

## Proposal Sheet & Acceptance Form

### 1. Base Contract Pricing

Item	Description	Amount (\$)
Annual Base Contract Cost	Comprehensive medical services for ADP 475-525	\$ _____
Monthly Base Payment	Annual Base ÷ 12	\$ _____
Contract Term	3 Years (No Auto-Renewal)	N/A

**2. Average Daily Population (ADP) Tiered Pricing:** Base pricing applies to an ADP range of 475-525 inmates. Adjustments apply when ADP falls below or exceeds this range.

#### A. ADP Below 475

ADP Range	Pricing Adjustment Method	Cost (\$)
Below 475	Vendor to specify reduced rate or credit methodology	\$ _____

#### B. ADP Above 525 (Incremental Pricing)

ADP Range	Increment	Price per Inmate	Total Monthly Adjustment
526-550	+25 inmates	\$ _____ per inmate	\$ _____
551-575	+25 inmates	\$ _____ per inmate	\$ _____
576-600	+25 inmates	\$ _____ per inmate	\$ _____
601-625	+25 inmates	\$ _____ per inmate	\$ _____
626+	+25 inmates	\$ _____ per inmate	\$ _____

*Additional tiers may be added as necessary.*

#### 3. Cost Pool Structure (Annual)

Cost Pool Tier	Dollar Range	County Share	Vendor Share
Tier 1	\$0 - \$124,999.99	0%	100%
Tier 2	\$125,000 - \$174,999.99	50%	50%
Tier 3	\$175,000 - \$199,999.99	75%	25%
Tier 4	\$200,000+	100%	0%

Covered services include outside medical care, medications, dental services, mental and behavioral health services, specialty care, and other eligible services as defined in the contract.

By signing below, the individual accepts and verifies, having examined the Proposal, as prepared by Iredell County, I hereby acknowledge and accept all terms, conditions and additional requirements noted therein and as follows that he/she is a duly authorized representative of the company listed above and is able to legally bind this company to this agreement.

\_\_\_\_\_  
Printed Name of Authorized Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Authorized Individual Signature

\_\_\_\_\_  
Title