

**PURCHASE OF SERVICES AGREEMENT
BETWEEN
ALAMANCE-CASWELL MH/DD/SA (Area Authority/LME)
AND
(PROVIDER Corporate Name)**

THIS AGREEMENT is made between **Alamance-Caswell MH/DD/SA** (herein known as the ‘Area Authority’), and _____, (herein known as the "Provider"), operating under the laws of the State of North Carolina. By means of this Agreement, the Area Authority is establishing a purchase of service relationship with the Provider. Except as herein specifically provided otherwise, this contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. Now, therefore, in consideration of the covenants mutually exchanged, the parties hereby agree as follows.

This Agreement is effective as of July 1, 2005 through June 30, 2006.

**ARTICLE I
RIGHTS AND OBLIGATIONS OF THE AREA AUTHORITY**

1.1 Provider Manual. The Area Authority shall provide to the Provider a copy of the “Provider Manual” and all subsequent revisions. The “Provider Manual” is considered a part of this agreement. **The Area Authority shall notify the provider of all changes to the Provider Manual. Substantive changes, which are defined as changes in the rights or obligations of either party, require both parties to agree in writing.** The Provider acknowledges receipt of the Provider Manual by signing this agreement. If terms of this Agreement conflict with information contained in the Provider Manual, the terms of this Agreement shall control.

1.2 Notification of Applicable Regulations. The Area Authority shall arrange for the provision to the Provider of copies or access to all pertinent rules, regulations, standards, and other information distributed by the Division of Mental Health/Developmental Disabilities/Substance Abuse Services (the “Division”) necessary for the performance of the Area Authority under the terms of this Agreement. The Area Authority shall notify the provider of any substantive change in regulation as soon as possible after receipt of the information from the Division. A list of such rules, regulations, etc., is attached as a part of the Provider Manual, Section II.

1.3 Monitoring Under Standards. The Area Authority shall monitor covered services being provided by the Provider to assure compliance with the rules of the North Carolina Commission for Mental Health, Developmental Disability, and Substance Abuse Services (the "Commission"), the Secretary, The Department of Health and Human Services, and G.S. 122C-142. The Area Authority shall also conduct local monitoring to ensure compliance with State, Medicaid, and other applicable federal rules and statutes (see Provider Manual, Sections II and VI). The frequency and the intensity of the local monitoring will be based upon criteria outlined in State rules (see NCAC 27G) and/or and assessment criteria subsequently issued by the Division of MH/DD/SAS. The covered services under this agreement are outlined in Attachment A and any addenda to the attachment.

1.4 Claims/Invoice Review. The Area Authority shall review claims and invoices, submitted by the provider within 60 days of services, within eighteen (18) calendar days after receipt and shall notify the Provider within that timeframe if the claims/invoice or portions of the claims/invoice is denied or if further information is necessary. The Area Authority shall pay approved or undisputed portions of the claims/invoice for services performed by the Provider within thirty (30) calendar days after approval. Such payment constitutes full and final payment of approved claims/invoice. See Provider Manual, Section IV, Prompt Pay Provisions.

1.5 Reimbursement Schedule. The amount and conditions of reimbursement for Covered Services rendered by the Provider to be paid to the Provider is set forth in **Attachment A**.

1.6 Informed Choice of Provider. The Area Authority shall provide information to individuals regarding services in accordance with the individuals' rights to choice as governed by State and Federal rules, and in accordance with the Area Authority's policies and procedures regarding medical necessity and clinical appropriateness. The information shall include names, contact information and locations of all providers who have met the credentialing standards of the Area Authority and are members in good standing of the Area Authority's Qualified Provider Network, as well as assistance to the consumer in obtaining answers to specific questions.

1.7 Training and Technical Assistance. The Provider must attend all relevant Orientation Sessions as determined by the LME at no charge to the Provider. The Provider shall attend all mandatory trainings as related to business practices at no charge to the Provider as space permits. The LME reserves the right to charge the usual and customary fee for additional staff attendance or scheduling additional trainings to meet Provider demand. The Provider shall also bear the cost of all trainings related to licensure or accreditation activities. The Provider must be able to demonstrate to Area Authority/County Program its application of training information received in the delivery of services and in compliance with the provisions of this Agreement.

