

**M/WBE UTILIZATION PLAN**

**INSTRUCTIONS:** This form must be submitted with any bid, proposal, or proposed negotiated contract or within a reasonable time thereafter, but prior to contract award. This Utilization Plan must contain a detailed description of the supplies and/or services to be provided by each certified Minority and Women-owned Business Enterprise (M/WBE) under the contract. Attach additional sheets if necessary.

Offeror's Name: Medicare Rights Center  
 Address: 266 W. 37<sup>th</sup> St., 3<sup>rd</sup> Floor  
 City, State, Zip Code: New York, NY 10018  
 Telephone No.: 212-204-6288  
 Region/Location of Work: New York State

Federal Identification No.: 13-3505372  
 Solicitation No.:  
 Project No.:  
 M/WBE Goals in the Contract: MBE 18% WBE 18%

1. Certified M/WBE Subcontractors/Suppliers Name, Address, Email Address, Telephone No.	2. Classification	3. Federal ID No.	4. Detailed Description of Work (Attach additional sheets, if necessary)	5. Dollar Value of Subcontracts/Supplies/Services and intended performance dates of each component of the contract.
A. Proftech Office Products 200 Clearbrook Rd. Elmsford, NY 10523	NYS ESD CERTIFIED <input checked="" type="checkbox"/> MBE <input type="checkbox"/> WBE		Purchase of office supplies	Approx. \$1320.00
B.	NYS ESD CERTIFIED <input type="checkbox"/> MBE <input type="checkbox"/> WBE			

6. IF UNABLE TO FULLY MEET THE MBE AND WBE GOALS SET FORTH IN THE CONTRACT, OFFEROR MUST SUBMIT A REQUEST FOR WAIVER FORM (M/WBE 104).

PREPARED BY (Signature):  DATE: 9/25/2015  NAME AND TITLE OF PREPARER (Print or Type): Fred Riccardi, Dir. Of Client Svs. SUBMISSION OF THIS FORM CONSTITUTES THE OFFEROR'S ACKNOWLEDGEMENT AND AGREEMENT TO COMPLY WITH THE M/WBE REQUIREMENTS SET FORTH UNDER NYS EXECUTIVE LAW, ARTICLE 15-A, 5 NYCRR PART 143, AND THE ABOVE-REFERENCED SOLICITATION. FAILURE TO SUBMIT COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A FINDING OF NONCOMPLIANCE AND POSSIBLE TERMINATION OF YOUR CONTRACT.	TELEPHONE NO.: 212-204-6241	EMAIL ADDRESS: friccardi@medicarerights.org	
	FOR M/WBE USE ONLY		
	REVIEWED BY: 	DATE: 6/13/16	
	UTILIZATION PLAN APPROVED: <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Date: _____ Contract No.: _____ Project No. (if applicable): _____  Contract Award Date: _____ Estimated Date of Completion: _____ Amount Obligated Under the Contract: _____ Description of Work: _____ NOTICE OF DEFICIENCY ISSUED: <input type="checkbox"/> YES <input type="checkbox"/> NO Date: _____ NOTICE OF ACCEPTANCE ISSUED: <input type="checkbox"/> YES <input type="checkbox"/> NO Date: _____		