CAPITAL AREA HEALTHY START COALITION

FLORIDA STANDARD CONTRACT

FOR SERVICES PROVIDED IN LEON COUNTY

THIS CONTRACT, is entered into between the Capital Area Healthy Start Coalition, Inc., hereinafter referred to as the "Coalition," and XXX, hereinafter referred to as the "Provider," and jointly referred to as the "parties." The purpose of this contract is to provide Healthy Start services in Leon County. The parties hereto agree as follows:

RECITALS:

WHEREAS, The primary objectives of the Healthy Start initiative are to reduce infant mortality and morbidity, to improve pregnancy outcomes, and to enhance the health and development of children from birth to age three; and

WHEREAS, Healthy Start Coalitions are a central component of this initiative; and

WHEREAS, The major goals of Healthy Start Coalitions are to establish, implement and monitor a system of care for pregnant women and children from birth to age three, and to administer Healthy Start care coordination services at an increased level of intensity and duration; and

WHEREAS, Healthy Start offers outreach to pregnant women, women of childbearing age, and children from birth to age three. The Healthy Start system of care offers universal prenatal and infant screenings to identify pregnant women and infants who are at risk for adverse birth, health, and developmental outcomes. Healthy Start eligible pregnant women and children from birth to age three are also offered care coordination and wraparound services that support families in reducing risk factors; and

WHEREAS, the Coalition has been created to develop services and resources for maternal and infant care in **Leon County** of the State of Florida; and,

WHEREAS, the Coalition is desirous of developing comprehensive and professional Healthy Start and care coordination services for the residents of Leon County in Florida needing maternal and infant care; and has been authorized by the Florida Department of Health to oversee the development of these services and resources through contracts with health care providers; and,

WHEREAS, the Provider is capable and willing to provide suitable services to persons needing maternal and infant care;

NOW, THEREFORE, in consideration of the mutual covenants contained herein, the parties hereto agree as follows:

I. THE PROVIDER HERETO AGREES:

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

B. Requirements of §287.058, Florida Statutes (FS).

To provide units of deliverables, including reports, findings, and drafts as specified in Attachment I, to be received and accepted by the Coalition prior to payment. The duties to be performed must be met for the completion of this Contract as specified in Attachment I. To allow public access to all documents, papers, letters, or other materials subject to the provisions of Chapter 119, F.S., made or received by the Provider in conjunction with this Contract. It is expressly understood that the Provider's refusal to comply with this provision shall constitute an immediate breach of this Contract.

C. To the Following Governing Law.

1. **State of Florida Law.**

This Contract is executed and entered into in the State of Florida, and shall be construed, performed, and enforced in all respects in accordance with the laws, rules, and regulations of the State of Florida. Each party shall perform its obligations herein in accordance with the terms and conditions of the Contract and all attachments incorporated herein by reference.

2. **Federal Law.**

a. If this contract contains federal funds, the provider shall comply with the provisions of 45 CFR, Part 74, and/or 45 CFR, Part 92, and other applicable regulations as specified in Attachment I.

b. If this agreement includes federal funds and more than $2,000 of federal funds will be used for construction or repairs, the provider shall comply with the provisions of the Copeland "Anti-Kickback" Act (18 U.S.C. 874 and 40

U.S.C. 276c), as supplemented by Department of Labor regulations (29 CFR part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or 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/she is otherwise entitled. All suspected violations must be reported to the Coalition.

c. If this agreement includes federal funds and said funds will be used for the performance of experimental, developmental, or research work, the Provider shall comply with 37 CFR, 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, the Provider shall comply with all applicable standards, orders, or regulations issued under §306 of the Clean Air Act, as amended (42 U.S.C. 1857(h) et seq.), §508 of the Clean Water Act, as amended (33 U.S.C. 1368 et seq.), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15). The Provider shall report any violations of the above to the Coalition.

e. To comply with the provisions of Section 216.347 F.S. which prohibits the expenditure of contract funds for the purpose of lobbying the Legislature, the judicial branch, or a State agency. If this contract contains federal funding in excess of $100,000, the Provider must, prior to contract execution, complete the Certification Regarding Lobbying form, Attachment V. 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 §§274A (e) of the Immigration and Naturalization Act (8 U.S.C. 1324 a) and section 101 of the Immigration Reform and Control Act of 1986. Such violation shall be cause for unilateral cancellation of this contract by the Coalition. The Provider is required to use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, https://e-verify.uscis.gov/emp, to verify the employment eligibility of all newly hired employees used by the Provider under this contract pursuant to section 448.095, Florida Statutes. The Provider must include in related subcontracts, if authorized under this contract, a requirement that subcontractors performing work or providing services pursuant to this Contract use the E-Verify system to verify employment eligibility of all newly hired employees used by the subcontractor for the performance of services under this contract. The Provider must provide the Coalition with an affidavit stating that they, and any of their subcontractors, do not employ, contract with, or subcontract with an unauthorized alien. The Provider must maintain a copy of such affidavit for the duration of the contract and submit the affidavit to the Coalition. If the Coalition or the Florida Department of Health has a good faith belief that the Provider or a subcontractor of the Provider knowingly violated section 448.095(1), Florida Statues, and notifies the Provider of such, but the Provider otherwise complied with this statute, the Coalition is required to immediately terminate the contract with the Provider.

g. The Provider shall comply with President's Executive Order 11246, Equal Employment Opportunity (30 FR 12319, 12935, 3 CFR, 1964-1965 Comp. P.339), as amended by President's Executive Order 11375, and as supplemented by regulations at 41 CFR, Part 60.

h. The Provider and any subcontractors agree to comply with the Pro-Children Act of 1994, Public Law 103- 277, 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. 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/or the imposition of an administrative compliance order on the responsible entity.

i. Health Insurance Portability and Accountability Act of 1996 (HIPAA): Where applicable, the Provider will comply with HIPAA as well as all regulations promulgated thereunder (45 CFR Parts 160, 162, and 164).

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 shall be performed through this website; however, if provider needs to change their FEID, they must contact the DFS Vendor Ombudsman Section at (850) 413-5519.

k. If the provider is determined to be a Subrecipient of federal funds, the provider will comply with the requirements

of the American Recovery and Reinvestment Act (ARRA) 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 the 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 https://fedgov.dnb.com/webform and www.ccr.gov.

D. Audits, Records, and Records Retention

1. Provider shall establish and maintain books, records, and documents (including electronic storage media) in accordance with generally accepted accounting principles, procedures, and practices, which sufficiently and properly reflect all revenues and expenditures of funds provided by the Coalition under this Contract.
2. Provider shall retain all client records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to this Contract for a period of ten (10) years after termination of the Contract, or if an audit has been initiated and audit findings have not been resolved at the end of ten (10) years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of this contract.
3. Refusal by the Provider to allow access to all records, documents, papers, letters, or other material or on-site activities related to this Agreement performance shall constitute a breach of this agreement.
4. The Provider shall be responsible for all storage fees associated with all records maintained under this Agreement. The Provider is also responsible for the destruction of all records that meet the retention schedule noted above.
5. Upon completion or termination of the Contract and at the request of the Coalition, the Provider will cooperate with the Coalition to facilitate the duplication and transfer of any records or documents belonging to the Coalition during the required retention period as specified in Section I, paragraph D.2. above.
6. Provider shall assure that these records shall be subject at all reasonable times to inspection, review, or audit by Federal, State, or Coalition staff.
7. Coalition staff, state, and Federal auditors, pursuant to 45 CFR, Part 92.36(i)(10), shall have full access to and the right to examine any of Provider's Contract and related records and documents, regardless of the form in which kept, at all reasonable times for as long as records are retained.
8. Provider shall provide a financial and compliance audit to the Coalition and to ensure that all related party transactions are disclosed to the auditor.
9. Provider shall include the aforementioned audit and record keeping requirements in all approved Contracts and assignments.
10. Provider shall complete the Federal Subrecipient and Vendor Determination Checklist annually.
11. If this contract indicates that the Provider is a recipient or subrecipient, the Provider will perform the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular A-133, and/or section 215.97 Florida Statutes, as applicable and conform to the following requirements:

    a. Documentation.

    1) Provider shall maintain separate accounting of revenues and expenditures of funds under this contract and each CSFA or CFDA number identified on Exhibit 1 attached hereto in accordance with generally accepted accounting practices and procedures. Expenditures which support provider 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.
    2) 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:
        a) allowable under the contract and applicable laws, rules and regulations;
        b) reasonable; and
        c) necessary in order for the recipient or subrecipient to fulfill its obligations under this contract.

3) The aforementioned documentation is subject to review by the Coalition, Department and/or the State Chief Financial Officer and the Provider will timely comply with any requests for documentation.

b. Financial Report.

1) Provider shall submit an annual financial report stating, by line item, all expenditures made as a direct result of services provided through the funding of this contract to the Coalition within 30 days of the end of the contract. If this is a multi–year contract, the Provider is required to submit a report within 30 days of the end of each year of the contract. Each report must be accompanied by a statement signed by an individual with legal authority to bind recipient or subrecipient certifying that these expenditures are true, accurate and directly related to this contract.

2) Provider shall ensure that funding received under this contract in excess of expenditures is remitted to the Coalition within 30 days of the earlier of the expiration of, or termination of, this contract.

9. Provider shall keep and maintain public records that ordinarily and necessarily would be required by the Provider in order to perform the service.

a. Public Records

1) Provider shall provide the public with access to such public records on the same terms and conditions that the public agency would provide the records and at a cost that does not exceed the cost provided in Chapter 119, FS, or as otherwise provided by law; ensure that public records that are exempt or that are confidential and exempt from public record requirements are not disclosed except as authorized by law; meet all requirements for retaining public records; transfer to the public agency, at no cost, all public records in possession of the contractor upon termination of the contract; and destroy any duplicate public records that are exempt or confidential and exempt. All records stored electronically must be provided to the public agency in a format that is compatible with the information technology systems of the agency.

2) Keep and maintain public records, as defined by Chapter 119, FS, that are required by the State of Florida, Department of Health, and the Coalition 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 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 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 or 4052 Bald Cypress Way, Bin A02, Tallahassee, FL 32399

3) 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), FS.

E. Monitoring by the Coalition.

To permit the Coalition Board of Directors and Coalition staff, with appropriate client authorization, to inspect any records, papers, documents, facilities, goods, and services of the Provider which are relevant to this Contract. The Provider will correct all noted deficiencies identified by the Coalition during such review within the specified period of time set forth in the review report. The Provider's failure to correct noted deficiencies may, at the sole and exclusive discretion of the Coalition, result in any one or any combination of the following: (1) the Provider being deemed in breach or default of this contract; (2) the withholding of payments to the Provider by the Coalition; and (3) the termination of this Contract for cause per 287.058 (1)(h), FS.

F. Indemnification.

NOTE: Paragraph I.F.1. and I.F.2. are not applicable to contracts executed with state agencies or subdivisions, as defined in §768.28, FS.

1. The Provider shall be liable for and shall indemnify, defend, and hold harmless the Coalition, their funders, and all of their 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 the 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. The Provider's inability to evaluate liability or its evaluation of liability shall not excuse the Provider's duty to defend and indemnify within seven (7) days after such notice by the Coalition is given by certified mail. Only adjudication or judgment after highest appeal is exhausted specifically finding the provider not liable shall excuse performance of this provision. The Provider shall pay all costs and fees related to this obligation and its enforcement by the Coalition. The Coalition's failure to notify the Provider of a claim shall not release the Provider of the above duty to defend.

G. Insurance.

1. Provider shall provide adequate liability insurance coverage on a comprehensive basis and 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 by §768.28, FS, the Provider accepts full responsibility for identifying and determining the type(s) and extent of liability insurance necessary to provide reasonable financial protections for the Provider and the clients to be served under this Contract. The limit of coverage under each policy maintained by the Provider does not limit the Provider's liability and obligations under this Contract. Upon the execution of this Contract, the Provider shall furnish the Coalition 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 Coalition reserves the right to require additional insurance where appropriate.
2. To the extent required by law, the Provider shall be self-insured against, or shall secure and maintain during the life of this Agreement, Worker's Compensation Insurance for all its employees connected with the work of this Agreement and, in case any work is subcontracted, the Provider shall require the subcontractor similarly to provide Worker's Compensation Insurance for all of the latter's employees unless such employees engaged in work under this Agreement are covered by the Provider's self-insurance program. Such self-insurance or insurance coverage shall comply with the Florida Worker's Compensation law. In the event hazardous work is being performed by the Provider under this Agreement and any class of employees performing the hazardous work is not protected under Worker's Compensation statutes, the Provider shall provide, and cause each subcontractor to provide, adequate insurance satisfactory to the Coalition, for the protection of its employees not otherwise protected.
3. The Provider shall provide adequate Automobile Liability Insurance to pay claims for damages to property, and for injuries to or death of any person or persons arising out of or related in any way to activities or the presence of its employees, agents or contractors on the Subject Property. The Provider shall set the limits of liability necessary to provide reasonable financial protections to the Provider, the Coalition, and the State of Florida under this Agreement. All insurance policies shall be with insurers licensed or eligible to transact business in the State of Florida. The Provider's current insurance policy(ies) shall contain a provision that the insurance will not be canceled for any reason except after thirty (30) calendar days written notice. The Provider shall provide thirty (30) calendar days written notice of cancellation to the Coalition's Contract Manager.
4. The Provider will provide Insurance certificates identifying the aforementioned coverage upon execution of this

Contract. Confirmation insurance policies required to be maintained by the Provider shall be written to insure losses on an "occurrence basis" and be primary and non-contributory to any insurance otherwise carried by the Coalition.

H. Safeguarding Information.

Provider shall not use or disclose any information concerning a recipient of services under this Contract for any purpose not in conformity with state and federal law or regulations except upon written consent of the recipient, or his responsible parent or guardian when authorized by law.

I. Assignments and Subcontracts.

1. Provider shall 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 Coalition, which shall not be unreasonably withheld. Any sub-license, assignment, or transfer otherwise occurring shall be null and void.
2. The Provider shall be responsible for all work performed and all expenses incurred with the project. If the Coalition permits the provider to subcontract all or part of the work contemplated under this contract, including entering into subcontracts with vendors for services and commodities, it is understood by the Provider that the Coalition shall not be liable to the subcontractor for any expenses or liabilities incurred under the subcontract and the Provider shall be solely liable to the subcontractor for all expenses and liabilities incurred under the subcontract.

J. Return of Funds.

Provider shall return to the Coalition any overpayments due to unearned funds or funds disallowed pursuant to the terms of this Contract that were disbursed to the Provider by the Coalition. In the event the Provider or its independent auditor discovers that overpayment has been made, the Provider shall repay said overpayment within twenty-five (25) calendar days without prior notification from the Coalition. In the event the Coalition first discovers an overpayment has been made, the Coalition will notify the Provider by letter of such a finding. Should repayment not be made in a timely manner, the Coalition will charge interest of one (1) percent per month compounded on the outstanding balance commencing thirty (30) calendar days after the date of notification.

K. Incident Reporting.

Abuse, Neglect, and Exploitation Reporting: In accordance with Florida law an employee of the Provider who knows or has reasonable cause to suspect that a child, aged person, or disabled adult is or has been abused, neglected, or exploited shall immediately report such knowledge or suspicion to the Florida Abuse Hotline on the single statewide toll-free telephone number (1-800-96ABUSE). Chapter 415, FS, pertains strictly to the mandatory reporting of abuse of vulnerable adults whereas Chapter 39, FS imposes reporting requirements related to the abuse of children.

L. Purchasing.

1. Procurement of Materials with Recycled Content: It is expressly understood and agreed that any products or materials which are the subject of or are required to carry out this contract shall be procured in accordance with the provisions of section 403.7065, FS.
2. 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, FS, shall register in the MyFloridaMarketPlace system unless exempted under Rule 60A-1.030(3), FAC.
3. MyFloridaMarketPlace Transaction Fee: The State of Florida, through the Department of Management Services, has instituted MyFloridaMarketPlace, a statewide Procurement system. Pursuant to section 287.057(22)(C), FS, all payments shall be assessed a Transaction Fee of one percent (1.0%), which the Provider shall pay to the State.
4. For payments within the State accounting system (FLAIR or its successor), the Transaction Fee shall, when possible, be automatically deducted from payments to the vendor. If automatic deduction is not possible, the vendor shall pay the Transaction Fee pursuant to Rule 60A-1.031(2), FAC. By submission of these reports and corresponding payments, vendor certifies their correctness. All such reports and payments shall be subject to audit by the State or its designee.
5. The Provider shall receive a credit for any transaction Fee paid by the Provider for the purchase of any item(s) if such item(s) are returned by the Provider through no fault, act, or omission of the Provider. Notwithstanding the foregoing, a Transaction Fee is non-refundable when an item is rejected or returned, or declined, due to the Provider's failure to perform or comply with specifications or requirements of the agreement. Failure to comply with these requirements shall constitute grounds for declaring the vendor in default and recovering reprocurement 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.

6. Alternative Contract Source: This Contract may be used as an alternative contract source, subject to approval from the Florida Department of Management Services, pursuant to section 287.042(16), Florida Statutes and Florida Administrative Code Rule 60A-1.045.

M. Transportation Disadvantaged.

If clients are to be transported under this contract, the Provider will comply with the provisions of Chapter 427, FS, and Rule Chapter 41-2, FAC. The Provider shall submit to the Department the reports required pursuant to Volume 10, Chapter 27, DOH Accounting Procedures Manual.

N. Civil Rights Requirements.

Civil Rights Certification: The Provider will comply with applicable provisions of DOH publication, "Methods of Administration, Equal Opportunity in Service Delivery."

O. Independent Capacity of the Contractor.

1. In the performance of this Contract, it is agreed between the parties that the Provider is an independent contractor and that the Provider is solely liable for the performance of all tasks and deliverables contemplated by this Contract which are not the exclusive responsibility of the Coalition.
2. The Provider, its officers, agents, employees, or subcontractors, in performance of this contract, shall act in the capacity of an independent Contractor and not as an officer, employee, or agent of the Coalition. Nor shall the Provider represent to others that it has the authority to bind the Coalition unless specifically authorized to do so.
3. Unless justified by the Provider and agreed to by the Coalition in Attachment I, the Coalition will not furnish services of support (e.g., office space, office supplies, telephone service, secretarial, or clerical support) to the Provider.
4. All deductions for social security, withholding taxes, contributions to unemployment compensation funds, and all necessary insurance for the Provider, the Provider's officers, employees, agents, subcontractors, or assignees shall be the responsibility of the Provider.

P. Sponsorship.

As required by section 286.25, FS, if the 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 shall, in publicizing, advertising, or describing the sponsorship of the program, state: *Sponsored by (Provider's name),* the *State of Florida, Department of Health and the Capital Area Healthy Start Coalition, Inc.* If the sponsorship reference is in written material, the words *State of Florida, Department of Health* shall appear in the same size letters or type as the name of the organization and the Healthy Start Coalition.

Q. Use of Funds for Lobbying Prohibited.

To comply with the provisions of section 11.062, FS, and section 216.347, FS, which prohibit the expenditure of Contract funds for the purpose of lobbying the Legislature, judicial branch, or a state agency.

R. Public Entity Crime and Discriminatory Vendor.

1. Pursuant to section 287.133, FS, the following restrictions are placed on the ability of persons convicted of public entity crimes to transact business with the Coalition: When a person or affiliate has been placed on the convicted vendor list following a conviction for a public entity crime, he/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, 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, FS, 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, FS, the following restrictions are placed on the ability of persons convicted of discrimination to transact business with the Coalition: When a person or affiliate has been placed on the discriminatory vendor list following a conviction for discrimination, he/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 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, FS, for CATEGORY TWO for a period of 36 months from the date of being placed on the discriminatory vendor list.

3. Scrutinized Companies:
   - **a.** The following paragraph applies regardless of the dollar value of the good or services provided in accordance with the requirements of section 287.135, Florida Statutes, the Provider certifies that it is not participating in a boycott of Israel. At the Coalition's option, the Contract may be terminated if the Provider is placed on the Quarterly List of Scrutinized Companies that Boycott Israel (referred to in statute as the "Scrutinized Companies that Boycott Israel List") or becomes engaged in a boycott of Israel.
   - **b.** The following paragraph applies only when goods or services to be provided are $1 million or more: In accordance with the requirements of section 287.135, Florida Statutes, the Provider certifies that it is not on the Scrutinized List of Prohibited Companies (referred to in statute as the "Scrutinized Companies with Activities in Sudan List" and the "Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List") and, to the extent not preempted by Federal law, that it has not been engaged in business operations in Cuba or Syria. At the Department's option, the Contract may be terminated if such certification (or the certification regarding a boycott of Israel) is false, if the Contractor is placed on the Scrutinized List of Prohibited Companies, or, to the extent not preempted by Federal law, if the Contractor engages in business operations in Cuba or Syria.

