

**RFA # 17-005  
HIV/AIDS Patient Care Services**



**FLORIDA DEPARTMENT OF HEALTH IN DESOTO COUNTY  
AREA 8 HIV/AIDS PROGRAM  
REQUEST FOR APPLICATIONS**

DOH RFA # 17-005  
HIV/AIDS Patient Care Services

Applicant Name: \_\_\_\_\_

Area(s) to be Served: \_\_\_\_\_

Annual Amount Requested: \_\_\_\_\_

Name of Contact Person: \_\_\_\_\_

Applicant Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_ Fax Number \_\_\_\_\_

Email Address: \_\_\_\_\_

Federal Employer Identification Number (FEID): \_\_\_\_\_

BY AFFIXING MY SIGNATURE ON THIS APPLICATION, I HEREBY STATE THAT I HAVE READ THE ENTIRE RFA TERMS, CONDITIONS, PROVISIONS AND SPECIFICATIONS AND ALL ITS ATTACHMENTS. I hereby certify that my company, its employees, and its principals agree to abide to all the terms, conditions, provisions and specifications during the competitive solicitation and any resulting contract including those contained in the attached Standard Contract.

Authorized Signature (Manual): \_\_\_\_\_

Authorized Signature (Typed or Printed) and Title: \_\_\_\_\_

\*An authorized representative is an officer of the Respondent's organization who has legal authority to bind the organization to the provisions of the Applications. This usually is the President, Chairman of the Board, or owner of the entity. A document establishing delegated authority must be included with the Application if signed by anyone other than the President, Chairman, or owner.

**This RFA is not a competitive solicitation subject to the notice or challenge provisions of section 120.57 (3) Florida Statutes.**

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**TIMELINE**

Prospective applicants shall adhere to the RFA timelines as identified below.

Schedule	Due Date	Location
Request for Applications Released and Advertised	<p><b>11/02/17</b></p> <p><b>11/03/17</b></p>	<p>Department of Health Grant Funding Opportunities Website:  <a href="http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-functions/purchasing/grant-funding-opportunities/index.html">http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-functions/purchasing/grant-funding-opportunities/index.html</a></p> <p>Vendor Bid System:  <a href="http://vbs.dms.state.fl.us/vbs/main_menu">http://vbs.dms.state.fl.us/vbs/main_menu</a></p>
Submission of Written Questions (Questions may be mailed, faxed or sent by e-mail.)	<b>11/15/17</b>	<p>Submit to: Jenny Turner, Office Operations Consultant I            Attention: <b>RFA #17-005</b>            Florida Department of Health, DeSoto County            34 South Baldwin Avenue            Arcadia, FL 34266            Fax: (863) 491-7598            Email: <a href="mailto:Jenny.Turner@flhealth.gov">Jenny.Turner@flhealth.gov</a></p>
Answers to Questions Posted on website	<b>11/30/17</b>	<p>Department of Health Grant Funding Opportunities Website:  <a href="http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-functions/purchasing/grant-funding-opportunities/index.html">http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-functions/purchasing/grant-funding-opportunities/index.html</a></p> <p>Vendor Bid System:  <a href="http://vbs.dms.state.fl.us/vbs/main_menu">http://vbs.dms.state.fl.us/vbs/main_menu</a></p>
Applications due (no faxed or e-mailed applications)	<p><b>Must be received NO LATER than 3:00 PM EST 12/21/17</b></p>	<p>Submit to: Jenny Turner, Office Operations Consultant I            Attention: <b>RFA #17-005</b>            Florida Department of Health, DeSoto County            34 South Baldwin Avenue            Arcadia, FL 34266</p>
Anticipated evaluation of applications	<b>12/22/17</b>	Review and Evaluation of Applications Begins
Anticipated award date	<b>1/11/18</b>	<p>Department of Health Grant Funding Opportunities Website:  <a href="http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-functions/purchasing/grant-funding-opportunities/index.html">http://www.floridahealth.gov/about-the-department-of-health/about-us/administrative-functions/purchasing/grant-funding-opportunities/index.html</a></p> <p>Vendor Bid System:  <a href="http://vbs.dms.state.fl.us/vbs/main_menu">http://vbs.dms.state.fl.us/vbs/main_menu</a></p>

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**Definitions**

- 1) **Acquired Immunodeficiency Syndrome (AIDS):** A disease caused by the human immunodeficiency virus.
- 2) **Administrative Cost:** In accordance with the *HRSA Ryan White Part B Manual*, usual and recognized overhead activities, including established indirect rates. This cost also includes management oversight of specific programs funded under Ryan White HIV/AIDS Program Part B, and program support such as quality assurance, quality control, and related activities. For this RFA, programmatic support costs must be no more than 5 percent of the amount awarded. The 5 percent cap is inclusive of any subcontracted administrative cost. All administrative costs must comply with the requirements outlined in 45 C.F.R. Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards.
- 3) **Allowable Services:** Specific services to be provided that include comprehensive core medical and support services for individuals with HIV disease as described in the attached Budget Summary.
- 4) **Applicant:** Entity submitting an application for funding.
- 5) **Application and Response:** the complete written response of the Proposer to the RFA, including properly completed forms, supporting documents, and attachments.
- 6) **Area 8 Ryan White service delivery system:** Network of service providers with agreements for providing Ryan White services in Charlotte, Collier, Desoto, Hendry, Glades, Lee and Sarasota Counties.
- 7) **Beneficiary:** any individual who received Ryan White and PCN Beneficiary direct and/or supportive services during the operating year.
- 8) **CAREWare:** free software provided by the DOH for managing and monitoring HIV/AIDS patient care services.
- 9) **Case Management:** a client-centered service that links clients with health care, psychosocial and other services to insure timely, coordinated access to medically appropriate levels of health and support services and continuity of care.
- 10) **Community-based organization (CBO):** An organization that provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease.
- 11) **Continuum of HIV Care:** A model that outlines the sequential steps or stages of HIV medical care that people living with HIV go through from initial diagnosis to achieving the goal of viral suppression (a very low level of HIV in the body), and shows the proportion of individuals living with HIV who are engaged at each stage. The Continuum of HIV Care is sometimes also referred to as the HIV Treatment Cascade or Care Continuum.
- 12) **Contract Manager:** an employee of the Department responsible for enforcing performance of the contract terms and conditions and serving as a liaison to the provider.

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- 13) **Contractor or Provider:** the business entity to which a contract has been awarded by the Department in accordance with an application submitted by that entity in response to this RFA.
- 14) **Department, DOH or Buyer:** Florida Department of Health in DeSoto County and may be used interchangeably.
- 15) **Eligible Person:** an applicant who meets all the criteria under Chapter 64D-4, Florida Administrative Code (“F.A.C.”)
- 16) **General Revenue (GR):** Funding allocated by the state legislature and distributed through the Department’s HIV/AIDS Section. See also: Patient Care Network-General Revenue (PCN) funding.
- 17) **Grantee:** the person or legal entity to which a grant is awarded and that is accountable for the use of the funds provided.
- 18) **Health Resources and Services Administration (HRSA):** The agency of the U.S. Department of Health and Human Services (HHS) that administers various primary care programs for the medically underserved, including the Ryan White HIV/AIDS Program.
- 19) **Human Immunodeficiency Virus (HIV):** The virus that causes AIDS.
- 20) **Low Income:** a person whose household income is at or below the maximum allowable amount as defined in Chapter 64D-4, F.A.C.
- 21) **Mandatory Requirement or Minimum Requirements:** the Department’s established requirements with respect to applications to be submitted. The use of “shall,” “must,” or “will” (except to indicate simple futurity) in this RFA indicates compliance is mandatory. Failure to meet mandatory requirements will cause rejection of the application or termination of the Contract/Direct Order.
- 22) **Medicaid:** a joint Federal and state program that helps with medical costs for some people with low incomes and limited resources.
- 23) **Minor Irregularity:** used in the context of this RFA and perspective Contract/Direct Order, indicates a variation from the application terms and conditions which does not affect the price of the response, or give the applicant(s) an advantage or benefit not enjoyed by other applicant(s), or does not adversely impact the interests of the Department.
- 24) **National HIV/AIDS Strategy (NHAS):** National strategy released in July 2010, by the Office of National AIDS Policy, with four main goals for HIV/AIDS in the United States to:
  - 1) Reduce new HIV infections
  - 2) Increase access to care and improve health outcomes for people living with HIV
  - 3) Reduce HIV-related disparities
  - 4) Achieve a more coordinated response.
- 25) **Part B Grantee:** the Florida Department of Health in DeSoto County Lead Agency.
- 26) **Patient Care Network-General Revenue (PCN):** Funding allocated by the state legislature and distributed through the Department’s HIV/AIDS Section. See also: General Revenue (GR) funding.
- 27) **People Living with HIV/AIDS (PLWHA):** Anyone infected with HIV/AIDS, including infants and children.

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- 28) **Proposer and Applicant(s):** the entity that submits materials to the Department in accordance with these instructions, or other entity responding to this RFA. The term “Vendor” may also be used.
- 29) **Provider:** An entity awarded a contract pursuant to the terms of this RFA.
- 30) **RFA:** This Request For Applications # 17-005 for patient care services.
- 31) **“Ryan White Client”** is defined as any individual who identifies as positive with HIV/AIDS and meets the criteria in Chapter 64D-4 and who is seeking patient care services.
- 32) **Ryan White Fiscal Part B Year:** April 1-March 30.
- 33) **Unmet Need:** Unmet Need is defined by HRSA as the number of individuals for which there is no evidence of any of the following three components of HIV primary medical care during a specified 12-month time frame: viral load (VL) testing, CD4 count, or provision of anti-retroviral therapy. Unmet Need is further defined as the need for HIV related health services for individuals with HIV, who are aware of their HIV status, but who are not receiving HIV primary health care.

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**Section 1.0 INTRODUCTION**

**1.1 Program Authority**

Section 381.003, Florida Statutes, entitled Communicable Disease and AIDS Prevention and Control, gives the Department authority to fund contracts under this RFA. Additionally, portions of this program are also governed by Florida Administrative Code Chapter 64D-4, entitled “Eligibility Requirements for HIV/AIDS Patient Care Programs;” HIV/AIDS Case Management Standards and Guidelines; Ryan White HIV/AIDS Treatment Extension Act of 2009 (Ryan White) program, as amended, and HRSA Program Policy Notices.

**1.2 Notice and Disclaimer**

The HIV/AIDS Patient Care Program (the “program”) is governed by Florida Statutes and Florida Administrative Code. Awards under this program are not purchases of services or commodities governed by Chapter 287, Florida Statutes. By this publication, the Department gives notice of the expected availability of funds and its application process. Contract awards, if any, will be determined by the Department in accordance with the program, as described in this RFA.

Contract awards will be determined by the Department at its sole discretion based on the availability of funds and the quality of the applications. The Department reserves the right to award one or multiple contracts, or to not award any contracts, if it deems it in the best interest of the state of Florida and the Department. The Department reserves the right to negotiate budgetary changes with applicants prior to the award of a contract.

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Applicants may decline the modified contract award or may request a commensurate modification in the scope of the project.

NOTE: The receipt of applications in response to this publication does not imply, or guarantee, that any one or all qualified applicants will result in a contract with the Department.

**1.3 Program Purpose**

The purpose of this RFA is to provide HIV/AIDS Patient Care Services with Ryan White Part B Consortia funding (Ryan White Consortia) in the state of Florida. This RFA will meet the requirements of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (the "Act") and any subsequent reauthorizations of the Act. This RFA will cover the provision of services in designated areas of the state of Florida, and will include administrative oversight of all service delivery within each designated geographic area (See section 2.2).

**1.4 Available Funding**

An estimated \$825,000 is available annually in Ryan White Consortia (Part B) funding over the multi-year contract cycle for this RFA. The number of contract awards will depend upon the amount of funds available, as well as the number and quality of applications received. The Department reserves the right to increase or reduce funding amounts for contract(s) resulting from this RFA. The Ryan White Consortia funds provided under this RFA are federal funds.

**1.5 Matching Funds**

There is no match requirement.

**1.6 Contract Term**

The initial term for contracts resulting from this RFA will be for a period of one year beginning from the date of execution of the contract plus two annual renewals. It is anticipated that the contracts will begin on April 1, 2018, and end March 31, 2021, for Ryan White Consortia. Contracts awarded under this RFA may be renewed annually up to two years' contingent upon a specific appropriation by the Legislature. Renewals must be in writing, subject to the same terms and conditions as set forth in the initial contract, made by mutual agreement, and will be contingent upon satisfactory fiscal and programmatic performance evaluations as determined by the Department and will be subject to the availability of funds.

**Section 2.0 PROGRAM OVERVIEW**

**2.1 Background**

The Department's mission is to protect, promote, and improve the health of all people in Florida through integrated state, county, and community efforts.



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As cited in, Florida Administrative Code Rule 64D-4.001, the goal of the Department is to provide primary health care, and support services, to low-income persons living with HIV disease, based on availability, accessibility, and funding of the program in the state of Florida. This is made possible through:

- Proper fiscal management
- Proper eligibility determination
- Proper service access
- Proper documentation
- Utilization of the State CAREWare database
- Prompt linkage to care post diagnosis or referral
- Proper medical treatment
- Proper laboratory monitoring
- Proper medication adherence

**2.2 Geographic Areas**

The tables below designate the geographic areas eligible for funding, funding amounts available and the services to be provided for the period of April 1, 2018 through March 31, 2021. These same geographic areas apply to this RFA. The number of clients served may vary. Applicants must submit only one application per service per geographic area.

**TABLE 1: Ryan White Consortia funding**

<b>Geographic areas</b>
Area 8: <ul style="list-style-type: none"> <li>• Charlotte</li> <li>• Collier</li> <li>• DeSoto</li> <li>• Hendry</li> <li>• Glades</li> <li>• Lee</li> <li>• Sarasota</li> </ul>

<b>Services to be provided</b>	<b>Funding available</b>
Medical Case Management	\$ 120,000
Ambulatory/Outpatient/Medical Care	\$ 267,850
Local Pharmaceutical Assistance	\$ 650
Health Insurance	\$ 6,000
Oral Health	\$ 206,250
Non-Medical Case Management	\$ 211,250
Mental Health	\$ 6,000
Substance Abuse Outpatient	\$ 7,000

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**2.3 Program Requirements**

Applicant will provide patient care and support services to eligible HIV/AIDS-infected individuals. Applicant must adhere to the requirements of Florida Administrative Code Chapter 64D-4, on patient eligibility. Applicant's proposed method of providing patient care is expected to improve the quality, availability, and to facilitate coordination of HIV/AIDS services within the designated area. This will improve the overall health of individuals living with HIV/AIDS. Applicants will operate in accordance with the most recent version of the following guidelines and manuals, as they are updated and amended throughout the term of the contract:

- The most current Florida Ryan White Part B/General Revenue Patient Care Network Programs Administrative Guidelines)  
[http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/\\_documents/admin-guidelines-2016-2017-final2.pdf](http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/_documents/admin-guidelines-2016-2017-final2.pdf)
- The most current Florida HIV/AIDS Patient Care Eligibility Procedures Manual (<http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/eligibility-information1.html>)
- The most current Florida HIV/AIDS Case Management Operating Guidelines (<http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/case-management-info.html>)
- The most current Ryan White HIV/AIDS Program Services Report Instruction Manual (<https://careacttarget.org/library/ryan-white-hivaids-program-services-report-rsr-instruction-manual>)
- The most current HRSA Monograph, Using Data to Measure Public Health Performance Guide ([https://careacttarget.org/sites/default/files/file-upload/resources/HRSA\\_HAB\\_Data\\_Monograph\\_Guide\\_for\\_Ryan\\_White\\_HIV\\_AIDS\\_Program-Grantees.pdf](https://careacttarget.org/sites/default/files/file-upload/resources/HRSA_HAB_Data_Monograph_Guide_for_Ryan_White_HIV_AIDS_Program-Grantees.pdf))
- Administration of needs assessments as required, including review of the most current needs assessment data (<http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/index.html>)
- The most current Ryan White HIV/AIDS Program Part B Manual published by the HIV/AIDS Bureau, HRSA, DHHS (<http://www.bvcog.org/wp-content/uploads/2014/09/HAB-Part-B-Manual-50820132.pdf>)
- The most current HRSA Policy Notices and Program Letters (<http://hab.hrsa.gov/manageyourgrant/policiesletters.html>)
- Administration of a local Ryan White Part B comprehensive plan as required, including a review of the most current Statewide Coordinated Statement of Need and Comprehensive Plan ([http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/\\_documents/Floridas-2012-15-SCSN-Comprehensive-Plan.pdf](http://www.floridahealth.gov/diseases-and-conditions/aids/patient-care/_documents/Floridas-2012-15-SCSN-Comprehensive-Plan.pdf))
- The National HIV/AIDS Strategy (NHAS) and The National HIV/AIDS Strategy Implementation Plan (<https://www.cdc.gov/hiv/policies/nhas.html> and <https://hab.hrsa.gov/about-ryan-white-hivaids-program/national-hivaids-strategy-updated-2020> )
- 2 C.F.R. Appendix II to Part 200 - Contract Provisions for Non-Federal Entity Contracts Under Federal Awards

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(<http://www.gpo.gov/fdsys/pkg/C.F.R.-2014-title2-vol1/pdf/C.F.R.-2014-title2-vol1-part200-appl.pdf>)

- 45 C.F.R. 75 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards  
(<http://www.eC.F.R..gov/cgi-bin/text-idx?node=pt45.1.75>)
- HRSA/HAB Glossary of Terms  
([http://www.sfcarecouncil.org/Documents/P&P%202014/Section%20G%20-%20Appendix,%20including%20Directives/G-8\\_HRSA\\_Glossary\\_of\\_Terms.pdf](http://www.sfcarecouncil.org/Documents/P&P%202014/Section%20G%20-%20Appendix,%20including%20Directives/G-8_HRSA_Glossary_of_Terms.pdf) )
- HRSA Policy Clarification Notice (PCN) #15-01, Treatment of Costs under the 10% Administrative Cap for Ryan White HIV/AIDS Program Parts A, B, C, and D  
(<https://hab.hrsa.gov/sites/default/files/hab/Global/pcn1501.pdf> )

## **2.4 Applicant's Results**

Applicants must address how they will improve the Continuum of HIV Care in their area if funding is provided. Applicants must identify the overall program purpose and program expectations and how the anticipated project results are consistent with the four goals of the 2010 National HIV/AIDS Strategy:

- 1) Reducing new HIV infections;
- 2) Increasing access to care and improving health outcomes for people living with HIV/AIDS;
- 3) Reducing HIV-related disparities and health inequities;
- 4) Achieving a more coordinated response to the HIV epidemic.

