89	
########	Patient	Total $ 15.89			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/30/18	2006104800	Qty=0060 PERMETHRIN 5% CRE		82.89	
########	Patient	Total $ 82.89			
********	Patient	[redacted]			
		700 S HYDRAULIC			

Continued on next page

Ph. (316) 685-2353

S T A T E M E N T

J-1
700 S. HYDRAULIC
WICHITA, KS 67211

Account Number: 108185-006901
Statement thru: 03/31/18

Date	Ticket	Description	Tax	Charges	Payments
03/15/18	2005985900	Qty=0020 AMOXICILLIN 875MG TAB		17.50	
03/15/18	2005986000	Qty=0010 CIPRO HC OTIC SUS		300.32	
03/27/18	2006075200	Qty=0030 CETIRIZINE TAB 10MG		8.00	
########	Patient	Total $ 325.82			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/08/18	2005913500	Qty=0018 VENTOLIN HFA 90MCG AER		74.13	
03/12/18	2005948300	Qty=0002 AZITHROMYCIN 500MG TAB		20.85	
########	Patient	Total $ 94.98			
********	Patient	[redacted]			
		700 S. HYDRAULIC			
03/22/18	2005658401	Rf#01 Qty=0100 PREVDNT 5000PST1.1PCT		32.13	
03/29/18	2005517901	Rf#01 Qty=0030 VENLAFAXINE HCL ER 75MG		19.96	
########	Patient	Total $ 52.09			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/07/18	2005907100	Qty=0020 SULFAMETH/TRIMETH 800-160 T		15.54	
03/07/18	2005907200	Qty=0022 MUPIROCIN 2% OIN		21.50	
########	Patient	Total $ 37.04			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/05/18	2005886100	Qty=0014 AMOX/CLAV 875-125MG TAB		23.78	
########	Patient	Total $ 23.78			
********	Patient	[redacted]			
		700 S HYDRAULIC			
03/26/18	2006063000	Qty=0030 SERTRALINE 50MG TAB		16.27	
03/27/18	2006075300	Qty=0020 SULFAMETH/TRIMETH 800-160 T		15.54	
03/27/18	2006075400	Qty=0022 MUPIROCIN 2% OIN		21.50	
########	Patient	Total $ 53.31			
********	Patient	J-1			
		700 S. HYDRAULIC			
03/06/18	2005894400	Qty=0100 KETOSTIX STRIP TES		22.14	
########	Patient	Total $ 22.14			
		Amount Financed $4,428.15			
		Days Financed 31			
03/31/18	9000000882	Finance Charge $67.69		67.69	

Continued on next page

Continued statement - Part 5

Ph. (316) 685-2353

S T A T E M E N T

J-1
700 S. HYDRAULIC
WICHITA, KS 67211

Account Number: 108185-006901
Statement thru: 03/31/18

A Monthly Finance Charge of 1.50% (18.00% APR) is charged on any unpaid previous balance.

Past Due	
Last Per	1459.30
30-Days	2968.85
60-Days	0.00
90-Days	0.00

Previous Balance	- Credits	- Payments	+ Current Charges	+ Account Charges	= Total Amount Due
4428.15	0.00	0.00	3679.69	67.69	$8,175.53

(Please return portion below with payment)

J-1
700 S. HYDRAULIC
WICHITA, KS 67211

Account Number: 108185-006901
Statement thru: 03/31/18
Amount Due: $8,175.53 by 04/30/18

Please indicate amount paid