EXHIBIT B.2

ARKANSAS STATE CLAIMS COMMISSION
-Claim Form-

Please note that all sections must be completed, or this form will be returned to you, which will delay the processing of your claim.

1. Claimant's Legal Counsel - ☐ **(If representing yourself (Pro Se) please check this box and proceed to section 2)**

Holmes	Ursula			
(last name)	(first name)		(email)	
1213 Union Avenue, Suite 205	Memphis	TN	38104	
(address)	(city)	(state)	(zip)	(primary phone)

Arkansas Bar Number: 2013130

If not licensed to practice law in Arkansas, please contact the Claims Commission for more information.

2. Claimant

Methodist Le Bonheur Healthcare			Tienne.Anderson@mlh.org	
(title/last name/first name or company)			(email)	
1211 Union Avenue	Memphis	TN	38103	(901) 552-6513
(address)	(city)	(state)	(zip)	(primary phone)

3. State Agency Involved: (must be an Arkansas state agency. The Arkansas Claims Commission has no jurisdiction over county, city, or other municipalities)

Arkansas Department of Human Services

(state agency involved)

4. Incident Date

2/19/2019

5. Claim Type

Unpaid Bill

Please provide a brief explanation of your claim. If additional space is required please attach additional statements to this form.

Per Randee Williams with DHS: We have been informed that this bill will have to go through the Claims Commission for payment. It is from the previous fiscal year, so we are unable to process it through the normal payment process. The link to the Claims Commission website is below. I have attached the paperwork that you have provided us that shows the State of Arkansas' portion of the bill and the court order that states the child was to be hospitalized so that the mother could be trained to care for him. If you need our assistance through the process, please let us know and we will try to help as much as we can. Thank you. \
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https://arclaimscommission.arkansas.gov/ \
\
\
Randee Williams\
Division of Children and Family Services/Independence County \
Area IX Fiscal Support Analyst/Financial Coordinator\
\
Claim is for 28 denied days at AFMC rate of $1836.00 per day = $51,408.00. Please see the attached.

5a. Check here if this claim involves damage to a motor vehicle. ☐

5b. Check here if this claim involves damage to property other than a motor vehicle. ☐

All property damage claims require a copy of your insurance declarations covering the property or motor vehicle at the time of damage.

I did not have insurance covering my property/motor vehicle at the time of damage. ☐

All property damage claims require ONE of the following (please attach):

1. **Invoice(s) documenting repair costs, OR**
2. **Three (3) estimates for repair of the damaged property, OR**
3. **An explaination why repair bill(s) or estimate(s) cannot be provided.**

6. Was a state vehicle involved? (If Yes, please complete the following section)

(type of state vehicle involved) (license number) (driver)

7. Check here if this claim involves personal injury.

All personal injury claims require a copy of your medical insurance information in place at the time of the incident.

I do not have health insurance ☐

8. Amount Sought: $51,408.00

(Signature) (Date)

BEFORE THE ARKANSAS STATE CLAIMS COMMISSION

METHODIST LEBONHEUR HEALTHCARE **CLAIMANTS**

V. **CLAIM NO. 210423**

ARKANSAS DEPARTMENT OF HUMAN SERVICES **RESPONDENT**

ORDER

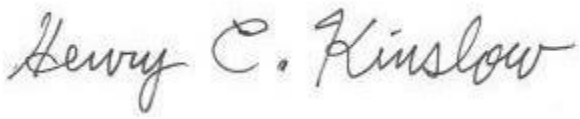
Now before the Arkansas State Claims Commission (the "Claims Commission") is the claim filed by Methodist LeBonheur Healthcare (the "Claimant") against Arkansas Department of Human Services (the "Respondent") for an unpaid bill in the amount of $51,408.00.

Respondent filed an answer recommending payment in the total amount of $27,540.00 based upon the length of the in-patient stay ordered by the court.

The Claims Commission sent correspondence to Claimant on December 7, 2020, advising Claimant that Respondent recommended payment in the amount of $27,540.00 only. In that correspondence, Claimant was given fifteen (15) calendar days to request a hearing and advised that if Claimant did not request a hearing within fifteen (15) days, the claim would be processed for the amount admitted by Respondent. Claimant was also advised that Claimant's claim for any other amounts would be dismissed for failure to respond. To date, Claimant has not responded to the Claims Commission's December 7, 2020, correspondence.

As such, the Claims Commission hereby unanimously ALLOWS this claim in the amount of $27,540.00 , as recommended by the Respondent and transmits this claim to the Arkansas General Assembly pursuant to Ark. Code Ann. § 19-10-215 for review, approval, and placement on an appropriations bill. Claimant's claim for any other amount is hereby dismissed.

IT IS SO ORDERED.



ARKANSAS STATE CLAIMS COMMISSION

Courtney Baird
Dexter Booth
Henry Kinslow, Co-Chair
Paul Morris, Co-Chair
Sylvester Smith

DATE: January 6, 2021

Notice(s) which may apply to your claim

(1) A party has forty (40) days from the date of this Order to file a Motion for Reconsideration or a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1). If a Motion for Reconsideration is denied, that party then has twenty (20) days from the date of the denial of the Motion for Reconsideration to file a Notice of Appeal with the Claims Commission. Ark. Code Ann. § 19-10-211(a)(1)(B)(ii). A decision of the Claims Commission may only be appealed to the General Assembly. Ark. Code Ann. § 19-10-211(a)(3).

(2) If a Claimant is awarded less than $15,000.00 by the Claims Commission at hearing, that claim is held forty (40) days from the date of disposition before payment will be processed. *See* Ark. Code Ann. § 19-10-211(a). Note: This does not apply to agency admissions of liability and negotiated settlement agreements.

(3) Awards or negotiated settlement agreements of $15,000.00 or more are referred to the General Assembly for approval and authorization to pay. Ark. Code Ann. § 19-10-215(b).