CONTRACT
BETWEEN

PARTNERS BEHAVIORAL HEALTH MANAGEMENT
Area Authority/LME-MCO
AND

[Company]

A PROVIDER OF MH/DD/SA SERVICES

THIS CONTRACT is made between Partners Behavioral Health Management, Area Authority/County Program (herein known as the Local Management Entity or LME-MCO), and **[Company]** (herein known as the "Provider"), operating under the laws of North Carolina. By means of this Contract, the Local Management Entity is establishing a relationship with Providers who are reimbursed for State Funded Services by the LME-MCO for approved activities and/or services.

This Contract is effective July 1, 2016 through June 30, 2017.

RECITALS

The LME-MCO and the Provider enter into this Contract to govern Provider's provision of mental health, developmental disabilities and substance abuse services to individuals referred to it by the LME-MCO.

The LME-MCO initially screens individuals seeking or needing mental health developmental disabilities and/or substance abuse services and refers individuals to Provider participants.

Individuals who are in need of mental health, developmental disability and/or substance abuse services choose providers for their services from a list of provider participants approved by the LME-MCO.

Provider represents that it is a qualified provider of one or more mental health, developmental disabilities and/or substance abuse services.

This Contract sets forth provisions pursuant to which Provider will provide mental health, developmental disabilities and/or substance abuse services to individuals who have chosen a Provider for such services.

NOW, THEREFORE, the LME-MCO and the Provider herein referred to as the "Parties" agree as follows:

Provider will provide mental health, developmental disabilities and/or substance abuse services to individuals who have chosen Provider for such services pursuant to and in compliance with the provisions of this Contract. The LME-MCO will provide access to such services to individuals, as well as quality assurance and monitoring relating to such services pursuant to and in compliance with this Contract. The Parties acknowledge and agree that this Contract is limited only to Provider's participation in LME-MCO's provider network for state-funded, non-Medicaid services only, separate from any participation or enrollment in the State Medicaid Plan administered by the North Carolina Department of Health and Human Services.

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ARTICLE I
RIGHTS AND OBLIGATIONS OF THE LOCAL MANAGEMENT ENTITY

1.0 Operations Manual. The LME-MCO shall make available to the Provider a copy of the "Operations and Provider Manual" which is incorporated by reference. If the terms of this Contract conflict with information contained in the Operations Manual, the terms of the Contract shall control. Partners Behavioral Health Management operations and provider manual is on our website at www.partnersbhm.org.

1.1 Notification of Applicable Laws and Regulations. The LME-MCO shall make available to Provider copies of or access to all pertinent rules, regulations, standards, and other information distributed by the Department of Health and Human Services (DHHS) and LME-MCO that are necessary for Provider's performance under the terms of this Contract. It is Provider's responsibility to access that information. The LME-MCO shall notify Provider of any substantive change in rule or regulation as soon as possible after receipt of the information from the DHHS. A list of rules and regulations is part of the Operations Manual. Provider acknowledges this LME-MCO notification is a courtesy and technical assistance afforded by LME-MCO, but that the Provider retains primary responsibility for staying informed on, and in compliance with, all applicable laws, regulations and requirements for the provision of services under this Contract.

1.2 Monitoring Under Standards. The LME-MCO shall be given full opportunity by Provider to review performance indicators on-site to evaluate compliance with the rules of the North Carolina Commission for Mental Health, Developmental Disability, and Substance Abuse Services (the "Commission"), the Secretary of the Department of Health and Human Services, and applicable law. The LME-MCO has the authority to conduct local monitoring to evaluate compliance with State, Federal, DHHS, and other applicable rules and statutes (see Operations Manual) and Provider shall cooperate with the LME-MCO in such monitoring. The frequency and the intensity of the local monitoring will be at the discretion of the LME-MCO.

1.3 Informed Choice of Provider. The LME-MCO provides information to covered individuals regarding their choice of Providers. The information includes names, contact information and locations of Providers.

1.4 Screening, Triage and Referral. The LME-MCO will work with community agencies to ensure that individuals can enter the system through many avenues in order to receive timely and effective service. An individual seeking access to services shall have an initial screening and triage by the LME-MCO (or its contract agent) in order to determine if a MH/DD/SA need exists. The LME-MCO ensures appropriate disposition. The Screening, Triage & Referral (STR) staff will complete an initial screening and the STR staff will then contact the provider of choice or (in the absence of consumer preference) an appropriate provider who represents an appropriate consumer-provider match to complete an assessment. TTY capability, for persons who have a hearing impairment and foreign language interpretation will be provided to the person making the referral or to the individual seeking service for the purposes of receipt of appropriate information for referral of services at no cost when necessary. Any authorized contract agent of the LME-MCO completing a screening on an individual shall submit all required data elements electronically within 5 calendar days of the screening to the LME-MCO.

SAMPLE

ARTICLE II
RIGHTS AND OBLIGATIONS OF PROVIDERS

2.0 Covered Services. Provider agrees to serve individuals eligible for the covered services identified in Attachment A in accordance with all requirements set forth or referenced in the Operations Manual and all subsequent revisions.