S. Patents, Copyrights, and Royalties.

1. If any discovery or invention arises or is developed in the course or as a result of work or services performed under this Contract, or in any way connected herewith, the Provider shall refer the discovery or invention to the Coalition to be referred to the Department of State to determine whether patent protection will be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of this Contract are hereby reserved to the State of Florida.

2. In the event that any books, manuals, films, or other copyrightable materials are produced, the Provider shall notify the Coalition to notify the Department of State. Any and all copyrights accruing under or in connection with the performance under this Contract are hereby reserved to the State of Florida.

3. The Provider, unless a state agency, shall 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 the Provider. The 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, the 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 the 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 shall include all royalties or cost arising from the use of such design, device, or materials in any way involved in the work.

T. Construction or Renovation of Facilities Using State Funds.

Any state funds provided for the purchase of or improvements to real property are contingent upon the 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 (5) 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, the Provider agrees that, if it disposes of the property before the Department's interest is vacated, the Provider will refund the proportionate share of the state's initial investment, as adjusted by depreciation.

U. Information Security and Information Technology.

The Provider shall maintain confidentiality of all data, files, and records including client records related to the services provided pursuant to this agreement and shall comply with state and federal laws, including, but not limited to sections 384.29, 381.004, 392.65, and 456.057, FS. Procedures must be implemented by the Provider to ensure the protection and confidentiality of all confidential matters. These procedures shall be consistent with the Department of Health Information Security Policies, as amended, which is incorporated herein by reference and the receipt of which is acknowledged by the Provider, upon execution of this agreement. The Provider will adhere to any amendments to the Coalition's security requirements provided to it during the period of this agreement. The Provider must also comply with any applicable

professional standards of practice with respect to client confidentiality.

Provider staff that have access connectivity to the Coalition's approved secure database shall be required to complete Security Awareness Training and HIPAA Training. The Provider shall also be required to sign a Data Security and Confidentiality Agreement and submit the completed form to the Coalition's Information Security designee. The requirements described in this Item must be completed before access to the approved secure data system is provided and annually thereafter.

V. Smartphone Applications.

If the Provider uses smartphone applications (apps) to allow providers direct access to documents and/or content, the Provider shall comply with the following. The Provider shall receive approval from the Provider's Information Technology Department before implementation of a smartphone application.

1. The smartphone application shall disclaim that the application being used is not private and that no PHI or personally identifiable information (PII) should be published on this application by the Provider; and

2. The Provider shall ensure that software applications obtained, purchased, leased, or developed are based on secure coding guidelines. For example: OWASP [Open Web Application Security Project] Secure Coding Principles – http://www.owasp.org/index.php/Secure_Coding_Principles; CERT Security Coding - http://www.cert.org/secure-coding/;T and Top10SecuritycodingPractices– https://www.securecoding.cert.org/confluence/display/seccode/Top+10+Secure+Coding+Practices

W. Travel Expenses

Travel expenses must be submitted in accordance with section 112.061, Florida Statutes. To be in compliance, the Provider must document travel using the State of Florida Authorization to Incur Travel Expenses Form (Form K) and the State of Florida Voucher for Reimbursement of Travel Expenses Form (Form L).

X. Prohibition of Gratuities

The Provider shall certify that no elected official or employee of the State of Florida has or shall benefit financially or materially from this Agreement in violation of the provisions of Chapter 112, F.S. This Agreement may be terminated if it is determined that gratuities of any kind were either offered or received by any of the aforementioned parties.

II. THE COALITION AGREES:

A. Contract Amount

To pay for contracted services according to the conditions of Attachment I, a projected amount not to exceed **$XXX,** subject to the availability of funds. The Coalition's performance and obligation to pay under this Contract is contingent upon an annual appropriation by the Legislature through the Department of Health and Medicaid funds earned through the Agency for Health Care Administration. 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.

See Attachment I.

III. THE COALITION AND THE PROVIDER MUTUALLY AGREE

A. Effective and Ending Dates.

This Contract with the Provider shall begin upon execution by both parties or on **July 1, 20XX** (whichever is earlier), and end on **June 30, 20XX**, inclusive.

B. Termination.

1. **Termination at Will.**

This Contract may be terminated by either party upon no less than sixty (60) calendar days notice in writing to the other party, without cause, unless a lesser time is mutually agreed upon in writing by both parties. Said notice shall 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 Coalition may terminate the contract upon no less

than *twenty-four (24) hours'* notice in writing to the Provider. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery. The Coalition shall be the final authority as to the availability and adequacy of funds. In the event of termination of this Contract, the Provider will be compensated for any work satisfactorily completed prior to notification of termination.

3. **Termination for Breach.**

   This Contract may be terminated for the Provider's non-performance upon no less than *twenty-four (24) hours* notice in writing to the Provider. If applicable, the Coalition may employ the default provisions in Chapter 60A-1.006 (3), FAC. Waiver of breach of any provisions of this Contract shall not be deemed to be a waiver of any other breach and shall not be construed to be a modification of the terms of this Contract. The provisions herein do not limit the Coalition's right to remedies at law or in equity**.**

C. Renegotiation or Modification.

Modifications of provisions of this Contract shall 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 negotiation process and subsequently identified in the Coalition's operating budget.

D. Official Payee and Representatives (Names, Addresses and Telephone Numbers).

1. The name (Provider name as shown on page 1 of this contract) and mailing address of the official payee to whom the payment shall be made is:

   Name

   Address

2. The name of the contact person, street address and phone number where financial and administrative records are maintained is:

   Name

   Organization

   Address

3. The name, address, and phone number of the Provider's representative responsible for administration of the program under this Contract is:

   Name

   Title

   Organization

   Address

4. The name of the contact person, address, and telephone number where the Coalition's financial and administrative records are maintained is:

   Chris Szorcsik, Executive Director

   Capital Area Healthy Start Coalition, Inc

   1311 N. Paul Russell Road, Suite A101

   Tallahassee, FL 32301

   850 488-0288, ext. 101

5. The name, address, and telephone number of the Contract Manager for the Coalition for this Contract is:

   Caroline Wilder, Administrative Director

   Capital Area Healthy Start Coalition, Inc.

   1311 N. Paul Russell Road, Suite A101

   Tallahassee, Florida 32301

6. Upon change of representatives (names, addresses, telephone numbers) by either party, notice shall be provided in writing to the other party and said notification attached to originals of this contract.

E. **All Terms and Conditions Included.**

This contract and its attachments as referenced, Attachments I – XII, 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 shall supersede all previous communications, representations, or agreements, either verbal or written between the parties. If any term or provision of the Contract is found to be illegal or unenforceable, the remainder of the Contract s h al I remain in full force and effect and such term or provision shall be stricken.

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

IN WITNESS THEREOF, the parties hereto have caused this 78-page contract to be executed by their undersigned officials as duly authorized.

PROVIDER:

Signed by: ______________________________________

Name:

TITLE:

DATE: ___________________________

COALITION: Capital Area Healthy Start Coalition, Inc

Signed by: _____________________________________

Name:

TITLE: President, CAHSC Board of Directors

DATE: __________________________________

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SCHEDULE OF EXHIBITS & ATTACHMENTS

ATTACHMENTS:

I. Contractual Responsibilities

II. Complaints and Grievances Procedure

III. Assurances for the Balanced Budget Act of 1997

IV. Debarment Certification

V. Certification Regarding Lobbying

VI. Civil Rights Compliance Checklist

VII. Funding Allocation Methodology Plan

VIII. CAHSC Financial Policies and Procedures for Subcontracted Providers

IX. Healthy Start Care Coordinator Training Policy and Procedures

X. Business Association Agreement

XI. Definition of Terms

XII. Financial and Compliance Audit/Exhibit

XIII. Healthy Start MomCare Network Exhibit

ATTACHMENT I CONTRACTUAL RESPONSIBILITIES

A. Services to be Provided.

1. General Description.

a. General Statement.

XXX, (hereinafter referred to as Provider) will address the health and wraparound service needs of pregnant women, Interconception women, and children from birth up to age three who are not enrolled in Medicaid for the funds provided under the Base Healthy Start Funds. Provider will address the health and wraparound service needs for those pregnant women and children up to age three enrolled in Medicaid for the funds provided by the Agency for Health Care Administration (AHCA). This will include Healthy Start Care Coordination and wraparound services and other related services in accordance with the Coalition's adopted Service Delivery Plan.

b. Authority.

1) **Capital Area Healthy Start Coalition, Inc.,** hereinafter referred to as "Coalition," is granted authority under Section 383.216, FS, and Chapters 64F-2 and 64F-3, FAC, and Ch. 18-009, §3 at 452, Laws of Fla.

2) The Coalition has been granted authority under the federal waiver and pursuant to section 409.906, FS, to provide counseling, education, risk-reduction and case management services, and quality assurance for all enrollees of the waiver.

The Agency for Health Care Administration shall contract with an administrative services organization representing all Healthy Start Coalitions providing risk appropriate care coordination and other services in accordance with a federal waiver and pursuant to s. 409.906. The contract shall require the network of coalitions to provide counseling, education, risk-reduction and case management services, and quality assurance for all enrollees of the waiver. The agency shall evaluate the impact of the MomCare network by monitoring each plan's performance on specific measures to determine the adequacy, timeliness, and quality of services for pregnant women and infants. The agency shall support this contract with certified public expenditures of general revenue appropriated for Healthy Start services and any earned federal matching funds.

c. Scope of Services.

1) Lead Agency Designation.

a) The Provider is designated as the lead agency for Healthy Start Care Coordination services and related activities in: **Leon County**

b) The Coalition will retain oversight responsibility as stated in the Healthy Start Standards and Guidelines, hereby made a part of this contract by reference.

2) Prenatal and Infant Risk Screening.

a) The Provider shall assist the Coalition in promoting the use of the Florida Prenatal and Infant (postnatal) Screening instruments by community prenatal and infant care providers.

b) Where applicable, the Provider will work with prenatal care medical providers to meet screening rate goals and will collaborate with Coalition staff to provide training and education as necessary.

c) The Provider will work with the Coalition to implement a system of regularly communicating with the health care providers of Healthy Start participants. This feedback will focus on patient status, services delivered, and related information.

3) Comprehensive Care Coordination.

a) The Provider shall deliver comprehensive care coordination including participant assessment and prioritization, development of participant plans of care, anticipatory guidance, support, referral to appropriate providers for the coordination of clinical and support services, and follow-up to assure identified risks are reduced and needs are met.

b) The Provider shall make an assessment of the participants' needs that are consistent with the delivery of risk-appropriate care.

4) Healthy Start Services.

a) The Provider shall deliver Healthy Start services, either through its staff or through a referral to community agencies, to address priority needs of Healthy Start participants.

b) The services shall include assessment of needs, prenatal and parenting education, general emotional support, stress management, nutrition education, breastfeeding education and support, smoking cessation, interconceptional counseling, community referrals based on risks and needs, child developmental screenings, and other screenings and service provisions offered in accordance with this contract and the Healthy Start Standards and Guidelines (HSSG) and as directed by the Coalition. If there is a discrepancy in service provisions between the HSSG and Coalition directives, the Coalition directives will prevail.

c) Provider shall coordinate the provision of services with Medicaid managed care plans for Healthy Start participants who are enrolled in the Statewide Medicaid Managed Care program to ensure services are not duplicated.

d) Provider shall implement a care coordination model (herein referred to as the "Healthy Start Pathways") that connects all at-risk pregnant women, infants, and children to evidence-based care using individualized pathways designed to produce healthy outcomes.

e) Each client will have a minimum of one home visit by Provider each month using the approved curriculum and schedule. [See definition of a home visit in Att. X.]

f) Conduct the following screenings per the approved model schedule and refer as needed: Substance use screen, intimate partner violence screen, tobacco screen and education, depression screen, developmental screens, and social-emotional screens and referral.

d. Healthy Start Program Purpose.

1) The primary purpose of the Healthy Start Program is to increase delivery of effective, evidence-based services that reduce infant mortality, reduce the number of low birthweight infants, and improve health and developmental outcomes for participants, including Medicaid recipients. Healthy pregnancies, births, and outcomes will decrease costs for health insurance companies including the Medicaid Program.

2. Participants to be Served.

a. Participants to be served are pregnant women and infants from birth up to age three. This includes participants who are not enrolled in Medicaid under the Healthy Start Base contract funds and those enrolled in Medicaid under the Medicaid Waiver contract funds.

b. This contract will also provide Healthy Start interconceptional care (ICC) services to all participants who are determined through the care coordination process to need services as outlined in the Healthy Start Standards and Guidelines.

c. Participants are initially screened by the Coordinated Intake and Referral (CI&R) program. Pregnant women, ICC women, and infants up to age 3 who agree to receive Healthy Start services are then referred by CI&R to the Healthy Start program.

d. Referrals come into CI&R via the Florida prenatal and infant risk screens, community referrals, and by self-referral.

B. Manner of Service Provision.

1. Service Tasks.

a. <u>Community Development Activities</u>

1) The Provider shall support and assist the Coalition in community development activities that increase awareness of the program and/or promote improved birth outcomes for pregnant women and infants.

b. <u>Healthy Start Services</u>

1) Care Coordination with the Medicaid Managed Care Plans

a) The Provider shall coordinate with the Medicaid managed care plans on services provided to participants who are enrolled in the Statewide Medicaid Managed Care program and who are also

receiving services from a Healthy Start Coalition, including:

(1) Data/information transfers to and from the Medicaid managed care plans;

(2) With appropriate consent, notifying the Medicaid managed care plans of recipients with substance exposure so they may provide and facilitate additional support and treatment;

(3) Scheduled and non-scheduled communications via telephone calls and emails; and

(4) Communication with, and participation in, interdisciplinary care team (ICT) meetings with Medicaid managed care plans and Healthy Start representatives, as needed.

b) The Provider shall maintain ongoing communications with the Medicaid managed care plans to coordinate the provision of services for pregnant women, infants and children under the age of thirty-six months who are jointly enrolled in the Statewide Medicaid Managed Care program and receiving services through the Leon County Healthy Start program. The Provider shall facilitate communications with the Medicaid managed care plans to ensure that there is no duplication in the provision of services.

c) The Provider shall participate in Interdisciplinary Care Team (ICT) meetings with the Medicaid managed care plans and Healthy Start Home Visiting representatives to discuss providers who are identified as appropriate for ICT staffing, as agreed upon by the managed care plans and Healthy Start, as follows:

(1) The Provider shall participate in, or conduct, regularly scheduled ICT meetings with the participant's managed care plan in order to match, but not overlap, the participant with the most appropriate community-based services and resources; and

(2) The Provider shall provide participants with a plan of care to assist and support them in accessing needed services and resources. The Provider shall ensure that the plan of care does not duplicate the managed care plan's care coordination efforts and shall share this information with the participant' managed care plan within thirty (30) calendar days of completion.

2) Healthy Start Prenatal and Infant-Child Pathways.

a) Participant Eligibility Criteria for the Healthy Start Prenatal and Infant Pathway

(1) The following participants are eligible for the Prenatal and Infant-Child Pathways if they have been identified to be at risk for poor birth, health, or developmental outcomes:

a) Pregnant Women

b) Infants and children ages birth through age thirty-six (36) months

b) Based on the information obtained through the CI&R process and Healthy Start client assessment, the Provider shall provide enhanced care coordination services through its Healthy Start Prenatal and Infant-Child Pathway program to pregnant women and children who are identified as being at risk for poor birth, health, or developmental outcomes.

c) The Provider shall assign each recipient participating in the Healthy Start Prenatal and Infant-Child Pathway program to a care coordinator.

d) Within thirty (30) calendar days of participant enrollment in the Healthy Start Prenatal and Infant-Child program, the Provider shall:

(1) Complete a face-to-face initial assessment using the Healthy Start Prenatal or Postnatal Comprehensive Assessments;

(2) Identify risks during the assessment and from the participant's screening tools such as the perinatal depression, intimate partner violence, substance abuse, and child development tools;

(3) Provide referral information to the participant for access to community services, including the reason for the referral, based on the risks and needs identified; and

(4) Evaluate any additional services needs and provide information to address risk factors and referrals to community resources as needed.

e) The Provider shall ensure that all Pathway services are provided face-to-face with the participant. The

Provider may also engage in communications on the participant's behalf (e.g., contact with community providers, etc.). Other Healthy Start non-Pathway services may be provided telephonically, such as follow-up to referrals made.

f) The Provider shall ensure that pregnant women who are participating in the Healthy Start Prenatal Pathway receive the following additional services:

(1) Evidence-based information, education, and screening (e.g., smoking cessation, perinatal depression, substance use, stress management, prenatal care;

(2) Assessing and addressing the social determinants of health;

(3) Facilitation of the participant's participation in the Interconception Care Curriculum; and

(4) Assistance as needed to ensure they access prenatal and postpartum medical care

g) The Provider shall ensure that infants and children who are participating in the Healthy Start Infant-Child Pathway receive the following services:

(1) Parent education using the approved curriculum;

(2) Developmental screenings and referrals to community resources, as necessary; and

(3) Assistance in finding a primary care provider.

h) If the Provider fails to comply with the requirements of this section, the Provider may be subject to liquidated damages and/or sanctions pursuant to Section C.1.c.

(3) Interconception Care Counseling (ICC) Pathway.

(a) The Provider shall provide Interconception Care (ICC) services during the period of time when a Healthy Start participant is between pregnancies as a preventive strategy to reduce risk factors that may affect the health and well-being of the mother and child, and that of any future children. The following participants are eligible for ICC services based on their risk status:

(1) Mothers of infants and children up to thirty-six (36) months of age in which the infant/child is currently participating in Healthy Start services; and

(2) Women who have suffered a pregnancy loss (miscarriage, stillbirth), an infant death, or have had a child placed out of the home, such as adoption or removal by the Department of Children and Families, and who are less than twelve (12) months postpartum.

(b) The Provider shall:

(1) Initiate ICC services within thirty (30) calendar days postpartum or thirty (30) calendar days after receipt of referral;

(2) Provide face-to-face services connecting women with local resources and counseling on contraceptive options, including the Long-Acting Reversible Contraceptives (LARCs);

(3) Provide face-to-face services to improve participation in the Family Planning Waiver (FPW):

i. For clients who are participating during their third trimester, introduce the FPW and strongly encourage participation;

ii. Further encourage participation by contacting the participant's health plan and requesting they assist in educating participant on the benefits of the FPW program;

iii. Provide participant with instructions during ICC face-to-face visits on how to complete the FPW application process.

(c) The Provider shall provide all participants meeting the eligibility criteria above with ICC services in accordance with the approved Florida DOH Healthy Start Standards and Guidelines and as directed by the Coalition.

(d) If the Provider fails to comply with the requirements of this section, the Provider may be subject to financial consequences and/or sanctions pursuant to Section C.1.c.

c) Service Provider Training

1) The Provider will comply with the Coalition's Healthy Start Care Coordinator Training Policies and Procedures (Attachment VIII).

2) The Provider will participate in webinar trainings and workshops, meetings, and conference calls, or any other activities as directed and required by the Coalition.

d) Data Entry

1) Healthy Start Services.

a) Provider shall ensure that services performed by Healthy Start funded staff are accurately coded and documented into the participant's Well Family System (WFS) database record within one (1) business day.

e) Customer Service/Call Number

1) The Provider shall incorporate and implement a complaint resolution and customer service tracking system. The Provider shall provide a U.S. based local telephone number to address customer service inquiries.

2) Provider may use an interactive voice response system provided that at each level the callers can choose to speak with a "live" person during normal business hours.

3) The Provider shall return all telephone calls and emails received during normal business hours up to 4:00 p.m. local time, on the same business day. Telephone calls and emails received after 4:00 p.m. local time shall be returned within one business day.

4) For calls received outside of normal business hours, the Provider shall provide the caller with a message that advises of the Provider's hours of operation, provides instructions for how to leave a message and how to request assistance, if needed, related to emergencies.

5) The Provider will provide a local customer service telephone number for all complaints, grievances, referrals and general questions regarding the Healthy Start Program for their area.

6) The customer service telephone number shall be staffed with trained personnel during normal business hours of 8:00 a.m. to 5:00 p.m., local time, Monday through Friday, excluding State of Florida observed holidays.