## **2.5 Current and Prior Funded Projects**

Applicants must describe how their experience or achievements from current or prior funded projects demonstrate their ability to carry out the program expectations outlined in this RFA.

## **Section 3.0 TERMS AND CONDITIONS OF SUPPORT**

### **3.1 Eligible Applicants**

Public and nonprofit entities are eligible applicants for this RFA. A for-profit entity is eligible only if it is the sole available provider of quality HIV/AIDS care in the area.

### **3.2 Eligibility Criteria**

All entities submitting an application must be registered in the state's MyFloridaMarketPlace. For more information, please visit:  
[http://dms.myflorida.com/business\\_operations/state\\_purchasing/myflorida\\_marketplace](http://dms.myflorida.com/business_operations/state_purchasing/myflorida_marketplace).  
If you need online help, go to [www.myFloridaMarketPlace.com](http://www.myFloridaMarketPlace.com). If you need assistance by telephone to register, call (866) 352-3776.

All entities doing business with the State of Florida must have a completed W-9 on file with the Department of Financial Services. Please see the W-9 website to complete:  
<https://flvendor.myfloridacfo.com> or call (850) 413-5519.

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**3.3 Corporate Status**

All corporations, limited liability companies, corporations not for profit, and partnerships seeking to do business with the State must be registered with the Florida Department of State in accordance with the provisions of Chapters 607, 608, 617 and 620, Florida Statutes, respectively prior to award.

**3.4 Use of Grant Funds**

Funds from this RFA must only be used for core medical and support services using Ryan White Part B Consortia funds. Applicants must not allocate more than 5 percent of the total amount awarded for programmatic costs.

As cited in the HRSA PCN #15-01, the portion of direct facilities expenses, to include only rent and utilities, for entities providing core medical and support services for Ryan White Part B eligible clients (e.g., clinic, pharmacy, food bank, substance abuse treatment facilities) are not required to be included in the programmatic cost cap, and instead could be counted under the relevant core medical or support service category. Ryan White Part B Sub-Recipients will be required to pay the Service Providers. In order for the Sub-Recipient to recover funds, they will need to provide proof of service by the Service Provider, thru invoice or billing forms, and include the amount requested as a line item on the Monthly Expenditure Report.

Applicants must comply with the administrative requirements outlined in 45 C.F.R. Part 75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards. In accordance with requirements imposed by the Office of Management and Budget, HHS adopted new grant regulations, codified at 45 C.F.R. Part 75, with an effective date of December 26, 2014. This guidance supersedes and streamlines requirements from OMB Circulars A-21, A-87, A-110, A-122, A-89, A-102 and A-133 and the guidance in Circular A-50 on Single Audit Act follow-up.

**3.5 Payment**

The Department will pay Provider using cost-reimbursement method of payment for the delivery of services provided in accordance with the terms and conditions of the resulting contract.

**3.6 Staffing Requirements**

The applicant must maintain sufficient personnel qualified to successfully execute services and obligations under any contract awarded through this RFA.

**3.7 Service Location**

**Service Delivery Location**

The Provider must offer services to clients at a minimum of Monday through Friday, excluding state holidays, from one or more service delivery locations.

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**Service Times**

The provider must offer services to clients at a minimum from 8am to 5pm EST, excluding state holidays, from one or more service delivery locations. With approval, community-based organizations may alter these hours as long as the hours are clearly described and posted and include a minimum of 40 hours per week.

**Changes in Location**

The Provider will notify the Department in writing a minimum of one (1) month prior to making changes in location.

**3.8 Data Requirements**

The successful respondent will be required to use DOH's CAREWare to capture pertinent clinical, eligibility, demographic and case management information. The Florida DOH HIV/AIDS Section and Department will develop and make available reports from the CAREWare database that will assist respondent(s) to remain in compliance with federal and state requirements. Over the course of the resulting contract, the successful respondent will be required to complete and provide at a minimum, an acceptable performance and compliance for the following performance measures:

**Performance Measure 1:** The successful respondent providing Medical Case Management must capture the clinical information necessary to monitor HRSA's Group One Clinical measures.

**Performance Measure 2:** The successful respondent providing Medical Case Management must maintain documentation that clients are eligible, as defined by Eligibility Rule 64D-4 FAC, at the time services are rendered.

**Performance Measure 3:** The successful respondent must maintain a quality management plan and procedure. The successful respondent shall have established a quality assurance (QA) program for services provided to Ryan White clients. Written program protocols shall be in place at the time of contract execution. A written report on QA program findings shall be provided at the time of annual site visits. The successful respondent will address all identified problems in a timely manner and, upon request, shall address specific issues raised by the Department.

**Performance Measure 4:** The successful respondent must notify Department Area 8 Lead Agency when a verbal or written complaint is filed related to any services.

**Performance Measure 5:** The successful respondent must submit the most current Agency disaster response plan to the Department Contract Manager within the first 60 days of the contract.

Acceptable performance of these Measures is required, and completion of additional performance measures may be required by the Department.

**Section 4.0 APPLICATION REQUIREMENTS**

**4.1 Application Forms**

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Applicants must use the forms included in this RFA. Alternate forms must not be used. Applications for funding must address all sections of the RFA in the order presented and in as much detail as requested. The provision of extraneous information should be avoided. Applications must adhere to the page limits as identified below.

**4.2 Instructions for Formatting Application**

- a) The title page (front page of this RFA) must be completed and used as the cover of the application.
- b) Applicants must use the application checklist in Section 4.13 to determine the order that information is presented in the application.
- c) Applications, along with all supporting documents, must be submitted in one packet.
- d) The original must be signed by an individual authorized to act for the applicant and to assume for the organization the obligations imposed by the terms and conditions of the RFA.
- e) All pages must be numbered, singled spaced, and use a one-inch margin.
- f) Use Times New Roman (12 point) font, or equivalent.
- g) Do not include any spiral or bound material or pamphlets.

**Note: Failure to submit all information requested may result in the applicant being considered non-responsive, and therefore not evaluated.**

**4.3 Title Page - One Page Limit**

Applicant must use the first page of this RFA as the title page. Alternate forms must not be used. Applicant is required to complete the following information:

- a) Applicant Name (Legal Name of the Organization)
- b) Area(s) to be Served
- c) Annual Amount Requested
- d) Name of Contact Person
- e) Applicant Mailing Address (including City, State and Zip code)
- f) Telephone Number(s), Fax Number
- g) Email Address of Contact Person
- h) Applicant Federal Employer Identification Number (FEID)
- i) Authorized Signature (person submitting the application on behalf of the applicant)
- j) Authorized Name and Title (person submitting the application on behalf of the applicant)

**4.4 Table of Contents - Two Page Limit**

Each copy of the application must contain a table of contents identifying the major sections as titled in the Application Checklist in 4.13 with corresponding page numbers.

**4.5 Project Summary - Two Page Limit**

Applicants must provide a succinct summary of the proposed project, in response to this RFA. The project summary must identify the main purpose of the project, the priority population(s) to be served, proposed components to be implemented, types of services

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offered, the area to be served, expected outcomes, and the total annual amount requested by funding source as detailed in Section 2.2, Tables 1-3.

**4.6 Statement of Need - Three Page Limit**

The statement of need must describe the necessity for the proposed project and at a minimum must include all of the following components in narrative form:

- a) Description of the HIV/AIDS infections within each geographic area
- b) Description of the assessed needs, including care needs and capacity development needs resulting from disparities in the availability of HIV-related services
- c) Description of priorities for the allocation of funds based on the size and demographics of the population to be served and identified needs
- d) Description of assessed gaps in care
- e) Description of assessed barriers to care

**4.7 Objectives - Three Page Limit**

Applicant will be responsible for providing patient care core medical and support services to PLWHA. If an Applicant intends to subcontract, it must explain how it will hold subcontractor(s) accountable so there is no diminution in services. All services specified in an application must be to improve quality and availability of, and to facilitate collaboration of HIV/AIDS services within the designated area to improve the overall health of PLWHA.

This section must describe the intended purpose and the expected project results related to program expectations. The objectives must correspond to the assessed needs, priorities, gaps in services, and barriers to care described in the preceding section, as well as the four primary goals of the NHAS. The objectives must consider an integrated service network that guides and tracks clients through a comprehensive array of clinical, mental health and social services in order to maximize access and outcomes.

While objectives utilize the language of outcomes, the objectives discussed in the application must express the expected outcomes in specific terms. The objectives must also establish a foundation for project assessment, which will be described in a subsequent section related to the applicant's evaluation plan.

**4.8 Program Plan - Five Page Limit**

This section must describe applicant's plan to achieve the objectives identified in the preceding section through a narrative that describes how the activities outlined in the Budget Narrative will achieve the following:

- 1) Address the four primary goals of the 2010 National HIV/AIDS Strategy as referenced in Section 2.4.
- 2) Address Unmet Need and reduce the number of persons out of care.
- 3) Address individuals who are unaware of their HIV status with regard to identifying them, making them aware of their status, referring them to care, and linking them to care.

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- 4) Ensure geographic parity in access to HIV/AIDS services throughout the geographic area.
- e) Address the needs of emerging populations.

This section must describe how applicant will use the Continuum of HIV Care to improve the quality of the HIV service delivery system, including strategic long-range planning utilizing surveillance and program data to assess and improve health outcomes. Applicants must incorporate the following components of the Continuum of HIV Care in their response:

- a) HIV testing and subsequent diagnosis
- b) Linkage to HIV medical care
- c) Continuous engagement in HIV medical care (retention)
- d) Initiation of antiretroviral therapy
- e) Suppressed viral load (<200 copies/mL)

**4.9 Evaluation Plan - Four Page Limit**

Applicants must describe how they will evaluate program activities. It is expected that evaluation activities will be implemented at the beginning of the contract in order to capture and document actions contributing to program outcomes. The evaluation plan must be able to produce documented results that demonstrate whether, and how, the strategies and activities funded under the program made a difference in the improvement of health outcomes for PLWHA and increasing access to care. The plan must identify the expected result (*i.e.*, a particular impact or outcome) for each major objective and activity, and discuss the potential for replication. In addition, applicants must describe their internal quality management plan, including the process for continued improvement and handling potential challenges.

**4.10 Management Plan - Ten Page Limit**

This section must describe the applicant's ability to successfully carry out the proposed project and to sustain the program once the contract ends. Applicants must identify in narrative form all of the following information:

- a) Information about the applicant, including history, administrative structure, mission, vision, goals and how they relate to the purposes of the proposed program.
- b) A description of how the program will be staffed (*e.g.*, paid staff or volunteers). Indicate how often employees are evaluated. Identify the number and type of positions needed; how they will be recruited and maintained; whether they will be full-time or part-time; and the qualifications proposed for each position, including type of experience and training required. Describe staff development and training practices, including both internal and external capacity trainings and any other relevant training.
- c) The last five years of previous experience providing services to the target population including a brief description of projects similar to the one proposed in response to the RFA. Include the length of time working with the target population and any services that the applicant currently provides to the target population. If applicant has not been in existence for more than five years, then



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describe relevant experience of key staff providing services to the target population.

- d) Applicants' capacity to implement and maintain the proposed project. Include information on project resources, materials, and space. Detail how Applicant is prepared to implement the required services and activities of the proposed project, or applicant's plan to build the capacity to implement and sustain (once project period ends) its proposed project.

**4.11 Collaboration - Two Page Limit**

This section must be used by the applicant to describe its efforts to partner with other organizations within the local community to deliver the proposed project. Collaboration may also be considered as a means of ensuring program sustainability once funding ends. Applicants must identify in narrative form all of the following information:

- a) Applicant's level of involvement with its local community planning partnership and community planning activities in its area. Detail the name of the planning partnership, and any personnel that are members of the partnership. Describe any committees/sub-groups that its personnel serve on, and their activities. Identify planned collaborative efforts with public/private agencies that address issues of PLWHA. Describe the coordination of the collaborative process used to plan and implement the proposed project, including, but not limited to, an explanation of who was involved, how these relationships will be maintained, the expected roles and responsibilities, and assurance that there is no duplication, or overlap, of services.
- b) How members of the target population and the local community will be involved in project implementation, including the following:
  - 1) A description of the methods used to engage communities, PLWHA, and impacted population groups to ensure that HIV activities are responsive to the needs in that service area.
  - 2) A description of engagement of impacted communities in the planning process to provide critical insight into developing solutions to health problems to assure the availability of necessary resources.

**4.12 Appendices**

Submit all of the following appendices to the application (appendix documents are not included in the page limit):

- A1. Budget Summary (Excel format available upon request.)
  - a) Use the format found in the RFA to provide a line-item budget.
  - b) All costs contained in the budget summary must be directly related to the services and activities proposed to be provided and identified in the application, as well as allowable and reasonable.
  - c) The proposed budget summary provides a breakdown of all requested cost items that will be incurred by the proposed project as they relate to the program plan.
- A2. Budget Narrative (Excel format available upon request.)
  - a) Use the format found in the RFA to provide justification and details for all cost items contained in the budget summary.

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- b) Include only expenses directly related to the project and necessary for program implementation.
  - c) Describe the administrative and fiscal infrastructure that will enable applicant to track and expend funds in accordance with generally accepted accounting practices.
- B1. Documentation of existing agreements with HIV/AIDS service providers where clients may be linked to care.
- B2. Letter(s) of agreement from integrated partner services, if applicable.
- C1. Organizational Chart that depicts the organizational structure of the project and outlines the professional roles of the staff and reporting relationships.
- C2. Copy of current Certificate of Incorporation.
- C3. Copies of key (management) personnel’s resumes, email addresses, and telephone numbers.
- C4. Current roster of the board of directors, including name, address, and telephone numbers.
- C5. Letter from the local community planning partnership chair confirming membership of applicant and identity of applicant’s personnel identified as members of the planning partnership.
- D1. Letters of agreement, or commitment, from partners, key stakeholders, and other local organizations where program activities will be implemented.
- D2. Agreements or letters of support with other collaborative partners, identifying their role and contribution to the project.