2.1 Maintenance of Facility Licensure, Accreditation and Credentialing. Provider and its agents providing services on its behalf under this Contract shall obtain and maintain in good standing all applicable accreditation(s), licenses and certificates required by the DHHS policy or law, including but not limited to licensure required by all appropriate agencies and/or Boards. The Provider and its agents providing services on the Provider's behalf under this Contract shall continuously, during the term of this Contract, meet all credentialing and privileging/competency standards as described in this Contract, the Operations Manual or as required by law, policy or regulation.

2.2 Service Record Compliance for Providers. Provider shall maintain a Service Record for each individual served in accordance with the Service Records standards set forth by State or federal law, Division's regulation or DHHS policy. The original Service Record related to services provided in accordance with this Contract shall be accessible for review for the purpose of monitoring services rendered, financial audits by third party payers and research and evaluation. Service records shall be retained for the duration and the format prescribed by the LME-MCO and by State and Federal law, regulation and policy. If for any reason Provider can no longer maintain the Service Record, Provider will contact the LME-MCO staff member responsible for Service Records to facilitate resolution. Upon request, Provider shall provide data about individuals for the research and study to the LME-MCO as permitted or required by DHHS and applicable Federal law. Upon request, Provider shall provide Service Records information about consumers referred by the LME-MCO for Quality Assurance and Utilization Management purposes of the LME-MCO.

2.3 Rights of Individuals. Provider shall conduct activities in a manner that shall deter, prevent, and avoid abuse, neglect, and/or exploitation of individuals in its care and to ensure compliance with all DHHS and Federal requirements and in accordance with the policies of the LME-MCO. The Provider agrees to maintain policies, procedures and monitoring as required in the DHHS Client Right's policy, the Operations Manual and the policies of the LME-MCO.

2.4 Adverse Selection. Provider shall be prohibited from arbitrarily declining, refusing to serve or ejecting consumers for the covered services under this Agreement. In the event that Provider declines a referral, refuses to serve or ejects a specific consumer, Provider shall give the LME-MCO specific reason for the decline, refusal or denial. In all cases of adverse selection, Provider must provide timely reasons, and where applicable, notice to ensure that continuity of care can be optimized. Refusal to accept a referral based upon the individuals source of reimbursement may constitute adverse selection. The LME-MCO may consider information regarding adverse selection in its evaluation of Provider.

2.5 Service Coordination. Continuity of care is expected for all individuals served under this Contract. In an effort to improve the coordination of supports and services within the LME-MCO's community of providers, Provider agrees to use good faith efforts to coordinate supports and services with other Provider participants, Carolina Access and other primary care providers for all individuals served under this Contract. The Provider shall obtain appropriate client authorizations and consents to release or exchange information. The Provider shall participate in team meetings and/or community collaborations and communicate regularly with other providers regarding mutual cases. The primary service provider who engages an Independent Practitioner (a directly enrolled clinician providing outpatient therapy) to serve consumers receiving benefits will maintain a contract with the Independent Practitioner to ensure care coordination. Providers who act as the

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clinical home such as those delivering Community Support, Community Support Team or Targeted Case Management Services must either provide or subcontract for psychiatric services when consumers need them. A pattern of failure to coordinate services in a timely manner, without demonstrated corrections may result in contract termination.

2.6 Quality Management. Provider shall conduct a quality management program in accordance with the DHHS policies and agrees to provide evidence of assessment of quality of care and best practices, effectiveness and satisfaction with services to the LME-MCO upon request. Provider shall abide by the treatment protocols, requirements for person-centered planning and implement evidence-based practices as defined and adopted by the Division of MH/DD/SA and any subsequent revisions. Provider shall ensure that corrective action is taken on a timely basis to address problems found through the quality management process.

2.7 Clinical Outcome Measures. At a minimum, the Provider shall complete the NC-TOPPS for the designated populations as well as all other Division of MH/DD/SA required outcomes assessments on clients admitted during each calendar quarter in accordance with Department guidelines and any subsequent changes thereto. (See Operations Manual). The LME-MCO shall define the guidelines for obtaining and submitting the outcomes data and convey this information to Provider. The appropriate outcome instrument to be used for a specific client will be dependent upon the age and primary disability category of the client and any changes made to these requirements by the Department of Health and Human Services through any outcome transition plan with the LME-MCO. Providers shall submit outcome instruments required by the Division of MH/DD/SAS in an amount, manner and schedule as described in the Operations Manual and as referenced in the most recent version of the Client Data Warehouse (CDW).

2.8 Incident Reporting. Provider shall report and respond to all client incidents as required under State and Federal law, rules and regulations. Incidents shall be reported in the manner prescribed and on a form provided by the Secretary of the DHHS. (See Operations Manual)

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

2.10 Suspension or Debarment. Provider certifies by signing this Contract that neither it nor its agents have been suspended or debarred by any applicable governmental authority from conducting any business or activities contemplated by this Contract whether under current corporate name or any additional name or former name, including the current or former name of a division, department, program or subsidiary.