1.8 Purchase of Equipment. If this Agreement includes payment for equipment purchased with non unit-cost reimbursement funds, such as start up or special purpose funding, title to the assets purchased under this Agreement in whole or in part rests with the Area Authority so long as the Provider continues to provide the services which are named in this Agreement. If such services are discontinued, disposition of the assets shall occur as approved by the Division of MH/DD/SAS and in accordance with North Carolina Administrative Code T10: 14C.1010.

ARTICLE II RIGHTS AND OBLIGATIONS OF PROVIDER

2.1 Covered Services. The Provider agrees to provide the Covered Services identified in Attachment A and all addenda in accordance with all requirements set forth or referenced in the Provider Manual and all subsequent revisions. The definitions of covered services and all revisions are referenced in Section II.

2.2 Maintenance of Facility Licensure and Credentialing. The Provider and its agents providing services on its behalf under this Agreement shall obtain and maintain in good standing all licenses and certificates required by law and as applicable, including but not limited to licensure by the appropriate State of North Carolina Departments, Divisions or Boards. The Provider and its agents providing services on the Provider's behalf under this Agreement shall continuously during the term of this Agreement meet all credentialing and privileging/competency standards as described in Section II of the Provider Manual and APSM 30-1, 10 NCAC 14V. The Provider must be accredited in accordance with state standards as described in APSM 30-1. The Provider shall not be paid for Covered Services provided for which the Provider does not have all required licensure and credentialing.

2.2 Service Record Compliance. The Provider shall maintain a Service Record for each Individual served in accordance with the Service Records standards set forth by the Division in APSM 45-2 and 45-2A and all subsequent revisions. The original Service Record related to services provided in accordance with this agreement shall be accessible for review for the purpose of monitoring services rendered, financial audits by third party payers, research and evaluation. Service records shall be retained for the duration and in the format prescribed by the Division of MHDDSA in the aforementioned standard. If for any reason the Provider can no longer maintain the Service Record, the Provider will contact the Area Authority staff member responsible for Service Records to facilitate resolution. Upon request, the Provider shall provide data about individuals for research and study to the Area Authority as permitted by applicable State and Federal law.

2.3 Rights of Individuals. The Provider shall conduct activities in a manner that shall deter, prevent, and avoid abuse, neglect, and/or exploitation of Individuals while in its care and to ensure compliance with all State and Federal requirements. The Provider agrees to maintain policies, procedures and monitoring as required in the State Client Right's policy and all subsequent revisions outlined in the Provider Manual, Section II (See APSM95-2, GS 122C, Article 3, and the Divisions' Client Rights policy and standards).

2.4 Adverse Selection. Provider shall be prohibited from arbitrarily declining, refusing to serve or ejecting a specific consumer for the covered services in this Agreement. In the event that Provider declines a referral, refuses to serve or ejects a specific consumer, Provider shall give specific reason for the denial that demonstrates the denial is not arbitrary.

2.5 Service Coordination. For purposes of this Agreement, "Provider Participant" shall refer to all service providers to whom the Area Authority refers consumers. In an effort to improve the coordination of supports and services within the Area Authority's community of providers, the Provider agrees to use good faith efforts to coordinate supports and services with other Provider Participants for all individuals served under this Agreement. Continuity of care shall be assured for all individuals served under this Agreement. The Provider shall obtain appropriate client authorizations and consents to release or exchange information. (See APSM 45-1 and NC confidentiality statutes)

2.6 Quality Management The Provider shall conduct a quality management program in accordance with the Division of MHDDSA State Plan: Blueprint for Change and subsequent revisions, and agrees to provide evidence of quality of care, effectiveness and satisfaction with services to the Area Authority upon request. The Provider shall abide by the treatment Protocols, requirements for person-centered planning and to implement evidence-based practices as defined and adopted by the Division of MHDDSA and any subsequent revisions. The Provider shall ensure that corrective action is taken on a timely basis to address problems found through the quality management process. In keeping with

performance-based contracting practice, the Provider shall also comply with the Performance Expectations as developed by the Area Authority and noted in Attachment ___ (See also provider manual Section VI).

2.7 Client Personal Outcomes: At a minimum, the provider shall complete DMHDDSA required outcomes assessments on a sample of all clients admitted during each calendar quarter in accordance with Division guidelines and any subsequent changes thereto. The Area Authority shall define the guidelines for obtaining and submitting the sample and convey this information to the Provider. In accordance with Division requirements, the appropriate outcomes instrument to be used for a specific client will be dependent upon the age and primary disability category of the client and any changes made to these requirements by the Division through any outcomes transition plan with the Area Authority. See Provider Manual, Section VI for details of instruments to be used and sampling and reporting requirements.