7) The Provider shall ensure that the individual numbers provide a before and after business hours message advising the caller of the hours of operation and allowing them to leave a message.

8) In accordance with Title VI of the Civil Rights Act of 1964, the Provider shall provide, free of charge, foreign language interpreter and translation services, and auxiliary aids and services to achieve effective communication with individuals requiring such assistance. The Provider shall ensure that there is a response to all written inquiries as soon as possible but no longer than three (3) business days from the date of receipt.

9) The Provider shall ensure that the message that is played for callers who are on hold does not include non-health related or marketing information. The Provider shall submit messages played while a caller is on hold to AHCA via the Coalition for prior approval.

10) If the Provider fails to comply with the requirements of this section, the Provider may be subject to financial consequences and/or sanctions pursuant to Section C.1.c.

f) Medicaid and Managed Care Organizations

1) The Provider shall verify eligibility for Medicaid prior to billing for any service. The Provider shall maintain a record of the participant's Medicaid identification number in the client's WFS database file. The Provider shall ensure that services provided are in coordination with the participant's Medicaid managed care plan.

g) Outreach and Training Materials

1) The Provider shall use appropriate outreach materials, training materials and instructional manuals. Outreach materials include flyers for events, Facebook pages or other social media, brochures, and any other materials that promote the Healthy Start program. Training materials include manuals, brochures, handouts, and audio/visual aids. All outreach material, training materials, and instructional manuals must be reviewed and approved by the AHCA and DOH through the Coalition prior to implementation. The Provider must submit all materials needing approval to the Coalition prior to any distribution.

2) The Provider shall provide written information on the Healthy Start Program and how to obtain help with a problem or concern related to their Healthy Start services to all participants.

3) At a minimum, program information shall include:

a) Information describing the Healthy Start program;

b) How to file a grievance if a problem or concern cannot be resolved;

c) Written information on the Healthy Start Program, along with the name, address, and telephone number of whom to contact to register a complaint or grievance;

d) Customer Service/Toll-Free Call Number information, as specified in this Contract; and

e) Information on oral translation services, language services and alternate formats for educational materials offered at no charge to the participant.

4) The Provider shall develop a comprehensive written cultural competency plan describing how services are provided in a culturally competent manner to recipients, including those with limited English proficiency.

5) The Provider shall ensure that all materials including outreach and training materials developed for the Medicaid population adhere to the following policies and procedures:

a) All materials must be at or near the fourth-grade reading comprehension level so that the materials are understandable (in accordance with section 1932(a)(5) of the Social Security Act as revised through Section 4701 of the 1997 Balanced Budget Act) and must be available in alternative formats (such as large print, video or audio recordings, or Braille) appropriate for persons with disabilities, free of charge. Materials shall be distributed in accordance with Section 4707 of the 1997 Balanced Budget Act. The Provider shall ensure that all written information is available in English, Spanish, Creole and other prevalent non-English languages, as appropriate. For the purposes of this Contract, prevalent means a non-English language spoken by at least five percent (5%) of the population covered under this Contract.

b) The Provider shall ensure that there is a comprehensive written cultural competency plan describing how services are provided in a culturally competent manner to participants, including those with limited English proficiency. The Provider shall ensure that oral interpretation services (or services in other appropriate means) are available to Healthy Start participants who speak any non-English language.

c) The Provider shall ensure that there is notification to its participants of the availability of oral interpretation services and information on how to access oral interpretation services. The Provider shall not charge the participants for language services.

d) All written materials used by the Healthy Start Program must be approved by ACHA and DOH through the Coalition prior to their use or dissemination to participants.

2. Staffing Requirements.

a. Staffing Levels.

1) The Provider shall establish staffing levels necessary for the completion of deliverables required by this attachment, and as outlined in the Healthy Start Standards and Guidelines, to ensure the optimal delivery of services to participants at an increased level of intensity and duration.

2) Provider shall ensure that there is a sufficient number of staff fluent in both English and Spanish to provide all contracted services or employ or contract with an interpreter as needed in order to fulfill the requirements of the Contract.

3) The Provider shall maintain copies of staff's current licenses and board certifications in a centralized administrative file.

b. Staffing.

1) In order to provide direct client services as well as continuous quality improvement, monitoring of the program, and training and monitoring of staff, Healthy Start staffing will consist of, at minimum, one full-time Healthy Start program manager, one full-time Healthy Start program supervisor, and 7 FTEs for Healthy Start Home visitors.

2) In order to recruit and retain staff, salaries must be competitive with local salaries for equitable positions. Minimum

starting salaries for Leon County Healthy Start staff will be:

a) Program Manager: $54,000.00 / year

b) Program Supervisor: $47,000.00 / year

c) Healthy Start home visitors: $40,000.00 / year

3) For staff retention, a market analysis of staff salaries should be completed annually and starting salaries adjusted based on the outcome of this analysis.

c. Healthy Start Provider Qualifications.

1) Healthy Start workers must meet one or more of the following educational requirements and have received all required trainings.

a) Minimum of a four-year college degree in social sciences; a health-related field such as nursing, health education, health planning, or health care administration; social work; or

b) Associate degree and licensure as a Registered Nurse with three years of public health/maternal-child health experience or licensure as a Licensed Practical Nurse with four years of public health/maternal child health experience.

c) The Provider shall meet all requirements for doing business in the State of Florida.

d. Staffing Changes.

1) The Provider shall notify the Coalition within one (1) business day of any staff member with access to WFS and/or Learning Management System (LMS) leaving the employment of Healthy Start so access to the databases can be removed. Notification shall be by e-mail to the Coalition's Contract Manager.

2) The Provider shall notify the Coalition within five (5) business days by e-mail of any staffing changes including terminations, new hires, and new positions. Notification shall be by e-mail to the Coalition's Contract Manager.

e. Staffing Obligations.

1) The Provider shall have at least one staff member attend each of the following by conference call, virtually or, if applicable, in person: Monthly monitoring meetings with the Coalition, monthly Fetal and Infant Mortality Review (FIMR) Case Review Team meetings, quarterly Coordinated Intake and Referral meetings, quarterly FIMR Community Action Team meetings, ICT calls with Medicaid plans as needed as described in section B.1.b.1), and at least one Tallahassee Memorial Healthcare NICU meetings per month (they are typically held weekly).

3. Service Location and Equipment.

a. Service Delivery Location.

1) The Provider's service area is **Leon County**.

2) The Provider shall ensure that the services are delivered in locations that are accessible to the population being served.

b. Service Times.

1) The Provider must be available Monday through Friday from 8:00 a.m. to 5:00 p.m., Eastern Time except for state holidays or administrative leave granted by the organization.

2) In the event all staff are out of the office, the Provider must have voicemail capabilities that must be checked daily Monday through Friday. The Provider shall ensure that all telephone calls are returned on the following business day.

c. Changes in Location.

The Provider shall notify the Coalition in writing of any changes in the Provider's office location a minimum of two (2) weeks prior to the change.

d. Equipment.

1) The Provider may use funds received from this contract for the purchase of equipment as defined and approved in the Provider's Budget Request Form (Form A).

2) The Provider is allowed to purchase equipment up to $1000.00 that is necessary for the provision of services under this contract.

3) Coalition approval is required for the purchase of equipment over $1000.00.

4. Deliverables.

a. Financial Reports.

1) <u>Annual Financial Report</u>. The Provider shall submit the following form(s) prior to the execution of the contract**:**

a) **Form A - Budget Narrative:** Line-item budget narrative to include a total of projected expenditures for Base and Medicaid Waiver Direct Service funds with a line-item justification for each approved categorical expense.

b) **Form B - Personnel List:** List of current staff to include employee name, job position, FTE, salary cost, and fringe cost. If changes occur to personnel, the updated list must be submitted with the next month's financial reports. Administrative support cannot be included in these projections.

c) **Form C - Administrative Support Budget Narrative and Personnel List:** Line-item budget narrative to include a total of projected expenditures for administrative support personnel and facilities. Budget amount shall not exceed ten percent (10%) of the total Healthy Start Direct Service budget.

2) <u>Monthly Financial Reports</u>. The Provider shall submit the following form(s) **within fifteen (15) calendar days** following the end of each month:

a) **Form B - Personnel List:** List of current staff to include employee name, job position, FTE, salary cost, and fringe cost, calculated by each month.

b) **Form C - Administrative Support Budget Narrative and Personnel List:** Line-item budget narrative to include a total of projected expenditures for administrative support personnel and facilities. Administrative Support shall not exceed ten (10) percent of the total earned.

c) **Form D - Expenditure Report:** Itemized Expenditure Report to Coalition Contract Manager for approval by line item, of all expenditures made by the Provider as a direct result of services provided pursuant to this contract. Revisions to the line-item budget shall be submitted to the Coalition for approval. Any revision to the budget must be accompanied by a formal request on letterhead, detailing what line item(s) funds are to be moved from, what line item(s) funds are to be moved to and justification for moving fund(s).

d) **Form E - Property Purchase List:** Listing of all purchases defined as non-expendable property. Said listing must include a description of the property, model number, manufacturer's serial number, funding source, information needed to calculate the federal and/or state share, date of acquisition, unit cost, property inventory number, and information on the location, use and condition, transfer, replacement or disposition of the property.

e) **Form F - Unexpended Funds Expenditure Report:** Itemized Expenditure Report to Coalition Contract Manager for approval by line item, of all expenditures made by the Provider as a direct result of services pursuant to this contract.

3) Quarterly Financial Reports

a) The Provider shall submit a quarterly general ledger to the Coalition within thirty (30) days after the end of each quarter of service

b. Quality Assurance and Emergency Management Plans

1) <u>Annual Plans</u>. The Provider shall submit the following documentation within thirty (30) calendar days following execution of the contract:

a) **Emergency Management Plan:** The Provider shall establish and maintain a Coalition-approved emergency management plan that describes the processes the Provider shall follow to ensure ongoing provision of services in a disaster or man-made emergency. The emergency management plan will include a risk assessment, procedures to comply with this Agreement during disasters, a communication plan during disasters, and training schedules for Provider staff. The emergency plan shall include a disaster recovery and business contingency

plan.

b) **Internal Quality Assurance (IQA) Plan**: The Provider shall establish and maintain a Coalition-approved Internal IQA Plan to ensure the appropriate administration of all responsibilities specified in this resulting Agreement. The Provider shall ensure that there are written procedures, program goals and objectives, and problem-solving activities to evaluate internal program and organizational activities for Healthy Start services. The Provider shall ensure the IQA addresses the following minimum elements:

(1) Quality assessment and monitoring activities to ensure that all functions are performed timely in accordance with this Agreement, including but not limited to a review of the following:

a) Policies and procedures;

b) Performance measurement results;

c) Internal grievances;

d) Complaints by recipients and other external parties;

e) Opportunities for improvement;

f) The frequency and type of supervision for staff; and

g) Remediation strategy when the Provider is in jeopardy of not meeting contractual requirements. The IQA plan shall stipulate that the Coalition shall be notified within five (5) business days of discovery.

c. Quality Assurance and Quality Improvement Reports.

1) Monthly QA/QI Report. The Provider shall submit the following form(s) **within ten (10) calendar days** after the end of each month of service:

a) **Form G –Healthy Start Staff and Services Report.** Monthly report on client services data; Healthy Start staff services, trainings, and community activities; and Provider needs.

b) **Form H – Medicaid Waiver Performance Measures Report.** Monthly report on review of Waiver Performance Measures as shown in reports in the Well Family System.

c) **Form I – Birth Outcomes Report.** Monthly report on birth outcomes for women in Healthy Start prenatally who delivered.

d) **Form J – Participant Incentives Report.** Monthly report on incentives given to Healthy Start participants.

2) Quarterly QA/QI Reports. The Provider shall submit the following form(s) within **fifteen (15) calendar days** after the end of each quarter of service:

a) **Form K - Record Reviews.** The Provider shall complete a minimum of thirty-five (35) in-depth record reviews per quarter. At least thirty (30) reviews should be from open cases and at least five (5) reviews should be from closed cases. Record reviews will include cases for infants, prenatal clients, and interconceptional clients.

b) **Form L – Record Reviews Summary Report.** Record review summary reports shall be compiled and submitted by the Provider quarterly. This report will contain a compilation of all cases reviewed during the quarter as submitted on Form H.

5. Performance Specifications.

a. Core Services Performance Measures.

1) At least **95.0 percent** of Healthy Start clients will receive an Initial Assessment, or an attempt to assess, within five (5) business days of receipt of the referral from CI&R (Measure A)

2) At least **95.0 percent** of new Healthy Start clients not reached at 1st attempt will receive a 2nd attempt within five (5) business days of 1st attempt, and the 3rd attempt to contact within five (5) business days of 2nd attempt (Measure B))

3) At least **95.0 percent** of Healthy Start records will contain documentation that a status letter of the Initial Assessment has been sent to the healthcare provider within thirty (30) calendar days from the first attempt to contact when the provider is known and there is a release to do so (Measure C)

4) At least **95.00 percent** of Healthy Start records will contain documentation of an Individualized Plan of Care

(IPC) at the Initial Assessment and at each subsequent encounter (Measure D)

5) At least **90.0 percent** of Healthy Start records will contain documentation of follow-up of the IPC and follow-up of referrals made at each subsequent encounter (Measure E)

6) At least **90.0 percent** of demographics pages will be completed for all Healthy Start participants who have had a completed Initial Assessment (Measure F)

7) At least **90.0 percent** of all clients who have a completed Initial Assessment, and will continue to receive ongoing care services, will have a Family Support Plan documented at the Initial Assessment (Measure G)

8) At least **90.0 percent** of Healthy Start client records will contain documentation that mandatory curriculum and appropriate screening tools were used or justification as to why they were not used (Measure H)

9) At least **90.0 percent** of participant encounters will be coded accurately (Measure I)

10) At least **85.0 percent** of all participant data, codes, case notes, and any other documentation will be entered into the client database system within one (1) business day of the service, or attempted service, being provided (Measure J)

11) At least **90.0 percent** of all client records will have ongoing documentation of their medical visits and upcoming appointments (Measure K)

b. Performance Measures for Medicaid Participants (Waiver measures).

1) At least **85.0 percent** of Healthy Start clients enrolled in the Prenatal or Infant-Child Pathway shall be screened for depression using the Edinburgh Postnatal Depression Screen according to the schedule outlined in the Perinatal Depression Screening Intervention Pathway (Waiver Measure 1)

2) At least **85.0 percent** of Healthy Start clients enrolled in the Prenatal or Infant-Child Pathway who were screened for depression and had a positive score shall be referred to available services for depression based on the recommended Perinatal Depression Screening & Intervention Pathway (Waiver Measure 2)

3) At least **85.0 percent** of Healthy Start clients enrolled in the Infant Pathway will receive the required ASQ-3 or ASQ-SE developmental screenings based on the schedule outlined in the Development Screening & Intervention Pathway (Waiver Measure 3)

4) At least **85.0 percent** of Healthy Start clients enrolled in the Infant-Child Pathway who score below the cut-off value on the ASQ-3 or ASQ-SE shall be referred to the available service outlined in the Screening & Intervention Pathway (Waiver Measure 4)

5) At least **85.0 percent** of post-partum clients enrolled in the Interconception Care Pathway shall receive education on the Florida Family Planning Waiver (Waiver Measure 5).

6. Monitoring and Evaluation.

a. Provider Responsibilities.

1) Required Reports.

Once all reports have been received and reviewed, the Coalition shall have five (5) business days to accept or reject the reports and notify Provider of any discrepancies in the reports. After notification, the Provider shall have five (5) business days to make corrections and resubmit for acceptance. Once reports have been approved, revisions will not be accepted and adjustments should be made in the next reporting period.

2) Coalition Monitoring and Site Visits.

The Provider agrees to cooperate in all such monitoring and evaluation activities established by the Coalition in this contract. The Provider shall make available to the Coalition and its staff all records and documentation, including Healthy Start participant charts, necessary for monitoring and evaluation, to the extent authorized by Florida law.

3) Internal Quality Assurance Program Plan.

The Provider shall conduct regular quality assurance and quality improvement activities pertaining to the services outlined in this contract. A copy of the plan for conducting these activities will be signed and

submitted to the Coalition (see B.4.b.1)b)

b. Coalition Responsibilities.

1) QA/QI Reviews, Monitoring Meetings, and Site Visits.

a) The Coalition shall monitor and evaluate the Provider's quality of service provisions and documentation. Monitoring and evaluation shall include, but is not limited to, review of client records, reports, and data in the Well Family System database; review of records, reports, data, and other documentation submitted by the Provider; interviews with Provider staff; and review of client surveys. The Coalition's monitoring and evaluation may include Coalition staff, Department of Health staff, Healthy Start MomCare Network staff, Agency for Health Care Administration staff, Coalition Board members, and Provider staff.

b) The Coalition will conduct monthly monitoring meetings with the Provider. The meetings will consist of review of services, sharing program updates, review of other issues, and support from the Coalition. An agenda will be developed by the Coalition for the monthly monitoring meetings with input from the Provider. The Coalition and Provider will have frequent contact as needed in addition to the monthly monitoring meetings.

c) The Coalition shall conduct an annual site visit, looking at the Provider's quality of service provisions, delivery of services, client documentation and services, community needs, and Provider needs. The Coalition will create a Reports of findings and will submit it to the Provider within sixty (60) days of completion of the site visit.

2) Financial Monitoring Review and Site Visit.

a) The Coalition shall review and monitor the Provider's expenditure reports quarter. The Provider shall submit a revised Budget Request if expenditures do not align with the Budget Request that was last approved by the Coalition. The Coalition will determine whether or not to approve the requested revisions to the budget.

b) The Coalition shall monitor and evaluate, at least annually, the Provider's financial records and fiscal procedures. Monitoring and evaluation shall include, but is not limited to, all financial reports and documents requested by the Coalition, reports and documents submitted by the Provider, and interviews with Provider's fiscal staff.

c) The Coalition's monitoring and evaluation may include State of Florida Department of Financial Services, Coalition staff, Department of Health staff, Healthy Start MomCare Network staff, Agency for Health Care Administration staff, Coalition Board members, and Provider staff.

c. Resolution of Issues/Problems Identified.

1) By execution of this contract the Provider agrees to be bound by its conditions and acknowledges and agrees that its performance must meet the standards set forth herein. If the Provider fails to meet the terms of this contract, the Coalition shall notify the Provider in writing of the specific performance failures and shall require the Provider to respond to the notification.

2) Performance Improvement Plans and Corrective Action Plans are developed in conjunction with the Provider in the event that Performance Specifications are not being met, contract requirements have not been met, or in the event that the program has had ongoing problems with program performance and has failed to meet goals set to improve performance.

a) Performance Improvement Plan (PIP).

(1) A PIP is based on failure to meet monthly or quarterly Performance Specifications.

(2) The plan may be initiated by the Provider or by the Coalition.

b) Corrective Action Plan (CAP).

(1) A CAP is based on a program's failure to meet Performance Specifications, failure to meet the goals set in previously placed PIPs, failure to meet contract requirements, and/or significant signs that the program is not functioning effectively and/or efficiently.

(2) The Coalition is responsible for developing a CAP that is mutually agreed upon by the Provider and the Coalition. In the event a mutual agreement cannot be reached, the Coalition shall have final

determination of the CAP requiring conformance with the contract. If the Provider fails to achieve compliance with the CAP within the specified time frame, the Coalition has the authority to terminate the contract for cause in the absence of any extenuating or mitigating circumstances

c) Development of PIPs and CAPs.

(1) Delineate services and processes that need improvement.

(2) Define strategies and process changes designed to directly improve performance outcomes.

(3) Include, at a minimum:

(a) Baseline data (when available) and a specific goal measurement to be achieved and maintained;

(b) The expected outcomes;

(c) The expected resolution dates;

(d) The status of progress toward full implementation of strategies and their impact on the performance outcome; and

(e) Discussion of additional strategies that will be attempted or of strategies found to be ineffective that will be discontinued.

C. Method of Payment.

1. Contract Amount.

The Coalition shall pay the Provider a projected total dollar amount not to exceed **$ XXX**, (will be Base + Waiver) based on the Coalition's current Funding.

a. Healthy Start Direct Services Funds.

Base and Medicaid Direct Service Funds will be paid monthly. This is a fixed price, fixed fee contract. Up to ten (10) percent of total earned may be used for Administrative Support.

1) Base Direct Service Funds.