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

Provider shall acquire and maintain the following insurance coverage, which cannot be suspended, voided, canceled or reduced unless the Provider and/or carrier give 30-days prior written notice to LME-MCO:

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a) Commercial General Liability:
Provider shall maintain bodily injury and property damage liability coverage as shall protect Provider and any approved subcontractor performing work under this Contract from claims of bodily injury or property damage which arise from operations of this Contract whether such operations are performed by Provider, any subcontractor or anyone directly or indirectly employed by either. The amounts of such insurance shall not be less than $1,000,000.00 each occurrence and $3,000,000.00 in the annual aggregate unless Provider, with prior written approval of the LME-MCO, names the LME-MCO as an additional insured, in which case limits of no less than $1,000,000.00 each occurrence and $1,000,000.00 in the annual aggregate would be acceptable.

b) Professional Liability:

Provider shall maintain such professional liability insurance coverage as shall protect the Provider from its failure to conform to the professional standard of care required under applicable law and under this Contract. The limits of liability shall be not less than $1,000,000.00 per occurrence and $3,000,000.00 in the annual aggregate. The Provider's professional liability insurance policy shall name the LME-MCO as additional insured. An original, signed, in force Certificate of Insurance for such coverage shall be provided to the LME-MCO upon execution of this Contract and throughout the duration of this Contract as insurance expires. LME-MCO may, at its sole discretion, waive this requirement in rare circumstances supported by an appropriate, timely and accurately completed written sworn exemption attestation and request form by the Provider.

c) Automobile Liability:

All agency owned or leased vehicles must have continuous automobile liability coverage during the term of this contract. The automobile liability insurance must be in an amount not less than $500,000 bodily injury each person, each accident $500,000 for property damage, $500,000 uninsured/underinsured motorist, and $5,000 medical payment. If individuals are transported in privately owned vehicles, the contract agency must carry $500,000 of non-owned automobile liability insurance. Providers may substitute a one million combined single limit liability policy for the $500,000/$500,000/$500,000 requirement. Licensed Practitioners who certify in writing that they do not transport clients shall not be required to obtain Automobile Liability Insurance.

d) Worker's Compensation and Occupational Disease Insurance:

Provider shall meet the statutory requirements of the State of North Carolina for Worker Compensation and Occupational Disease Insurance, currently $100,000.00 per accident limit, $500,000.00 disease per policy limit, $100,000.00 disease each employee limit, providing coverage for employees and owner. Licensed Practitioners who do not employ any staff shall not be required to obtain Worker's Compensation or Employer's Liability Insurance.

e) Certificates of Insurance:

The Provider agrees to notify the LME-MCO by telephone and by providing written notice within five (5) days after receipt of information that the insurance carrier either intends to amend or terminate a policy or has amended or terminated any insurance policy providing the coverage referred to above. If Provider changes insurance carriers during the performance period of this Contract, Provider shall provide evidence to the LME-MCO within five (5) days. Subcontractors must be required by Provider to meet all the insurance requirements of this Contract, including providing the LME-MCO with certificates of such insurance. DHHS reserves the right to exempt

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certain lines of business from this requirement. Nonetheless, this does not relieve Provider from maintaining full coverage as well.

2.12 Federal Requirements. Provider by signing this contract agrees to comply with all governmental requirements applicable to the services being provided and to its operations, including, but not limited to the Business Associate Agreement: Certification Regarding Environmental Tobacco Smoke: Certification Regarding Lobbying: Certification Regarding Drug-Free Workplace Requirements: and Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transactions. (See Appendices A, B, C and D)

2.13 Clinical Information Data Submission. Providers that are authorized to conduct an assessment of a referred individual will submit all required data elements electronically within 5 calendar days of the last assessment session to the LME-MCO, using the protocol(s) and formats described in the Operations Manual. Provider shall establish review procedures to ensure that a minimum of 90 percent of all elements for each record are complete and accurate and a minimum of 85 percent of all elements for each record are coded as something other than “Other” or “Unknown” within 30 days of first submission.

2.14 First Responder for Crisis/Emergency. A Provider delivering a service with defined first responder responsibilities or who are designated in the Person Centered Plan (PCP) (which will include a comprehensive crisis plan) shall act as first responder to individuals referred by the LME-MCO if and when the individual and/or a member of their support system initiates contact for assistance involving a psychiatric crisis or emergency. Only those individuals whose distress represents a clear and present danger to self or others, and/or those individuals whose level of distress is not alleviated following reasonable efforts, shall be referred to the LME-MCO's crisis service. Provider shall notify the individual and his/her support system of the process for accessing crisis/emergency services 24 hours a day, 7 days a week, 365 days a year, both orally and in writing at initial contact. The notification shall include contact information for an alternate source of assistance in the eventuality that Provider is not available. Crisis services do not require prior authorization from the LME-MCO.

2.15 Utilization Management Requirements. Provider shall abide by clinically sound criteria. Provider shall seek authorization prior to service delivery and provide accurate and thorough information requested so that service provision is not unduly delayed or disrupted.

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

2.17 Response to Survivors of Disasters and other Hazards. If designated by the LME-MCO, Provider, under the direction of the LME-MCO and in coordination with the local Emergency Management agency(ies), shall deploy behavioral health disaster responders to deliver behavioral health disaster services to survivors and other responders within the counties served by the LME-MCO. Behavioral health disaster services may be required at the site of a disaster, in emergency shelters, on the telephone/TTY machine, and other sites in which other disaster response agencies provide information or services to survivors and responders (e.g., FEMA Disaster Application Centers, emergency medical intervention, decontamination or quarantine sites). When it is determined that survivors or other disaster responders are in need of longer term mental health, developmental disabilities, and/or substance abuse services, Provider's behavioral health disaster responders shall refer such persons in need to the LME-MCO or its designee for further assistance.