2.8 Incident Reporting. The Provider shall report and respond to all client incidents as outlined in State rules (See 10A NCAC 27G). Incidents shall be reported in the manner prescribed by said rules and on a form provided by the Secretary (See also Provider Manual Sections II and VI).

2.9 Reports of Regulatory Authorities. Copies of surveys, reviews and/or audits performed by primary accrediting or regulatory authorities that are utilized to confirm operational compliance of the Provider, and require corrective action on the part of the Provider, shall be provided to the Area Authority upon receipt/completion.

2.10 Suspension or Debarment. The Provider certifies by signing this agreement that neither it nor its agents have been suspended or debarred from doing this type of business, under the current corporate name or any additional name or former name, including the current or former name of a division, department, program or subsidiary, by any applicable governmental authority. See Appendix D for further details.

2.11 Billing. The provider is responsible for billing first and third party payments. The Provider is responsible for reporting to the Area Authority such funding by providing copies of the Explanation of Benefits. See also Section 3.13 of this Agreement.

2.12 Schedule of Fees. The Provider shall be responsible for the adoption, assessment, collection, and disposition of fees in accordance with G.S. 122C-146 and all subsequent revisions.

2.13 Liability Insurance. The Provider, prior to service delivery, shall provide proof of and continuously maintain insurance coverage with a carrier authorized to do business in North Carolina, or maintain equivalent coverage under a self-insurance program that is approved by the North Carolina Department of Insurance. Liability may be on an occurrence basis or claims-made basis. If the policy is on a claims-made basis, an extended reporting endorsement (tail coverage) shall also be provided for a period of not less than three (3) years after the end of the term of this Agreement, or an endorsement shall be provided for continued liability coverage with a retroactive date on or before the beginning of the term of this Agreement.

Provider shall acquire and maintain:

a) Commercial General Liability:

Bodily injury and property damage liability as shall protect the Provider and any approved subcontractor performing work under this Agreement from claims of bodily injury or property damage which arise from operations of this Agreement whether such operations are performed by Provider, any subcontractor or anyone directly or indirectly employed by either. The amounts of such insurance shall not be less than \$1,000,000.00 each occurrence and \$3,000,000.00 in the annual aggregate unless the Provider names the Area Authority as an additional insured, in which case limits of no less than \$1,000,000.00 each occurrence and \$1,000,000.00 in the annual aggregate are acceptable.

b) Professional Liability (where applicable):

As shall protect the Provider's failure to conform to the professional standard of care required under state law and under this Agreement. The limits of liability shall be not less than \$1,000,000.00 per occurrence and \$3,000,000.00 in the annual aggregate.

c) Automobile Liability:

Fleet vehicles or hired cars: Limits must be in an amount not less than \$1,000,000.00 bodily injury each person, each accident, and \$1,000,000.00 for property damage, or \$1,000,000.00 combined single limit each occurrence/aggregate. If individuals are transported in privately owned vehicles, the Provider must carry \$1,000,000.00 of non-owned automobile liability insurance.

d) Worker's Compensation and Occupational Disease Insurance:

Meeting the statutory requirements of the State of North Carolina; and Employer's Liability \$100,000.00 per accident limit, \$500,000.00 disease per policy limit, \$100,000.00 disease each employee limit, providing coverage for employees and owner.

e) Certificates of Insurance:

Certificates of such insurance shall be furnished to the Area Authority and shall contain the provision that should any of the above described policies be amended or cancelled before the expiration date thereof, the issuing insurance company will endeavor to mail 30 days written notice to the Area Authority. The Provider agrees to notify the Area Authority by telephone and by providing written notice within five (5) days after receipt of information that the insurance carrier either intends to amend or terminate a policy or has amended or terminated any insurance policy providing the coverage referred to above. If the provider changes insurance carriers during the performance period of this Agreement, the Provider shall provide evidence to the Area Authority within five (5) days. Subcontractors, as part of the approval process by the Area Authority, must be required by the Provider to meet all the insurance requirements of this Agreement, including providing the Area Authority with certificates of such insurance. Nonetheless, this does not relieve the Provider from maintaining full coverage as well.