(a) The Coalition will pay the Provider for completion of the deliverables, not including Deliverable 4.d.1 that relates to Medicaid Waiver funds, a total amount not to exceed **$ XXX** for the contract term. Payments will be made as follows:

(b) The Coalition will pay Provider the amount of **$ XXX** for the months of July 20XX through May **$ XXX** for the month of June 20XX.

(c) The Provider shall request payment through properly completed and signed Base Funds Invoice (Form B). Upon receipt, the Provider shall receive payment via an electronic transfer from the Capital Area Healthy Start Coalition.

(d) The Coalition's performance and obligation to pay under this contract is contingent upon an annual appropriation by the budgets of the State and Federal governments.

2) Medicaid Waiver Direct Client Services Funds.

(a) The Coalition shall pay the Provider a projected monthly amount of **$ XXX**, for a total projected amount not to exceed **$ XXX**, based on earnings as defined in the Coalition's Allocation Methodology Plan – Attachment VII, and the receipt of properly completed deliverables.:

(b) Coalition payment to the provider shall be contingent upon the HSMN payment for services rendered to eligible, enrolled Medicaid recipients.

(c) The Provider understands that Medicaid monthly payments for Healthy Start shall fluctuate based on the Medicaid earnings.

(d) Funds are subject to the availability of funds from the Agency and HSMN. Delays in payment which result from failure of the Agency and HSMN to provide timely payments of these shall not constitute breach of this contract. Provider agrees to continue service delivery without interruption during such

periods.

(e) Any unexpended funds at the end of the contract period shall be retained by or returned to the Coalition. The Provider may be allowed, based on the discretion of the Coalition, to carry forward funds into the next fiscal year.

3) Base and Waiver (Medicaid) Funding.

(a) Funds are subject to the availability of funds from DOH, AHCA, and HSMN. Delays in payment which result from failure of DOH, AHCA, or HSMN to provide timely payments of these shall not constitute breach of this contract. Provider agrees to continue service delivery without interruption during such periods.

(b) All Base funds must be spent during the FY. Any unexpended Base funds at the end of the contract period shall be returned to the Coalition. The Provider may be allowed, based on the discretion of the Coalition, to carry forward up to **$ XXX** in unexpended Medicaid funds into the next fiscal year.

b. Disbursement of Funds.

1) The Provider must request payment on a monthly basis through submission of properly completed invoices (Base funds – Form B; Medicaid Waiver funds – Form C) within fifteen (15) calendar days following the end of the period for which payment is being requested. The Coalition shall have (10) calendar days to review the received invoices. The Coalition will notify the Provider if revisions are needed. The Provider shall have fifteen (15) business days to make revisions and resubmit the invoice(s) to the Coalition.

2) The Coalition shall have ten (10) business days from date of receipt of all funds for the month of services from the State of Florida, Department of Financial Services, and the Healthy Start MomCare Network to disburse the funds to the Provider.

3) The cost of services paid under any other contract or from any other source are not eligible for reimbursement under this Contract.

c. Financial Consequences.

Performance Standards Requirement	**Liquidated Damages that may be Imposed**
1) The Provider shall ensure that all five Medicaid Waiver performance measures (Waiver measures 1-5) are met each calendar month.	$500.00 per Medicaid Waiver performance measure per month in which performance measures are unmet.
2) The Provider shall ensure that all other Performance Measures are met.	Not meeting Performance Measures Standards may result in termination of contract.
3) The Provider shall submit required reports within the time prescribed by the Coalition.	Failure to submit reports by the prescribed time will result in a two percent (2%) reduction in Base funds payment and then $50.00 per business day of Medicaid funds until submitted.
4) The Provider shall submit an Emergency Management Plan that will include a Disaster Recovery Plan to the Coalition within 30 calendar days after execution of this contract.	$150.00 per day for each business day past the due date in which the Coalition has not received the document.
5) The Provider shall submit an Internal Quality Assurance Plan to the Coalition within 30 calendar days after execution of this contract.	$150.00 per day for each business day past the due date in which the Coalition has not received the document.

6) The Provider shall not give to Medicaid clients any printed material that has not been pre-approved by AHCA. If the Provider has printed material they would like to have approved, the material will be given to the Coalition by the 10th of each month. It will not be distributed until receiving approval.	$500.00 for each incident in which non-approved material was disseminated to Medicaid clients.
7) The Provider shall submit ad hoc reports within fourteen (14) calendar days after the request is made from the Coalition.	$2,000.00 for each missed occurrence.
8) The Provider shall not use program data or client information for activities outside those required by this contract. All use of Program data or client information must be approved by AHCA via the Coalition.	$500.00 to $5,000.00 per incident, per occurrence, depending upon the severity in which the Provider inappropriately releases program data or client information.
9) The Provider shall maintain a complaint/grievance log and report complaints and/or grievances as required in the contract.	$150.00 per occurrence that is not in compliance.
10) The Provider shall comply with data maintenance requirements as outlined in this contract.	$150.00 per occurrence that is not in compliance.
11) The Provider shall ensure staffing levels are sufficient to complete all of the responsibilities outlined in the Contract, and that qualified staff are delivering all services. The Provider shall notify the Coalition, in writing, within five (5) business days of changes to staffing.	$150.00 per day for each business day past the five business day requirement in which the Coalition has not received the documentation.
12) The Provider shall develop and submit background screening and use E-Verify as required in the contract.	$250.00 per occurrence that is not in compliance.
13) The Provider shall not release client's personal health information (PHI) in accordance with the Health Portability and Accountability Act (HIPAA) contract.	$500.00 to $5,000.00 per incident, per occurrence, depending upon the severity in which the Provider inappropriately releases PHI.
14) The Provider shall comply with public records laws in accordance with 119.07 F.S.	$5,000.00 per occurrence that is not in compliance.
15) Complete initial renewal background screenings will occur within the required timeframes.	$250.00 per occurrence that is not in compliance.

D. Special Provisions.

1. Background Screening.

The Provider shall ensure that Provider's staff and subcontracted staff who have direct service contact with Healthy Start and/or SOBRA participants, or who have direct access to any PII, PHI, or financial information, including managing employees, will have a Level 2 background screening or criminal history (state and national) background check as provided in section 943.0542(2), FS. If there are questions as to whether a background screening is required for a particular position the subcontracted Provider should consult with the Coalition. Initial screening includes fingerprint checks through the Florida Department of Law Enforcement (FDLE) and the Federal Bureau of Investigation (FBI).

The subcontracted Provider must initiate background screening, including fingerprinting, at the time an applicant or subcontractor accepts a job offer or a volunteer agrees to perform services for the organization. The subcontracted Provider must provide written confirmation to the Coalition that the background screening has been completed with respect to each employee and volunteer of the subcontracted Provider providing direct services. No employee or volunteer shall remain in service with Provider or a subcontractor with an unfavorable background screening or a background screening that reflects the offenses listed in section 435.04(2), FS. The background screening results shall

be retained on file at the Provider's location. Failure to comply with background screening requirements may result in the termination of the contract.

Background screening will be completed with results every five years. The Provider does not have to re-screen staff or subcontracted staff that have been previously screened for purposes of employment within this same agency within the last five years.

2. Balanced Budget Act of 1997.

The Provider shall ensure their system of care for pregnant women, infants and children from birth to age three includes the Assurances for the Balanced Budget Act of 1997, Attachment III.

3. Civil Rights Compliance Checklist.

A standardized questionnaire must be completed if Provider is a recipient of a federal funding program. This questionnaire is included as Attachment VI and must be completed by Provider as a condition of this Contract.

4. Completion or Termination of Contract.

Upon completion or termination of the Contract and at the request of the Coalition, the Provider shall cooperate with the Coalition to facilitate the duplication and transfer of any records, documents, and educational material belonging to the Coalition during the required retention period as specified.

5. Confidentiality.

The Provider will receive appropriate and relevant information concerning Medicaid enrolled recipients consistent with legal guidelines outlined in section 409.907, FS. The Provider shall ensure and safeguard the use and disclosure of information pertaining to current or former Medicaid enrolled recipients and comply with all state and federal laws pertaining to confidentiality of the enrolled recipient information. Medicaid enrolled recipient information is strictly confidential, and under no circumstances shall this information be duplicated or provided to anyone for any purpose other than the activities required by this contract. Medicaid and non-Medicaid recipient information may not be utilized to solicit for other services offered by the Provider not covered in this contract.

6. Contract Renewal.

This contract may be renewed on a yearly basis for no more than three (3) years beyond the initial contract. Such renewals shall be made by mutual agreement and shall be contingent upon satisfactory fiscal and programmatic performance evaluations as determined by the Coalition. Renewal shall be subject to the availability of funds.

7. Daily Operations and Policies and Procedures.

The Healthy Start Standards and Guidelines is intended to guide the operation of the Healthy Start program, and can be located at the following website: http://www.floridahealth.gov/programs-and-services/childrens-health/healthy-start/index.html. When there is a conflict of language between the Healthy Start Standards and Guidelines and this contract, the contract shall govern.

8. Data Use and Disclosure.

The AHCA and HSMN shall have the right to use, disclose, or duplicate all Florida Medicaid participant data developed, derived, documented, or furnished by the Provider resulting from the contract.

AHCA maintains ownership of the data sets and all Medicaid participant records used in the Program. Upon the written request of AHCA, HSMN, or the Coalition, copies of Medicaid participant records relating to the Provider shall be transferred to AHCA, HSMN, and/or the Coalition at no expense to AHCA, HSMN, and/or the Coalition.

No data (such as utilization and trends) shall be disseminated, published or incorporated into a separate central database or warehouse without the express prior written consent of AHCA and HSMN via the Coalition.

The Provider shall not use the data for marketing purposes, unless approved by AHCA and HSMN via the Coalition.

AHCA authorizes the Provider to issue press releases about services provided to AHCA, HSMN, and Medicaid participants and the outcomes from these services with prior written consent of AHCA and HSMN via the Coalition. The Provider agrees not to distribute these releases without AHCA or HSMN's prior approval of the final language.

The data shall be used solely for purposes of the Program, unless approved by the AHCA or HSMN.

AHCA and HSMN reserve the right to share data and/or reports obtained from this contract with any State of Florida

Agency deemed appropriate.

9. Debarment and Lobbying Certification.

If this Contract contains federal funding in excess of $100,000, the Provider shall, prior to contract execution, complete and return to the Contract Manager the Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion form, Attachment IV, and the Certification Regarding Lobbying form, Attachment V.

10. Disaster Recovery Plan.

The Provider shall develop and maintain a disaster recovery plan. The disaster recovery plan shall limit service interruption to a period of twenty-four (24) clock hours and shall ensure compliance with all requirements under this contract.

The records back-up standards and a comprehensive disaster recovery plan shall be developed and maintained by the Provider for the entire period of the contract.

The Provider shall ensure a disaster recovery plan for restoring day-to-day operations including alternate locations for the Provider to conduct the requirements of this contract.

The Provider shall maintain database back-ups in a manner that shall eliminate disruption of service or loss of data due to system or program failures or destruction.

The Provider shall finalize the disaster recovery plan within fifteen (15) calendar days after the contract execution date. The Coalition may request to review the Provider's disaster recovery plan.

11. E-Verify System.

The Provider agrees to utilize 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 the Provider. The Provider shall also include a requirement in subcontracts that the subcontractor shall utilize the E-Verify system to verify the employment eligibility of all new employees hired during the contract term. Contractors meeting the terms and conditions of the E-Verify System are deemed to be in compliance with this provision.

12. Failure to Provide Services.

Failure of the Provider to provide services required under this contract may result in the Coalition withholding any payment due to the Provider.

13. Force Majeure.

The Coalition shall not be liable for any excess costs to the Provider if the Coalition's, AHCA's, or HSMN's failure to perform under the contract arises out of causes beyond the control and without fault or negligence on the part of the Coalition, Network or Agency. The Provider shall not be liable for performance of the duties and responsibilities of the contract when its failure to perform arises from causes beyond its control and without fault or negligence on the part of the Provider. These include destruction to the facilities or extended dislocation of staff due to hurricanes, fire, war, riots, and other similar acts. The Provider shall have a Coalition approved emergency management plan specifying what actions the Provider shall conduct to ensure the ongoing provisions of services in a disaster or man-made emergency. The emergency plan shall include a disaster recovery and business contingency plan.

14. Fraud and Abuse.

The Provider shall report fraud and abuse to AHCA, with a copy to the Coalition and HSMN, as referenced in 42 CFR 455.1(a)(1). For each complaint of fraud and abuse, the Provider must supply the following:

- **a.** Name and Medicaid number
- **b.** Source of complaint
- **c.** Type of provider
- **d.** Nature of complaint
- **e.** Approximate dollars involved
- **f.** Legal and administrative disposition of the case

The Provider shall cooperate with AHCA and/or state during an investigation of fraud or abuse, complaint, or grievances.

15. HIPAA.

Where applicable, the Provider shall comply with the Health Insurance Portability and Accountability Act (42 U.S.C. section 210 et seq.) as well as regulations promulgated thereunder (45 C.F.R. Parts 160, 162 and 164).

16. Well Family System Access.

The Provider shall comply with applicable professional standards of practice with respect to participant confidentiality and information obtained through access to WFS as stated in this Contract.

17. Legislative Decrease in Funding.

Funds may be reduced in this contract through forthcoming legislative appropriations and later identified in the operation budget. If this contract is executed prior to the amount of the decrease being known or effective, then an amendment must be executed for the decrease. The Provider shall submit a revised budget and budget narrative detailing the adjusted funding amount.

18. Legislative Increase in Funding.

Additional funds may be added to this contract through forthcoming legislative appropriations and later identified in the operation budget for the increase of funding. If this contract is executed prior to the amount of increase being known or effective, then an amendment must be executed for the increase. The Provider shall submit a revised budget and budget narrative detailing the use of the additional funds.

19. Misuse of Symbols, Emblems, or Names in Reference to Medicaid.

No person or the Provider may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words “Medicaid,” “Agency for Health Care Administration,” or “Healthy Start MomCare Network” except as required in this contract, unless prior written approval is obtained from AHCA via the Coalition. Specific written authorization from the AHCA and HSMN, via the Coalition, is required to reproduce, reprint, or distribute any AHCA form, application, or publication for a fee. State and local governments are exempt from this prohibition. A disclaimer that accompanies the inappropriate use of Program or Network terms does not provide a defense. Each piece of mail or information constitutes a violation.

20. Non-Expendable Property.

Non-expendable property is defined as tangible personal property of a non-consumable nature that has an acquisition cost of $1000 or more per unit and an expected useful life of at least one year, and hard-bound books, which are not circulated to students or the general public, with the value or cost of $250 or more. Hardback books with a value or cost of $250 or more should be classified as OCO (Other Capital Outlay) expenditures.

All such property purchased with funds from this contract shall be listed on the property records of the Provider. Said listing shall include a description of the property, model number, manufacturer’s serial number, funding source, information needed to calculate the federal and/or state share, date of acquisition, unit cost, property inventory number, and information on the location, use and condition, transfer, replacement or disposition of the property. All such property purchased with Healthy Start funds from this contract shall be inventoried on the Property Purchase List (Form #).

Title (ownership) to all non-expendable property acquired with funds from this contract shall be vested in the Coalition upon completion or termination of the contract. If the Provider is a county health department, title (ownership) to all non-expendable property acquired with funds from the contract shall be vested in the Department of Health upon completion or termination of the contract.

At no time shall the Provider dispose of non-expendable property purchased with Healthy Start funds from this contract except with the permission of the Coalition in accordance with their instructions.

21. Other Funds.

The Provider may utilize funds obtained from sources other than those provided through this Contract for either the operation of the Provider or for contracting with other subcontracted providers to deliver direct participant services. These funds may include, but are not limited to, gifts, contracts, grants, or donations from local, state, and federal agencies, community service agencies, corporations, and private citizens.

22. Unexpended Funds.

The Provider must ensure that funding received under this contract in excess of expenditures is remitted to the Coalition by check within 45 days following the contract period. In the event of contract termination, the Provider must ensure that funding received under this contract in excess of expenditures is remitted to the Coalition within 45 days of termination of the contract.

ATTACHMENT II

COMPLAINTS AND GRIEVANCES PROCEDURE

Informing Participant of their Complaint and Grievance Rights

A participant is defined as a person receiving services, or who has been referred to receive services, from the Healthy Start program.

Healthy Start participants are advised, through written information provided by the Healthy Start program, how to obtain help with a problem or concern related to their Healthy Start services. Information is given on how to file a grievance if the problem or concern cannot be resolved. The Healthy Start program's written information contains the name, address, and telephone number for the participant to contact and register a complaint or grievance.

The Provider shall ensure that there are written procedures that address the participant's rights, including, but not limited to, the following:

- How to receive information about available service options;
- The right to be treated with respect and in consideration of their dignity and privacy;
- The right to participate in decisions regarding their care; and
- Freedom to exercise their rights. The Provider shall ensure that the participant's decision to exercise their rights does not adversely affect the services that the participant receives through the Healthy Start Program.

If the Provider fails to comply with the requirements of this section, the Provider may be subject to financial consequences and/or sanctions pursuant to Attachment I, Section C.1.c.

Complaints

A complaint is defined as any expression of dissatisfaction by a participant, including dissatisfaction with the administration or provision of services, which relates to the quality of care provided.

Registering a Complaint

When a participant expresses a dissatisfaction that requires follow-up, the person receiving the complaint will document the details on a Healthy Start Services Complaint Summary Sheet (Attachment). The person completing the form will give the form to their immediate supervisor the same day the complaint is received. The supervisor will assign someone to investigate the complaint and assign a date for final findings and resolution within five business days of the date of the receipt of the complaint.

Action on a Complaint

The person assigned to investigate the complaint will document the findings on the Healthy Start Services Complaint Summary Sheet. The Healthy Start Services Complaint Summary Sheet will then be reviewed by the supervisor who will indicate concurrence with the findings and resolution by dating and signing the form. The person assigned to the complaint will then contact the complainant by phone or letter and inform them of the outcome. If resolution of the complaint requires assistance from outside parties, written consent of the complainant must be obtained prior to further action. This contact will be documented.

Documentation from contacts with any involved party of the complaint (i.e., document date, time, name of person and information received) will be attached to the Healthy Start Services Complaint Summary Sheet.

If a mutual resolution cannot be agreed to between the supervisor and person filing a complaint, the participant will have the right to a mediator or a meeting with the Coalition's grievance committee (typically consisting of Coalition Director, board members and at least one consumer) prior to reporting to the Department of Health (DOH) and Agency for Health Care Administration (AHCA). Note, at any time the participant may request to contact DOH, Healthy Start MomCare Network and AHCA.

Cross-referenced files and a log are kept, recording the name and address of each participant registering a complaint. A copy of the completed Healthy Start Services Complaint Summary Sheet is kept in the file.

The supervisor will send a copy of the complainant's completed and de-identified Healthy Start Services Complaint Summary Sheet to the Healthy Start Coalition's Executive Director within two business days after the resolution of the complaint.

Medical Care Complaint

When a quality of medical care complaint is reported, the supervisor will, within the same business day, report the complaint to the Healthy Start Coalition's Executive Director. The Healthy Start Coalition's Executive Director will refer the complaint within two business days to AHCA's District Medicaid Office and the Healthy Start MomCare Network Contract Manager. Any investigation will be conducted by AHCA. AHCA will be responsible for any investigation and follow up on all medical care complaints.

Grievance

A grievance is defined as a written complaint submitted by or on behalf of a participant regarding the availability, delivery, or quality of services.

Filing a Grievance

All grievances must be submitted in writing and date stamped upon receipt. Written consent to release this information is obtained from the participant.

Action on a Grievance

Upon receipt of a grievance, the Healthy Start Services Grievance Summary Sheet (Attachment) is completed and the grievance is attached.

The person receiving the grievance and completing the Healthy Start Services Grievance Summary Sheet will, within the same business day, notify their immediate supervisor and forward the written grievance and the Healthy Start Services Grievance Summary Sheet to the supervisor.

The supervisor will review the grievance and the Healthy Start Services Grievance Summary Sheet, and, within the same business day, notify the Healthy Start Coalition's Executive Director.

The supervisor is responsible for resolving operational type grievances. They will provide a written response to the grievant within thirty days from the initial filing by the participant.

Cross-referenced files and a log are kept, recording the name and address of each participant registering a grievance. A copy of the completed Healthy Start Services Grievance Summary Sheet is kept in the file.

The participant shall have the right to seek review of the grievance findings and recommendations to the Healthy Start Coalition, The Network, and AHCA.