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2.18 Training and Technical Assistance. The LME-MCO reserves the right to charge the usual and customary fee for additional staff attendance or scheduling additional trainings to meet Provider demand. The LME-MCO shall also mandate Provider attendance at selected Clinical Sessions of which the Provider bears the cost, whether the LME-MCO sponsored or offered by outside Parties. The Provider shall also bear the cost of all trainings related to licensure or accreditation activities. The Provider must be able to demonstrate to the LME-MCO its application of training information received in the delivery of services and in compliance with the provisions of this Contract.

2.19 Coordination of Benefits. Provider agrees to assist in the coordination of each individual's health care benefits so as to avoid undue delay in the provision of service and to ensure that public funds shall be used only if and when other sources of first and third Party payment have been exhausted. Providers shall make every reasonable effort to verify all insurance and other third Party benefit plan details during first contact, so that persons are directed to appropriate Providers, and to comply with North Carolina law. Where available, Provider is required to bill a consumer's private insurance. During an emergency, Provider shall provide the necessary services and then assist to coordinate payment.

ARTICLE III
MUTUAL RIGHTS AND OBLIGATIONS OF BOTH PARTIES

3.0 Health Insurance Portability and Accountability Act (HIPAA). The Provider and the LME-MCO shall comply with current HIPAA privacy and security rules and regulations as in effect from time to time and each Party shall provide evidence to the other of this compliance upon request as embodied in Attachment C titled Business Associate Addendum to Standard Contract and 42 CFR, Part 2. This includes, but is not limited to, the responsibility of each Party to determine when it is exchanging non-treatment-related information with the other Party or with other entities, in order to obtain or perform a business service related to the performance of this Contract, and to implement a specific business Contract with the other Party or other entity if so. The Parties hereto specifically agree to amend this Contract on a timely basis as necessary to comply with any and all laws relating to privacy and/or security of healthcare information, including the Health Insurance Portability and Accountability Act of 1996 (45 CFR Parts 160, 162 & 164 and 42 CFR, part 2) and any subsequent modifications thereof.

3.1 Confidentiality. Provider and LME-MCO shall protect the confidentiality of any and all individuals and will not discuss, transmit, or narrate in any form other information, medical or otherwise, received in the course of providing services hereunder, except as authorized by the individual, his legally responsible person, or as otherwise permitted or required by law. The Provider and LME-MCO shall, in addition, meet all confidentiality requirements promulgated by any applicable governmental authority.

3.2 Compliance with Civil Rights and Disability Law. The Provider and LME-MCO shall comply with Title VI and VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 (ADA), the North Carolina Persons with Disabilities Protection Act, and all requirements imposed by Federal and State regulations, rules, and guidelines issued pursuant to these laws for both personnel employed and individuals served.

3.3 Reasonable Accommodations for Persons with Disabilities. Once a person with a disability has requested an accommodation, or if a potential accommodation is obvious in the circumstances, the Provider shall attempt to make reasonable accommodations as required by law. Reasonable accommodations may include but are not limited to the provision of sign language interpreting services, mechanical aids or other ancillary services that enable a person with a disability to benefit from the service array offered by the Provider.

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3.4 Governing Laws. The laws of the State of North Carolina shall govern the validity and interpretation of the provisions, terms, and conditions of this Contract. Venue over any action arising out of this Contract shall lie only in the county(s) in the LME-MCO's catchment area.

3.5 Entire Contract Modification. This Contract, along with the Operations Manual and other standards or documents specifically incorporated herein, constitutes the entire understanding of the Parties and this Contract shall not be altered, amended, or modified except by a Contract in writing, properly executed by the duly authorized officials of both Parties.

3.6 Dispute Resolution. The Parties shall first attempt to resolve any disagreement between them through the DHHS Appeals Process. However, a failure to do so shall not operate as a failure to exhaust administrative remedies.

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

3.8 Hold Harmless. The LME-MCO and Provider agree to each be solely responsible for their own acts or omissions in the performance of each of their individual duties hereunder, and shall be financially and legally responsible for all liabilities, costs, damages, expenses and attorney fees resulting from, or attributable to any and all of their individual acts or omissions. No Party shall have any obligation to indemnify the other, and/or its agents, employees and representatives.

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

3.10 Subcontracting. Provider shall notify the LME-MCO of any subcontract or assignment any of the services contemplated under this Contract. Any subcontracts or assignments for program delivery shall be subject to all conditions of this Contract. The LME-MCO may assign its rights and obligations under this Contract without approval of providers.

3.11 Non-Exclusivity. This Contract is not exclusive. The LME-MCO and Providers have the right to enter into a similar Contract with any other LME-MCO and/or other providers at any time.