**4.13 Order of Application Package**

The application must address each section in as much detail as requested and necessary, avoiding the inclusion of extraneous information and adhering to the page limit, excluding appendices. Applicants must submit all items in the following order:

REQUEST FOR APPLICATIONS CHECKLIST	
This checklist is to be used by applicants to help ensure that all parts of the application are included.	
CHECKLIST ITEMS	PAGE LIMIT
1. Title Page	One Page
2. Table of Contents	Two Pages
3. Project Summary	Two Pages
4. Statement of Need	Three Pages
5. Objectives	Three Pages
6. Program Plan	Five Pages
7. Evaluation Plan	Four Pages
8. Management Plan	Ten Pages
9. Collaboration	Two Pages
Appendix A	Budget Allocation A.1. Budget Summary - as specified. A. 2. Budget Narrative - as specified.
Appendix B	Agreements B.1. Documentation of existing agreements with HIV/AIDS service providers where clients may be linked to care.

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	B.2. Letter(s) of agreement from integrated partner services, if applicable.
Appendix C	Organizational Capacity Documentation C.1. Organizational chart. C.2. Certificate of Incorporation. C.3. Copies of key (management) personnel’s resumes, email addresses and telephone numbers. C.4. Current roster of the board of directors, including name, address and telephone numbers. C.5. A letter from the local community planning partnership chair confirming membership of agency personnel identified as members of the planning partnership.
Appendix D	Collaboration Documentation D.1. Letters of agreement or commitment - as specified D.2. Agreements, or letters of support, with other collaborative partners – as specified.

**Section 5.0 SUBMISSION OF APPLICATION**

Applications must be submitted in the manner described in this section.

**5.1 Application Deadline**

Applications must be received no later than 3:00 p.m., Eastern Time, on Thursday, December 21, 2017.

**5.2 Submission Methods**

- a) Applicants are required to complete, sign, and return the “Title Page” with the application.
- b) Applications must be sent by U.S. Mail, courier, or hand-delivered to the location identified in Section 5.4.
- c) Applications submitted electronically will NOT be considered for this solicitation.
- d) The Department is not responsible for improperly marked applications.
- e) The Department’s clock will provide the official time for application receipt.
- f) One original and five copies of each application clearly marked on the outside with the application number and the name of the applicant must be submitted in a sealed box or envelope.
- g) It is the responsibility of the applicant to ensure the application is submitted to the correct office and prior to the deadline identified in the Timeline.
- h) Applications received after the deadline are not eligible for review or consideration.

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- i) Materials submitted will become the property of the state of Florida and accordingly, the state reserves the right to use any concepts or ideas contained in the application.

**5.3 Late Applications**

**Applications that are not received by the time specified will not be considered.**

**5.4 Where to Send Your Application**

For U.S Mail or Overnight Shipping:

Jenny Turner, Office Management Consultant I

Attention: **RFA #17-005**

Florida Department of Health, DeSoto County

34 South Baldwin Avenue

Arcadia, FL 34266

**5.5 Inquiries/Written Questions**

Questions related to this RFA must be received in writing by the contact person identified in the Timeline and by the indicated date and time. No questions will be accepted after the date and time reflected in the Timeline. Any questions as to the requirements of this RFA, or any apparent omissions or discrepancy, must be presented to the Department in writing via e-mail. Applicants are encouraged to write "RFA Question" in the subject line of email communications. The Department will determine the appropriate action necessary, if any, and may issue a written amendment to the RFA. Answers will be posted as noted in the Timeline. No telephone calls will be accepted.

**Section 6.0 EVALUATIONS OF APPLICATIONS**

**6.1 Initial Review of Applications**

Applications that are not complete, or that do not conform to, or address the criteria of the RFA will be considered non-responsive. Complete applications are those that include the required items as listed in the application checklist in Section 4.13 of this application.

**6.2 How Applications are Scored**

The quality of each response to an evaluated area listed below will be considered when determining a value. Applicants can earn up to a total of 100 points with zero being the lowest possible total. Awarded points will be the average score of each evaluator's score truncated to a whole number. Applications scored on the following as indicated below.

- a) Statement of Need: Applicants will be evaluated on their description of the necessity for the proposed project. **(Maximum 5 points)**.

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- b) Objectives: Applicants will be evaluated on their description of the intended purpose and the expected project results related to program expectations. **(Maximum 5 points)**
- c) Program Plan: Applicants will be evaluated on their approach to administering and providing core medical/support services to eligible clients in the specified area service will be provided. **(Maximum 25 points)**
- d) Evaluation Plan: Applicants will be evaluated on how they evaluate program activities. **(Maximum 5 points)**
- e) Management Plan: Applicants will be evaluated on their ability to successfully carry out the proposed project and to sustain the program once contract funding ends. **(Maximum 20 points)**
- f) Collaboration: Applicants will be evaluated on their efforts to partner with other organizations within the local community to deliver the proposed project. **(Maximum 5 points)**
- g) Budget: The budget summary must be completed using Appendix A1 (Budget Summary). The budget narrative must include a detailed explanation of the budget using Appendix A2 (Budget Narrative). **(Maximum 20 points)**
- h) Programmatic Cost: Applicants will be evaluated on their ability to perform the activities outlined in their program plan below the 5 percent programmatic cost cap. **(Maximum 5 points)**
- i) Experience: Applicants will be evaluated on how many years' experience they have in administering a HIV/AIDS Patient Care Program similar to the scale and scope of the proposed project. **(Maximum 10 points)**

**6.3 Contract Awards**

Contract awards will be determined by the Department at its sole discretion based on the availability of funds. Funding decisions are wholly at the discretion of the Department notwithstanding evaluation point totals. See Section 1.4.

**6.4 Posting of Awards**

Notice of intent to award will be posted on the Florida Department of Health Grant Funding Opportunities webpage.

**Section 7.0 REPORTING AND OTHER REQUIREMENTS**

**7.1 Post Award Requirements**

Selected applicants will be required to complete and submit the following:

- a) Monthly Expenditure Reports
- b) Ryan White Services Reports
- c) Monthly invoices for payment
- d) Quarterly Financial Reports
- e) Collect and enter data in CAREWare for clients receiving core medical and support services
- f) Monthly Grievance Log/Report
- g) CAREWare Eligibility Review Tool

**7.2 Licenses, Permits, and Taxes**

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Applicants must pay for all licenses, permits and taxes required to operate in the state of Florida. Applicants must comply with all applicable federal, state, and local laws, ordinances, codes, regulations, action transmittals, program instructions, and other requirements at no cost to the Department.

**7.3 Qualifications**

Selected applicants will be responsible for the staff affiliated with the RFA, ensuring they have the education, experience and training necessary to successfully carry out duties, including any professional licensure or certification which may be required by law. Persons hired to work through this grant should be familiar and comfortable with the cultural norms and beliefs of the target population.

**7.4 Standard Contract**

Applicants must review, and become familiar with, the Department's Standard Contract, which contains administrative, financial and non-programmatic terms and conditions mandated by federal or state law and policy of the Department of Financial Services. Use of the Standard Contract is mandatory for Departmental contracts as they contain the basic clauses required by law. The terms and conditions contained in the Standard Contract are non-negotiable.

**7.5 Required Certifications**

Applicants must sign and return the required certifications form with their response.

**7.6 Conflict of Interest**

Section 287.057(17)(c), Florida Statutes, provides, "A person who receives a contract that has not been procured pursuant to subsections (1)-(3) to perform a feasibility study of the potential implementation of a subsequent contract, who participates in the drafting of a solicitation or who develops a program for future implementation, is not eligible to contract with the Department for any other contracts dealing with that specific subject matter, and any firm in which such person has any interest in not eligible to receive such contract. However, this prohibition does not prevent a Respondent who responds to a request for information from being eligible to contract with the Department". The Department considers participation through decision, approval, disapproval, recommendation, preparation of any part of a purchase request, influencing the content of any specification or procurement standard, rendering of advice, investigation, or auditing or any other advisory capacity to constitute participation in drafting of the solicitation. Acknowledge acceptance on Required Certifications, Attachment IV

**7.7 Public Records and Trade Secrets**

Notwithstanding any provisions to the contrary, public records must be made available pursuant to the provisions of the Public Records Act. If the applicant considers any portion of its application to this RFA to be confidential, exempt, trade secret or otherwise

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not subject to disclosure pursuant to Chapter 119, Florida Statutes, the Florida Constitution or other authority, the applicant must segregate and clearly mark the document(s) as “**CONFIDENTIAL.**”

Simultaneously, the applicant must provide the Department with a **separate redacted electronic copy** of its application with the claimed protected information redacted and briefly describe in writing the grounds for claiming exemption from the public records law, including the specific statutory citation or other legal authority for such exemption. This redacted copy must contain the Solicitation name, number, and the name of the applicant on the cover, and must be clearly titled “**REDACTED COPY.**”

The Redacted Copy must be provided to the Department at the same time the applicant submits its application and must only exclude or redact those exact portions that are claimed confidential, proprietary, or trade secret. The applicant will be responsible for defending its determination that the redacted portions of its application are confidential, trade secret or otherwise not subject to disclosure. Further, the applicant must protect, defend, and indemnify the Department for any and all claims arising from or relating to the determination that the redacted portions of its response are confidential, proprietary, trade secret or otherwise not subject to disclosure. If the applicant fails to submit a redacted copy with its application, all records submitted are public records and the Department will produce all documents, data or records submitted by the applicant in answer to a public records request.

# **ATTACHMENTS**



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**ATTACHMENT I  
REQUIRED CERTIFICATIONS  
STATEMENT OF NO INVOLVEMENT  
CONFLICT OF INTEREST STATEMENT (NON-COLLUSION)**

I hereby certify that my company, its employees, and its principals, had no involvement in performing a feasibility study of the implementation of the subject contract, in the drafting of this solicitation document, or in developing the subject program. Further, my company, its employees, and principals, engaged in no collusion in the development of the instant bid, proposal or reply. This bid, proposal or reply is made in good faith and there has been no violation of the provisions of Chapter 287, Florida Statutes, the Administrative Code Rules promulgated pursuant thereto, or any procurement policy of the Department of Health. I certify I have full authority to legally bind the Bidder, Respondent, or Vendor to the provisions of this bid, proposal or reply.

\_\_\_\_\_  
Signature of Authorized Representative\*

\_\_\_\_\_  
Date

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**ATTACHMENT II  
CERTIFICATION REGARDING LOBBYING  
CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS**

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in the connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid, to any person for influencing or attempting to influence an officer or an employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in the connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit *Standard Form-LLL, Disclosure Form to Report Lobbying*, in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by §1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Authorized Individual**

\_\_\_\_\_  
**Application or Contract Number**

\_\_\_\_\_  
**Address of Organization**

\_\_\_\_\_  
**Name of Organization**

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**ATTACHMENT III**

**Combined HIPAA Privacy Business Associate Agreement and Confidentiality Agreement and HIPAA Security Rule Addendum and HI-TECH Act Compliance Agreement and the Florida Information Protection Act of 2014**

This Agreement is entered into between the Florida Department of Health, DeSoto County ("Covered Entity"), and \_\_\_\_\_ ("Business Associate"). The parties have entered into this Agreement for the purpose of satisfying the Business Associate contract requirements in the regulations at 45 CFR 164.502(e) and 164.504(e), issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Security Rule, codified at 45 Code of Federal Regulations ("C.F.R.") Part 164, Subparts A and C; Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub. L. No. 111-5 (Feb. 17, 2009) and related regulations.

**1.0 Definitions**

Terms used but not otherwise defined in this Agreement shall have the same meaning as those terms in 45 CFR 160.103 and 164.501. Notwithstanding the above, "Covered Entity" shall mean the State of Florida Department of Health. "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g); "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or his designee; and "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

**Part I: Privacy Provisions**

**2.0 Obligations and Activities of Business Associate**

- (a) Business Associate agrees to not use or further disclose Protected Health Information ("PHI") other than as permitted or required by Sections 3.0 and 5.0 of this Agreement, or as required by Law.
- (b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.
- (c) Business Associate agrees to take reasonable measures to protect and secure data in electronic form containing personal information as defined by §501.171, Florida Statutes.
- (d) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.
- (e) Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement of which it becomes aware.
- (f) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
- (g) Business Associate agrees to provide access, at the request of Covered Entity or an Individual, and in a prompt and reasonable manner consistent with the HIPAA regulations, to Protected Health Information in a designated record set, to the Covered Entity or directly to an Individual in order to meet the requirements under 45 CFR 164.524.
- (h) Business Associate agrees to make any Amendment(s) to Protected Health Information in a designated record set that the Covered Entity or an Individual directs or agrees to pursuant to 45 CFR 164.526, in a prompt and reasonable manner consistent with the HIPAA regulations.
- (i) Business Associate agrees to make its internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity available to the Covered Entity, or at the request of the Covered Entity, to the Secretary in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

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- (j) Business Associate agrees to document disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.
- (k) Business Associate agrees to provide to Covered Entity or an Individual an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528, in a prompt and reasonable manner consistent with the HIPAA regulations.
- (l) Business Associate agrees to satisfy all applicable provisions of HIPAA standards for electronic transactions and code sets, also known as the Electronic Data Interchange (EDI) Standards, at 45 CFR Part 162 no later than October 16, 2003. Business Associate further agrees to ensure that any agent, including a subcontractor, that conducts standard transactions on its behalf, will comply with the EDI Standards.
- (m) Business Associate agrees to determine the Minimum Necessary type and amount of PHI required to perform its services and will comply with 45 CFR 164.502(b) and 514(d).
- (n) Business Associate agrees to comply with all aspects of §501.171, Florida Statutes.

**3.0 Permitted or Required Uses and Disclosures by Business Associate General Use and Disclosure.**

- (a) Except as expressly permitted in writing by Department of Health, Business Associate may use Protected Health Information only to carry out the legal responsibilities of the Business Associate, but shall not disclose information to any third party without the expressed written consent of the Covered Entity.
- (b) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information to provide data aggregation services to Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).
- (c) Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j) (1).

**4.0 Obligations of Covered Entity to Inform Business Associate of Covered Entity's Privacy Practices, and any Authorization or Restrictions.**

- (a) Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR 164.520, as well as any changes to such notice.
- (b) Covered Entity shall provide Business Associate with any changes in, or revocation of, Authorization by Individual or his or her personal representative to use or disclose Protected Health Information, if such changes affect Business Associate's uses or disclosures of Protected Health Information.
- (c) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522, if such changes affect Business Associate's uses or disclosures of Protected Health Information.

**5.0 Confidentiality under State Law.**

- (a) In addition to the HIPAA privacy requirements and the data security requirements of §501.171, Florida Statutes, Business Associate agrees to observe the confidentiality requirements of Sections 456.057, Florida Statutes.
- (b) Receipt of a Subpoena. If Business Associate is served with subpoena requiring the production of Department of Health records or information, Business Associate shall immediately contact the Department of Health, Office of the General Counsel, (850) 245-4005. A subpoena is an official summons issued by a court or an administrative tribunal, which requires the recipient to do one or more of the following:
  - 1. Appear at a deposition to give sworn testimony, and may also require that certain records be brought to be examined as evidence.
  - 2. Appear at a hearing or trial to give evidence as a witness, and may also require that certain records be brought to be examined as evidence.
  - 3. Furnish certain records for examination, by mail or by hand-delivery.

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- (c) Employees and Agents. Business Associate acknowledges that the confidentiality requirements herein apply to all its employees, agents and representatives. Business Associate assumes responsibility and liability for any damages or claims, including state and federal administrative proceedings and sanctions, against Department of Health, including costs and attorneys' fees, resulting from the breach of the confidentiality requirements of this Agreement.

**6.0 Permissible Requests by Covered Entity.**

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

**7.0 Term and Termination.**

(a) Term.

The Term of this Agreement shall be effective as of \_\_\_\_\_, and shall terminate on \_\_\_\_\_. Prior to the termination of this Agreement, the Business Associate shall destroy or return to the Covered Entity all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity. If it is infeasible or impossible to return or destroy Protected Health Information, the Business Associate shall immediately inform the Covered Entity of that and the parties shall cooperate in securing the destruction of Protected Health Information, or its return to the Covered Entity. Pending the destruction or return of the Protected Health Information to the Covered Entity, protections are extended to such information, in accordance with the termination provisions in this Section.

(b) Termination for Cause.

Without limiting any other termination rights the parties may have, upon Covered Entity's knowledge of a material breach by Business Associate of a provision under this Agreement, Covered Entity shall provide an opportunity for Business Associate to cure the breach or end the violation. If the Agreement of Business Associate does not cure the breach or end the violation within the time specified by Covered Entity, the Covered Entity shall have the right to immediately terminate the Agreement. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

(c) Effect of Termination.