2.14 Submission of Invoices. The Provider shall submit an invoice to the Area Authority within sixty (60) days of the date of service. All invoices submitted by the Provider to the Area Authority after sixty (60) days will be excluded from timelines governing the prompt pay provisions. See Provider Manual, Section IV for specific requirements for claims submission.

2.15 Paybacks: Unless specifically approved otherwise in writing by the Area Program The Provider shall pay back within sixty (60) days to the Area Authority the amount paid by the Area Authority to Provider for all noncompliant events or services as a result of a failure on the part of the Provider to comply with Medicaid or other funding source requirements, including but not limited to documentation, licensure, and credentialing requirements.

2.16 Financial Audit: The Provider shall adhere to Generally Accepted Accounting Principles. When required and requested, the Provider shall make available to the Area Authority its accounting records relative to services provided to or on behalf of the Area Authority in accordance with this Agreement for the purpose of audit by State authorities or the Area Authority. The Provider, when required by North Carolina General Statute or in accordance with the annual contract between the State and the Area Authority, shall have an annual audit by an independent certified public accountant (CPA). A further explanation of these requirements is outlined in APSM 75-1, Section 4.2, and these requirements are construed to be part of substantial compliance with North Carolina General Statute 159 Local Government Finance Act. If required, a copy of the independent audit shall be forwarded to:

Office of the State Auditor
300 North Salisbury Street
Raleigh, NC 27603-5903

2.18 Budget Revisions and Fund Balance. This Agreement is a purchase of service agreement; therefore, no budget revisions or fund balance procedures are applicable.

2.19 Preservation of DHHS Public Funds. Provider shall demonstrate good faith efforts to seek alternative and/or supplemental sources of financing so as to reduce dependency on government monies. Providers offering mental health and/or substance abuse services on an outpatient basis shall demonstrate good faith efforts to seek and/or maintain membership on major commercial insurance panels, including but not limited to Blue Cross/Blue Shield.

2.20 Disaster Plan. The Provider shall establish a comprehensive written disaster plan that ensures minimal disruption of service delivery and prompt restoration of operations, consistent with the requirements of the Department Of Health & Human Services for the Covered Services of this Agreement.

2.21 Federal Requirements. The Provider shall comply with all governmental requirements applicable to the services being provided and to its operations, including, but not limited to the Certification Regarding Environmental Tobacco Smoke (Appendix A); Certification Regarding Lobbying (Appendix B); Certification Regarding Drug-Free Workplace Requirements (Appendix C); and Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions (Appendix D).

**ARTICLE III
RIGHTS AND OBLIGATIONS OF BOTH PARTIES**

3.1 Health Insurance Portability and Accountability Act (HIPAA). The Provider and the Area Authority shall ensure compliance with current HIPAA privacy and security rules and regulations and subsequent revisions, and each party shall provide evidence to the other party of this compliance upon request. This includes but is not limited to the responsibility of each party to determine when it is exchanging non-treatment-related information with the other party or with other entities, in order to obtain or perform a business service related to the performance of this Agreement, and to implement a specific business agreement with the other party or other entity if so. The parties hereto specifically agree to amend this Agreement on a timely basis as necessary to comply with any and all laws relating to privacy and/or security of healthcare information, including the Health Insurance Portability and Accountability Act of 1996 (45 CFR, Parts 160 & 164:HIPAA) and any subsequent modifications thereof. If the parties are unable to agree to such amendments, they agree to use the dispute resolution terms of this Agreement. If the parties are still unable to agree, this Agreement will terminate in accordance with Section 4.2 Involuntary Termination. Disclosures for treatment purposes are governed by state and federal confidentiality laws and regulations (See Provider manual, Section IAPSM 45-1, NC GS Chapter 122C and 42 CFR Part II).

3.2 Confidentiality. The Provider and Area Authority shall protect the confidentiality of any and all Individuals and will not discuss, transmit, or narrate in any form other information, medical or otherwise, received in the course of providing services hereunder, except as authorized by the Individual, his legally responsible agent, or as otherwise permitted by law. The Provider and Area Authority shall, in addition, meet all confidentiality guidelines promulgated by any applicable governmental authority. (See Provider Manual, Section II, APSM 45-1, NC GS 122C-52, and 42 CFR, Part II).

3.3 Governing Laws. The laws of the State of North Carolina shall govern the validity and interpretation of the provisions, terms, and conditions of this Agreement.