3.12 Mergers, Name Changes and Acquisitions and Changes in Ownership or Control. Both parties shall be responsible for notification to the Division of Facility Services and to the LME-MCO of all such changes when required to do so. Each Party shall promptly notify the other in writing regarding any merger, name change, acquisition of another company, and change in ownership or control. The surviving entity shall be bound by all the terms and conditions of this Contract.

3.13 Conflict of Interest. Provider and LME-MCO will comply with all applicable laws regarding Conflict of Interest.

3.14 Response Time. Both parties shall implement policies, procedures, performance standards and monitoring and shall consistently provide adequate staffing and scheduling to ensure compliance with the Division of MH/DD/SA Services' "immediacy of need protocol" such that: 1. Individuals in emergency status, meaning a situation which threatens the health, safety or welfare of the individual and/or of others, shall result in a face-to-face assessment which shall commence no

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later than two hours from notification to either Party, 2. Individuals in urgent status, meaning their situation is likely to escalate into an emergency, must be seen face-to-face (assessment and/or services) within 48 hours of first notification, 3. Individuals with routine needs must be seen face-to-face (assessment and/or services) within fourteen (14) calendar days of first notification, and 4. Individuals released/discharged from a hospital or institution must be seen within 5 days of release.

ARTICLE IV
TERM AND TERMINATION

4.0 Term. Refer to page one for the term of this contract.

4.1 Provider Termination. This contract may be terminated at any time by mutual consent of both parties or 30 days after one of the contracting parties give notice of termination. (NCAC 27A .0106)

4.2 LME-MCO Termination. The LME-MCO may immediately terminate this Contract for cause. The cause for termination shall be documented in writing presented to the Provider detailing the grounds for termination. Prior to termination of this Contract for cause, such as repeated non-performance of obligations without corrective action, violations of professional standards or the commission of unlawful acts, the LME-MCO may elect to halt or restrict commerce between the parties. The LME-MCO shall make such decisions and the Provider shall be notified in writing of the rationale and specifications of the suspension and the conditions that must be met to end the suspension. The LME-MCO may terminate this Contract in its discretion if Provider is acquired, merged or experiences a change in ownership or control.

4.3 Notice. Either Party may at any time change its address for notification purposes by mailing a notice to the other Party at the address designated by that Party. The new address shall be effective on the date specified in such notice, or if no date is specified, on the tenth (10th) day following the date such notice is received.

4.4 Option for Limited Renewal. The LME-MCO may, by written notice to the Provider executed by the LME-MCO Director, extend the term of this contract with the concurrence of the provider.

ARTICLE V
FINANCIAL REQUIREMENTS

5.0 Claims/Invoice Review. The LME-MCO shall review claims within eighteen (18) calendar days after receipt and shall notify Provider within that timeframe if the claims/invoice or portions of the claims/invoice are denied or if further information is necessary. The LME-MCO shall pay approved or undisputed portions of the claims/invoice for services performed by Provider within thirty (30) calendar days after approval. Such payment constitutes full and final payment of approved claims/invoice.

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

5.2 Purchase of Equipment. If this Contract includes payment for equipment purchased with non unit-cost reimbursement (non-UCR), such as start up or special purpose expenditures, title to the assets purchased under this Contract in whole or in part rests with the LME-MCO so long as the Provider continues to provide the services which are named in this Contract. If such services are discontinued, disposition of the assets shall occur as approved by the Division of MH/DD/SAS and in accordance with North Carolina law.

SAMPLE

5.3 Billing. Provider is responsible for billing for all first and third Party payment.

5.4 Schedule of Fees. Provider shall be responsible for the adoption, assessment, collection, and disposition of fees in accordance with all applicable law.

5.5 Submission of Billing. Provider shall submit billing claims to the LME-MCO within ninety (90) days of the date of service or sooner if required by IPRS timely filing deadlines. State Funded services MUST be submitted in AlphaMCS within 90 days of the actual date of service to be considered for reimbursement. Claims for services that are submitted after 90 days from the actual date of service WILL BE DENIED.

5.6 Recovery of Paybacks. Unless specifically approved otherwise in writing by the LME-MCO, Provider shall pay back within sixty (60) days to the LME-MCO the amount paid by LME-MCO to Provider for all non-compliant events or services. In the event Provider has paybacks, they will be notified via letter from the LME-MCO. Provider is responsible for reimbursing the LME-MCO funds that were denied or non-compliant.

5.7 Financial Audit. Provider shall adhere to Generally Accepted Accounting Principles. When required and requested, Provider shall make available to LME-MCO its accounting records relating to services provided to or on behalf of the LME-MCO under this Contract for the purpose of audit by the DHHS for Federal authorities or by the LME-MCO. Provider, when required by law or in accordance with the annual Contract between the DHHS and the LME-MCO, shall have an annual audit by an independent certified public accountant (CPA). If required, a copy of the independent audit shall be forwarded to:

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

5.8 Contract. This Contract is a purchase of service Contract for UCR funds and a financial assistance Contract for non-UCR funds.

5.9 Effect of Termination. All payments provided herein shall be adjusted so as not to exceed the amount due for services actually rendered prior to the date of termination. If advance payments have been made for covered services not provided as of the date of termination, Provider shall promptly repay all excess funds. If additional payments are due from the LME-MCO, said payments shall be made only after receipt of final invoice and report.