1. Within sixty (60) days after termination of the Agreement for any reason, or within such other time period as mutually agreed upon in writing by the parties, Business Associate shall return to Covered Entity or destroy all Protected Health Information maintained by Business Associate in any form and shall retain no copies thereof. Business Associate also shall recover, and shall return or destroy with such time period, any Protected Health Information in the possession of its subcontractors or agents.
2. Within fifteen (15) days after termination of the Agreement for any reason, Business Associate shall notify Covered Entity in writing as to whether Business Associate elects to return or destroy such Protected Health Information, or otherwise as set forth in this Section 4.4. If Business Associate elects to destroy such Protected Health Information, it shall certify to Covered Entity in writing when and that such Protected Health Information has been destroyed. If any subcontractors or agents of the Business Associate elect to destroy the Protected Health Information, Business Associate will require such subcontractors or agents to certify to Business Associate and to Covered Entity in writing when such Protected Health Information has been destroyed. If it is not feasible for Business Associate to return or destroy any of said Protected Health Information, Business Associate shall notify Covered Entity in writing that Business Associate has determined that it is not feasible to return or destroy the Protected Health Information and the specific reasons for such determination. Business
3. Associate further agrees to extend any and all protections, limitations, and restrictions set forth in this Agreement to Business Associate's use or disclosure of any Protected Health Information retained after the termination of this Agreement, and to limit any further uses or disclosures to the purposes that make the return or destruction of the Protected Health Information not feasible.

**RFA # 17-005**  
**HIV/AIDS Patient Care Services**

4. If it is not feasible for Business Associate to obtain, from a subcontractor or agent, any Protected Health Information in the possession of the subcontractor or agent, Business Associate shall provide a written explanation to Covered Entity and require the subcontractors and agents to agree to extend any and all protections, limitations, and restrictions set forth in this Agreement to the subcontractors' or agents' uses or disclosures of any Protected Health Information retained after the termination of this Agreement, and to limit any further uses or disclosures to the purposes that make the return or destruction of the Protected Health Information not feasible.

**Part II: Security Addendum**

**8.0 Security**

WHEREAS, Business Associate and Department of Health agree to also address herein the applicable requirements of the Security Rule, codified at 45 Code of Federal Regulations ("C.F.R.") Part 164, Subparts A and C, issued pursuant to the Administrative Simplification provisions of Title II, Subtitle F of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA-AS"), and the Florida Information Protection Act (FIPA) §501.171, Florida Statutes, so that the Covered Entity may meet compliance obligations under HIPAA-AS and FIPA the parties agree:

(a) Security of Electronic Protected Health Information.

Business Associate will develop, implement, maintain, and use administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information (as defined in 45 C.F.R. § 160.103) and Personal Information (as defined in §501.171, Florida Statutes) that Business Associate creates, receives, maintains, or transmits on behalf of the Plans consistent with the Security Rule.

(b) Reporting Security Incidents.

1. Business Associate will report to Covered Entity within 24 hours of the discovery of any incident of which Business Associate becomes aware that is:
  - (a) a successful unauthorized access, use or disclosure of the Electronic Protected Health Information or a successful unauthorized access of data in an electronic form containing Personal Information as defined in §501.171, Florida Statute; or
  - (b) a successful major
    - (1) modification or destruction of the Electronic Protected Health Information or
    - (2) interference with system operations in an information system containing the Electronic Protected Health Information.
2. Upon the Department of Health's request, Business Associate will report any incident of which Business Associate becomes aware that is a successful minor
  - (a) modification or destruction of the Electronic Protected Health Information or
  - (b) interference with system operations in an information system containing the Electronic Protected Health Information.
  - (c) Compliance Date.  
The parties to this Amendment will comply with Sections (a) through (c) of this Section 9 by the later of the (1) the last date set forth in the signature blocks below.
  - (d) Conflicts.  
The provisions of this Section 9 will override and control any conflicting provision of this agreement.
  - (e) Corrective Action:  
Business Associate agrees to take prompt corrective action and follow all provisions required in state and federal law to notify all individuals reasonably believed to be potentially affected by the breach.
  - (f) Cure:  
Business Associate agrees to take prompt corrective action to cure any security deficiencies.

**RFA # 17-005  
HIV/AIDS Patient Care Services**

**Part III**

**9.0 Miscellaneous**

- (a) **Regulatory References.** A reference in this Agreement to a section in the Privacy Rule or the Security Rule means the section as in effect or as amended, and for which compliance is required.
- (b) **Amendment.** Upon the enactment of any law or regulation affecting the use or disclosure of Protected Health Information, Personal Information, Standard Transactions, the security of Health Information, or other aspects of HIPAA-AS or FIPA applicable or the publication of any decision of a court of the United States or any state relating to any such law or the publication of any interpretive policy or opinion of any governmental agency charged with the enforcement of any such law or regulation, either party may, by written notice to the other party, amend this Agreement in such manner as such party determines necessary to comply with such law or regulation. If the other party disagrees with such Amendment, it shall so notify the first party in writing within thirty (30) days of the notice. If the parties are unable to agree on an Amendment within thirty (30) days thereafter, then either of the parties may terminate the Agreement on thirty (30) days written notice to the other party.
- (c) **Survival.** The respective rights and obligations of Business Associate under Section 7.0 of this Agreement shall survive the termination of this Agreement.
- (d) **Interpretation.** Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule and the confidentiality requirements of the State of Florida.
- (e) **No third party beneficiary.** Nothing expressed or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the parties and the respective successors or assignees of the parties, any rights, remedies, obligations, or liabilities whatsoever.
- (f) **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the state of Florida to the extent not preempted by the Privacy Rules or other applicable federal law.
- (g) The laws of the State of Florida shall apply to the interpretation of this Agreement or in case of any disagreement between the parties; the venue of any proceedings shall be the appropriate federal or state court in Leon County, Florida.
- (h) **Indemnification and performance guarantees.** Business Associate shall indemnify, defend, and save harmless the State of Florida and Individuals covered for any financial loss as a result of claims brought by third parties and which are caused by the failure of Business Associate, its officers, directors or agents to comply with the terms of this Agreement. Additionally, Business Associate shall indemnify the State of Florida for any time and expenses it may incur from breach notifications that are necessary under either §501.171, Florida Statute or the HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414, which are caused by the failure of Business Associate, its officers, directors or agents to comply with the terms of this Agreement.
- (i) **Assignment:** Business Associate shall not assign either its obligations or benefits under this Agreement without the expressed written consent of the Covered Entity, which shall be at the sole discretion of the Covered Entity. Given the nature of this Agreement, neither subcontracting nor assignment by the Business Associate is anticipated and the use of those terms herein does not indicate that permission to assign or subcontract has been granted.

For: **FLORIDA DEPARTMENT OF HEALTH**

For: \_\_\_\_\_  
(Name of Business Associate)

By: \_\_\_\_\_

By: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Approved as to form and legality: Office of the General Counsel



# APPENDICES

## ATTACHMENT \_\_\_\_\_

### FINANCIAL AND COMPLIANCE ATTACHMENT

The administration of resources awarded by the Department of Health to Provider may be federal or state financial assistance as defined by 2 C.F.R. § 200.40 and/or section 215.97, Florida Statutes, and subject to audits and/or monitoring by the Department of Health, as described in this section. For this contract, the Department of Health has determined the following relationship exist:

1. \_\_\_\_\_ **Vendor.** Funds used for goods and services for the Department of Health's own use and creates a procurement relationship with Provider which is not subject to compliance requirements of the Federal/State program as a result of the contract.
2. \_\_\_\_\_ **Recipient/Subrecipient of state financial assistance.** Funds may be expended only for allowable costs resulting from obligations incurred during the specified contract period. In addition, any balance of unobligated funds which has been advanced or paid must be refunded to the state agency. As well as funds paid in excess of the amount to which the recipient/subrecipient is entitled under the terms and conditions of the contract must be refunded to the state agency.
3. \_\_\_\_\_ **Recipient/Subrecipient of federal financial assistance.** Funds paid in excess of the amount to which the recipient/subrecipient is entitled under the terms and conditions of the contract must be refunded to the state agency. In addition, the recipient/subrecipient may not earn or keep any profit resulting from Federal financial assistance, unless explicitly authorized by the terms and conditions of the Federal award.

#### MONITORING

In addition to reviews of audits conducted in accordance with 2 C.F.R. Part 200, subpart F (formerly OMB A-133) and section 215.97, Florida Statutes, monitoring procedures may include, but not be limited to, on-site visits by Department of Health staff, limited scope audits, and/or other procedures. By entering into this contract, Provider agrees to comply and cooperate with any monitoring procedures/processes deemed appropriate by the Department of Health. In the event the Department of Health determines that a limited scope audit of Provider is appropriate, Provider agrees to comply with any additional instructions provided by the Department of Health to Provider regarding such audit. Provider further agrees to comply and cooperate with any inspections, reviews, investigations, or audits deemed necessary by the Chief Financial Officer (CFO) or Auditor General.

#### AUDITS

##### PART I: FEDERALLY FUNDED

This part is applicable if Provider is a State or local government or a non-profit organization as defined in 2 C.F.R. Part 200, subpart F.

1. In the event that Provider expends \$750,000 or more in Federal awards during its fiscal year, Provider must have a single or program-specific audit conducted in accordance with the provisions of 2 C.F.R. § 200.501. EXHIBIT 1 to this contract indicates Federal resources awarded through the Department of Health by this contract. In determining the Federal awards expended in its fiscal year, Provider shall consider all sources of Federal awards, including Federal resources received from the Department of Health. The determination of amounts of Federal awards expended should be in accordance with the guidelines established by 2 C.F.R. §§ 200.502-.503. An audit of Provider conducted by the Auditor General in accordance with the provisions of 2 C.F.R., subpart F will meet the requirements of this part.
2. In connection with the audit requirements addressed in Part I, paragraph 1, Provider shall fulfill the requirements relative to auditee responsibilities as provided in 2 C.F.R. §§ 200.508-.512.
3. If Provider expends less than \$750,000 in Federal awards in its fiscal year, an audit conducted in accordance with the provisions of 2 C.F.R. § 200.501(d) is not required. In the event that Provider expends less than \$750,000 in Federal awards in its fiscal year and elects to have an audit conducted in accordance

with the provisions of 2 C.F.R. § 200.506, the cost of the audit must be paid from non-Federal resources (i.e., the cost of such audit must be paid from Provider resources obtained from other than Federal entities.)

4. An audit conducted in accordance with this part shall cover the entire organization for the organization's fiscal year. Compliance findings related to contracts with the Department of Health shall be based on the contract's requirements, including any rules, regulations, or statutes referenced in the contract. The financial statements shall disclose whether or not the matching requirement was met for each applicable contract. All questioned costs and liabilities due to the Department of Health shall be fully disclosed in the audit report with reference to the Department of Health contract involved. If not otherwise disclosed as required by 2 C.F.R. § 200.510, the schedule of expenditures of Federal awards shall identify expenditures by funding source and contract number for each contract with the Department of Health in effect during the audit period. Financial reporting packages required under this part must be submitted within the earlier of 30 days after receipt of the audit report or 9 months after the end of Provider's fiscal year end.

## **PART II: STATE FUNDED**

This part is applicable if Provider is a nonstate entity as defined by section 215.97(1)(n), Florida Statutes.

1. In the event that Provider expends a total amount of state financial assistance equal to or in excess of \$750,000 in any fiscal year of such Provider (for fiscal years ending June 30, 2017 or thereafter), Provider must have a State single or project-specific audit for such fiscal year in accordance with section 215.97, Florida Statutes; applicable rules of the Department of Financial Services; Chapter 10.550 (local governmental entities) or Chapter 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General. EXHIBIT I to this contract indicates state financial assistance awarded through the Department of Health by this contract. In determining the state financial assistance expended in its fiscal year, Provider shall consider all sources of state financial assistance, including state financial assistance received from the Department of Health, other state agencies, and other nonstate entities. State financial assistance does not include Federal direct or pass-through awards and resources received by a nonstate entity for Federal program matching requirements.
2. In connection with the audit requirements addressed in Part II, paragraph 1, Provider shall ensure that the audit complies with the requirements of section 215.97(8), Florida Statutes. This includes submission of a financial reporting package as defined by section 215.97(2), Florida Statutes, and Chapter 10.550 (local governmental entities) or Chapter 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General.
3. If Provider expends less than \$750,000 in state financial assistance in its fiscal year (for fiscal years ending June 30, 2017 or thereafter), an audit conducted in accordance with the provisions of section 215.97, Florida Statutes, is not required. In the event that Provider expends less than \$750,000 in state financial assistance in its fiscal year and elects to have an audit conducted in accordance with the provisions of section 215.97, Florida Statutes, the cost of the audit must be paid from the nonstate entity's resources (i.e., the cost of such an audit must be paid from Provider resources obtained from other than State entities).
4. An audit conducted in accordance with this part shall cover the entire organization for the organization's fiscal year. Compliance findings related to contracts with the Department of Health shall be based on the contract's requirements, including any applicable rules, regulations, or statutes. The financial statements shall disclose whether or not the matching requirement was met for each applicable contract. All questioned costs and liabilities due to the Department of Health shall be fully disclosed in the audit report with reference to the Department of Health contract involved. If not otherwise disclosed as required by Florida Administrative Code Rule 69I-5.003, the schedule of expenditures of state financial assistance shall identify expenditures by contract number for each contract with the Department of Health in effect during the audit period. Financial reporting packages required under this part must be submitted within 45 days after delivery of the audit report, but no later than 9 months after Provider's fiscal year end for local governmental entities. Non-profit or for-profit organizations are required to be submitted within 45 days after delivery of the audit report, but no later than 9 months after Provider's fiscal year end. Notwithstanding the applicability of this portion, the Department of Health retains all right and obligation to monitor and oversee the performance of this contract as outlined throughout this document and pursuant to law.

### PART III: REPORT SUBMISSION

1. Copies of reporting packages for audits conducted in accordance with 2 C.F.R. § 200.512 and section 215.97(2), Florida Statutes, will be submitted by or on behalf of Provider directly to each of the following:

- A. The Department of Health as follows:

[SingleAudits@flhealth.gov](mailto:SingleAudits@flhealth.gov)

Pursuant to 2 C.F.R. § 200.521, and section 215.97(2), Florida Statutes, Provider shall submit an electronic copy of the reporting package and any management letter issued by the auditor to the Department of Health.

Audits must be submitted in accordance with the instructions set forth in Exhibit 3 hereto, and accompanied by the Single Audit Data Collection Form, Exhibit 4. Files which exceed electronic email capacity may be submitted on a CD or other electronic storage medium and mailed to:

**Florida Department of Health**  
Bureau of Finance & Accounting  
Attention: Single Audit Review  
4052 Bald Cypress Way, Bin B01  
Tallahassee, FL 32399-1729.

- B. The Federal Audit Clearinghouse (FAC), the Internet Data Entry System (IDES) is the place to submit the Federal single audit reporting package, including form SF-SAC, for Federal programs. Single audit submission is required under the Single Audit Act of 1984 (amended in 1996) and 2 C.F.R. § 200.36 and § 200.512. The Federal Audit Clearinghouse requires electronic submissions as the only accepted method for report compliances. FAC's website address is: <https://harvester.census.gov/sac/>
- C. Other Federal agencies and pass-through entities in accordance with 2 C.F.R. §200.331 and § 200.517.
- D. Additionally, copies of state financial assistance (CSFA) reporting packages required by Part II of this contract shall be submitted to the Auditor General's Office (one electronic and one paper copy of the financial reporting package).

- The electronic copy should be emailed by or on behalf of Provider directly to the Auditor General's Office at: [flaudgen\\_localgovt@aud.state.fl.us](mailto:flaudgen_localgovt@aud.state.fl.us).
- Paper copies mail to:  
**Auditor General's Office**  
Claude Pepper Building, Room 401  
111 West Madison Street  
Tallahassee, Florida 32399-1450

2. Any reports, management letter, or other information required to be submitted to the Department of Health pursuant to this contract shall be submitted timely in accordance with 2 C.F.R. § 200.512, Florida Statutes, and Chapter 10.550 (local governmental entities) or Chapter 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General, as applicable.
3. Providers, when submitting financial reporting packages to the Department of Health for audits done in accordance with 2 C.F.R. § 500.512 or Chapter 10.550 (local governmental entities) or Chapter 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General, should indicate the date that the reporting package was delivered to Provider in correspondence accompanying the reporting package.