3.4 Entire Agreement; Modification. This Agreement, along with the Provider Manual, constitutes the entire understanding of the parties and this Agreement shall not be altered, amended, or modified except by an agreement in writing, properly executed by the duly authorized officials of both parties.

3.5 Dispute Resolution. The parties shall attempt to resolve any disagreement between them through the Provider Grievance Process (G.S. 122C-151.4). See Provider Manual.

3.6 Invalid Provisions. If any term, provision, or condition of this Agreement is found to be illegal, void, or unenforceable to a court of competent jurisdiction, the rest of this Agreement shall remain in full force and effect. The invalidity or unenforceability of any term or provision hereof shall in no way affect the validity or enforceability of any other term or provision.

3.7 Hold Harmless. To the extent permitted by law, the Provider and its agents agrees to hold the Area Authority and its agents harmless from and against any and all claims, expenses (including attorney fees), costs or liability for acts or omissions of the Provider and its agents. To the extent permitted by law, the Area Authority and its agents agrees to hold the Provider and its agents harmless from and against any and all claims, expenses (including attorney fees), costs or liability for acts or omissions of the Area Authority and its agents. If this agreement is terminated, the rights and obligations of the parties under this agreement shall survive the termination of the agreement regarding any liability for acts or omissions that occurred prior to the termination.

3.8 Compliance with Title VI and VII. Both parties shall comply with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990 (ADA), and all requirements imposed by Federal regulations, rules, and guidelines issued pursuant to these Titles for both personnel employed and individuals served.

3.9 Independent Contractor. This agreement is not intended and shall not be construed to create the relationship of agent, servant, employee, partnership, joint venture, or association between the Provider and the Area Authority, their employees, partners, or agents, but rather is an agreement by and among independent contractors; provided this shall not be construed to preclude the Provider from utilizing service agreements for provision of professional services in place of employment agreements.

3.10 Subcontracting. The Provider shall not subcontract or assign any of the services contemplated under this agreement without obtaining prior written approval from the Area Authority. Any approved subcontracts or assignments for program delivery shall be subject to all conditions of this Agreement. The Area Authority has the right to enter into a similar agreement with any other professional organization cooperating in the conduct of the Area Authority's services.

3.11 Mergers, Name Changes and Acquisitions and Changes in Ownership or Control. Each shall inform the other party in writing regarding any merger, name change, acquisition of another company, and change in ownership or control. The surviving entity shall be bound by all the terms and conditions of this Agreement.

3.12 Conflict of Interest. The Provider and the Area Authority will comply with the Conflict of Interest Guidelines per GS 133-32.

3.13 Coordination of Benefits. Both parties agree to assist in the coordination of each Individual's health care benefits so as to avoid undue delay in the provision of service and to ensure that Federal and State-allocated funding shall be used only if and when other sources of first and third party payment have been exhausted. Both parties agree to make every reasonable effort to verify all insurance and other third party benefit plan details during first contact, so that persons are directed to appropriate providers and to ensure compliance with North Carolina General Statute Chapter 122C. During an emergency, the Provider shall provide the necessary services and then assist to coordinate payment. See also Section 2.12 of this Agreement.

3.14 Response Time. Provider shall implement policies, procedures, performance standards and monitoring and shall consistently provide adequate staffing and scheduling to ensure compliance with the Department of MH/DD/SAS Services' "immediacy of need protocol", such that: 1. Individuals in emergency status, meaning a situation which threatens the health, safety or welfare of the Individual and/or of others, shall result in a face-to-face assessment which shall commence no later than two hours from notification to either party, 2. Individuals in urgent status, meaning their situation is likely to escalate into an emergency, must be seen face-to-face within 48 hours of first notification, and 3. Individuals with routine needs must be seen face-to-face (assessment and /or services) within seven (7) calendar days of first notification.

**ARTICLE IV
TERMINATION**

4.1 Voluntary Termination. This Agreement may be terminated at any time upon the mutual consent of both parties or after thirty (30) days upon written notice of termination by one of the contracting parties.

4.2 Involuntary Termination. Either party may immediately terminate this Agreement with cause. The cause for termination shall be documented in writing and presented to the other party in writing detailing the grounds for termination.

4.3 Effect of Termination. All payments provided herein shall be adjusted so as not to exceed the amount due for services actually rendered prior to the date of termination. If advance payments have been made for Covered Services not provided as of the date of termination, the Provider shall promptly refund all excess funds paid. If additional payments are due from the Area Authority, said payments shall be made only after receipt of final invoice and report.