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

Provider Name: [Company]

Address: [Company Address]

Phone: [Company Phone]

Provider's Federal ID:

PRINTED NAME **DULY AUTHORIZED OFFICIAL (TITLE)**

SIGNATURE **DATE**

Partners Behavioral Health Management
901South New Hope Road
Gastonia, NC 28054

CHIEF EXECUTIVE OFFICER **DATE**

Per N.C. Gen.Stat. §159-28, this instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

FINANCE OFFICER **DATE**

SAMPLE

Attachment A
REIMBURSEMENT SCHEDULE FOR SERVICES

[Company]

Services listed in this Attachment are to be provided to consumers in Burke, Catawba, Cleveland, Gaston, Iredell, Lincoln, Surry and/or Yadkin Counties. The services being purchased with this contract are listed below, and include only those services that have been approved by the LME-MCO for named provider. Current Medicaid rates as posted on the DMA website will be used for reimbursement of billed services. The DMA website address for fees is www.ncdhhs.gov/dma/fee. As rates change, written notification will be provided via Communication Bulletins and website postings. Contracts will not be amended for rate changes.

Total maximum amount to be reimbursed for UCR and Non-UCR for this fiscal year is $.

Unit Cost Reimbursed (UCR) Services funded by State and Federal Funds will be billed through the LME-MCO on a unit basis. The total amount reimbursable for the UCR services listed in the immediate grid below for **July 1, 2016 through June 30, 2017** is **$** . The Provider must submit Service Authorization Request(s) [SAR's] to provide and bill for **UCR State Funded** services via Alpha MCS. UCR Service(s) must be authorized by Partners BHM Utilization Management Department prior to service delivery and billing. Authorization does not guarantee payment**.** Consumer must meet target population requirements and be eligible for the benefit on the date of service.

SERVICE LISTING

The status of the TCL I individual must be verified by the MCO prior to the submission of claims utilizing the DJ modifier.

Non-Unit Cost Reimbursed (Non-UCR) {if applicable – if not delete this entire section}
Services funded by State and Federal Funds will be billed to the LME-MCO via electronic invoice with expenditures and backup as applicable and noted below. Some Federal funded programs and grants have particular expenditure requirements, which will be listed below. The total amount reimbursable for the Non-UCR services listed in the immediate grid below for FY16-17 is **$** .

See below grid for allocations:

Type	Non-UCR Federal	Requirements (as applicable and listed)
	$	Invoice, Expenditures
	$	
Type	**Non-UCR State**	**Requirements (as applicable and listed)**

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	$	
	$	
Type	**Non-UCR County**	**Requirements (as applicable and listed)**
	$	

PROVIDER SPECIFIC INSTRUCTIONS BY ABOVE CATEGORY:

Reimbursement is contingent on fund availability from the State. Payment to Provider is contingent on appropriate service provision and documentation by qualified staff, and appropriate billing of authorized services. Non-UCR funding must be invoiced. Provider should submit expenditures and invoice monthly to Accounts Payable, Partners BHM, 901 S. New Hope Road, Gastonia, NC, 28054 or Email to RShort@partnersbhm.org.

Non-UCR Federal Expenditure related submissions (as applicable) must include copies of receipts, copies of checks for expenses, along with general ledger reports for each service category in which reimbursement is being requested.

Partners BHM will perform quarterly reviews and reserves the right to adjust amounts according to utilization and funding availability. Claims must be submitted within 90 days from date of service in order to be reimbursed. **Services submitted after 90 days will be denied.** Provider must use appropriate billing codes when invoicing, based on provider credentials. Rates will be paid according to current Division of Medical Assistance (DMA) rate schedules or as negotiated.

It is understood and agreed by Provider that any agreements by LME-MCO to pay any amounts to Provider on any basis other than fee-for-service, are applicable solely to the contract period from **July 1, 2016 through June 30, 2017**, and that such payments shall not obligate LME-MCO to fund Provider in a manner other than on a fee-for-services basis in this Contract or any future Contracts.

Service codes, descriptions and rates for covered MH/DD/SA services are posted on the DMA website at www.ncdhhs.gov/dma/fee.

Service Definitions are located at www.ncdhhs.gov/mhddsas/providers/servicedefs/index.htm.

Provider hereby agrees to fully comply with all requirements pursuant to Health Insurance Portability and Accountability Act of 1996, as modified and amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), as well as related Federal regulations including but not limited to the Omnibus Final Rule effective 2013. Failure to comply may result in the termination of this contractual agreement between Partners BHM and Provider.

SAMPLE

ATTACHMENT B
CORE PERFORMANCE INDICATORS FOR PROVIDERS OF MH/DD/SA SERVICES

1. Providers shall be responsible for full participation in an LME-MCO monitoring/review process that includes the Division of MH/DD/SA Confidence Assessment Criteria and the Local Monitoring discussion guide. Frequency of reviews and corrective requirements are determined by

demonstration of acceptable compliance with quality indicators and scores from the Confidence Assessment.

2. 100% of all Level I Incidents as defined by the NC Division of MH/DD/SAS shall be recognized, adequately responded to, and reported/documented internally by the Provider, and reported in aggregate form quarterly to the LME-MCO.