**PART IV: RECORD RETENTION**

Provider shall retain sufficient records demonstrating its compliance with the terms of this contract for a period of six years from the date the audit report is issued, and shall allow the Department of Health or its designee, the CFO, or the Auditor General access to such records upon request. Provider shall ensure that audit working papers are made available to the Department of Health, or its designee, CFO, or Auditor General upon request for a period of six years from the date the audit report is issued, unless extended in writing by the Department of Health.

**End of Text**

Contract #: \_\_\_\_\_

**EXHIBIT 1**

Federal Award Identification #: \_\_\_\_\_

Department's Federal Award Date: \_\_\_\_\_ Department's Federal Award Indirect Rate: \_\_\_\_\_

**1. FEDERAL RESOURCES AWARDED TO THE SUBRECIPIENT PURSUANT TO THIS AGREEMENT CONSIST OF THE FOLLOWING:**

Federal Agency 1 \_\_\_\_\_ CFDA# \_\_\_\_\_ Title \_\_\_\_\_ \$ \_\_\_\_\_

Federal Agency 2 \_\_\_\_\_ CFDA# \_\_\_\_\_ Title \_\_\_\_\_ \$ \_\_\_\_\_

TOTAL FEDERAL AWARDS \$ \_\_\_\_\_

**COMPLIANCE REQUIREMENTS APPLICABLE TO THE FEDERAL RESOURCES AWARDED PURSUANT TO THIS AGREEMENT ARE AS FOLLOWS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. STATE RESOURCES AWARDED TO THE RECIPIENT PURSUANT TO THIS AGREEMENT CONSIST OF THE FOLLOWING:**

State financial assistance subject to section 215.97, Florida Statutes: CSFA# \_\_\_\_\_ Title \_\_\_\_\_  
\$ \_\_\_\_\_

State financial assistance subject to section 215.97, Florida Statutes: CSFA# \_\_\_\_\_ Title \_\_\_\_\_  
\$ \_\_\_\_\_

TOTAL STATE FINANCIAL ASSISTANCE AWARDED PURSUANT TO SECTION 215.97, FLORIDA STATUTES  
\$ \_\_\_\_\_

**COMPLIANCE REQUIREMENTS APPLICABLE TO STATE RESOURCES AWARDED PURSUANT TO THIS AGREEMENT ARE AS FOLLOWS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Financial assistance not subject to section 215.97, Florida Statutes or 2 C.F.R. § 200.40: \$ \_\_\_\_\_

Financial assistance not subject to section 215.97, Florida Statutes or 2 C.F.R. § 200.40: \$ \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Matching and Maintenance of Effort \***

Matching resources for federal Agency(s):

Agency: \_\_\_\_\_ CFDA# \_\_\_\_\_ Title \_\_\_\_\_ \$ \_\_\_\_\_

Maintenance of Effort (MOE):

Agency: \_\_\_\_\_ CFDA# \_\_\_\_\_ Title \_\_\_\_\_ \$ \_\_\_\_\_

\*Matching Resources, MOE, and Financial Assistance not subject to section 215.97, Florida Statutes or 2 C.F.R. § 200.306 amounts should not be included by Provider when computing the threshold for single audit requirements totals. However, these

amounts could be included under notes in the financial audit or footnoted in the Schedule of Expenditures of Federal Awards and State Financial Assistance (SEFA). Matching, MOE, and Financial Assistance not subject to section. 215.97, Florida Statutes or 2 C.F.R. § 200.306 is not considered State or Federal Assistance.

## EXHIBIT 2

### PART I: AUDIT RELATIONSHIP DETERMINATION

Providers who receive state or federal resources may or may not be subject to the audit requirements of 2 C.F.R. § 200.500, and/or section 215.97, Florida Statutes, Providers who are determined to be recipients or subrecipients of federal awards and/or state financial assistance may be subject to the audit requirements if the audit threshold requirements set forth in Part I and/or Part II of Exhibit 1 is met. Providers who have been determined to be vendors are not subject to the audit requirements of 2 C.F.R. § 200.501, and/or section 215.97, Florida Statutes. Providers who are "higher education entities" as defined in Section 215.97(2)(h), Florida Statutes, and are recipients or subrecipients of state financial assistance, are also exempt from the audit requirements of Section 215.97(2)(a), Florida Statutes. Regardless of whether the audit requirements are met, providers who have been determined to be recipients or subrecipients of Federal awards and/or state financial assistance must comply with applicable programmatic and fiscal compliance requirements.

**For the purpose of an audit, the Provider has been determined to be:**

- Vendor not subject to 2 C.F.R. § 200.501 and/or section 215.97, Florida Statutes
- Recipient/subrecipient subject to 2 C.F.R. § 200.501 and/or section 215.97, Florida Statutes
- Exempt organization not subject to 2 C.F.R. § 200.501; For Federal awards for-profit subrecipient organizations are exempt as specified in 2 C.F.R. § 200.501(h).
- Exempt organization not subject to section 215.97, Florida Statutes, for state financial assistance projects, public universities and community colleges. Exempt organizations must comply with all compliance requirements set forth within the contract.

NOTE: If Provider is determined to be a recipient/subrecipient of federal and or state financial assistance and has been approved by the department to subcontract, it must comply with section 215.97(7), Florida Statutes, and Florida Administrative Code Rule 69I-.5006, [state financial assistance] and 2 C.F.R. § 200.330 [federal awards].

### PART II: FISCAL COMPLIANCE REQUIREMENTS

**FEDERAL AWARDS OR STATE MATCHING FUNDS ON FEDERAL AWARDS.** Providers who receive Federal awards, state maintenance of effort funds, or state matching funds on Federal awards and who are determined to be a subrecipient must comply with the following fiscal laws, rules and regulations:

1. 2 C.F.R. Part 200- Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards
2. Reference Guide for State Expenditures
3. Other fiscal requirements set forth in program laws, rules, and regulations

\*Some Federal programs may be exempted from compliance with the Cost Principles Circulars as noted in the 2 C.F.R. § 200.401(5) (c).

\*\*For funding passed through U.S. Health and Human Services, 45 C.F.R. Part 92; for funding passed through U.S. Department of Education, 34 C.F.R. Part 80.

**STATE FINANCIAL ASSISTANCE.** Providers who receive state financial assistance and who are determined to be a recipient/subrecipient must comply with the following fiscal laws, rules and regulations:

1. Section 215.97, Florida Statutes
2. Florida Administrative Code Chapter 69I-5,
3. State Projects Compliance Supplement
4. Reference Guide for State Expenditures
5. Other fiscal requirements set forth in program laws, rules and regulations

Additional guidance may be obtained at [Audit Guidance](#). \*Enumeration of laws, rules and regulations herein is not exhaustive or exclusive. Fund recipients will be held to applicable legal requirements whether or not outlined herein.

**End of Text**



### EXHIBIT 3

#### INSTRUCTIONS FOR ELECTRONIC SUBMISSION OF SINGLE AUDIT REPORTS

Single Audit reporting packages ("SARP") must be submitted to the Department in an electronic format. This change will eliminate the need to submit multiple copies of the reporting package to the Contract Managers and various sections within the Department and will result in efficiencies and cost savings to Provider and the Department. Upon receipt, the SARP's will be posted to a secure server and accessible to Department staff.

The electronic copy of the SARP should:

- Be in a Portable Document Format (PDF).
- Include the appropriate letterhead and signatures in the reports and management letters.
  - Be a single document. However, if the financial audit is issued separately from the Single Audit reports, the financial audit reporting package may be submitted as a single document and the Single Audit reports may be submitted as a single document. Documents which exceed 8 megabytes (MB) may be stored on a CD and mailed to: Bureau of Finance & Accounting, Attention: Single Audit Review, 4052 Bald Cypress Way, Bin B01 (HAFA), Tallahassee, FL 32399-1729.
- Be an exact copy of the final, signed SARP provided by the Independent Audit firm.
- Not have security settings applied to the electronic file.
- Be named using the following convention: [fiscal year] [name of the audited entity exactly as stated within the audit report].pdf. For example, if the SARP is for the 2015-2016 fiscal year for the City of Gainesville, the document should be entitled 2010 City of Gainesville.pdf.
- Be accompanied by the attached "Single Audit Data Collection Form." This document is necessary to ensure that communications related to SARP issues are directed to the appropriate individual(s) and that compliance with Single Audit requirements is properly captured.

Questions regarding electronic submissions may be submitted via e-mail to [SingleAudits@flhealth.gov](mailto:SingleAudits@flhealth.gov) or by telephone to the Single Audit Review Section at (850) 245-4185.

# Single Audit Data Collection Form

## GENERAL INFORMATION

### 1. Fiscal period ending date for the Single Audit.

Month	Day	Year
/	/	

### 2. Auditee Identification Number

a. Primary Employer Identification Number (EIN)

		--									
--	--	----	--	--	--	--	--	--	--	--	--

b. Are multiple EINs covered in this report  Yes  No  
c. If "yes", complete No. 3.

### 3. ADDITIONAL ENTITIES COVERED IN THIS REPORT

Employer Identification #		Name of Entity	
	--		
	--		
	--		
	--		

### 4. AUDITEE INFORMATION

a. Auditee name:	
b. Auditee address (number and street)	
City	
State	Zip Code
c. Auditee contact Name: 	
Title: 	
d. Auditee contact telephone ( ) -	
e. Auditee contact FAX ( ) -	
f. Auditee contact E-mail 	

### 5. PRIMARY AUDITOR INFORMATION

a. Primary auditor name:	
b. Primary auditor address (number and street)	
City	
State	Zip Code
c. Primary auditor contact Name: 	
Title: 	
d. Primary auditor contact telephone ( ) -	
e. Primary auditor E-mail ( ) -	
f. Audit Firm License Number 	

**6. AUDITEE CERTIFICATION STATEMENT** – This is to certify that, to the best of my knowledge and belief, the auditee has: (1) engaged an auditor to perform an audit in accordance with the provisions of 2 C.F.R. § 200. 512 and/or section 215.97, Florida Statutes, for the period described in Item 1; (2) the auditor has completed such audit and presented a signed audit report which states that the audit was conducted in accordance with the aforementioned Circular and/or Statute; (3) the attached audit is a true and accurate copy of the final audit report issued by the auditor for the period described in Item 1; and (4) the information included in this data collection form is accurate and complete. I declare the foregoing is true and correct.

**AUDITEE CERTIFICATION** Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date Audit Received From Auditor: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name of Certifying Official: \_\_\_\_\_  
(Please print clearly)  
Title of Certifying Official: \_\_\_\_\_  
(Please print clearly)  
Signature of Certifying Official: \_\_\_\_\_

## EXHIBIT 4

**STATE OF FLORIDA  
DEPARTMENT OF HEALTH  
STANDARD CONTRACT**

THIS CONTRACT is entered into between the State of Florida, Department of Health, hereinafter referred to as the “Department,” and \_\_\_\_\_ hereinafter referred to as “Provider,” and jointly referred to as the “parties.”

**THE PARTIES AGREE:**

**I. PROVIDER AGREES:**

**A. To provide services in accordance with the terms specified in Attachment I.**

**B. To the Following Governing Law**

1. State of Florida Law: This contract is executed and entered into in the state of Florida, and will be construed, performed, and enforced in all respects in accordance with the laws, rules, and regulations of the state of Florida. Each party will perform its obligations in accordance with the terms and conditions of this contract.
2. Federal Law
  - a. If this contract contains federal funds, Provider must comply with the provisions of 2 C.F.R. part 200, appendix II, and other applicable regulations as specified in Attachment I.
  - b. If this contract includes federal funds that will be used for construction or repairs, Provider must comply with the provisions of the Copeland “Anti-Kickback” Act (18 U.S.C. section 874), as supplemented by Department of Labor regulations (29 C.F.R. part 3, “Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States”). The act prohibits providers from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled. All suspected violations must be reported to the Department.
  - c. If this contract includes federal funds that will be used for the performance of experimental, developmental, or research work, Provider must comply with 37 C.F.R., part 401, “Rights to Inventions Made by Nonprofit Organizations and Small Business Firms under Governmental Grants, Contracts, and Cooperative Agreements.”
  - d. If this contract contains federal funds and is over \$100,000, Provider must comply with all applicable standards, orders, or regulations of the Clean Air Act, as amended (42 U.S.C. chapter 85) and the Clean Water Act, as amended (33 U.S.C. chapter 26), Executive Order 11738, and Environmental Protection Agency regulations codified in Title 40 of the Code of Federal Regulations. Provider must report any violations of the above to the Department.
  - e. If this contract contains federal funding in excess of \$100,000, Provider must, prior to contract execution, complete the Certification Regarding Lobbying form, Attachment\_\_\_\_. If a Disclosure of Lobbying Activities form, Standard Form LLL, is required, it may be obtained from the Contract Manager. All disclosure forms as required by the Certification Regarding Lobbying form must be completed and returned to the Contract Manager.
  - f. Employment of unauthorized aliens is a violation of the Immigration and Naturalization Act, 8 U.S.C. section 1324a, and such violation will be cause for unilateral cancellation of this contract by the Department. Provider must use the U.S. Department of Homeland Security’s E-Verify system, <https://e-verify.uscis.gov/emp>, to verify the employment eligibility of all new employees hired during the contract term by Provider. Provider must also include a requirement in subcontracts that the subcontractor must use the E-Verify system to verify the employment eligibility of all new employees performing work or providing services under this contract who are hired by the subcontractor during the contract term. Providers meeting the terms and conditions of the E-Verify System are deemed to be in compliance with this provision.
  - g. Provider must comply with President’s Executive Order 11246, Equal Employment Opportunity (30 Fed. Reg. 12935), as amended by President’s Executive Order 11375, (32 Fed. Reg. 14303), and as supplemented by regulations at 41 C.F.R. chapter 60.
  - h. Provider must comply with the Pro-Children Act of 1994, 20 U.S.C. sections 6081-6084, which requires that smoking not be permitted in any portion of any indoor facility used for the provision of federally funded services including health, day care, early childhood development, education or library services on a routine or regular basis, to children up to age 18. Provider’s failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and the imposition of an administrative compliance order on the responsible entity. Provider must include a similar provision in any subcontracts it enters under this contract.
  - i. Health Insurance Portability and Accountability Act of 1996 (HIPAA): When applicable, Provider must comply with Federal Privacy and Security Regulations developed by the U.S. Department of Health and Human Services as specified in 45 C.F.R. parts 160 and 164 promulgated pursuant to HIPAA, Pub. L. No. 104-191, and the Health Information Technology for Economic and Clinical Health Act, Title XIII of Division A, Title IV of Division B, Pub. L. No 111-5, collectively referred to as “HIPAA.”
  - j. Provider is required to submit a W-9 to the Department of Financial Services (DFS) electronically prior to doing business with the state of Florida via the Vendor Website at <https://flvendor.myfloridacfo.com>. Any subsequent changes to Provider’s

W-9 must be made on this website; however, if Provider needs to change its Federal Employer Identification Number (FEID), it must contact the DFS Vendor Ombudsman Section at (850) 413-5519.

- k. If Provider is determined to be a subrecipient of federal funds, Provider will comply with the requirements of the American Recovery and Reinvestment Act and the Federal Funding Accountability and Transparency Act, by obtaining a DUNS (Data Universal Numbering System) number and registering with the federal Central Contractor Registry (CCR). No payments will be issued until Provider has submitted a valid DUNS number and evidence of registration (*i.e.*, a printed copy of the completed CCR registration) in CCR to the Contract Manager. To obtain registration and instructions, visit <http://fedgov.dnb.com/webform> and [www.ccr.gov](http://www.ccr.gov).