Medical Care Grievance

When a quality of medical care grievance is reported, the supervisor will report the grievance, within the same business day, to the Healthy Start Coalition's Executive Director. The Healthy Start Coalition's Executive Director will refer the grievance within two business days to AHCA's District Medicaid Office and the Healthy Start MomCare Network Contract Manager. AHCA will be responsible for any investigation and follow up on all medical care grievances.

Adverse Incident Report

The purpose of this report is to ensure timely and accurate reporting of adverse incidents occurring within the Healthy Start program. This report must be completed and submitted to the Coalition within one (1) business day from when the adverse incident occurred.

HEALTHY START SERVICES COMPLAINT SUMMARY SHEET

Date Received:_________________ Received By:____
Name and Title

____ Last
Name of Complainant First Name MI

____
Address (Number, Street, Apartment)

____
City, State and Zip Code

____
Home Phone Work Phone Medicaid I.D. Number

Type of Complaint: Operational______________ Medical______________ Other_____________

Name and Telephone Number of Person or Care Provider Involved (If Applicable)

____
Name Telephone Number

Summary of Complaint: [Include Witness(es) if Applicable]____

____

____

Supervisor complaint referred to:____ Date:____________________

Assigned to by supervisor:____ Date:____________________

Investigation and Findings:____

____ Actions

taken:____

____

Supervisor Review:____ Date:______________________

____
Supervisor Signature and Title

Date Copy Sent to Healthy Start Coalition Executive Director:_____________________

HEALTHY START SERVICES GRIEVANCES SUMMARY SHEET

Date Received __________________ Received By:____
Name and Title

____
Last Name of Grievant First Name MI

____
Address (Number, Street, Apartment)

____
City, State and Zip Code

____
Home Phone Work Phone Medicaid I.D. Number

Type of Grievance: Operational_________________ Medical_____________ Other ____________

Name and Telephone Number of Person or Care Provider Involved (If Applicable)

____
Name Telephone Number

Summary of Grievance: [Include Witness(es) if Applicable] ____

____

____

Supervisor Notified:____ Date________________ Time ________________

Supervisor Review:____Date_______________ Time _________________

____
Signature

Healthy Start Coalition Executive Director Notified By:_____________________________________

Date:_____________________Time:___________________________

Investigation and Findings:____

____ Actions taken:____

____

Florida Healthy Start Program Incident Report

The purpose of this document is to provide Healthy Start Program service providers with a tool to ensure timely reporting of adverse incidents occurring within Healthy Start Program families.

Please submit this completed form via email to Chris@CapitalAreaHealthyStart.org within one business day of notification when a Healthy Start Program client experiences an adverse incident.

CLIENT INFORMATION (Do not include Personally Identifiable Information)

WFS Case ID: _______________ Date of Initial Assessment/Enrollment: _______________

HSMN Client / Other Family Member Directly Impacted by Adverse Incident:

☐ **Enrolled Client** ☐ **Other**

INCIDENT INFORMATION

Notification date: _____________
Incident date: _____________

Incident:

☐ **Enrolled Client death**
☐ **Enrolled Client suicidal attempt**
☐ **Enrolled Client homicidal ideation or attempt**
☐ **Enrolled Client formal grievance**
☐ **Home visitor initiated 911 call**
☐ **Other: _________________**

Brief description, including age(s) of child(ren):

In the occurrence of a child removal or death, please describe any prior involvement with CPS, including any calls made to the abuse hotline, etc.:

SUPPORTS PROVIDED FOR STAFF AND CLIENT

Describe support provided for staff and clients such as grief counseling, community services to assist with family's needs (burial services, shelter, substance abuse counseling, legal assistance).

Brief description:

Staff member completing form (type/print): ____ Date: ________________

NOTE: Submission of this form does not satisfy mandatory reporting requirements, provider agency or evidence-based model reporting requirements, or other required reporting. The provider agency is expected to follow its adopted policies and procedures regarding investigation of and documentation requirements pertaining to any adverse incident reported.

ATTACHMENT III

ASSURANCES FOR BALANCED BUDGET

1. The Florida Department of Health (“Department”), the Agency for Health Care Administration (“Agency”), and Centers for Medicare and Medicaid Services may inspect and audit any financial records of the Department or Department’s subcontractors relating to the Healthy Start Coordinated Care System for Pregnant Women and Infants.
2. The Department assures written information will be available to the Healthy Start Coordinated Care System for Pregnant Women and Infants participants in the prevalent non-English languages in Florida. The Department assures enrollees are not charged for any interpretation services.
3. The Department assures providers of the Healthy Start Coordinated Care System for Pregnant Women and Infants will have in place a grievance procedure for program participants.
4. The Department assures the providers of the Healthy Start Coordinated Care System for Pregnant Women and Infants services will attempt to contact participants within five business days of receipt of participant’s name and contact information to assure timely access to program services.
5. The Department assures the providers of the Healthy Start Coordinated Care System for Pregnant Women and Infants services will provide written materials in an easily understood language and format. Communications shall be at or near the fourth (4th) grade comprehension level. Written material will be available in alternative formats that take into consideration special needs.
6. The Agency assures that Healthy Start Coordinated Care System for Pregnant Women and Infants program participants will receive the same notice of any disenrollment from Medicaid as that provided to any other Medicaid recipient.
7. The Agency assures that Healthy Start Coordinated Care System for Pregnant Women and Infants program participants will receive the same notice of the right to a grievance procedure, appeal, and fair hearing procedures and timeframes as provided to any other Medicaid recipient.
8. The Department assures the providers of the Healthy Start Coordinated Care System for Pregnant Women and Infants services will inform the enrollee of their rights to change prenatal care providers and the mechanism to do so when the enrollee is notified of their prenatal care provider assignment. The provider will, within 30 days of eligibility notification from the Agency’s fiscal agent, register the enrollee with the selected prenatal care provider. If the enrollee has not made a decision within 30 days, the provider will assign a prenatal care provider by selecting from prenatal care providers within a thirty-minute drive of the enrollee’s residence. If there is more than one prenatal care provider who meet this requirement, the provider shall assign a prenatal care provider to the enrollee based upon a locally established unbiased protocol.
9. The Department assures the providers of the Healthy Start Coordinated Care System for Pregnant Women and Infants services will inform the enrollee recipient that her prenatal care provider can be changed for up to 60 days from provider enrollment. However, after 60 days, it is recommended that the recipient would only change providers for the following reasons:
   a) Change of recipient’s county of residence;
   b) Cause, such as recipient’s inability to schedule appointments in a timely manner with the provider, or patient/ provider conflict;
   c) Prenatal care provider termination from Medicaid or relocation;
   d) Recommendation of provider based on complications of recipient’s pregnancy such as to a Regional Perinatal Intensive Care Center provider; and
   e) If automatic assignment of a prenatal care physician was made by the Provider, the Provider shall recommend that the recipient not change her provider after 60 days from the date notified.
10. The Department assures the Provider may not discriminate for the participation or reimbursement of any staff who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.

11. The Department will assure that the Healthy Start Coordinated Care System for Pregnant Women and Infants provider staffing levels has adequate capacity to perform the roles and responsibilities as outlined in the Healthy Start Standards and Guidelines.
12. In the event a provider of the Healthy Start Coordinated Care System for Pregnant Women and Infants services is aware a woman is no longer pregnant, the Provider will make a good faith effort to notify the Agency of the change in eligibility status.
13. The Department will assure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the providers or the Department treat the enrollee.
14. The Department will assure that providers will be held in compliance with all Federal and State laws and regulations including title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.
15. The Department will assure that providers may not prohibit, or otherwise restrict, a staff health care professional acting within the lawful scope of practice from advising or advocating on behalf of an enrollee for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; for any information the enrollee needs in order to decide among all relevant treatment options; for the risks, benefits, and consequences of treatment or non-treatment; for the enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
16. The providers will submit marketing products, and drafts of products that can reasonably be interpreted as intended to market to potential enrollees, to the Department prior to distribution.
17. The Department assures the provider delivery network is sufficient to provide adequate access to all services as per the Healthy Start Standards and Guidelines and is supported by written contract agreements.
18. The Department assures that the providers meet the Healthy Start Standards and Guidelines for timely access to services. Timely access to services will be a component of the quarterly performance monitoring by the provider and the Department. The Department will monitor quarterly performance improvement plans on any providers not meeting performance measures.
19. The Department assures that the providers follow the Healthy Start Standards and Guidelines criteria for the delivery of services in a culturally competent manner to all enrollees and participants, including those with limited English proficiency.
20. The Department assures that the provider network is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees and participants in the service area.
21. The Department assures that the providers will notify the Department and the Agency of any enrollment problems via routinely scheduled conference calls.
22. The Department assures the providers of the Healthy Start Coordinated Care System for Pregnant Women and Infants services, where applicable, will comply with the Health Insurance Portability and Accountability Act as well as all regulations promulgated thereunder (45 CFR, Parts 160, 162 and 164).
23. The Department assures the providers of the Healthy Start Coordinated Care System for Pregnant Women and Infants services will identify if the enrollee or participant has any special needs and assist in the receipt of care.
24. The Department assures the providers of the Healthy Start Coordinated Care System for Pregnant Women and Infants services will perform services as set forth in the Healthy Start Standards and Guidelines.
25. The Department assures the providers of the Healthy Start Coordinated Care System for Pregnant Women and Infants services will maintain staffing levels necessary for the completion of the optimum level of program services. The provider will not arbitrarily deny or reduce the amount, duration, or scope of a service solely because of the diagnosis or condition.
26. The Department assures the providers will submit to the Department on a quarterly basis a progress report on the achievement of agreed upon performance measures by providers, copies of quality assurance monitoring reports, quality assurance/quality improvement summary record review forms. Compensation to staff performing quality improvement/ quality assurance activities will not provide incentive for the staff to deny, limit or discontinue necessary services to any enrollee/participant.
27. The Department assures the providers will develop and implement a written plan for quarterly quality monitoring and evaluating of services. This plan shall specify any records, reports, documents, tools and methods to be utilized in conducting monitoring and evaluation activities.
28. The Department assures the providers will meet the provider competencies and qualifications as outlined in the Healthy Start Standards and Guidelines.
29. The Department assures the providers may not employ or contract with staff excluded from participation in Federal health care

programs under either section 1128 or section 1128A of the Social Security Act.

30. The Department assures that any provider subcontracts include the applicable requirements of 42 CFR Part 438, services are evaluated for quality, specific activity and report responsibilities, and provides for corrective action sanctions if the subcontractor's performance is inadequate.

31. The Department assures that any provider subcontracts are monitored for performance on an ongoing basis and the provider has an annual contract monitoring review.

32. The Department assures that the provider and subcontractor will develop a corrective action plan for any deficiencies identified through the contract monitoring of subcontracts.

33. The Department assures the Healthy Start Standards and Guidelines are based on valid research, reviewed and updated as appropriate in consultation with the providers, and consider the needs of the enrollees and participants.

34. The Department assures the providers will not knowingly have a relationship, as a director, owner or employee, with an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549; an individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1).

35. The Department assures that the Agency and the Centers for Medicare and Medicaid Services may inspect and audit any financial records of the providers or the providers' subcontractors relating to the Healthy Start Coordinated Care System for Pregnant Women and Infants. There will be no restrictions on the right of the Agency and the Centers for Medicare and Medicaid Services to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs.

36. The Department assures that any enrollee and participant survey results may be disclosed to the Agency, and upon request, disclosed to enrollees and participants.

37. The Department assures the right in written provider contracts to make any and all reasonable determinations it deems necessary to protect the best interest of the State of Florida and the health, safety and welfare of the enrollee and participant. Such determinations may include, but are not limited to, all terms and conditions of, and any amendments to the contract.

38. The Department assures the providers' performance must meet the standards set forth in contract and is bound by contract conditions. If the provider fails to meet contract terms the Department will notify the provider in writing of the specific performance failures and may require the provider to respond to the performance failures by developing a corrective action plan that is mutually agreed upon by the provider and the Department. In the event a mutual agreement cannot be reached, the Department will have final determination of the corrective action plan requiring conformance with the contract. If the provider fails to achieve compliance with the corrective action plan, the Department has the authority to terminate the contract for cause in the absence of any extenuating or mitigating circumstances. The determination of extenuating or mitigating circumstances is the exclusive determination of the Department.

39. The Department assures the Center for Medicare and Medicaid Services, the Health and Human Service Inspector General, the U.S. Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of providers that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to staff personnel for the purpose of interview and discussion related to such documents. The rights of access are not limited to the required retention period but shall last as long as records are retained.

40. The Department assures contracts shall contain provisions requiring Equal Employment Opportunity Provisions.

41. The Department assures if any discovery or invention arises or is developed in the course or as a result of work or services performed under this contract, or in any way connected herewith, the provider shall refer the discovery or invention to the Department to be referred to the Department of State to determine whether patent protection will be sought in the name of the State of Florida. Any and all patent rights accruing under or in connection with the performance of this contract are hereby reserved to the State of Florida.

42. The Department assures the provider shall comply with all applicable standards, orders, or regulations issued under §306of the Clean Air Act, as amended (42 U.S.C. 1857(h) et seq.), §508 of the Clean Water Act, as amended (33 U.S.C. 1368 et seq.), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR Part 15).

43. The Department assures the provider shall certify that no 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 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. The Department assures provider will include the language of this certification 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.

44. The Department assures the provider will certify that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal Department or Agency.

45. The Department assures the Provider shall ensure that all contract material records and documentation are maintained for a period of ten years after the end of the contract or the completion of the financial audit, whichever is later. The provider shall ensure that all records and documentation containing medical information on individual participants are maintained for a minimum period of ten years.

ATTACHMENT IV

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION CONTRACTS/SUBCONTRACTS

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987 Federal Register (52 Fed. Reg., pages 20360-20369).

INSTRUCTIONS

1. Each provider whose contract/subcontract equals or exceeds $25,000 in federal monies must sign this certification prior to the execution of each contract/subcontract. Additionally, providers who audit federal programs must also sign, regardless of the contract amount. DOH cannot contract with these types of providers if they are debarred or suspended by the federal government.
2. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, the Federal Government may pursue available remedies, including suspension and/or debarment.
3. The provider shall provide immediate written notice to the contract manager at any time the provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms “debarred”, “suspended”, “ineligible”, “person”, “principal”, and “voluntarily excluded”, as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the contract manager for assistance in obtaining a copy of those regulations.
5. The provider agrees, by submitting this certification, that it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this contract/subcontract unless authorized by the federal government.
6. The provider further agrees by submitting this certification that it will require each subcontractor of this contract/subcontract, whose payment will equal or exceed $25,000 in federal monies, to submit a signed copy of this certification.
7. The Department of Health may rely upon a certification of a provider that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting/subcontracting unless it knows that the certification is erroneous.
8. This signed certification must be kept in the contract manager’s file. Subcontractor’s certifications must be kept at the contractor’s business location.

CERTIFICATION

(1) The prospective provider certifies, by signing this certification, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this contract/subcontract by any federal department or agency.

(2) Where the prospective provider is unable to certify to any of the statements in this certification, such prospective provider shall attach an explanation to this certification.

(3) By initialing, Contract Manager confirms that prospective provider has not been listed in the System for Award Management (SAM) database__________________________ Verification Date__________________

Name: ______________________________ Title: ______________________________

Signature: ____ Date: ____________________________________

ATTACHMENT V

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 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 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: ____________________

Name of Organization: ___

Address of Organization: ______________________________

12/96

ATTACHMENT VI
CIVIL RIGHTS COMPLIANCE CHECKLIST

STATE OF FLORIDA
DEPARTMENT OF HEALTH

For Fiscal Year July 1, 202# to June 30, 202#

The follow 8 pages contain a thumbnail of the DOH Civil Rights Compliance Checklist. The Provider will be provided with a PDF fillable version of the Civil Rights Compliance Checklist that is to be completed by the Provider and submitted to the Coalition.

Florida Department of Health
Office of the General Counsel
Equal Opportunity Section

CIVIL RIGHTS COMPLIANCE CHECKLIST FOR THE DEPARTMENT OF HEALTH AND PROVIDERS

The Florida Department of Health (Department) and its Providers are committed to equality in opportunity for all persons without regard to race, color, national origin, age, disability, and sex (including pregnancy, sexual orientation, gender identify, and sex characteristics). Note, not all bases apply to all Department programs and activities. Additionally, reprisal or retaliation is prohibited for prior civil rights activity in any program or activity conducted or funded by a federal agency.

The Equal Opportunity Section (EOS) monitors civil rights compliance of the Department and its Providers and ensures resolution of noncompliance is accomplished within federal guidelines. A provider is an individual, organization, institution, or agency from which the Department purchases or arranges for the provision of client services or benefits under departmental programs and activities.

The EOS, the Department's programs, and its Providers must work together to resolve noncompliance matters in a timely manner. Each applicable Department program must use the Civil Rights Compliance Checklist (CRCC) to evaluate all programs for civil rights compliance in accordance with federal requirements.

Additionally, Grant Managers and Contract Managers are responsible for monitoring Providers to ensure compliance with all applicable federal civil rights laws and nondiscrimination provisions. The monitoring must use this checklist. Prior to the approval of each contract, the designated Grant Manager or Contract Manager must review the completed CRCC to ensure it is complete. Each Grant Manager or Contract Manager must maintain the CRCC for each Provider. Additional monitoring may be conducted as needed by the Grant Manager, Contract Manager, or the EOS to ensure compliance in accordance with federal requirements.

Programs such as Women, Infants, and Children (WIC) and Child and Adult Care Food Program (CACFP) may require additional compliance reviews and monitoring by the applicable federal agency. Significant findings discovered during a compliance review of a USDA program or activity must be reported in writing to the reviewed entity and to the FNS Regional Civil Rights Officer. A significant finding is an egregious and repetitive finding or a policy or procedure that has a disproportionate, adverse effect on a particular protected class (disparate impact).

Section 1: Contact Information

Name of DOH Office/Division/CHD/Provider: ____

Address:____

City:____________________________ State:____________ County:______________________

Telephone Number: ___________________________ Fax Number: _____________________________

Completed By: _______________________________ Date: _________________________________

Briefly describe the type of services being provided:

Section 2: Designation of a Civil Rights Compliance Officer

1. Have you designated an individual to coordinate compliance with Civil Rights? Yes ☐ No ☐
   a. If so, provide their name, position title, and contact information: Name:

____

Position Title:

____

Contact Information:

____

Section 3: Notification

Notification must be made to program participants and applicants of their rights and responsibilities, their protection against discrimination, and the procedures for filing a discrimination complaint.

1. Do you use forms of communication such as letters, brochures, bulletins, newspapers, posters, face-toface contacts, radio, and televisions announcements to disseminate information about programs, activities, and applicable civil rights requirements? Yes ☐ No ☐
2. Do you ensure all photographs and other graphics used to provide program information display participants of different races, colors, sexes, and national origins? Yes ☐ No ☐
3. Do you ensure translated information and materials are provided in areas with a significant proportion of non-English speaking persons as needed? Yes ☐ No ☐
4. Do you post multilingual notices information persons with disabilities about the availability of free auxiliary aids and services and reasonable modifications and how to request these services in an alternative format, when necessary, that persons with disabilities can understand? Yes ☐ No ☐
5. Do you ensure that program regulations and guidelines are made available upon request? Yes ☐ No ☐
6. Do you provide specific program information that is pertinent to participation to program participants and applicants during the initial visit? Yes ☐ No ☐
7. If administering a USDA program or activity, do you ensure the appropriate And Justice for All poser is displayed in a prominent location where these services are delivered? Yes ☐ No ☐

Section 4: Race/Ethnicity Data Collection, Maintenance and Reporting

Providers must ensure the appropriate data is collected and maintained when required by federal and state statutes, regulations, and directives. This includes collection of race and ethnicity in accordance with the U.S. Office of Management and Budget (OMB) and each federal or state agency requirements. This data will be used to determine how effectively the Department's programs and activities are reaching potential eligible persons and beneficiaries, identify areas where additional outreach is needed, assist in the selection of locations for civil rights compliance reviews, and complete reports as required.

1. Do you notify the applicant that collection of race and ethnicity data is voluntary? Yes ☐ No ☐
2. Do you provide the applicant with the reason for collecting this data, such as to determine how effectively the Department's programs are reaching potentially eligible persons and beneficiaries and to monitor the State agencies Civil Rights compliance? Yes ☐ No ☐

3. Do you notify the applicant that their response will not affect consideration of their application and may be protected by the Privacy Act of 1972? Yes ☐ No ☐
4. Do you inform the applicant that race and ethnicity information is kept confidential? Yes ☐ No ☐
5. Do you notify the applicant that another method of identification of his or her race and ethnicity will be made and recorded in the data system if they decline to self-identify when the applicant visits the local office? Yes ☐ No ☐
6. Do you collect information about ethnicity before race? Yes ☐ No ☐
7. Do you provide an option to select one or more races? Yes ☐ No ☐

Section 5: Collection and Verification of Social Security Numbers, Citizenship, and Immigration

Collection and verification of citizenship, immigration status and social security numbers (SSNs), must only occur when required by federal statutes and regulation.