3. At least 85% of all Level II Incidents as defined by the NC Division of MH/DD/SAS shall be recognized, adequately responded to, and reported to the LME-MCO and the Department within 72 hours via the *DHHS Incident & Death Form*. An aggregate total for the quarter will be part of the Provider's quarterly report to the LME-MCO.
4. At least 85% of all Level III Incidents as defined by the NC Division of MH/DD/SAS shall be recognized, adequately responded to, and reported verbally immediately to the LME-MCO, and in written form to the LME-MCO and the Department within 72 hours via the DHHS Incident & Death Form. The Provider shall convene an incident review committee within 24 hours. Deaths that occur within 7 days of seclusion or restraint are reported immediately to the LME-MCO. An aggregate total for the quarter will be part of the Provider's quarterly report to the LME-MCO.

5. Providers shall implement policies, procedures, and practices to attempt to achieve 0% client rights violations. 100% of all substantiated client rights violations shall be reported through the Incident reporting process to the Customer Services/Consumer Affairs Unit of the Area Program/County Program Quality Management Department, and show evidence of being acted upon.

6. 100% of quality of care issues, as noted through Area Authority monitoring, shall promptly begin to be addressed through the development and initiation of a corrective action plan submitted for approval to the LME-MCO within the time limits specified in the LME-MCO's Quality Management Plan.

7. A representative sample of consumers shall be given the opportunity to express their *perception of satisfaction* for services received through the implementation of an empirical process no less often than twice a year. Survey results are submitted to the LME-MCO. Providers may meet this requirement by full participation in the LME-MCO's Quarterly Consumer Satisfaction Survey. The Provider is also required to participate in the Division of MH/DD/SAS's annual Consumer Satisfaction Survey.

8. When applicable, Providers shall meet no less than 85% of established time frames for initial face-to-face consumer contact (Emergent: within 2 hours; Urgent: within 48 hours; Routine: 14 calendar days.).

9. Providers shall meet 100% compliance with Operations Manual administration protocols for established Outcome Measures for each eligible consumer (NC-TOPPS). As applicable to the service population, Providers shall participate in the annual Core Indicators survey (DD consumers and families).

10. Providers shall demonstrate a Continuous Quality Improvement (CQI) process by identifying a minimum of 3 improvement projects acted upon per year. Projects and results will be reported to the LME-MCO in any quarter of completion.

11. Providers shall comply with current North Carolina E-Verify laws, including ensuring compliance by subcontractors.

SAMPLE

12. Partners has adopted the following measures for integration into provider contracts beginning July 1, 2015. **This is continuing for the FY16/17 contracts.**

Domain	Outcome	Measures
1. Claims Accuracy	Increase Provider Claims Approval Rate	Provider must have a claims approval rate at or above 80% in each quarter of the fiscal year per funding source. (applies to provider specific denial reasons, not LME/MCO issues)
2. UM Authorizations Approval	Increase Authorization Approval Rates	Provider must demonstrate an authorization approval rate on service requests is at or above 75% during the Partners' identified quarter of each fiscal year (example, July, August, September) –across all services and all providers
3. NCTOPPs Compliance	Increased timeliness of 3 month interview submissions	95% of all Provider 3 month interview submissions will be in compliance with timely submission requirements. ***(for all providers required to submit NCTOPPs and for the services that required NC TOPPs submission)***

Partners Behavioral Health Management

SPECIFIC SERVICE DELIVERY PERFORMANCE INDICATORS

***Subject*:** Information Exchange between Partners BHM & Providers

Purpose: Communication expectations ensure that required grant, financial & other County, State, and/or Federal reporting information is made available to the LME-MCO and other applicable parties.

SPECIFIC SERVICE DELIVERY PERFORMANCE INDICATORS

I. Financial

A. Accounting and Claims Processing:

1) Provider must maintain an accounting and claims processing system compliant with N.C. Gen.Stat. §159-26 and shall have proper internal controls to ensure proper record keeping and generally accepted accounting procedures are continually in place.

2) Provider must have a system in place that allows an audit to be completed for consumer accounts. In the event an overpayment of funds is found during an audit, the Provider must repay said funds within 30 days to LME-MCO.

B. Billing

Consumers eligible for Medicaid are not eligible to receive IPRS/State Funding. IPRS funds are a payer of last resort. Providers must collect first and third party revenue. The Provider must have a system in place to monitor such activity and subsequently repay any related amounts to consumers.

II. Best Practice Model

SAMPLE

A. Provide/coordinate psychiatric services along with clinical home for these consumers if in the person-centered plan.

B. Assure all consumers have choice of provider and these processes are followed for transition of consumers as well as referrals.

C. Providers must fully comply with First Responder duties.

III. Committee Participation

A. Partners would like the Provider to attend or actively participate in the Community Collaborative process for children's families and attend work groups or committees as invited by the LME-MCO.

IV. Authorizations

A. Providers will comply with the following regarding service authorizations.
   1) Submit authorization requests at least 14 days before the end of an existing authorization.
   2) Limit request(s) to service type, scope and duration that is medically necessary and consistent with IPRS benefit grids.
   3) Submit all documentation that is requested by the LME-MCO staff to conduct Utilization Review within timeframes communicated.