**C. Audits, Records (including electronic storage media), and Records Retention**

1. To establish and maintain books, records, and documents in accordance with generally accepted accounting procedures and practices, which sufficiently and properly reflect all revenues and expenditures of funds provided by the Department under this contract.
2. To retain all client records, financial records, supporting documents, statistical records, and any other documents pertinent to this contract for a period of six years after termination of the contract, or if an audit has been initiated and audit findings have not been resolved at the end of six years, the records must be retained until resolution of the audit findings or any litigation which may be based on the terms of this contract.
3. Upon completion or termination of this contract and at the request of the Department, Provider will, at its expense, cooperate with the Department in the duplication and transfer of any said records or documents during the required retention period as specified in Section I, paragraph C.2., above.
4. Persons duly authorized by the Department and federal auditors, pursuant to 2 C.F.R. section 200.336, will have full access to and the right to examine any of Provider's records and documents related to this contract, regardless of the form in which kept, at all reasonable times for as long as records are retained.
5. To ensure these audit and record keeping requirements are included in all subcontracts and assignments.
6. If Provider is a recipient or subrecipient as specified in Attachment \_\_\_\_\_, Provider will perform the required financial and compliance audits in accordance with the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, 2 C.F.R. part 200, subpart F and section 215.97, Florida Statutes, as applicable and conform to the following requirements:
  - a. Documentation. To maintain separate accounting of revenues and expenditures of funds under this contract and each Catalog of State Financial Assistance (CSFA) or Catalog of Federal Domestic Assistance (CFDA) number identified on the attached Exhibit 1, in accordance with generally accepted accounting practices and procedures. Expenditures which support Provider's activities not solely authorized under this contract must be allocated in accordance with applicable laws, rules, and regulations and the allocation methodology must be documented and supported by competent evidence.
  - b. Provider must maintain sufficient documentation of all expenditures incurred (e.g., invoices, canceled checks, payroll detail, bank statements, etc.) under this contract which evidences that expenditures are:
    - 1) Allowable under the contract and applicable laws, rules, and regulations;
    - 2) Reasonable; and
    - 3) Necessary in order for Provider to fulfill its obligations under this contract.All documentation required by this section is subject to review by the Department and the state of Florida Chief Financial Officer. Provider must timely comply with any requests for documentation.
  - c. Annual Financial Report. Within 45 days from the end of each contract year, but no later than submission of the final invoice for that year, submit to the Department an annual financial report stating, by line item, all expenditures made as a direct result of services provided through this contract. Each report must include a statement signed by an individual with legal authority to bind Provider, certifying that these expenditures are true, accurate, and directly related to this contract.
  - d. To ensure that funding received under this contract in excess of expenditures is remitted to the Department within 45 days of the end of each contract year and the contract end date.
7. Public Records: Keep and maintain public records, as defined by Chapter 119, Florida Statutes that are required by the Department to perform the services required by the contract. Upon request from the Department's custodian of public records, provide the Department with a copy of the requested public records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed that provided in Chapter 119, Florida Statutes, or as otherwise provided by law. Ensure that public records that are exempt or that are confidential and exempt from public record disclosure are not disclosed, except as authorized by law for the duration of the contract term and following completion of the contract if Provider does not transfer the public records to the Department. Upon completion of the contract, transfer to the Department at no cost, all public records in possession of Provider or keep and maintain public records required by the Department to perform the contract services. If Provider transfers all public records to the Department upon completion of the contract, Provider will destroy any duplicate public records that are exempt or confidential and exempt. If Provider keeps and maintains public records upon completion of the contract, Provider will meet all applicable requirements for retaining public records. All records stored electronically must be provided to the Department, upon request of the Department's custodian of public records, in a format that is compatible with the information technology systems of the Department. The Department may unilaterally terminate this contract if Provider refuses to allow access to all public records made or maintained by Provider in conjunction with this contract, unless the records are exempt from section 24(a) of Art. I of the State Constitution and section 119.07(1), Florida Statutes.

**If the Provider has questions regarding the application of Chapter 119, Florida Statutes, to the Provider's duty to provide public records relating to this contract, contact the custodian of public records at (850)245-4005, [PublicRecordsRequest@flhealth.gov](mailto:PublicRecordsRequest@flhealth.gov) or 4052 Bald Cypress Way, Bin A02, Tallahassee, FL 32399.**

8. Cooperation with Inspectors General: To the extent applicable, Provider acknowledges and understands it has a duty to and will cooperate with the inspector general in any investigation, audit, inspection, review, or hearing pursuant to section 20.055(5), Florida Statutes.
- D. Monitoring by the Department:** To permit persons duly authorized by the Department to inspect any records, papers, documents, facilities, goods, and services of Provider, which are relevant to this contract, and interview any clients or employees of Provider to assure the Department of satisfactory performance of the terms and conditions of this contract. Following the Department's monitoring, at its sole and exclusive direction, the Department may provide Provider with a written report or take other actions including the assessment of financial consequences pursuant to section 287.058(1)(h), Florida Statutes, and termination of this contract for cause.
- E. Indemnification**
  1. Provider is liable for and will indemnify, defend, and hold harmless the Department and all of its officers, agents, and employees from all claims, suits, judgments, or damages, consequential or otherwise and including attorneys' fees and costs, arising out of any act, actions, neglect, or omissions by Provider, its agents, or employees during the performance or operation of this contract or any subsequent modifications thereof, whether direct or indirect, and whether to any person or tangible or intangible property.
  2. Provider's inability to evaluate liability or its evaluation of no liability will not excuse Provider's duty to defend and indemnify the Department within seven days after certified mail or courier delivery notice from the Department. Only adjudication or judgment after highest appeal is exhausted specifically finding Provider not liable will excuse performance of this provision. Provider will pay all costs and fees related to this obligation and its enforcement by the Department. The Department's failure to notify Provider of a claim will not release Provider of the above duty to defend. **NOTE: This section, I.E, Indemnification, is not applicable to contracts executed between state agencies or subdivisions, as defined in section 768.28, Florida Statutes.**
- F. Insurance:** To provide adequate liability insurance coverage on a comprehensive basis and to hold such liability insurance at all times during the existence of this contract and any renewal(s) and extension(s) of it. Upon execution of this contract, unless it is a state agency or subdivision as defined in section 768.28, Florida Statutes, Provider accepts full responsibility for identifying and determining the type(s) and extent of liability insurance necessary to provide reasonable financial protections for Provider and the clients to be served under this contract. The limits of coverage under each policy maintained by Provider do not limit Provider's liability and obligations under this contract. Upon the execution of this contract, Provider must furnish the Department written verification supporting both the determination and existence of such insurance coverage. Such coverage may be provided by a self-insurance program established and operating under the laws of the state of Florida. The Department reserves the right to require additional insurance as specified in Attachment I.
- G. Safeguarding Information:** Not to use or disclose any information concerning a recipient of services under this contract for any purpose not in conformity with state and federal law except upon written consent of the recipient, or the responsible parent or guardian when authorized by law.
- H. Assignments and Subcontracts**
  1. To neither assign the responsibility of this contract to another party nor subcontract for any of the work contemplated under this contract without prior written approval of the Department, which will not be unreasonably withheld. Any sub-license, assignment, or transfer otherwise occurring will be null and void. In the event the use of subcontracts is allowed, Provider will remain responsible for all work performed and all expenses incurred in connection with the contract. In addition, this contract will bind the successors, assigns, and legal representatives of Provider and of any legal entity that succeeds to the obligations of the Department.
  2. Provider will be responsible for all work performed and all expenses incurred for this contract. If the Department permits Provider to subcontract all or part of the work contemplated under this contract, including entering into subcontracts with vendors for services or commodities, the Department will not be liable to the subcontractor for any expenses or liabilities incurred under the subcontract and Provider will be solely liable to the subcontractor for all expenses and liabilities incurred under the subcontract. If the Department permits Provider to subcontract, such permission will be indicated in Attachment I.
  3. The Department will at all times be entitled to assign or transfer, in whole or part, its rights, duties, or obligations under this contract to another governmental agency in the state of Florida, upon prior written notice to Provider.
  4. Unless otherwise stated in the contract between Provider and subcontractor, payments made by Provider to the subcontractor must be within seven working days after receipt of full or partial payments from the Department in accordance with section 287.0585, Florida Statutes. Failure to pay within seven working days will result in a penalty charged against Provider to be paid by Provider to the subcontractor in the amount of one-half of one percent of the amount due per day from the expiration of the period allowed herein for payment. The penalty will be in addition to actual payments owed and will not exceed 15 percent of the outstanding balance due.
- I. Return of Funds:** Return to the Department any overpayments due to unearned funds or funds disallowed and any interest attributable to such funds pursuant to the terms of this contract that were paid to Provider by the Department. In the event that Provider or its

independent auditor discovers that overpayment has been made, Provider will repay the overpayment within 40 calendar days without prior notification from the Department. In the event that the Department first discovers an overpayment has been made, the Department will notify Provider in writing of such a finding. Should repayment not be made in the time specified by the Department, Provider will pay interest of one percent per month compounded on the outstanding balance after 40 calendar days after the date of notification or discovery.

**J. Transportation Disadvantaged:** If clients are to be transported under this contract, Provider must comply with the provisions of Chapter 427, Florida Statutes, and Florida Administrative Code Chapter 41-2. Provider must submit the reports required pursuant to the Department's Internal Operating Procedure (IOP) 56-58-15, Transportation Disadvantaged Procedure.

**K. Purchasing**

1. Prison Rehabilitative Industries and Diversified Enterprises, Inc. (PRIDE): It is expressly understood and agreed that any articles which are the subject of, or required to carry out, this contract shall be purchased from the corporation identified under Chapter 946, Florida Statutes, in the same manner and under the same procedures set forth in section 946.515(2) and (4), Florida Statutes; and for purposes of this contract the person, firm, or other business entity carrying out the provisions of this contract (Provider) shall be deemed to be substituted for this agency (the Department) insofar as dealings with such corporation are concerned. This clause is not applicable to subcontractors unless otherwise required by law. An abbreviated list of products and services available from PRIDE may be obtained by contacting PRIDE at 1-800-643-8459.
2. Procurement of Materials with Recycled Content: Any products or materials which are the subject of, or are required to carry out this contract will be procured in accordance with the provisions of sections 287.045 and 403.7065, Florida Statutes.
3. MyFloridaMarketPlace Vendor Registration: Each vendor doing business with the state of Florida for the sale of commodities or contractual services as defined in section 287.012, Florida Statutes, must register in the MyFloridaMarketPlace system, unless exempted under Florida Administrative Code Rule 60A-1.030(3).
4. MyFloridaMarketPlace Transaction Fee:
  - a. The state of Florida, through the Department of Management Services, has instituted MyFloridaMarketPlace, a statewide procurement system. Pursuant to section 287.057(22), Florida Statutes, all payments will be assessed a Transaction Fee of one percent, which Provider will pay to the State.
  - b. For payments within the State accounting system (FLAIR or its successor), the Transaction Fee will, when possible, be automatically deducted from payments to the vendor. If automatic deduction is not possible, Provider will pay the Transaction Fee pursuant to Florida Administrative Code Rule 60A-1.031(2). By submission of these reports and corresponding payments, vendor certifies their correctness. All such reports and payments will be subject to audit by the State or its designee.
  - c. Vendor will receive a credit for any Transaction Fee paid by Vendor for the purchase of any item, if such item is returned to Vendor through no fault, act, or omission of Vendor. Notwithstanding the foregoing, a Transaction Fee is non-refundable when an item is rejected or returned, or declined, due to the vendor's failure to perform or comply with specifications or requirements of this contract. Failure to comply with these requirements will constitute grounds for declaring the vendor in default and recovering procurement costs from the vendor in addition to all outstanding fees. Providers delinquent in paying transaction fees may be excluded from conducting future business with the State.

**L. Civil Rights Requirements:** Civil Rights Certification: Provider must comply with applicable provisions of the Department's publication titled, "Methods of Administration, Equal Opportunity in Service Delivery."

**M. Independent Capacity of the Provider**

1. Provider is an independent contractor and is solely liable for the performance of all tasks and deliverables contemplated by this contract.
2. Except where Provider is a state agency, Provider, its officers, agents, employees, subcontractors, or assignees, in performance of this contract, will act in the capacity of an independent contractor and not as an officer, employee, or agent of the state of Florida. Provider will not represent to others that it has the authority to bind the Department unless specifically authorized to do so.
3. Except where Provider is a state agency, Provider, its officers, agents, employees, subcontractors, or assignees are not entitled to state retirement or state leave benefits, or to any other compensation of state employment as a result of performing the duties and obligations of this contract.
4. Provider agrees to take such actions as may be necessary to ensure that each subcontractor of Provider understand they are independent contractor and will not be considered or permitted to be an agent, servant, joint venturer, or partner of the state of Florida.
5. Unless justified by Provider and agreed to by the Department in Attachment I, the Department will not furnish services of support (e.g., office space, office supplies, telephone service, secretarial, or clerical support) to Provider, or its subcontractor or assignee.
6. All deductions for social security, withholding taxes, income taxes, contributions to unemployment compensation funds, and all necessary insurance for Provider, Provider's officers, employees, agents, subcontractors, or assignees will be the responsibility of Provider.

**N. Sponsorship:** As required by section 286.25, Florida Statutes, if Provider is a non-governmental organization which sponsors a program financed wholly or in part by state funds, including any funds obtained through this contract, it will, in publicizing, advertising, or describing the sponsorship of the program, state: "*Sponsored by (Provider's name) and the State of Florida, Department of Health.*" If the sponsorship reference is in written material, the words "*State of Florida, Department of Health*" will appear in at least the same size letters or type as Provider's name.

- O. Final Invoice:** To submit the final invoice for payment to the Department no more than \_\_\_\_ days after the contract ends or is terminated. If Provider fails to do so, all right to payment is forfeited and the Department will not honor any requests submitted after the aforesaid time period. Any payment due under the terms of this contract may be withheld until all deliverables and any necessary adjustments have been approved by the Department.
- P. Use of Funds for Lobbying Prohibited:** Comply with the provisions of sections 11.062 and 216.347, Florida Statutes, which prohibit the expenditure of contract funds for the purpose of lobbying the Legislature, judicial branch, or a state agency.
- Q. Public Entity Crime and Discriminatory Vendor**
1. Pursuant to section 287.133, Florida Statutes, the following restrictions are placed on the ability of persons convicted of public entity crimes to transact business with the Department: When a person or affiliate has been placed on the convicted vendor list following a conviction for a public entity crime, he or she may not submit a bid on a contract to provide any goods or services to a public entity, may not submit a bid on a contract with a public entity for the construction or repair of a public building or public work, may not submit bids on leases of real property to a public entity, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in section 287.017, Florida Statutes, for CATEGORY TWO for a period of 36 months from the date of being placed on the convicted vendor list.
  2. Pursuant to section 287.134, Florida Statutes, the following restrictions are placed on the ability of persons convicted of discrimination to transact business with the Department: When a person or affiliate has been placed on the discriminatory vendor list following a conviction for discrimination, he or she may not submit a bid on a contract to provide any goods or services to a public entity, may not submit a bid on a contract with a public entity for the construction or repair of a public building or public work, may not submit bids on leases of real property to a public entity, may not be awarded or perform work as a contractor, supplier, subcontractor, or consultant under a contract with any public entity, and may not transact business with any public entity in excess of the threshold amount provided in section 287.017, Florida Statutes, for CATEGORY TWO for a period of 36 months from the date of being placed on the discriminatory vendor list.
- R. Patents, Copyrights, and Royalties**
1. Any inventions or discoveries developed in the course of or as a result of services performed under this contract which are patentable pursuant to 35 U.S.C. section 101, are the sole property of the state of Florida. Provider must inform the Department of any inventions or discoveries developed in connection with this contract, and will be referred to the Department of State for a determination on whether patent protection will be sought for the invention or discovery. The state of Florida will be the sole owner of all patents resulting from any invention or discovery made in connection with this contract.
  2. Provider must notify the Department of State of any books, manuals, films, or other copyrightable works developed in connection with this contract. Any and all copyrights accruing under or in connection with the performance under this contract are the sole property of the state of Florida.
  3. Provider, without exception, will indemnify and save harmless the state of Florida and its employees from liability of any nature or kind, including cost and expenses for or on account of any copyrighted, patented, or unpatented invention, process, or article manufactured by Provider. Provider has no liability when such claim is solely and exclusively due to the Department of State's alteration of the article. The state of Florida will provide prompt written notification of claim of copyright or patent infringement. Further, if such claim is made or is pending, Provider may, at its option and expense, procure for the Department of State, the right to continue use of, replace, or modify the article to render it non-infringing. If Provider uses any design, device, or materials covered by letters, patent, or copyright, it is mutually agreed and understood without exception that the bid prices will include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work.
- S. Construction or Renovation of Facilities Using State Funds:** Any state funds provided for the purchase of or improvements to real property are contingent upon Provider granting to the state a security interest in the property at least to the amount of the state funds provided for at least five years from the date of purchase or the completion of the improvements or as further required by law. As a condition of a receipt of state funding for this purpose, Provider agrees that, if it disposes of the property before the state's interest is vacated, Provider will refund the proportionate share of the state's initial investment, as adjusted by depreciation or appreciation.
- T. Electronic Fund Transfer:** Provider agrees to enroll in Electronic Fund Transfer (EFT) provided by DFS. Questions should be directed to DFS's EFT Section at (850) 410-9466. The previous sentence is for notice purposes only. Copies of the authorization form and sample bank letter are available from DFS.
- U. Information Security:** Maintain confidentiality of all data, files, and records including client records related to the services provided pursuant to this contract and will comply with state and federal laws, including, but not limited to, sections 381.004, 384.29, 392.65, and 456.057, Florida Statutes.
- V. Venue:** Venue for any legal actions arising from this contract will be in Leon County, Florida, unless the contract is entered into on by one of the Department's county health department, in which case, venue for any legal actions will be the pertinent county.
- II. METHOD OF PAYMENT**
- A. Contract Amount:** The Department agrees to pay Provider for completion of the deliverables as specified in Attachment I, in an amount not to exceed\_\_\_\_, subject to the availability of funds. The state of Florida's performance and obligation to pay under this contract is contingent upon an annual appropriation by the Legislature. The costs of services paid under any other contract or from any other source are not eligible for reimbursement under this contract.