1. Do you inquire about, collect, and verify citizenship, immigration status, and social security numbers? Yes ☐ No ☐
   a. If so, please note the regulatory citation that authorizes such inquiries?
      ____
      ____
      ____
   b. If so, do you ensure the collection of this information does not result in an access barrier or unlawful discrimination in the Department of Health's programs and activities? Yes ☐ No ☐

Section 6: Training

The Department requires all Provider staff involved in administering or delivering the Department's programs and activities to meet all civil rights training requirements. It is imperative that individuals who routinely interact with clients that are receiving benefits or services under departmental programs or activities understand the requirements for reasonable modifications, equally effective communication for individuals with disabilities, communication with and assisting individuals with Limited English Proficiency (LEP), accepting calls placed through the Florida Relay system, and identifying alternative ways to provide access to programs and services when necessary to accommodate individuals with a disability and other civil rights matters.

1. Have you developed civil rights training? Yes ☐ No ☐
2. If so, do you your staff participate in civil rights training? Yes ☐ No ☐
   a. If so, how often?
      ____
      ____
      ____
3. Do your staff take a refresher civil rights training? Yes ☐ No ☐
   a. If so, how often?
      ____
      ____
      ____
4. Do you keep a record of training that has been completed by staff? Yes ☐ No ☐

Section 7: Complaints of Discrimination

Notification must be made to program participants and applicants of their rights and responsibilities,

their protection against discrimination, and the procedures for filing a discrimination complaint. All written or verbal complaints alleging discrimination based on race, color, national origin, age, sex (including pregnancy, gender identity, sexual orientation, and sex characteristics), disability, or reprisal or retaliation for engaging in prior civil rights activity in any of the Department's programs or activities are reviewed and processed by the Department in accordance with federal requirements and this procedure. Providers must forward all discrimination complaints to the Office of the General Counsel, EOS upon receipt for processing.

1. Have you received any complaints of discrimination from any program participants or applicants?
   Yes ☐ No ☐
   a. If so, have you forwarded the complaints to the EOS? Yes ☐ No ☐

Providers must notify complainants of their right to file a complaint directly with the appropriate federal agency.

1. Do you notify individuals of their right to file a complaint with the U.S. Department of Justice Civil Rights Division, U.S. Department of Agriculture, or the U.S. Health and Human Services? Yes ☐ No ☐

When communicating with individuals who have limited English proficiency (LEP), individuals with disabilities, or individuals who are illiterate regarding any aspect of the complaint process, Providers must provide communication assistance, other modifications, or accommodations and/or alternative formats when necessary to ensure equally effective communication.

1. Do you provide communication assistance to individuals who have limited English proficiency regarding the complaint process? Yes ☐ No ☐
2. Do you provide communication assistance to individuals with disabilities regarding the complaint process? Yes ☐ No ☐
3. Do you provide communication assistance to individuals who are illiterate regarding the complaint process? Yes ☐ No ☐

Section 8: Language Access

Providers must ensure meaningful access for individuals with limited English proficiency and when accessing the Department's programs and activities.

1. Have you designated a language access coordinator? Yes ☐ No ☐ a. If so, provide their name, position title, and contact information:
   ____
   ____
2. How do you determine the presence and needs of Limited English Proficiency or Non-English speaking (LEP) groups within your service area?
   ____
   ____
   a. What is the total number of LEP individuals who use or receive any type of services or benefits from your program each year?
   ____
   b. How many each month?
   ____
3. Specify the top six most frequently encountered non-English languages in your program.
   ____
   ____
   ____
4. How does your program plan for meeting the needs of LEP groups within your service area?

____
____
____

5. Do you have language access policies and, if so, are they written in accordance with the Department of Health's Language and Disability Access Plan? Yes ☐ No ☐

6. What type of written guidelines have staff been given on serving LEP persons?

____
____
____
____

   a. Have staff received training on serving LEP persons? Yes ☐ No ☐
   b. When? ____
   c. By whom? ____

7. Have multilingual staff received training on how to interpret? Yes ☐ No ☐

8. Have the language skills of multilingual staff been tested to determine proficiency levels? Yes ☐ No ☐
   a. If so, when? ____
   b. By whom? ____
   c. What is the proficiency rating? ____

9. How are clients informed about the availability of services in languages other than English?

____
____
____

10. How do you identify LEP individuals? (Select all that apply)

☐ Assume limited English proficiency if communication seems impaired ☐ Respond to individual requests for language assistance services ☐ Self-identification by the non-English speaker or LEP individual ☐ Ask open-ended questions to determine language proficiency on the telephone or in person	☐Use of "I Speak" language identification cards or posters ☐ Based on written material submitted to the agency (e.g., complaints) ☐ We have not identified non-English speakers or LEP individuals ☐ Other (Please specify): ____ ____

11. How do staff communicate with LEP groups or applicants?

____
____

12. What types of language assistance services do you provide? (Select all that apply)

☐ Bilingual staff ☐ In-house interpreters (oral) ☐ In-house translators (documents) ☐ Contracted interpreters ☐ Contracted translators ☐ Telephone interpretation services ☐ Video interpretation services ☐ Language bank or dedicated pool of interpreters or translators	☐ Volunteer interpreters or translators ☐ Interpreters or translators borrowed from another agency ☐ Other (Please specify): ____ ____ ____ ____ ____

13. How do you ensure interpreters and translators are qualified and competent to interpret vital information for LEP individuals?
____
____
____

14. Do you ask or allow LEP individuals to provide their own interpreters or have family members, friends or children interpret for LEP customers? Yes ☐ No ☐
    a. If so, is free language assistance offered prior to using the customer's informal interpreter for communication purposes? Yes ☐ No ☐
    b. Is a waiver of free interpreter services offered to the customer to sign voluntarily? Yes ☐ No ☐
    c. Is this wavier provided to the LEP customer in a written, translated form or is translated orally using a qualified, competent interpreter? Yes ☐ No ☐
15. How do staff record and track the primary language spoken and language assistance rendered to LEP customers at the point of service?
____
____

16. Where is the information stored?
____
____

17. Do you participate in any outreach efforts to LEP groups to make them aware of your program's activities, services, or benefits? Yes ☐ No ☐

18. How do you ensure outreach plans include strategies to reach LEP populations and materials are linguistically and culturally appropriate?
____
____
____

19. How has your program ensured meaningful access to vital information on your website?
____
____

20. Are websites available in languages other than English? Yes ☐ No ☐
21. When your agency updates information on its website, does it also add that content in non-English languages? Yes ☐ No ☐

22. Have you developed a local supplemental language access plan that includes additional local resources to provide meaningful access to individuals with limited English proficiency? Yes ☐ No ☐

Section 9: Disability Access - Reasonable Modifications

Providers must ensure equal opportunity participation and equally effective communication for individuals with disabilities when accessing the Department's programs and activities.

1. If you have fifteen (15) or more employees, have you designated a Section 504 Coordinator? Yes ☐ No ☐
2. If you are a state or local government agency with 50 or more employees, have you appointed an ADA Coordinator? Yes ☐ No ☐
   a. If so, provide their name, position title, and contact information.
      Name:
      ____
      Position Title:
      ____
      Contact Information:
      ____
3. Do you have policies and procedures require staff to make reasonable modifications in policies, practices and procedures and ensure equally effective communication for individuals with disabilities in accordance with the federal statutes and regulations for disability compliance (Section 504, ADA, and ADAAA)?
   Yes ☐ No ☐
4. How do you plan to ensure individuals with disabilities are afforded an equal opportunity to participate in your programs, activities, services, or benefits?
   ____
   ____
5. How do you notify individuals with disabilities about the availability of reasonable modifications and free auxiliary aids and services in a format that they can understand?
   ____
   ____
6. How do you ensure equally effective communication with individuals with disabilities?
   ____
   ____
   ____
7. What type of auxiliary aids and services does staff utilize when communicating with individuals with disabilities (qualified sign language interpreters, note takers, screen readers, video interpreting services, assistive listening systems, taped texts, audio recordings, large print, Brailed materials, large print materials, closed-captioned decoders, etc.)?
   ____
   ____
8. Do you contract with qualified interpreter services and other providers so that interpreters and other aids and services will be available on short notice? Yes ☐ No ☐
9. What are your policies and practices regarding the use of family, friends, and minor children as interpreters for individuals with disabilities?
   ____
   ____
10. How do you ensure websites are accessible to individuals with disabilities?
   ____
   ____

11. How do local agencies record, and track communication assistance or other reasonable modifications provided to individuals with disabilities?

    ____

    ____
12. Do staff have access to a TTY, and do they understand how to return communications received on a TTY or Relay Service? Yes ☐ No ☐
13. How do you train employees about effective communication and how to obtain and use auxiliary aids and services?

    ____

    ____
14. Has your office been reviewed for physical accessibility? Yes ☐ No ☐
15. Have you developed a local supplemental disability access plan that includes additional local resources to ensure equal opportunity participation and equally effective communication for individuals with disabilities when accessing the Department's programs and activities? Yes ☐ No ☐

Created August 2023

ATTACHMENT VII

DIRECT SERVICE FUNDING ALLOCATION METHODOLOGY FOR 202#-202#

Base Funding Allocation Methodology

Variable	Percent Applied
Function 3: Interventions	
Non-Medicaid Births & Non-Medicaid Served	100%
$XXX per county	

Contract Year	Data Source
20XX – 20XX	20XX-20XX & 20XX-20XX; year average

Base Direct Service funds in contract are a fixed amount using the Base Funding Allocation Methodology based on the Non-Medicaid births from 20XX – 20XX and Non-Medicaid served 20XX-20XX.

Medicaid Waiver Funding Allocation Methodology

Coalition payment to the provider shall be contingent upon the HSMN payment for services rendered to eligible, enrolled Medicaid recipients for the services outlined below.

HEALTHY START MEDICAID REIMBURSABLE SERVICES	
Service Name	Unit Reimbursement Amount
Care Coordination with the Medicaid Managed Care Plans	$43.94 per unit (up to 1 unit per recipient)
Healthy Start Prenatal Pathways	$202.89 per unit (up to 18 visits per recipient)
Healthy Start Infant-Child Pathways	$202.89 per unit (up to 36 visits per recipient)
Interconception Care Pathway – Face-to-Face	$202.89 per unit (up to 8 unit per recipient)

Medicaid unit prices were determined using the amount received from the Healthy Start MomCare Network for billable services less five 8.5% percent administration and 3% holdback.

Additionally, 2% will be held back in contingency reserves for potential future funding needs as determined by the Coalition's Board of Directors (i.e., data system, service provider, Medicaid paybacks, etc.).

ATTACHMENT VIII

FINANCIAL POLICIES AND PROCEDURES MANUAL

FOR SUBCONTRACTED PROVIDERS

Table of Contents

I. Definitions and Acronyms

A. Definitions

B. Acronyms

II. Basic Policy Statement

III. Line of Authority

A. Board of Directors

B. Executive Committee

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A. Base Direct Service Contract Funds

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V. Unallowable Expenditures

A. Base Direct Service Contract Funds

B. Medicaid Waiver Direct Service Contract Funds

C. All Contract Funds

I. DEFINITIONS AND ACRONYMS

A. Definitions

Administrative Support: Support not directly related to services, such as personnel, budget, payroll, bookkeeping, purchasing; also means work assisting an administrator through office management.

Rollover Funds: Unexpended funds from the previous contract that were approved to be used in the subsequent contract year.

B. Acronyms

FAHSC: Florida Association of Healthy Start Coalitions

CAHSC: Capital Area Healthy Start Coalition

WFS: Well Family System

II. BASIC POLICY STATEMENT

A. Capital Area Healthy Start Coalition, Inc., hereafter referred to as the Coalition, is committed to responsible financial management. The entire organization including the Board of Directors and staff will work together to ensure that all financial matters of the organization are addressed with care, integrity and in the best interest of the Coalition.

B. The policy and procedural guidelines contained in this manual are designed to:

1. Provide a framework for submission and approval of budgets and budget adjustments;
2. Ensure the best use of CAHSC funds; and
3. Ensure compliance with federal, state, local and nonprofit funding requirements.

III. LINE OF AUTHORITY

A. Board of Directors.

Has the authority to and is responsible for:

1. Executing any policies it deems to be in the best interest of the organization within parameters of the organization's articles of incorporation, bylaws, contractual requirements and federal, state and local law; and
2. Approving subcontracted providers' annual budgets, budget adjustments, and proposed budgets for rollover funds.

B. Executive Committee

Has the authority to and is responsible for:

1. Considering matters referred to it by the President of the Board of Directors; and
2. Exercising, in the absence of the Board of Directors, authority of the Board of Directors provided, however, that the delegation shall not operate to relieve the Board of Directors of any responsibility imposed by law or the bylaws.

C. Coalition Staff

Has the authority to and is responsible for:

1. Fulfilling the services needed by the Coalition as specified in their contracts with the Department of Health and the Healthy Start MomCare Network.
2. Collecting, reviewing, and approving subcontracted Providers' annual budgets, quarterly budgets, budget

adjustments, and proposed budgets for rollover funds;

3. Reviewing subcontracted Providers' budgets for accuracy and allowable expenditures;
4. Conducting an annual fiscal audit of each subcontracted provider; and
5. Providing monthly financial statements to the Board of Directors.

IV. ALLOWABLE EXPENDITURES

Expenditures must be actually incurred; supporting documentation is required.

A. Base Direct Service Contract Funds

1. Direct client services staff salary and fringe
2. Care Coordination and Wraparound services
3. Outreach to identify participants
4. Educational materials
5. Staff training
6. Travel reimbursement at the approved state rate (travel is subject to limits/per diems in §112.061, FS)
7. Up to 10% for indirect costs
    - Shared program administrative overhead costs should be allocated proportionally among all funding sources using a standard methodology. Indirect costs are for items that benefit multiple programs and/or the whole organization.
        - Administrative staff salary and fringe (i.e., Regional Executive Director, Associate Director of Healthy Start programs, Community Relations staff, home office staff)
        - Liability Insurance
        - Equipment rental/maintenance
        - Storage

B. Medicaid Waiver Direct Service Contract Funds

1. Direct client services staff salary and fringe
2. Care Coordination and Wraparound services
3. Outreach to identify participants
4. Educational materials
5. Staff training
6. Travel reimbursement at the approved state rate
7. Up to 10% for indirect costs
    - Shared program administrative overhead costs should be allocated proportionally among all funding sources using a standard methodology. Indirect costs are for items that benefit multiple programs and/or the whole organization.
        - Administrative staff salary and fringe (i.e., Regional Executive Director, Associate Director of Healthy Start programs, Community Relations staff, home office staff)
        - Liability Insurance
        - Equipment rental/maintenance
        - Storage

V. UNALLOWABLE EXPENDITURES

A. Base Direct Service Contract Funds

1. Services that are not care coordination and/or wraparound services as stated in the *Healthy Start Standards and Guidelines*

B. Waiver Contract Funds

1. Services that are not care coordination and/or wraparound services as stated in the *Healthy Start Standards and Guidelines*

C. All Contract Funds

1. Clinical Prenatal Care
2. Educational materials not approved by AHCA/DOH
3. Food, including snacks and drinks (except for meals as part of travel expenses - Form K)
4. Vehicles
5. Gas/Fuel (unless for a rental car)
6. Vehicle maintenance
7. Undocumented expenditures
8. Purchase and presentment of plaques for outstanding service*
9. Entertainment for visiting dignitaries*
10. Decorative items (globes, statues, potted plants, picture frames, etc.)*
11. Gift cards

* (Per Rule 3A-40.103, F.A.C.)

This list is not all-inclusive. The critical budget question is always "are the costs reasonable, allowable and necessary?" The answer to all three must be "yes."

The remainder of this page intentionally left blank.

ATTACHMENT IX

HEALTHY START STAFF TRAINING POLICIES AND PROCEDURES

The following trainings must be completed upon hire (within 60 days) and prior to providing services to Healthy Start participants. Training requirements may change throughout the contract year as directed by the Coalition.

A. Healthy Start System of Care:

1. All direct service staff must be trained on the Healthy Start System of Care
2. Training will be via a DOH or HSMN approved method as directed by the Coalition
3. The following LMS web training(s) must be completed:
    a. *Well Family System Documentation on the New System of Care*

B. Overview of local Maternal and Child Health (MCH) Systems of Care:

1. Healthy Start staff will be provided with an overview of the Leon County CI&R program and services
2. Healthy Start staff will be provided with an overview of Coalition programs, services, outreach, and local initiatives
3. Healthy Start staff will be trained on the Florida Prenatal Screen and the Florida Infant Screen
4. Healthy Start staff will be aware of available community resources
5. The Coalition with support the Provider in providing the MCH trainings

C. HIPAA, Security, and Confidentiality:

1. All direct service staff must complete HIPAA, Security, and Confidentiality training prior to working directly with clients
2. All non-direct client services staff who have access to client records must complete HIPAA, Security, and Confidentiality training prior to having access to client records

D. Prenatal and Parenting Education and Support:

1. Healthy Start care coordinators providing services to prenatal and/or infant-child participants must complete training in the use of the *Partners for a Healthy Baby* curriculum.

E. Interconception Education and Counseling:

1. Healthy Start care coordinators providing services to prenatal, ICC, and/or infant-child participants must complete the mandatory training in the use of the Interconception Education and Counseling curriculum approved by DOH.
2. The following LMS web training(s) must be completed:
    a. *Family Planning Contraceptive Counseling: Family Planning 101*
    b. One Key Question

F. Tobacco Education and Cessation:

1. Healthy Start care coordinators providing services to prenatal and infant-child participants must complete training in the use of the SCRIPT curriculum.
2. Healthy Start care coordinators will learn how to refer all participants who smoke, or have household members who smoke, to the Florida Tobacco-Free Quitline and website.

G. Perinatal Depression:

1. Care Coordinators providing services to prenatal, ICC, and/or infant-child participants must complete training in the use of the Mothers and Babies Curriculum.
2. The following LMS web training(s) must be completed:
    a. *Edinburgh Depression Scale Training* (Web Training)

H. Substance Abuse:

1. The following LMS web training(s) must be completed:
   a. Substance Abuse Model 3: Strategies for Working with Substance-Involved Families

I. Ages and Stages Questionnaire:

1. Healthy Start care coordinators providing services to infant-child participants must complete training in the use of following the Ages and Stages Questionnaires: ASQ-3, birth to 36 months; ASQ-SE, 12 months.
   2. The following LMS web training(s) must be completed:
      a. *Using the ASQ-3 and ASQ-SE2 Together*

J. Intimate Partner Violence:

1. The following LMS web training(s) must be completed:
   a. *Screening for and Identifying Intimate Partner Violence*

K. Breastfeeding Education and Support:

1. Healthy Start care coordinators providing services to prenatal and/or infant-child participants must complete a Coalition-approved course of at least 20 hours of breastfeeding training that meets the requirements of the HSSG within six (6) months of hire.
2. If a Healthy Start care coordinator is currently a Certified Lactation Counselor (CLC) or certified as an International Board of Lactation Consultant (IBCLC), they do not need the 20 hours of breastfeeding training.

The remainder of this page intentionally left blank.

ATTACHMENT X

BUSINESS ASSOCIATE AGREEMENT
(XXX is Business Associate)

This Business Associate Agreement ("Agreement"), effective July 1, 202# (the "Effective Date"), is entered into by and between XXX ("Business Associate") and the Capital Area Healthy Start Coalition, Inc. ("Covered Entity").

The parties to this Attachment agree that the following provisions constitute a business associate agreement for purposes of complying with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This Attachment is applicable if the Business Associate is a business associate within the meaning of the Privacy and Security Regulations, 45 C.F.R. 160 and 164.

The Business Associate certifies and agrees as to abide by the following:

1. Definitions. Unless specifically stated in this Attachment, the definition of the terms contained herein shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164.

    a. Protected Health Information. For purposes of this Attachment, protected health information shall have the same meaning and effect as defined in 45 C.F.R. 160 and 164, limited to the information created, received, maintained or transmitted by the Business Associate from, or on behalf of, the Coalition.

    b. Security Incident. For purposes of this Attachment, 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 and includes any event resulting in computer systems, networks, or data being viewed, manipulated, damaged, destroyed or made inaccessible by an unauthorized activity.