4.4 Notice. Either party may at any time change its address for notification purposes by mailing a notice as required herein. The new address shall be effective on the date specified in such notice, or if no date is specified, on the tenth (10th) day following the date such notice is received.

4.4 Option for limited Renewal: The Area Authority may, by written notice to the Provider executed by the Area Director, extend the term of this Agreement by three (3) months.

IN WITNESS WHEREOF, each party has caused this Agreement to be executed in multiple copies, each of which shall be deemed an original, as the act of said party. Each individual signing below warrants he/she is duly authorized by the party to sign this agreement and to bind the party to the terms and conditions of this agreement.

Provider name/ address

Federal ID No. _____

DULY AUTHORIZED OFFICIAL

DATE

PRESIDENT, BOARD OF DIRECTORS

DATE

ALAMANCE-CASWELL MH/DD/SA (Area Authority/LME) 319-A N. Gra.-Hopedale Road, Burlington NC 27217

DULY AUTHORIZED OFFICIAL

DATE

CHAIR, AREA BOARD

DATE

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

FINANCE OFFICER

DATE

ATTACHMENT A
REIMBURSEMENT SCHEDULE FOR SERVICES
(Provider Name)

Note: Procedures for filing claims are detailed in the Provider Manual, Section IV.

**ATTACHMENT B
BUSINESS ASSOCIATE AGREEMENT**

This Agreement is made effective the **1st of July 2005**, by and between **Provider**, hereinafter referred to as “Covered Entity” and **Area Authority** hereinafter referred to as “Business Associate”, (individually, a “Party” and collectively, the “Parties”).

WITNESSETH:

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as “the Administrative Simplification provisions,” direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services has issued regulations modifying 45 CFR Parts 160 and 164 (the “HIPAA Security and Privacy Rule”); and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby Business Associate will provide certain services to Covered Entity, and, pursuant to such arrangement, Business Associate may be considered a “business associate” of Covered Entity as defined in the HIPAA Security & Privacy Rule (the agreement evidencing such arrangement is entitled **Purchase of Service Agreement** dated **July 1, 2005** and is hereby referred to as the “Arrangement Agreement”); and

WHEREAS, Business Associate may have access to Protected Health Information (as defined below) in fulfilling its responsibilities under such arrangement;

I. DEFINITIONS

Except as otherwise defined herein, any and all capitalized terms in this Section shall have the definitions set forth in the HIPAA Privacy Rule. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Privacy Rule, as amended, the HIPAA Security & Privacy Rule shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Security & Privacy Rule, but are nonetheless permitted by the HIPAA Security & Privacy Rule, the provisions of this Agreement shall control.

The term “Protected Health Information” means individually identifiable health information including, without limitation, all information, data, documentation, and materials, including without limitation, demographic, medical and financial information, that relates to the past, present, or future physical or MH/DD/SA or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Business Associate acknowledges and agrees that all Protected Health Information that is created or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display by Covered Entity or its operating units to Business Associate or is created or received by Business Associate on Covered Entity’s behalf shall be subject to this Agreement.

II. CONFIDENTIALITY REQUIREMENTS

(a) Business Associate agrees:

- (i) to use or disclose any Protected Health Information solely: (1) for meeting its obligations as set forth in any agreements between the Parties evidencing their business relationship or (2) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom Covered Entity is required to disclose such information or as otherwise permitted under this Agreement, the Arrangement Agreement (if consistent with this Agreement and the HIPAA Security & Privacy Rule), or the HIPAA Security & Privacy Rule, and (3) as would be permitted by the HIPAA Security & Privacy Rule if such use or disclosure were made by Covered Entity;
- (ii) at termination of this Agreement, the Arrangement Agreement (or any similar documentation of the business relationship of the Parties), or upon request of Covered Entity, whichever occurs first, if feasible, Business

Associate will return or destroy all Protected Health Information received from or created or received by Business Associate on behalf of covered entity that Business Associate still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, Business Associate will extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible; and

(iii) to ensure that its agents, including a subcontractor, to whom it provides Protected Health Information received from or created by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply to Business Associate with respect to such information and agrees to implement reasonable and appropriate safeguards to protect any of such information which is electronic protected health information. In addition, Business Associate agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause Business Associate to breach the terms of this Agreement.