**B. Contract Payment:**

1. Provider must submit bills for fees or other compensation for services or expenses in sufficient detail for a proper pre-audit and post-audit thereof.
2. Where reimbursement of travel expenses are allowable as specified in Attachment I, bills for any travel expenses must be submitted in accordance with section 112.061, Florida Statutes. The Department may, if specified in Attachment I, establish rates lower than the maximum provided in section 112.061, Florida Statutes.
3. Pursuant to section 215.422, Florida Statutes, the Department has five working days to inspect and approve goods and services, unless this contract specifies otherwise. With the exception of payments to health care providers for hospital, medical, or other health care services, if payment is not available within 40 days, measured from the latter of the date the invoice is received or the goods or services are received, inspected and approved, a separate interest penalty set by the State of Florida's Chief Financial Officer pursuant to section 55.03, Florida Statutes, will be due and payable in addition to the invoice amount. To obtain the applicable interest rate, contact the Department's fiscal office or contract administrator. Payments to health care providers for hospitals, medical, or other health care services, will be made not more than 35 days from the date eligibility for payment is determined, at the daily interest rate of 0.03333 percent. Invoices returned to Provider due to preparation errors will result in a payment delay. Interest penalties less than one dollar will not be enforced unless Provider requests payment. Invoice payment requirements do not start until a properly completed invoice is provided to the Department.

**C. Vendor Ombudsman:** A Vendor Ombudsman has been established within DFS whose duties include acting as an advocate for providers who may be experiencing problems in obtaining timely payment from a state agency. The Vendor Ombudsman may be contacted at (850) 413-5516 or by calling the DFS Consumer Hotline at 1-(800)-342-2762.

**III. PROVIDER CONTRACT TERM**

**A. Effective and Ending Dates:** This contract will begin on \_\_\_\_\_ or on the date on which the contract has been signed by both parties, whichever is later. It will end on\_\_\_\_\_.

**B. Termination**

1. Termination at Will: This contract may be terminated by either party upon no less than 30 calendar days' written notice to the other party, without cause, unless a lesser time is mutually agreed upon in writing by both parties. The notice must be delivered by certified mail, return receipt requested, or in person with proof of delivery.
2. Termination Because of Lack of Funds: In the event funds to finance this contract become unavailable, the Department may terminate the contract upon no less than 24 hours' written notice to Provider. The notice must be delivered by certified mail, return receipt requested, or in person with proof of delivery. The Department will be the final authority as to the availability and adequacy of funds.
3. Termination for Breach: This contract may be terminated for non-performance upon no less than 24 hours' written notice to Provider. If applicable, the Department will employ the default provisions in Florida Administrative Code Rule 60A-1.006(3). Waiver of breach of any provisions of this contract will not be deemed to be a waiver of any other breach and will not be construed to be a modification of the terms of this contract. The provisions herein do not limit the Department's right to remedies at law or in equity.
4. In the event this contract is terminated, Provider will be compensated for any deliverables completed prior to the Department's notification to Provider of contract termination.

**C. Renegotiation or Modification:** Modifications of provisions of this contract will only be valid when they have been reduced to writing and duly signed by both parties. The rate of payment and dollar amount may be adjusted retroactively to reflect price level increases and changes in the rate of payment when these have been established through the appropriations process and subsequently identified in the Department's operating budget.

**D. Contract Representatives Contact Information:**

1. The name, mailing address, and telephone number of Provider's official payee to whom the payment will be made is:

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2. The name of the contact person and street address where Provider's financial and administrative records are maintained is:

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3. The name, address, and telephone number of the Department's Contract Manager is:

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4. The name, address, and telephone number of Provider's representative responsible for administration of the program under this contract is:

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5. Provide written notice to the other party of any changes in the above contract representative's contact information. Any such changes will not require a formal amendment to this contract.
- E. All Terms and Conditions Included:** This contract and its attachments and exhibits as referenced, \_\_\_\_\_ contain all the terms and conditions agreed upon by the parties. There are no provisions, terms, conditions, or obligations other than those contained herein, and this contract will supersede all previous communications, representations, or agreements, either verbal or written between the parties. If any term or provision of this contract is found to be illegal or unenforceable, the remainder of the contract will remain in full force and effect and such term or provision will be stricken.

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**I have read the above contract and understand each section and paragraph.**

**IN WITNESS THEREOF**, the parties hereto have caused this \_\_\_\_\_ page contract to be executed by their undersigned, duly authorized, officials.

**PROVIDER:** \_\_\_\_\_

**STATE OF FLORIDA, DEPARTMENT OF HEALTH**

**SIGNATURE:** \_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_

**PRINT/TYPE NAME:** \_\_\_\_\_

**PRINT/TYPE NAME:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

**STATE AGENCY 29-DIGIT FLAIR CODE:** \_\_\_\_\_

**BY SIGNING THIS CONTRACT, THE ABOVE ATTESTS THERE IS EVIDENCE IN THE CONTRACT FILE DEMONSTRATING THIS CONTRACT WAS REVIEWED BY THE DEPARTMENT'S OFFICE OF THE GENERAL COUNSEL.**

**FEID# (OR SSN):** \_\_\_\_\_

**PROVIDER FISCAL YEAR ENDING DATE:** \_\_\_\_\_

## BUDGET NARRATIVE

 Ryan White Consortia

 Patient Care Network

**Organization Name:**

**For Contract Period: 04/01/18 - 03/31/19**

### A. ADMINISTRATIVE: 7.5% cap on Administrative costs inclusive of subcontracts

Salaries: <small>(Copy &amp; paste rows as needed.)</small>	Total Salary	Amount charged to contract
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**For each position include:**

(1-1) **Position Title/Position Number:** (As it appears in the table of organization; CHDs include position #)

(1-2) Job Responsibilities as related to the funded work: (Please describe in the cell below the specific job duties paid for by the funding source indicated above and how these duties relate to the HIV Patient Care provision)

(1-3) Salary Breakdown :

					\$0	\$0
For any amounts listed in "Other" category to the right, please specify here (include amount and description):	PART A:	%	\$			
	PART B Admin:	%	\$			
	PART B Direct Care:	%	\$			
	PART B CQM:	%	\$			
	PART B P&E:	%	\$			
	Emerging Comm.	%	\$			
	General Rev-PCN:	%	\$			
	General Rev-CHD:	%	\$			
	HOPWA:	%	\$			
	Other:	%	\$			
Totals 100%	0%	\$0.00				

(2-1) **Position Title/Position Number:** (As it appears in the table of organization; CHDs include position #)

(2-2) Job Responsibilities as related to the funded work: (Please describe in the cell below the specific job duties paid for by the funding source indicated above and how these duties relate to the HIV Patient Care provision)

(2-3) Salary Breakdown :

					\$0	\$0
For any amounts listed in "Other" category to the right, please specify here (include amount and description):	PART A:	%	\$			
	PART B Admin:	%	\$			
	PART B Direct Care:	%	\$			
	PART B CQM:	%	\$			
	PART B P&E:	%	\$			
	Emerging Comm.	%	\$			
	General Rev-PCN:	%	\$			
	General Rev-CHD:	%	\$			
	HOPWA:	%	\$			
	Other:	%	\$			
Totals 100%	0%	\$0.00				

(3-1) <b>Position Title/Position Number:</b> (As it appears in the table of organization; CHDs include position #)				
(3-2) Job Responsibilities as related to the funded work: (Please describe in the cell below the specific job duties paid for by the funding source indicated above and how these duties relate to the HIV Patient Care provision)				
(3-3) Salary Breakdown :			\$0	\$
For any amounts listed in "Other" category to the right, please specify here (include amount and description):	PART A:	%	\$	
	PART B Admin:	%	\$	
	PART B Direct Care:	%	\$	
	PART B CQM:	%	\$	
	PART B P&E:	%	\$	
	Emerging Comm.	%	\$	
	General Rev-PCN:	%	\$	
	General Rev-CHD:	%	\$	
	HOPWA:	%	\$	
	Other:	%	\$	
Totals 100%	0%	\$0.00		
(4-1) <b>Position Title/Position Number:</b> (As it appears in the table of organization; CHDs include position #)				
(4-2) Job Responsibilities as related to the funded work: (Please describe in the cell below the specific job duties paid for by the funding source indicated above and how these duties relate to the HIV Patient Care provision)				
(4-3) Salary Breakdown :			\$0	\$
For any amounts listed in "Other" category to the right, please specify here (include amount and description):	PART A:	%	\$	
	PART B Admin:	%	\$	
	PART B Direct Care:	%	\$	
	PART B CQM:	%	\$	
	PART B P&E:	%	\$	
	Emerging Comm.	%	\$	
	General Rev-PCN:	%	\$	
	General Rev-CHD:	%	\$	
	HOPWA:	%	\$	
	Other:	%	\$	
Totals 100%	0%	\$0.00		
<b>*** COPY AND PASTE ADDITIONAL POSITIONS ON THIS LINE</b>				
<b>TOTAL SALARY</b>			\$0	\$0

<b>Fringe Benefits</b>		<b>Total Fringe Benefits</b>	<b>Amount charged to contract</b>
FICA:		\$	\$
Life/Health/Vision/Dental/Disability:		\$	\$
Retirement:		\$	\$
Other: (Please specify in the row below)		\$	\$
<b>TOTAL FRINGE</b>		\$0	\$0
<b>Travel:</b> (Please place total travel costs and include breakdown of travel expenses in the tab titled travel)			
		\$0	\$0
<b>Office Expenses:</b> (Please describe office expenses related to the funded scope of work in the row below)			
		\$0	\$0
<b>Equipment:</b> (Please describe equipment expenses related to the funded scope of work in the row below)			
		\$0	\$0
<b>Other (Specify):</b> (Please describe other expenses related to the funded scope of work in the row below)			
<b>ADMINISTRATION SUBTOTAL</b>		\$0	\$0
<input checked="" type="checkbox"/> Check to ensure that the Administration Subtotal is not more than 7.5% of Grand Total, which equals \$0			

**B. CORE MEDICAL AND SUPPORT SERVICES**

**a. Ambulatory/Outpatient Medical Care**

**Rent/Occupancy Cost**

**Justification:** (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)

<b><u>Total Rent/Occupancy Cost Amount:</u></b>		<b>\$0</b>
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**Utilities**

**Justification:** (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)

<b><u>Total Utilities Amount:</u></b>		<b>\$0</b>
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**Other Allowable Programmatic Administrative Expenses:** (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. **NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.**)

<b><u>Total Allowable Programmatic Administrative Amount:</u></b>		<b>\$0</b>
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 **Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0**

**1. Providers/Facilities:** (List all providers or facilities where services will be provided.)

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**2. Additional Provider/Facility Information:** [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]

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**3. Allocation Methodology:** (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)

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**4. Additional Information:** (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)

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<b><u>Total amount allocated to Ambulatory/Outpatient Medical Care:</u></b>		<b>\$0</b>
<b>AMBULATORY/OUTPATIENT MEDICAL CARE SUBTOTAL:</b>		<b>\$0</b>

<b>b. AIDS Pharmaceutical Assistance (Local)</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
<b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to AIDS Pharmaceutical Assistance (Local):</b>	
<b>\$0</b>	
<b>AIDS PHAMACEUTICAL ASSISTANCE (LOCAL) SUBTOTAL:</b>	
<b>\$0</b>	

<b>c. Early Intervention Services</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
<b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Early Intervention Services:</b>	
<b>\$0</b>	
<b>EARLY INTERVENTION SUBTOTAL:</b>	
<b>\$0</b>	


<b>d. Oral Health Care</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
 <b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Oral Health Care:</b>	
<b>\$0</b>	
<b>ORAL HEALTH SUBTOTAL:</b>	
<b>\$0</b>	



<b>e. Health Insurance Premium/Cost Sharing</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
	<b>\$0</b>
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
	<b>\$0</b>
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
	<b>\$0</b>
 <b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Health Insurance Premium/Cost Sharing:</b>	
	<b>\$0</b>
<b>HEALTH INSURANCE PREMIUM/COST SHARING SUBTOTAL:</b>	
	<b>\$0</b>

<b>f. Home and Community - Based Services</b>	
<b>Rent/Occupancy Cost</b>	
Justification: (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	<b>\$0</b>
<b>Utilities</b>	
Justification: (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	<b>\$0</b>
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
Justification: (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	<b>\$0</b>
<input checked="" type="checkbox"/> Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Home and Community - Based Services:</b>	<b>\$0</b>
<b>HOME AND COMMUNITY-BASED SERVICES SUBTOTAL:</b>	<b>\$0</b>


<b>g. Home Health Care</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
<b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Home Health Care:</b>	
<b>\$0</b>	
<b>HOME HEALTH CARE SUBTOTAL:</b>	
<b>\$0</b>	

<b>h. Mental Health Services - Outpatient</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
 <b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Mental Health Services - Outpatient:</b>	
<b>\$0</b>	
<b>MENTAL HEALTH SERVICES -OUTPATIENT SUBTOTAL:</b>	
<b>\$0</b>	

<b>i. Medical Nutrition Therapy</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
	<b>\$0</b>
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
	<b>\$0</b>
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
	<b>\$0</b>
<b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Medical Nutrition Therapy:</b>	
	<b>\$0</b>
<b>MEDICAL NUTRITION THERAPY SUBTOTAL:</b>	
	<b>\$0</b>

<b>j. Medical Case Management (including Treatment Adherence)</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
<b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Medical Case Management (including Treatment Adherence):</b>	
<b>\$0</b>	
<b>MEDICAL CASE MANAGEMENT (INCLUDING TREATMENT ADHERENCE) SUBTOTAL:</b>	
<b>\$0</b>	


<b>K. Substance Abuse Services - Outpatient</b>	
<b>Rent/Occupancy Cost</b>	
Justification: (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
Justification: (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
Justification: (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
<b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Substance Abuse Services - Outpatient:</b>	
<b>\$0</b>	
<b>SUBSTANCE ABUSE - OUTPATIENT SUBTOTAL:</b>	
<b>\$0</b>	

<b>I. Case Management (Non-Medical)</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
 <b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Case Management (Non-Medical):</b>	
<b>\$0</b>	
<b>CASE MANAGEMENT (NON-MEDICAL) SUBTOTAL:</b>	
<b>\$0</b>	




<b>m. Emergency Financial Assistance</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
<b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Emergency Financial Assistance:</b>	
<b>\$0</b>	
<b>EMERGENCY FINANCIAL ASSISTANCE SUBTOTAL:</b>	
<b>\$0</b>	

<b>n. Food Bank/Home Delivered Meals</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
	<b>\$0</b>
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
	<b>\$0</b>
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
	<b>\$0</b>
<input checked="" type="checkbox"/> Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Food Bank/Home Delivered Meals:</b>	
	<b>\$0</b>
<b>FOOD BANK/HOME DELIVERED MEALS SUBTOTAL:</b>	
	<b>\$0</b>

<b>o. Health Education/ Risk Reduction</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
	<b>\$0</b>
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
	<b>\$0</b>
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
	<b>\$0</b>
 <b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Health Education/ Risk Reduction:</b>	
	<b>\$0</b>
<b>HEALTH EDUCATION/RISK REDUCTION SUBTOTAL:</b>	
	<b>\$0</b>

<b>p. Housing</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
<b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Housing Services:</b>	
<b>\$0</b>	
<b>HOUSING SERVICES SUBTOTAL:</b>	
<b>\$0</b>	

<b>g. Linguistic Services</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
<input checked="" type="checkbox"/> <b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Linguistic Services:</b>	
<b>\$0</b>	
<b>LINGUISTIC SERVICES SUBTOTAL:</b>	
<b>\$0</b>	