2. Applicability of HITECH and HIPAA Privacy Rule and Security Rule Provisions. As provided by federal law, Title XIII of the American Recovery and Reinvestment Act of 2009 (ARRA), also known as the Health Information Technology Economic and Clinical Health (HITECH) Act, requires a Business Associate (XXX) that contracts with the Coalition, a HIPAA covered entity, to comply with the provisions of the HIPAA Privacy and Security Rules (45 C.F.R. 160 and 164) and comply with 45 C.F.R. 162 as applicable.

3. Use and Disclosure of Protected Health Information. The Business Associate shall comply with the provisions of 45 CFR 164.504(e)(2)(ii). The Business Associate shall not use or disclose protected health information other than as permitted by this Agreement or by federal and state law. The sale of protected health information or any components thereof is prohibited except as provided in 45 CFR 164.502(a)(5). The Business Associate will use appropriate safeguards to prevent the use or disclosure of protected health information for any purpose not in conformity with this Agreement and federal and state law. The Business Associate will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information the Coalition creates, receives, maintains, or transmits on behalf of the Coalition.

4. Use and Disclosure of Information for Management, Administration, and Legal Responsibilities. The Business Associate is permitted to use and disclose protected health information received from the Coalition for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, in accordance with 45 C.F.R. 164.504(e)(4). Such disclosure is only permissible where required by law, or where the Business Associate obtains reasonable assurances from the person to whom the protected health information is disclosed that: (1) the protected health information will be held confidentially, (2) the protected health information will be used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and (3) the person notifies the Business Associate of any instance of which it is aware in which the confidentiality of the protected health information has been breached.

5. Disclosure to Third Parties. The Business Associate will not divulge, disclose, or communicate protected health information to

any third party for any purpose not in conformity with this Agreement without prior written approval from the Coalition. The Business Associate shall ensure that any agent, including a subcontractor, to whom it provides protected health information received from, or created or received by the Business Associate on behalf of the Coalition, agrees to the same terms, conditions, and restrictions that apply to the Business Associate with respect to protected health information. The Business Associate's subcontracts shall fully comply with the requirements of 45 CFR 164.314(a)(2)(iii).

6. Access to Information. The Business Associate shall make protected health information available in accordance with federal and state law, including providing a right of access to persons who are the subjects of the protected health information in accordance with 45 C.F.R. 164.524.

7. Amendment and Incorporation of Amendments. The Business Associate shall make protected health information available for amendment and to incorporate any amendments to the protected health information in accordance with 45 C.F.R. 164.526.

8. Accounting for Disclosures. The Business Associate shall make protected health information available as required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528. The Business Associate shall document all disclosures of protected health information as needed for the Coalition to respond to a request for an accounting of disclosures in accordance with 45 C.F.R. 164.528.

9. Privacy Protection. The Business Associate shall permit an individual to request a restriction on the use and disclosure of protected health information about the individual to carry out treatment, payment, or health care operations; and disclosures permitted under 164.510(b) in accordance with 45 C.F.R. 164.522. The Business Associate shall permit an individual to request to receive communications of protected health information from the Business Associate by alternative means or at alternative locations in accordance with 45 C.F.R. 164.522.

10. Access to Books and Records. The Business Associate shall make its internal practices, books, and records relating to the use and disclosure of protected health information received from, or created or received by the Business Associate on behalf of the Coalition, available to the Secretary of the Department of Health and Human Services ("HHS") or the Secretary's designee for purposes of determining compliance with the HHS Privacy Regulations.

11. Reporting. The Business Associate shall make a good faith effort to identify any use or disclosure of protected health information not provided for in this Agreement.

    a. To Coalition. The Business Associate will report to the Coalition in the manner and format obtained from the Agreement Manager, within ten (10) business days of discovery, any use or disclosure of protected health information not provided for in this Agreement of which the Business Associate is aware. The Business Associate will report to the Coalition in the manner and format obtained from the Agreement Manager, within twenty-four (24) hours of discovery, any security incident of which the Business Associate is aware. A violation of this paragraph shall be a material violation of this Agreement. Such notice shall include the identification of each individual whose unsecured protected health information has been or is reasonably believed by the Business Associate to have been, accessed, acquired, used, or disclosed during such breach.

    b. To Individuals. In the case of a breach of protected health information discovered by the Business Associate, the Business Associate shall first notify the Coalition of the pertinent details of the breach and upon prior review by the Coalition shall notify each individual whose unsecured protected health information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, used or disclosed as a result of such breach. Such notification shall be in writing by first-class mail to the individual (or the next of kin if the individual is deceased) at the last known address of the individual or next of kin, respectively, or, if specified as a preference by the individual, by electronic mail. Where there is insufficient, or out-of-date contact information (including a phone number, email address, or any other form of appropriate communication) that precludes written (or, if specifically requested, electronic) notification to the individual, a substitute form of notice shall be provided, including, in the case that there are 10 or more individuals for which there is insufficient or out-of-date contact information, a conspicuous posting for a period of at least 90 days on the Web site of the covered entity involved or notice in major print or broadcast media, including major media in the geographic areas where the individuals affected by the breach likely reside. In any case deemed by the Business Associate to require urgency because of possible imminent misuse of unsecured protected health information, the Business Associate may also provide information to individuals by telephone or other means, as appropriate.

c. To Media. In the case of a breach of protected health information discovered by the Business Associate where the unsecured protected health information of more than 500 persons is reasonably believed to have been, accessed, acquired, used, or disclosed, after prior review by the Coalition, the Business Associate shall provide notice to prominent media outlets serving the State, relevant portion of the State, or jurisdiction involved.

d. To Secretary of Health and Human Services (HHS). The Business Associate shall cooperate with the Coalition to provide notice to the Secretary of HHS of unsecured protected health information that has been acquired or disclosed in a breach.

e. Business Associates Who Are Covered Entities. In the event of a breach by the Business Associate, or a contractor or subcontractor of the Business Associate, and the Business Associate is a HIPAA covered entity, the Business Associate, not the Coalition, shall be considered the covered entity for purposes of notification to the Secretary of HHS pursuant to 45 CFR 164.408. The Business Associate shall be responsible for filing the notification to the Secretary of HHS and will identify itself as the covered entity in the notice. If the breach was with respect to 500 or more individuals, at least 5 business days prior to filing notice with the Secretary of HHS the Business Associate shall provide a copy of the notice and breach risk assessment to the Coalition for review. Upon prior review by the Coalition of the notice and breach risk assessment, the Business Associate shall file the notice with the Secretary of HHS within the notification timeframe imposed by 45 C.F.R. 164.408(b) and contemporaneously submit a copy of said notification to the Coalition. If the breach was with respect to less than 500 individuals, the Business Associate shall notify the Secretary of HHS within the notification timeframe imposed by 45 C.F.R. 164.408(c) and shall contemporaneously submit a copy of said notification to the Coalition.

f. Content of Notices. All notices required under this Attachment shall include the content set forth in 42 U.S.C. 17932(f) and 45 C.F.R. 164 Subpart D, except those references therein to a “covered entity” shall be read as references to the Business Associate.

g. Financial Responsibility. The Business Associate shall be responsible for all costs related to the notices required under this Attachment.

h. Other Reporting. The Business Associate shall comply with any other applicable reporting requirements in conformity with federal and state laws. If notifications are made under any such laws, copies of said notifications shall be provided contemporaneously to the Coalition.

12. Mitigation. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of protected health information in violation of this Attachment.

13. Termination. Upon the Business Associate’s discovery of a material breach of this Attachment, the Coalition shall have the right to assess liquidated damages as specified elsewhere in the agreement to which this Attachment is included, and/or to terminate this Agreement.

14. Effect of Termination. At the termination of this Agreement, the Business Associate shall return all protected health information that the Business Associate still maintains in any form, including any copies or hybrid or merged databases made by the Business Associate; or with prior written approval of the Coalition, the protected health information may be destroyed by the Business Associate after its use. If the protected health information is destroyed pursuant to the Coalition’s prior written approval, the Business Associate must provide a written confirmation of such destruction to the Coalition. If return or destruction of the protected health information is determined not feasible by the Coalition, the Business Associate agrees to protect the protected health information and treat it as strictly confidential.

The Business Associate has caused this Attachment to be signed and delivered by its duly authorized representative, as of the date set forth below.

______________________________________ ____________________

Signature of Authorized Representative Date

______________________________________ ____________________

Printed Name of Authorized Representative Title

ATTACHMENT XI

DEFINITION OF TERMS

1) Ad HOC – A report designed for a specific purpose, case or situation.

2) Administrative Services Organization (ASO) – For the purposes of this Contract, an entity representing all Healthy Start Coalitions providing risk appropriate care coordination and other services in accordance with a federal waiver and pursuant to section 409.906, F.S

3) AHCA – This term refers to Agency for Health Care Administration.

4) Ages and Stages Questionnaire— A developmental tool to screen children for developmental delays.

5) At-risk – Participants who have factors in their lives that predispose them to risk for adverse outcomes.

6) Attempt to Contact – The work efforts related to trying to contact a Healthy Start referred participant. Attempts to contact can include phone calls, letters, and face-to-face attempts.

7) Broadcast – Video, audio, text, or email messages transmitted through an internet, cellular. or wireless network for display on any device.

8) Business Day – Monday through Friday, except holidays observed by regular State of Florida employees. Timeframes requiring completion within a number of business days shall mean by 5:00 p.m. local time on the last business day.

9) Calendar Day – The consecutive days of a month, including weekends and holidays.

10) Care Coordination – The coordination, facilitation and provision of care services, as defined under the process referenced in Section 383.011, Florida Statutes and the *Healthy Start Standards and Guidelines*, that are identified through screening and assessment that is aimed at helping families receive the appropriate interventions and reducing Healthy Start participant risk and maximizing outcome.

11) CFR – Code of Federal Regulations.

12) Child – A child from their first birthday (age 1) up until their 3rd birthday.

13) Community Development Activities – Activities that increase awareness of the program, increase participant rates, screening rates and/or promote improved birth outcomes for pregnant women and infants. Activities include but are not limited to: health fairs; community presentations, Interagency network meetings, committee meetings, Services Delivery Plans, baby showers, board and coalition development, community service projects, social media efforts, and partnership development efforts.

14) Community Family Planning Services – Resources and services available within a community to support a woman's reproductive life course and services provided under Title X.

15) Community Health Assessment Resource Tool Set (CHARTS) – One-Stop site for Florida Public Health Statistics and community health data. This site also provides Florida's Healthy Start Coalitions with on-line access to Prenatal and Risk Screenings, Interconception care, substance use, care coordination, and wraparound service reports along with other Florida health data.

16) Community Resources – Supportive opportunities and services provided by others in the community that may complement or overlap those provided by Healthy Start. Examples include prenatal and primary care providers, postpartum home visitors, teen pregnancy programs, substance abuse treatment providers, religious organizations, and neighborhood and community centers.

17) Complaint – Any oral or written expression of dissatisfaction by a recipient or provider that relates to the quality of services provided pursuant to this Contract. Possible subjects for complaints include, but are not limited to, the quality of care, the services provided, aspects of interpersonal relationships such as rudeness of a staff member, failure to respect the recipient's rights, or provisions of services that relate to the quality of care rendered by a provider pursuant to the provider's Healthy Start Agreement. A complaint is a subcomponent of the grievance and appeal system. A complaint is not considered a grievance until the written complaint is received by the Coalition.

18) Coordinated Intake and Referral (CI&R)— A community-based program that provides intakes for pregnant women,

infants/children, and ICC women and refers them to local maternal and child health home visiting programs based on risks and needs. Also called the Connect Program.

19) Core Services – Standardized services that are provided to Healthy Start participants regardless of county of service. These include CONNECT Coordinated Intake and Referral, Healthy Start Home Visiting and care coordination, and interconception care services.

20) Deliverable – The tangible work product resulting from this contract which is to be described and provided to the contract manager in the form and manner at the time requested by this contract.

21) DOH **–** Florida Department of Health.

22) Direct Service – Per Chapter 64F-2.001(4), Florida Administrative Code, the professional and paraprofessional activities that entail a cost in time and effort spent in personal contact with participants of prenatal and infant health services. Such activities include, but are not limited to, routine prenatal care, health and social services, case management of participants, and outreach to specific individuals.

23) Edinburgh Postnatal Depression Scale— A screening tool to assist in identifying possible symptoms of depression in women.

24) Encounter – A direct or indirect service provided with or on behalf of a client. A direct service encounter is a successful contact with a participant via a home visit or other types of approved communication. An indirect encounter is interactions with other agencies on a client's behalf.

25) Enhanced Services – Services that are provided to Healthy Start participants when funding is available and there is a need for Healthy Start to provide the service. Service availability varies from county to county and may include childbirth education including doula services; parenting education and support; nutritional counseling; psychosocial counseling, smoking cessation counseling; breastfeeding education and support; and other services which improve health and developmental outcomes and access to care. Enhanced services are part of the Healthy Start system of care and can be provided individually or in group settings, in the home, neighborhood, school, workplace, or clinic, wherever the concerns, priorities, and needs of the participant and family can best be met.

26) Enrollee – A woman, infant, or child that is enrolled in Medicaid and qualifies for the Healthy Start Coordinated Care System for Pregnant Women and Infants services.

27) Executive Summary Report (ESR) – Healthy Start service report from the Department of Health's data system, compiled by the Office of Planning, Evaluation and Data Analysis, that summarizes data from birth records, Healthy Start screening, and services report data sets.

28) Face-to-Face Contact – Interaction that occurs in person with the enrollee.

29) Fetal and Infant Mortality Review (FIMR) Project – A community-based, action oriented process aimed at improving services, systems, and resources for women, infants, and families. FIMR convenes experts within communities that examine confidential, de-identified cases of fetal and infant deaths to help understand root causes and factors that impact child outcomes. These findings become preventative measures, implemented at the community level, to improve birth outcomes for babies in the state. CAHSC has a FIMR program that reviews fetal and infant death cases that occur to families residing in Leon, Wakulla, Jefferson, Madison, Taylor, and Gadsden counties.

30) FIMR Case Reviews – The process of gathering information (i.e., abstraction) regarding fetal or infant death from all available records, maternal and family interviews (when locatable and consent is obtained), case summary presentation, for CRT review.

31) FIMR Case Team Review (CRT) Team – A community-based, multi-disciplinary panel that reviews cases of abstracted data on an aggregate and individual case level to determine trends and barriers in the system of care and develop recommendations for improving the local system of care and other interventions to reduce fetal and infant deaths.

32) FIMR Community Action Team (FIMR CAT) – A panel of stakeholders, including representatives from agencies such as hospitals, health departments, medical societies, community leaders, schools, civic and business leaders, and consumers, responsible for reviewing CRT recommendations and developing and implementing strategies to reduce fetal and infant deaths. The CAHSC FIMR CAT meets quarterly.

33) FIMR Region – The counties designated by the Florida Department of Health to be served by the Healthy Start Coalition for purposes of the FIMR program. CAHSC facilitates a FIMR program that reviews fetal and infant death cases that occur to families residing in Leon, Wakulla, Jefferson, Madison, Taylor, and Gadsden counties.

34) Family Planning Waiver – The Family Planning Waiver (FPW) Program provides family planning and family planning-related services to eligible women ages 14 through 55. Eligibility is limited to women who whose pregnancy Medicaid coverage has

expired and to women who have lost Medicaid coverage for reasons other than the expiration of the pregnancy Medicaid. Women enrolled in the program are eligible for up to 24 months for Family Planning Waiver services.

35) Family Support Plan (FSP) – The purpose of the Family Support Plan is to involve participants/families in activities that may reduce their identified risk factors and may improve birth outcomes and child health and development outcomes. A FSP is not a plan of care. It is a participant-centered plan that help participants/families to create their own goals.

36) Follow-up – Communication with the participant, either by phone, in person, text, e-mail, or by letter.

37) Financial Consequence – As required pursuant to Section 287.058, Florida Statutes, if Provider fails to perform in accordance with the contract.

38) Grievance – A written complaint submitted by or on behalf of an enrollee or provider to the Coalition, DOH, AHCA, or the HSMN pertaining to the availability, coverage, delivery, or quality of services provided pursuant to this Contract. Grievances are of a more serious nature and generally require investigation into allegations regarding the quality of care and a complaint.

39) Health Equity – The concept that everyone should have a fair opportunity to attain their full health potential, regardless of their social, economic, demographic, or geographic background, and that no one should be disadvantaged from achieving that potential.

40) Health Management System (HMS) – The Department of Health’s data system that compiles prenatal risk screens data as entered by county health department staff.

41) Healthy Families Florida – Healthy Families Florida is a community-based, voluntary home visiting program designed to enable children to grow up healthy, safe, and nurtured. The program promotes positive parenting and healthy child development, thereby preventing abuse and other poor childhood outcomes.

42) Healthy Start – A comprehensive maternal and infant health care program, established by the Department of Health, that provides education and referrals to pregnant women, women and families with children under the age of three years, women who have had a recent loss (miscarriage, stillbirth, infant death), and women who have recently had an infant placed out of the home by adoption or removal by the Department of Children and Families.

43) Healthy Start Coalition – An organization or a group of individuals who have demonstrated their interest in forming a community prenatal and infant health Coalition, have completed the establishment process per Rule 64F-2.003 and have been approved by the Department of Health as a Healthy Start Coalition to provide universal risk screening, risk appropriate care coordination and other interventions to all pregnant women and newborn infants in Florida in accordance with a federal waiver and pursuant to Section 409.906, F. S. In the event that a Coalition is not established in a county, by section 383.216, F.S., the management of the Healthy Start Program is carried out by the local county health department. For the purposes of this Contract, the term “Coalition” includes the county health department when the county health department is acting in the role of the Coalition. Also referred to as “Coalition,” means an alliance of private and public individuals or groups organized, consistent with Section 383.216, Florida Statutes, to assess needs, prepare plans, build community support, and ensure services are available to promote and protect the health and well-being of pregnant women, Interconceptional women, and children from birth to age three.

44) Healthy Start MomCare Network (HSMN) **-** For the purposes of this Agreement, HSMN is the ASO that represents all Healthy Start Coalitions to assure services are provided in accordance with Medicaid waiver and state law requirements.

45) Healthy Start Standards and Guidelines – Procedures developed by the Florida Department of Health to guide implementation of Healthy Start Program.

46) Healthy Start Universal Prenatal and Infant Screens— Statutorily mandated screening of all of Florida’s pregnant women and newborn infants to help identify those at risk for poor birth outcome, health, or developmental outcomes.

47) HITECH Act – Legislation that addresses the privacy and security concerns associated with the electronic transmission of health information, in part, through several provisions that strengthen the civil and criminal enforcement of the HIPAA rules.

48) Home Visitation Advisory Committee – A group of at least one representative from each participating home visiting agency, Healthy Start Care Coordination staff, and Healthy Start Coalition staff.

49) Home Visits – Client services that are provided face-to-face by Healthy Start staff with the client present and participating in the encounter. Although meeting with clients in their homes is preferable, clients can choose where they want to meet as long as the environment is safe. All face-to-face encounters, regardless of where they take place, meet the requirements of

"home visits" as long as client services are provided per approved curriculum and schedules. This includes all encounters that are documented in WFS as Initial Assessments, Care Coordination Face to Face, and/or ICC Show Your Love.

50) Individualized Plan of Care (IPC) – A written statement in a participant's record initiated at the initial assessment that states the interventions needed based on risks and needs and the plan of action to be pursued. The IPC is evaluated and updated at each subsequent encounter.

51) Infant – Newborn up until their 1st birthday.

52) Initial Assessment – A face-to-face assessment of enrollee's risks and services needs. This assessment is completed by a face-to-face evaluation in collaboration with the enrollee and family if appropriate. This face-to-face assessment is completed by Healthy Start staff and serves as the enrollment process into Healthy Start services.

53) Initial Intake– The legislatively mandated point-of-entry into Healthy Start care coordination. Initial Intakes are completed by the Coordinated Intake and Referral program staff, and are completed by verbal communication, either by telephone or face-to-face. Participants who chose Healthy Start as their home visiting program are referred into the Healthy Start program upon completion an Initial Intake.

54) Interconception Care and Counseling (ICC) – ICC services provide comprehensive information and education for up to 12 months after delivery related to the optimal health status needed by any woman of reproductive age to improve the birth outcome of a potential subsequent pregnancy. ICC is a set of interventions that aim to identify and modify biomedical, behavioral, and social risks to a women's health or pregnancy outcome through prevention and management.