- (b) Notwithstanding the prohibitions set forth in this Agreement, Business Associate may use and disclose Protected Health Information as follows:
- (i) if necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that as to any such disclosure, the following requirements are met:
- (A) The disclosure is required by law; or
 - (B) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;
- (ii) for data aggregation services, if to be provided by Business Associate for the health care operations of Covered Entity pursuant to any agreements between the Parties evidencing their business relationship. For purposes of this Agreement, data aggregation services means the combining of Protected Health Information by Business Associate with the protected health information received by Business Associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.
- (c) Business Associate will implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this Agreement Business Associate will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any electronic protected health information that it creates, receives, maintains, or transmits on behalf of covered entity as required by the HIPAA Security and Privacy Rule.
- (d) The Secretary of Health and Human Services shall have the right to audit Business Associate's records and practices related to use and disclosure of Protected Health Information to ensure Covered Entity's compliance with the terms of the HIPAA Security & Privacy Rule.
- (e) Business Associate shall report to Covered Entity any use or disclosure of Protected Health Information which is not in compliance with the terms of this Agreement of which it becomes aware. Business Associate shall report to covered entity any security incident of which it becomes aware. For purpose of this agreement Security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. In addition, 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.

III. AVAILABILITY OF PHI

Business Associate agrees to make available Protected Health Information to the extent and in the manner required by Section 164.524 of the HIPAA Security & Privacy Rule. Business Associate agrees to make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with the requirements of Section 164.526 of the HIPAA Security & Privacy Rule. In addition, Business Associate agrees to make

Protected Health Information available for purposes of accounting of disclosures, as required by Section 164.528 of the HIPAA Security & Privacy Rule.

IV. TERMINATION

Notwithstanding anything in this Agreement to the contrary, Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately if Covered Entity determines that Business Associate has violated any material term of this Agreement. If Covered Entity reasonably believes that Business Associate will violate a material term of this Agreement and, where practicable, Covered Entity gives written notice to Business Associate of such belief within a reasonable time after forming such belief, and Business Associate fails to provide adequate written assurances to Covered Entity that it will not breach the cited term of this Agreement within a reasonable period of time given the specific circumstances, but in any event, before the threatened breach is to occur, then Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately.

V. MISCELLANEOUS

Except as expressly stated herein or the HIPAA Security & Privacy Rule, the parties to this Agreement do not intend to create any rights in any third parties. The obligations of Business Associate under this Section shall survive the expiration, termination, or cancellation of this Agreement, the Arrangement Agreement and/or the business relationship of the parties, and shall continue to bind Business Associate, its agents, employees, contractors, successors, and assigns as set forth herein.

This Agreement may be amended or modified only in a writing signed by the Parties. No Party may assign its respective rights and obligations under this Agreement without the prior written consent of the other Party. None of the provisions of this Agreement are intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the provisions of this Agreement and any other agreements between the Parties evidencing their business relationship. This Agreement will be governed by the laws of the State of North Carolina. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

The parties agree that, in the event that any documentation of the arrangement pursuant to which Business Associate provides services to Covered Entity contains provisions relating to the use or disclosure of Protected Health Information which are more restrictive than the provisions of this Agreement, the provisions of the more restrictive documentation will control. The provisions of this Agreement are intended to establish the minimum requirements regarding Business Associate's use and disclosure of Protected Health Information.

In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect. In addition, in the event a party believes in good faith that any provision of this Agreement fails to comply with the then-current requirements of the HIPAA Security & Privacy Rule, such party shall notify the other party in writing. For a period of up to thirty days, the parties shall address in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Agreement fails to comply with the HIPAA Security & Privacy Rule, then either party has the right to terminate upon written notice to the other party.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

COVERED ENTITY:

BUSINESS ASSOCIATE:

By: _____

By: _____

Title: _____

Title: _____

ATTACHMENT C

PERFORMANCE INDICATORS FOR PROVIDERS OF MH/DD/SA SERVICES

1. Providers shall be responsible for full participation in an Area Authority/County Program monitoring/review process that includes the Department of MH/DD/SA Confidence Assessment Criteria, and the Local Monitoring discussion guide. Frequency of reviews and corrective requirements are determined by demonstration of acceptable compliance with quality indicators and scores from the Confidence Assessment.
2. 100% of all Level I Incidents as defined by the NC Department of MH/DD/SAS shall be recognized, adequately responded to, and reported/documented internally by the Provider, and reported in aggregate form quarterly to the Area Authority/County Program.
3. 100% of all Level II Incidents as defined by the NC Department of MH/DD/SAS shall be recognized, adequately responded to, and reported to the Area Authority/County Program and Department within 72 hours via the *DHHS Incident & Death Form*. An aggregate total for the quarter will be part of the Provider's quarterly report to the Area Authority/County Program.
4. 100% of all Level III Incidents as defined by the NC Department of MH/DD/SAS shall be recognized, adequately responded to, and reported verbally immediately to the Area Authority/County Program, and in written form to the Area Authority/County Program and Department within 72 hours via the *DHHS Incident & Death Form*. The Provider shall convene an incident review committee within 24 hours. Deaths that occur within 7 days of seclusion or restraint are reported immediately to the Area Authority/County Program. An aggregate total for the quarter will be part of the Provider's quarterly report to the Area Authority/County Program.
5. Providers shall implement policies, procedures, and practices to attempt to achieve 0% client rights violations. 100% of all substantiated client rights violations shall be reported through the Incident reporting process to the Customer Services/Consumer Affairs Unit of the Area Program/County Program Quality Management Department, and show evidence of being acted upon.
6. 100% of quality of care issues, as noted through Area Authority monitoring, shall promptly begin to be addressed through the development and initiation of a corrective action plan submitted for approval to the Area Authority/County Program within the time limits specified in the Area Authority/County Program's Quality Management Plan.
7. A representative sample of consumers shall be given the opportunity to express their *perception of satisfaction* for services received through the implementation of an empirical process no less often than twice a year. Survey results are submitted to the Area Authority. Providers may meet this requirement by full participation in the Area Authority/County Program's Quarterly Consumer Satisfaction Survey. The Provider is also required to participate in the Department's annual Consumer Satisfaction Survey.
8. When applicable...Providers shall meet no less than 100% with established time frames for initial face-to-face consumer contact (Emergent: within 2 hours; Urgent: within 48 hours; Routine: 7 calendar days.).
9. Providers shall meet 100% compliance with Provider Manual administration protocols for established Outcome Measures for each eligible consumer (NC-TOPPS, COIs, NC-SNAP). As applicable to the service population, Providers shall participate in the annual Core Indicators survey (DD consumers & families). 10. Providers shall demonstrate a Continuous Quality Improvement (CQI) process by identifying a minimum of 3 improvement projects acted upon per year. Projects and results will be reported to the Area Authority/County Program in any quarter of completion.

APPENDIX A

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Certification for Contracts, Grants, Loans and Cooperative Agreements

Public Law 103-227, Part C-Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or Medicaid funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.

By signing and submitting this application, the Contractor certifies that it will comply with the requirements of the Act. The Contractor further agrees that it will require the language of this certification be included in any sub awards which contain provisions for children's services and that all sub grantees shall certify accordingly.

APPENDIX B

CERTIFICATION REGARDING LOBBYING **Department of Health and Human Services** **Division of Mental Health, Developmental Disabilities and Substance Abuse Services**

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 employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in 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 employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in 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 Section 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.

APPENDIX C

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS
Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

- I. By execution of this Agreement the Contractor certifies that it will provide a drug-free workplace by:
 - A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor’s workplace and specifying the actions that will be taken against employees for violation of such prohibition;
 - B. Establishing a drug-free awareness program to inform employees about:
 - (1) The dangers of drug abuse in the workplace;
 - (2) The Contractor’s policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
 - C. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph (a);
 - D. Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the agreement, the employee will:
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;
 - E. Notifying the Department within ten days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction;
 - F. Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted:
 - (1) Taking appropriate personnel action against such an employee, up to and including termination; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and
 - G. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

The site(s) for the performance of work done in connection with the specific agreement are listed below:

- 1. _____
(Street address) (City, county, state, zip code)
- 2. _____
(Street address) (City, county, state, zip code)

Contractor will inform the Department of any additional sites for performance of work under this agreement.

False certification or violation of the certification shall be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment (Section 4 CFR Part 85, Section 85.615 and 86.620).

APPENDIX D
CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY
AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS
Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Instructions for Certification

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant will provide immediate written notice to the person to which the proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency of which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transactions

- (1) The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
- (2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.