<b>r. Medical Transportation Services</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
 <b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Medical Transportation Services:</b>	
<b>\$0</b>	
<b>MEDICAL TRANSPORTATION SERVICES SUBTOTAL:</b>	
<b>\$0</b>	

<b>s. Outreach Services</b>	
<b>Rent/Occupancy Cost</b>	
Justification: (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
Justification: (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
Justification: (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
<input checked="" type="checkbox"/> Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Outreach Services :</b>	
<b>\$0</b>	
<b>OUTREACH SERVICES SUBTOTAL:</b>	
<b>\$0</b>	

<b>t. Psychosocial Support Services</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
<input checked="" type="checkbox"/> <b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Psychosocial Support Services:</b>	
<b>\$0</b>	
<b>PSYCHOSOCIAL SUPPORT SERVICES SUBTOTAL:</b>	
<b>\$0</b>	



<b>u. Referral for Health Care/Supportive Services</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
<b>\$0</b>	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
<b>\$0</b>	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
<b>\$0</b>	
<b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Referral for Health Care/Supportive Services:</b>	
<b>\$0</b>	
<b>REFERRAL FOR HEALTH CARE/SUPPORTIVE SERVICES SUBTOTAL:</b>	
<b>\$0</b>	

<b>v. Substance Abuse Services - Residential</b>	
<b>Rent/Occupancy Cost</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable rent/occupancy cost of each facility will not supplant funding for client services.)	
<b>Total Rent/Occupancy Cost Amount:</b>	
\$0	
<b>Utilities</b>	
<b>Justification:</b> (Provide justification for how funding used for the allowable utilities of each facility will not supplant funding for client services.)	
<b>Total Utilities Amount:</b>	
\$0	
<b>Other Allowable Programmatic Administrative Expenses:</b> (List the allowable programmatic expenses with associated costs, that are not required to be included in the administrative costs as specified in PCPN #2016-01. <b>NOTE: The total of these expenses can NOT exceed 5% of the total amount of this line item.</b> )	
<b>Justification:</b> (Provide justification for how funding used for the allowable programmatic administrative expenses will not supplant funding for client services.)	
<b>Total Allowable Programmatic Administrative Amount:</b>	
\$0	
<b>Check to ensure that the programmatic administrative expenses do not exceed 5% of the line item, which equals \$0</b>	
<b>1. Providers/Facilities:</b> (List all providers or facilities where services will be provided.)	
<b>2. Additional Provider/Facility Information:</b> [For each provider listed above (1), provide the following information: authorization protocol (the process for approving and tracking an authorized service for a client), how provider will be paid (unit cost, Medicaid rate, by diagnosis code, etc.), anticipated units of service, anticipated number of visits, service limitations and caps.]	
<b>3. Allocation Methodology:</b> (Explain how the amount allocated to this service was decided. Describe the process for priority setting and allocations.)	
<b>4. Additional Information:</b> (Include any information that you think would be helpful in describing your service delivery system for this service. This may include a description of guiding principles developed by consortium and other related policies or guidelines.)	
<b>Total amount allocated to Substance Abuse Services - Residential:</b>	
\$0	
<b>SUBSTANCE ABUSE SERVICES - RESIDENTIAL SUBTOTAL:</b>	
<b>\$0</b>	

<b>CORE MEDICAL AND SUPPORT SERVICES SUBTOTAL:</b>	<b>\$0</b>
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<b>C. CLINICAL QUALITY MANAGEMENT (CQM): 5% cap on CQM costs inclusive of subcontracts</b>
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**Service activities:** [Explain the services to be provided as they relate to the CQM Activities, which include: Capacity building, Management of Clinical Quality Management Program (e.g. convening a quality committee, implementing quality improvement projects), Data management (e.g. performance measure data collection, aggregation, analysis, and reporting), Clinical Quality Management site visit (e.g. patient chart audits, meeting with patients), Estimated patient experience (e.g. surveys, focus groups, patient interviews), Training (clinical care and quality-related)]

**Allocation Methodology:** (Include information such as basis for expenditure, review process)

**Service Delivery Process:** (Include information such as full/partial payment, units of service, number of visits, authorization protocol, service limitations and caps, exceptions)

**Additional Guidelines:** (Include description of guiding principles developed by consortium, and other related policies or guidelines)

<b>Total amount for the activities described above:</b>	<b>\$0</b>
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**Clinical Quality Management Provider:** (Enter name and address of CQM provider below)

<b>Salaries:</b> (Copy & paste rows as needed.)	<b>Total Salary</b>	<b>Amount charged to contract</b>
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**For each position include:**

(1-1) **Position Title/Position Number:** (As it appears in the table of organization; CHDs include position #)

(1-2) **Job Responsibilities as related to the funded work:** (Please describe in the cell below the specific job duties paid for by the funding source indicated above and how these duties relate to the HIV Patient Care provision)

(1-3) **Salary Breakdown :**

					<b>\$0</b>	<b>\$</b>
For any amounts listed in "Other" category to the right, please specify here (include amount and description):	PART A:	%	\$			
	PART B Admin:	%	\$			
	PART B Direct Care:	%	\$			
	PART B CQM:	%	\$			
	PART B P&E:	%	\$			
	Emerging Comm.	%	\$			
	General Rev-PCN:	%	\$			
	General Rev-CHD:	%	\$			
	HOPWA:	%	\$			
	Other:	%	\$			
	<b>Totals 100%</b>	<b>0%</b>	<b>\$0.00</b>			


<b>(2-1) Position Title/Position Number:</b> (As it appears in the table of organization; CHDs include position #)					
<b>(2-2) Job Responsibilities as related to the funded work:</b> (Please describe in the cell below the specific job duties paid for by the funding source indicated above and how these duties relate to the HIV Patient Care provision)					
<b>(2-3) Salary Breakdown :</b>				\$0	\$
For any amounts listed in "Other" category to the right, please specify here (include amount and description):	PART A:	%		\$	
	PART B Admin:	%		\$	
	PART B Direct Care:	%		\$	
	PART B CQM:	%		\$	
	PART B P&E:	%		\$	
	Emerging Comm.	%		\$	
	General Rev-PCN:	%		\$	
	General Rev-CHD:	%		\$	
	HOPWA:	%		\$	
	Other:	%		\$	
	Totals 100%	0%		\$0.00	
<b>(3-1) Position Title/Position Number:</b> (As it appears in the table of organization; CHDs include position #)					
<b>(3-2) Job Responsibilities as related to the funded work:</b> (Please describe in the cell below the specific job duties paid for by the funding source indicated above and how these duties relate to the HIV Patient Care provision)					
<b>(3-3) Salary Breakdown :</b>				\$0	\$
For any amounts listed in "Other" category to the right, please specify here (include amount and description):	PART A:	%		\$	
	PART B Admin:	%		\$	
	PART B Direct Care:	%		\$	
	PART B CQM:	%		\$	
	PART B P&E:	%		\$	
	Emerging Comm.	%		\$	
	General Rev-PCN:	%		\$	
	General Rev-CHD:	%		\$	
	HOPWA:	%		\$	
	Other:	%		\$	
	Totals 100%	0%		\$0.00	
<b>(4-1) Position Title/Position Number:</b> (As it appears in the table of organization; CHDs include position #)					
<b>(4-2) Job Responsibilities as related to the funded work:</b> (Please describe in the cell below the specific job duties paid for by the funding source indicated above and how these duties relate to the HIV Patient Care provision)					
<b>(4-3) Salary Breakdown :</b>				\$0	\$
For any amounts listed in "Other" category to the right, please specify here (include amount and description):	PART A:	%		\$	
	PART B Admin:	%		\$	
	PART B Direct Care:	%		\$	
	PART B CQM:	%		\$	
	PART B P&E:	%		\$	
	Emerging Comm.	%		\$	
	General Rev-PCN:	%		\$	
	General Rev-CHD:	%		\$	
	HOPWA:	%		\$	
	Other:	%		\$	
	Totals 100%	0%		\$0.00	

**COPY AND PASTE ADDITIONAL POSITIONS ON THIS LINE**

<b>TOTAL SALARY</b>	\$0	\$0
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Additional narrative (if necessary):

**CLINICAL QUALITY MANAGEMENT SUBTOTAL** \$0

 **Check to ensure that the CQM Subtotal is not more than 5% of Grand Total, which equals \$0**

**D. PLANNING AND EVALUATION (P&E): 2.5% cap on P&E costs inclusive of subcontracts**

**Service activities:** (Explain the services to be provided as they relate to Planning and Evaluation Activities, which include: Capacity-building to increase the availability of services, Technical assistance to contractors, Program evaluation, Assessment of service delivery patterns, Assessment of need, Obtaining community input, Drug utilization reviews)

**Allocation Methodology:** (Include information such as basis for expenditure, review process)

**Service Delivery Process:** (Include information such as full/partial payment, units of service, number of visits, authorization protocol, service limitations and caps, exceptions)

**Additional Guidelines:** (Include description of guiding principles developed by consortium, and other related policies or guidelines)

**Total amount for the activities described above:**

**Planning and Evaluation Provider:** (Enter name and address of P&E provider below)

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<b>Salaries:</b> (Copy & paste rows as needed.)	<b>Total Salary</b>	<b>Amount charged to contract</b>
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**For each position include:**

(1-1) **Position Title/Position Number:** (As it appears in the table of organization; CHDs include position #)

(1-2) **Job Responsibilities as related to the funded work:** (Please describe in the cell below the specific job duties paid for by the funding source indicated above and how these duties relate to the HIV Patient Care provision)

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(1-3) **Salary Breakdown :** \$0 \$

For any amounts listed in "Other" category to the right, please specify here (include amount and description):	PART A:	%	\$	
	PART B Admin:	%	\$	
	PART B Direct Care:	%	\$	
	PART B CQM:	%	\$	
	PART B P&E:	%	\$	
	Emerging Comm.	%	\$	
	General Rev-PCN:	%	\$	
	General Rev-CHD:	%	\$	
	HOPWA:	%	\$	
	Other:	%	\$	
	Totals 100%	0%	\$0.00	

(2-1) **Position Title/Position Number:** (As it appears in the table of organization; CHDs include position #)

(2-2) **Job Responsibilities as related to the funded work:** (Please describe in the cell below the specific job duties paid for by the funding source indicated above and how these duties relate to the HIV Patient Care provision)

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(2-3) **Salary Breakdown :** \$0 \$

For any amounts listed in "Other" category to the right, please specify here (include amount and description):	PART A:	%	\$	
	PART B Admin:	%	\$	
	PART B Direct Care:	%	\$	
	PART B CQM:	%	\$	
	PART B P&E:	%	\$	
	Emerging Comm.	%	\$	
	General Rev-PCN:	%	\$	
	General Rev-CHD:	%	\$	
	HOPWA:	%	\$	
	Other:	%	\$	
	Totals 100%	0%	\$0.00	

<b>(3-1) Position Title/Position Number: (As it appears in the table of organization; CHDs include position #)</b>				
<b>(3-2) Job Responsibilities as related to the funded work: (Please describe in the cell below the specific job duties paid for by the funding source indicated above and how these duties relate to the HIV Patient Care provision)</b>				
<b>(3-3) Salary Breakdown :</b>			<b>\$0</b>	<b>\$</b>
For any amounts listed in "Other" category to the right, please specify here (include amount and description):	PART A:	%	\$	
	PART B Admin:	%	\$	
	PART B Direct Care:	%	\$	
	PART B CQM:	%	\$	
	PART B P&E:	%	\$	
	Emerging Comm.	%	\$	
	General Rev-PCN:	%	\$	
	General Rev-CHD:	%	\$	
	HOPWA:	%	\$	
	Other:	%	\$	
Totals 100%			0%	\$0.00
<b>(4-1) Position Title/Position Number: (As it appears in the table of organization; CHDs include position #)</b>				
<b>(4-2) Job Responsibilities as related to the funded work: (Please describe in the cell below the specific job duties paid for by the funding source indicated above and how these duties relate to the HIV Patient Care provision)</b>				
<b>(4-3) Salary Breakdown :</b>			<b>\$0</b>	<b>\$</b>
For any amounts listed in "Other" category to the right, please specify here (include amount and description):	PART A:	%	\$	
	PART B Admin:	%	\$	
	PART B Direct Care:	%	\$	
	PART B CQM:	%	\$	
	PART B P&E:	%	\$	
	Emerging Comm.	%	\$	
	General Rev-PCN:	%	\$	
	General Rev-CHD:	%	\$	
	HOPWA:	%	\$	
	Other:	%	\$	
Totals 100%			0%	\$0.00
COPY AND PASTE ADDITIONAL POSITIONS ON THIS LINE				
<b>TOTAL SALARY</b>			<b>\$0</b>	<b>\$0</b>
Additional narrative (if necessary):				
<b>PLANNING AND EVALUATION SUBTOTAL</b>				<b>\$0</b>
Check to ensure that the P&E Subtotal is not more than 5% of Grand Total, which equals \$0				





<b>ADMINISTRATION SUBTOTAL</b>	<b>\$0</b>
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<b>CORE MEDICAL AND SUPPORT SERVICES SUBTOTAL</b>	<b>\$0</b>
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<b>CLINICAL QUALITY MANAGEMENT SUBTOTAL</b>	<b>\$0</b>
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<b>PLANNING AND EVALUATION SUBTOTAL</b>	<b>\$0</b>
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<b>GRAND TOTAL A,B,C &amp; D</b>	<b>\$0</b>
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# BUDGET SUMMARY

Ryan White Consortia  
 Patient Care Network/GR

Organization Name: \_\_\_\_\_

For Contract Period: 4/1/18 - 3/31/19

## A. PROGRAMMATIC COSTS:

(5% cap on Programmatic costs inclusive of subcontracts)

	<u>Original Allocation</u>	<u>Increase/Decrease</u>	<u>Revised Allocation</u>
<b>Programmatic Subtotal:</b>	\$ <u>0</u>	\$ <u>0</u>	\$ <u>0</u>

## B. CORE MEDICAL AND SUPPORT SERVICES COSTS:

### Core Medical Services:

	<u>Original Allocation</u>	<u>Increase/Decrease</u>	<u>Revised Allocation</u>
a. Ambulatory/Outpatient Medical Care	\$ <u>0</u>	0	\$ <u>-</u>
b. AIDS Pharmaceutical Assistance (Local)	\$ <u>0</u>	\$ <u>0</u>	\$ <u>-</u>
c. Early Intervention Services	\$ _____	\$ _____	\$ <u>-</u>
d. Oral Health Care	\$ <u>0</u>	\$ <u>0</u>	\$ <u>0</u>
e. Health Insurance Premium/Cost Sharing	\$ <u>0</u>	\$ <u>0</u>	\$ <u>-</u>
f. Home and Community-Based Services	\$ _____	\$ _____	\$ _____
g. Home Health Care	\$ _____	\$ _____	\$ _____
h. Mental Health Services - Outpatient	\$ <u>0</u>	\$ <u>0</u>	\$ <u>-</u>
i. Medical Nutrition Therapy	\$ _____	\$ _____	\$ _____
j. Medical Case Management (including treatment adherence)	\$ <u>0</u>	\$ <u>0</u>	\$ <u>0</u>
k. Substance Abuse Services - Outpatient	\$ <u>0</u>	\$ <u>0</u>	\$ <u>-</u>

### Support Services:

l. Case Management (Non-Medical)	\$ <u>0</u>	\$ <u>0</u>	\$ <u>0</u>
m. Emergency Financial Assistance	\$ _____	\$ _____	\$ _____
n. Food Bank/Home Delivered Meals	\$ _____	\$ _____	\$ _____
o. Health Education/Risk Reduction	\$ _____	\$ _____	\$ _____
p. Linguistic Services	\$ _____	\$ _____	\$ _____
q. Medical Transportation Services	\$ _____	\$ _____	\$ _____
r. Outreach Services	\$ _____	\$ _____	\$ _____
s. Psychosocial Support Services	\$ _____	\$ _____	\$ _____
t. Referral for Health Care/Supportive Services	\$ _____	\$ _____	\$ _____
u. Substance Abuse Services - Residential	\$ _____	\$ _____	\$ _____
v. Treatment Adherence Counseling	0	0	0

<b>Core Medical and Support Services Subtotal</b>	\$ <u>0</u>	\$ <u>0</u>	\$ <u>0</u>
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<b><u>GRAND TOTAL A &amp; B for Ryan White</u></b>	\$ <u>0</u>	\$ <u>0</u>	\$ <u>0</u>
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(Please use the signature block below if completing line-item revision)

Provider Signature	Date
Contract Manager Signatur	Date