55) Interconception Care Curriculum — Health-based curriculum that includes information on women's health topics that may influence outcomes of a woman's future pregnancies.

56) Interconception Services – Services provide comprehensive information and education related to the optimal health status needed by any eligible woman of reproductive age to improve the birth outcome of a subsequent pregnancy. Interconception services assist in the advancement of women's health by providing support for healthier environments and lifestyles. This service includes information on access to care, baby spacing, reproductive health and family planning, basic nutrition, physical activity, maternal infections, chronic health conditions, substance use, risk factors associated with smoking, mental health, and environmental risk factors.

57) Interconception Woman – A woman who has previously been pregnant and is capable of becoming pregnant in the future who has risk factors that may lead to a poor pregnancy outcome and is also a Healthy Start prenatal client; a mother who is being provided services on behalf of her Healthy Start infant, or any non-pregnant woman who had a pregnancy and has risk factors that may lead to a poor subsequent pregnancy outcome.

58) Internal Quality Assurance (IQA) – A systematic approach to continuously assess and improve the overall quality of a program or service by identifying positive and negative program processes, services, and outcomes. IQA is facilitated through measurement and analysis of performance measures and contract deliverables. Periodic measurement and evaluation of program outcomes provide assurance that program practices are consistent with contractually established standards, guidelines, and procedures. The ongoing monitoring of services, outcomes and processes impacting service delivery are key factors are achieving quality maintenance and quality improvement.

59) Learning Management System (LMS) – Online training portal administered by MIECHV to track professional development for home visiting workforce.

60) Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV) – A program that gives pregnant women and families, particularly those considered at-risk, necessary resources and skills to raise children who are physically, socially, and emotionally healthy and ready to learn.

61) Medicaid – The medical assistance program authorized by Title XIX of the Social Security Act, 42U.S.C.S.1936, and administered in Florida by the Agency for Health Care Administration.

62) Medicaid Enrollee – A pregnant woman, infant or child who is enrolled in Medicaid.

63) Memorandum of Agreement (MOA) – An agreement between the Provider and another provider of Healthy Start services, such as psychosocial counseling or data entry, that contain: purpose or goal; agencies involved; roles and responsibilities; requirements; procedures; interagency dispute process; time period covered; and signatures and date.

64) Mothers and Babies—An evidence-based program and approved by the DOH that promotes healthy mood, bonding with one's baby, and strategies for pregnant women and new moms to cope with stress in their lives.

65) Motivational Interviewing – A goal-directed, client-centered counseling style to elicit behavioral change by helping clients to explore and reduce ambivalence. The approach has been scientifically proven effective across a variety of clients and for a

variety of issues, including substance abuse, health promotion, medical treatment adherence, and mental health issues.

66) Outreach – A systematic, family-centered, community-based activity that promotes improved pregnancies and infant health outcomes through public awareness, education, and access to services. This includes participant identification and education, provider recruitment and retention, and community education. All these efforts are designed to increase participant, provider and community awareness in an effort to link pregnant women and infants to needed services, and/or make these services more accessible.

67) Participant – Pregnant women, interconceptional care women, and infants/children from birth up until their 3rd birthday who have been referred for Healthy Start services. If a participant is an infant/child, the term "participant" includes their parent(s) or guardian(s). This term is interchangeable with the term "client."

68) Partners for a Healthy Baby – A research-based and practiced-informed curriculum developed by the Florida State University Center for Prevention and Early Intervention Policy used to strengthen home visiting models and improve birth outcomes, reduce rates of child abuse, increase intervals between pregnancies, strengthen families, enhance child health outcomes, and support maternal self- sufficiency.

69) Protected Health Information – For purposes of this Agreement, protected health information shall have the same meaning and effect as defined in 45 CFR and 164, limited to the information created, received, maintained or transmitted by the Provider from, or on behalf of AHCA, DOH, HSMN, or the Coalition.

70) Quality Assurance/Quality Improvement (QA/QI) – The continuous process for internal and external evaluation and reporting on the structure, process and outcome of the prenatal and infant health care delivery network. The process evaluates the extent to which Providers are in compliance with pre-established standards and includes corrective action planning and implementation aimed at services not meeting standards.

71) Quarter – A three-month period of the contract, coinciding with the state's fiscal year. The quarters for this Contract are July through September (first quarter), October through December (second quarter), January through March (third quarter), and April through June (fourth quarter).

72) Record Review – A process of determining the quality assurance and improvement by reviewing Healthy Start participant records.

73) Referral— Information provided to a client about a community agency that may be able to assist the them in receiving services from the agency, or a direct referral to the agency on a clients behalf. Referrals may be provided verbally, in writing, or a specific forms designed for this purpose.

74) Risk Appropriate Care – The provision of supports and services that directly address identified risk factors that participants or families are unable to solve without assistance. The concept of risk appropriate care implies that if the family is capable of solving the risk without external intervention, then resources will not be used with that family but rather will be targeted to those most at need.

75) Florida Prenatal and Infant Screens – Environmental screens to assess risk factors for adverse health outcomes.

76) SCRIPT (Smoking Cessation Reduction in Pregnancy Treatment) – The Healthy Start Program core service component for smoking cessation in accordance with Chapter 10 of the Healthy Start Standard and Guidelines. Providers must offer the SCRIPT program to all pregnant women and mothers who smoke. The SCRIPT program requires a mandatory training. If a woman declines the program, or if the caregiver who smokes is not the mother, they must be referred to the Tobacco Free Florida's Quitline and website. Both programs are evidence-based.

77) Service Delivery Plan – The coalition-written document, adopted by the Board and members and approved by DOH, in addition to the Healthy Start program core set of outcomes and performance measures, establishes outcome and process objectives using an Assessment Protocol for Excellence in Public Health (APEX/PH) or other approved needs assessment model. Priority service needs, priority target groups and programmatic strategies for the Coalition's service area are also developed. The Service Delivery Plan describes the community network that will ensure early and continuous prenatal, infant and child health care for all persons in need in the service area. The first Service Delivery Plan is submitted at the inception of the coalition being approved by DOH and is updated at intervals determined by DOH.

78) Social Determinants of Health – Factors in the social, economic, and physical environment that influence health, including housing, employment, education, transportation, poverty, racism, and toxic stress.

79) Tracking – Those activities related to following up on referrals or the receipt of other services to determine whether Healthy Start participants are able to access or continue participation in services.

80) Unexpended Funds – Funds earned from the previous contract year that were not expended.

81) Unit – Time spent providing services to a participant or on behalf of a participant. Units of time are to be documented for time spent with a client in a home visit, follow up activities, attempts to contact, telephone calls and other forms of communication with the client, preparation time, travel time to and from the visit, documentation time, and any other work specific to the client, such as communication with another agency on the client's behalf. Each unit of service represents 15 minutes of time with a minimum of one unit to be documented for each encounter or attempted encounter.

82) Universal Prenatal and Infant Screening – The use of selected risk factors to identify pregnant women and infants who are at increased risk for mortality and morbidity, birth complications or adverse outcomes as designated in accordance with Florida Administrative Code, Section 64C-7.011.

83) Well Family System – The Florida Association of Healthy Start Coalition's data system developed to enhance the service delivery, reporting and evaluation of the Florida Healthy Start Program.

84) Wraparound Services – The services provided to participants that maximize access to and participation in comprehensive prenatal and child health care such as participant identification, childbirth education, parenting education and support, nutritional counseling and support, psychosocial counseling, smoking cessation counseling, breastfeeding education and support, home visiting, ICC, and other services that optimize outcomes.

85) Other definition of terms used in this contract are as set forth in Chapters 64F-2 and 64F-3, F.A.C. and the *Healthy Start Standards and Guidelines* that are hereby incorporated by reference. If any changes are made to these documents during the year, the contracted Provider agrees to abide by these changes, after notice of such changes and a reasonable time to comply is provided by the Coalition, or such changes are adopted or incorporated by reference in the rules of the Coalition.

ATTACHMENT XII

Financial and Compliance Audit

AUDIT REQUIREMENTS FOR AWARDS OF STATE AND FEDERAL FINANCIAL ASSISTANCE

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

1. ________ **Vendor/Contractor (215.97(z), F.S.) and (2 CFR § 200.23)**. Funds used for goods and services for the Department of Health's own use and creates a procurement relationship with Recipient which is not subject to single audit act compliance requirements for the Federal/State program as a result of this contract agreement.

   A vendor/contractor agreement may also be used with an established Service Organization (SO) that is serving as a Third- Party Administrator and in this case, is subject to SSAE18 audit reporting requirements (see Part III. Other Audit Requirements).

2. ___X____**Recipient/Subrecipient of state financial assistance (215.97(o)(y), F.S.)**. 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 Department of Health as the state awarding 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 Department of Health.

3. ________ **Recipient/Subrecipient of federal financial assistance (2 CFR § 200.40)** . 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 Department of Health as the Pass-Through state awarding 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 or this agreement.

Note: A vendor/contractor vs. recipient/subrecipient determination must conclude with the completion of **Exhibit 2** to identify the recipient's audit's relationship with the department.

MONITORING

In addition to reviews of audits conducted in accordance with 2 CFR Part 200, Subpart F (formerly A-133) - Audit Requirements, and section 215.97, Florida Statutes (F.S.), as revised (see AUDITS below), monitoring procedures may include, but not be limited to, on-site visits by Department of Health staff, limited scope audits as defined by 2 CFR §200.425, or other procedures. By entering into this agreement, the recipient agrees to comply and cooperate with any monitoring procedures or processes deemed appropriate by the Department of Health. In the event the Department of Health determines that a limited scope audit of the recipient is appropriate, the recipient agrees to comply with any additional instructions provided by Department of Health staff to the recipient regarding such audit. The recipient further agrees to comply and cooperate with any inspections, reviews, investigations, or audits deemed necessary by the Chief Financial Officer (CFO) or Auditor General.

AUDIT GUIDANCE

PART I: FEDERALLY FUNDED

This part is applicable if Recipient is a State or local government or a non-profit organization as defined in 2 CFR §200.90, §200.64, and §200.70.

1. If a recipient expends $750,000 or more in Federal awards during its fiscal year, the recipient must have a single or program-specific audit conducted in accordance with the provisions of 2 CFR 200, Subpart F - Audit Requirements. **EXHIBIT 1** to this form lists the federal resources awarded through the Department of Health by this agreement. In determining the federal awards expended in its fiscal year, the recipient 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 in 2 CFR §§200.502-503. An audit of the recipient conducted by the Auditor General in accordance with the provisions of 2 CFR §200.514 will meet the requirements of this Part.

2. In connection with the audit requirements addressed in Part I, paragraph 1, Recipient shall fulfill the requirements relative to auditee responsibilities as provided in 2 CFR §§ 200.508-.512.

3. If a recipient expends less than $750,000 in Federal awards in its fiscal year, the recipient is not required to have an audit conducted in accordance with the provisions of 2 CFR 200, Subpart F - Audit Requirements. If the recipient 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 CFR 200, Subpart F - Audit Requirements, the cost of the audit must be paid from non-federal resources (i.e., the cost of such an audit must be paid from recipient resources obtained from other than federal entities).

Note: Audits 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 agreement's requirements, including any rules, regulations, or statutes referenced in the contract. The financial statements shall disclose whether 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 CFR § 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 Recipient's fiscal year end.

PART II: STATE FUNDED

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

1. If a recipient expends a total amount of state financial assistance equal to or in excess of $750,000 in any fiscal year of such recipient (for fiscal years ending June 30, 2017 or thereafter), recipient 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, recipient 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, recipient 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 a recipient 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 a recipient 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 recipient resources obtained from other than state funds).

Note: 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 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 recipient'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 recipient'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: OTHER AUDIT REQUIREMENTS

This part is applicable to a contractor, vendor and/or provider organization serving as a third-party administrator on behalf of FDOH programs and is classified or determined in the FDOH contract agreement to be a Service Organization (SO).
If the contracted entity is determined to be a Service Organization (SO), the entity must perform an attestation to the Service Organization Controls (SOC) and submit to FDOH a "Statement on Standards for Attestation Engagements (SSAE18) audit report within the assigned timeframe as agreed upon in the SO's contract agreement. The hired Auditor must make an evaluation consistent with the FDOH contract terms and conditions to determine which SSAE18 report types to perform for the required SOC types. Below are the options available for the SSAE18 reports;

TYPES:

1. **SOC 1** – A report on controls over financial reporting.
    - **Type 1 Report** - Report on the fairness of the presentation of management's description of the service organization's system and the suitability of the design of the controls to achieve the related control

objectives included in the description as of a specified date.

- **Type 2 Report** - Report on the fairness of the presentation of management's description of the service organization's system and the suitability of the design and operating effectiveness of the controls to achieve the related control objectives included in the description throughout a specified period. (Auditor conducts testing)

2. **SOC 2** – A report on controls that may be relevant to security, availability, processing Integrity, confidentiality or privacy. These reports are intended to meet the needs of a broad range of users that need detailed information
and assurance about the controls at a service organization relevant to security, availability, and processing integrity of the systems the service organization uses to process users' data and the confidentiality and privacy of the information processed by these systems. These reports can play an important role in:

- Oversight of the organization
- Vendor management programs
- Internal corporate governance and risk management processes
- Regulatory oversight

- **Type 1 Report** - Report on the fairness of the presentation of management's description of the service organization's system and the suitability of the design of the controls to achieve the related control
objectives included in the description as of a specified date.

- **Type 2 Report** - Report on the fairness of the presentation of management's description of the service organization's system and the suitability of the design and **operating effectiveness** of the controls to
achieve the related control objectives included in the description throughout a specified period. (**Auditor conducts testing**)

PART IV: REPORT SUBMISSION

1. Copies of single audit reporting packages for state financial assistance (CSFA) and federal financial assistance (CFDA) conducted in accordance with **2 CFR § 200.512 and section 215.97(2), Florida Statutes**, shall be submitted by or on behalf of recipient directly to:

A. The Department of Health as follows:

SingleAudits@flhealth.gov

Pursuant to 2 CFR § 200.521, and section 215.97(2), Florida Statutes, recipient 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: FCAM,
Single Audit Review 4052 Bald
Cypress Way, Bin B01
Tallahassee, FL 32399-1701.

B. The Auditor General's Office as follows:

One electronic copy email by or on behalf of recipient directly to the Auditor General's Office at: flaudgen_localgovt@aud.state.fl.us.

One paper copy mail to:

Auditor General's Office
Claude Pepper Building,
Room 401 111 West
Madison Street
Tallahassee, Florida 32399-1450

2. In addition to item 1, electronic copies of reporting packages for federal financial assistance (CFDA) conducted in accordance with **2 CFR § 200.512** shall also be submitted by or on behalf of recipient directly to each of the following:

   A. 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 CFR § 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/facweb/

   B. When applicable, other Federal agencies and pass-through entities in accordance with 2 CFR §200.331 and § 200.517.

3. Copies of SSAE18 reports and supporting documents shall be submitted by or on behalf of SO/Third Party Administrator directly to the FDOH designated Contract Manager (CM) as outlined in each SO contract agreement.

Note: 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 CFR § 200.512 and Florida Statutes, Chapter 10.550 (local governmental entities) or Chapter 10.650 (nonprofit and for-profit organizations), Rules of the Auditor General, as applicable.

Recipients, when submitting financial reporting packages to the Department of Health for audits done in accordance with 2 CFR §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 recipient in correspondence accompanying the reporting package.

PART V: RECORD RETENTION

Recipient 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. Recipient 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

EXHIBIT 1

Contract #: HSLEON-SAMPLE

Federal Award Identification #: B04MC33830 (Maternal and Child Health Block Grant)

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

Federal Agency 1 HRSA (Health Resources and Services Admin, Dept of HHS) CFDA# 93.994 Title Title V $ ##

Federal Agency 1 HRSA – State Match CFDA# 93.994 Title Title V $ ##

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 (exempt) to section 215.97, Florida Statutes or 2 CFR § 200.40: $______________

Financial assistance not subject (exempt) to section 215.97, Florida Statutes or 2 CFR § 200.40: $______________

____

Matching and Maintenance of Effort *

Matching resources for federal Agency(s):

Agency: HRSA-HHS CFDA# 93.994 Title Title V – State Match $ ##

Maintenance of Effort (MOE):

Agency:__________________________CFDA#_________Title $__________________

***Matching Resources, MOE, and Financial Assistance not subject to section 215.97, Florida Statutes or 2 CFR § 200.306 amounts should not be included by recipient when computing the threshold for s ingle 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 CFR § 200.306 i s not considered State or Federal Assistance.

EXHIBIT 2

PART I: AUDIT RELATIONSHIP DETERMINATION

Recipients who receive state or federal resources may or may not be subject to the audit requirements of 2 CFR § 200.500, and/or section 215.97, Florida Statutes, recipients 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. Recipients who have been determined to be vendors are not subject to the audit requirements of 2 CFR § 200.501, and/or section 215.97, Florida Statutes. Recipients 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, recipients 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 single audit compliance requirements, the Recipient has been determined to be:

_____Vendor/Contractor not subject to 2 CFR § 200.501 and/or section 215.97, Florida Statutes

_X___ Recipient/subrecipient subject to 2 CFR § 200.501 and/or section 215.97, Florida Statutes

_____ Exempt organization not subject to 2 CFR § 200.501; For Federal awards for-profit subrecipient organizations are exempt as specified in 2 CFR § 200.501(h).

_____ Exempt organization not subject to section 215.97, Florida Statutes, for state financial assistance projects, public universities, community colleges, district school boards, branches of state (Florida) government, and charter schools are exempt. Exempt organizations must comply with all compliance requirements set forth within the contract.

For other audit requirements, the Recipient has been determined to be:

_____ Service Organization (SO) subject to SSAE18 reporting requirements

NOTE: If a recipient 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 CFR § 200.330 [federal awards].

PART II: FISCAL COMPLIANCE REQUIREMENTS

FEDERAL AWARDS OR STATE MATCHING FUNDS ON FEDERAL AWARDS. Recipients 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 CFR 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 CFR § 200.401(5) (c).

**For funding passed through U.S. Health and Human Services, 45 CFR Pa rt 92; for funding passed through U.S. Department of Education, 34 CFR Pa rt 80.

STATE FINANCIAL ASSISTANCE. Recipients 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

This document may be obtained online through the FLHealth website under Audit Guidance. *Enumeration of laws, rules and regulations herein is not exhaustive or exclusive. Funding to recipients will be held to applicable legal requirements whether or not outlined herein.

EXHIBIT 3

INSTRUCTIONS FOR ELECTRONIC SUBMISSION OF SINGLE AUDIT REPORTS

Part I: Submission to FDOH

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 recipient 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 s ingle document. Documents which exceed 8 megabytes (MB) may be stored on a CD and mailed to: Bureau of Finance & Accounting, Attention: FCAM, Single Audit Review, 4052 Bald Cypress Way, Bin B01 (HAFA), Tallahassee, FL 32399- 1701.

- 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 2016-17 fiscal year for the City of Gainesville, the document should be entitled 2016 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 i s properly captured.

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

Part II: Submission to Federal Audit Clearinghouse

Click Here for instructions and guidance to submit the completed SF-SAC report to the Federal Audit Clearinghouse website or click Here to access the SF-SAC Worksheet & Single Audit Component Checklist Form.

Part III: Submission to Florida Auditor General

Click Here for questions and other instructions for submitting Single SAC reports to the State of Florida, Auditor General's Office.

EXHIBIT 4

Single Audit Data Collection Form

Part 1: 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	**5. PRIMARY AUDITOR INFORMATION**
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 CFR § 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:____________________

ATTACHMENT XII
HEALTHY START MOMCARE NETWORK EXHIBIT
XXX, 202#-202# FY

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

Federal Program 497 US Department of Health and Human Services **$##**
CFDA#: 93.778 Medicaid Assistance Payments

STATE FUNDS AWARDED TO THE RECIPIENT PURSUANT TO THIS AGREEMENT CONSIST OF THE FOLLOWING MATCHING FUNDS FOR FEDERAL PROGRAMS:

Federal Program 497 Department of Health and Human Services **$##**
CFDA#: 93.778 Medicaid Assistance Payments

STATE FUNDS AWARDED TO THE RECIPIENT PURSUANT TO THIS AGREEMENT CONSIST OF THE FOLLOWING FUNDS SUBJECT TO SECTION 215.97 F.S.:

N/A $ 0.00

TOTAL AWARD **$##**