In order for Partners Behavioral Health Management to report pertinent information to federal, state and local authorities (as mandated by various contracts and agreements), providers are expected to submit the data listed below according to the related timelines. In order to ensure timely payment, all required information must be submitted as detailed below.

Providers will acknowledge all referrals (accept the referral) made to them via the Slot Scheduler via Provider Portal within 24 hours or next business day, by checking the acknowledgement checkbox in the referral.

If a Provider is unable to acknowledge (accept) the referral they will email Customer Services at AccessStaff@partnersbhm.org and inform Customer Services that the consumer will need to be scheduled with another provider and why.

Areas of reporting include (where applicable), but are not necessarily limited to:

Reporting Requirement	Applicable Service	Submission Timeline
After-care Planning w/ State Operated Facilities		Day After No Show
CARF (Applies to Non-Accredited Providers)		As Requested
Client Movement Report	All	Each occurrence
Complete Admissions Data	All	Enrollment / Authorization
Complete Diagnostic Data	All	Enrollment / Authorization

SAMPLE

Complete Drug of Choice Data	All	Enrollment / Authorization
Complete ID & Demographic Data	All	Enrollment / Authorization
Continuous Quality Improvements (CQI) Projects	All	3 Per Year, or as mandated by Division and/or accreditation
Death Reports: Level II	All	Within 72 hours
Death Reports: Level III	All	Immediate verbal/written w/in 24 hrs.
Diversion Law (MR consumers)		At Placement
DSS Referrals	All	As Referred
Financial & Annual Statement	All	Annually; after each official audit
Housing Programs		March 7th
JCPC Client Tracking Form		Enrollment / Authorization
JCPC Semi-Annual Report		January 10th & July 10th
Juvenile Court Services Referrals		As Referred
Level I Incident Reports	All	Quarterly by 10th of month
Level II Incident Reports	All	Within 72 hours of Incident
Level III Incident Reports	All	Immediate verbal/written w/I 72 hrs.
MAJORS Report / JJSAMHP	MAJORS	Monthly by the 10th
National Core Indicators	DD Providers	2nd / 3rd Qtr. - As Scheduled
NC-SNAP	DD Providers	Enrollment / Yearly
NC-TOPPS Transfer/Discharge	MH & SA Providers	At Transfer/Discharge
NC-TOPPS Initial	MH & SA Providers	Within 30 days of First Service (New) In conjunction with PCP Update (Current)
NC-TOPPS Update	MH & SA providers	As Scheduled
No Missing Data	All	Enrollment / Authorization
No Unknown Data	All	Enrollment / Authorization
Out of Home Community Placement	All	At Placement
Quality Improvement Practices and Outcomes	All	As Requested
Restrictive Intervention Reports	All	Within 72 hours of Incident
SAPTBG Compliance Report	SA Providers	January 10th & July 10th
Service Information – Audits	All	As Requested
State Consumer Satisfaction Survey	All	1st Qtr. - As Scheduled
State/Federal Funding MH Adult Reports: (PATH, MH Block Grant, SAPTBG, etc.)	Homelessness, SA Providers	January 10th & July 10th
Work First	Work First-SA	Quarterly by 10th of month
Urgent and Routine No Show List	All	Daily
Weapon's Permit Information		As Requested

Emergent-Client Specific	*Urgent-Client Specific*	*Routine-Client Specific*
Who was seen within 2 hours of referral from Clinical Services	Who was seen within 48 hours of Clinical Services referral	Who was seen within 14 days of Clinical Services referral
Who could have been seen but consumer decided not to show up until later	Who could have been seen but consumer decided not to show until later or declined an appointment until later	Who could have been seen but consumer decided not to show until later or declined an appointment until later
Who could not be seen within two hours because Provider had no availability of services	Who could not be seen within 48 hours because Provider had no availability of services	Who could not be seen within fourteen days because Provider had no availability of services
Who did not show at all	Who did not show at all	Who did not show at all

APPENDIX A

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

(Note: The phrase "prospective lower tier participant" means providers under contract with the Division.)

SAMPLE

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

Instructions for Certification

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of the fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant will provide immediate written notice to the person to whom the proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549, 45 CFR Part 76. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter any lower tier covered transaction with a person who is debarred, suspended, determined ineligible or voluntarily excluded from participation in this covered transaction unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion - Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency of which it determines the eligibility of its principals. Each participant may, but is not required to, check the Non procurement List.

8. Nothing contained in the foregoing shall be construed to required establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized in paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension, and/or debarment.

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

SAMPLE

(1) The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

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

______________________________	______________________________
Signature	Title
______________________________	______________________________
Agency/Organization	Date

(Certification signature should be same as Contract signature).

APPENDIX B

CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

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

I. By execution of this Agreement the Contractor certifies that it will provide a drug-free workplace by:

A. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

B. Establishing a drug-free awareness program to inform employees about:

(1) The dangers of drug abuse in the workplace;

(2) The Contractor's policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

C. Making it a requirement that each employee be engaged in the performance of the agreement be given a copy of the statement required by paragraph A;

D. Notifying the employee in the statement required by paragraph A that, as a condition of employment under the agreement, the employee will:

(1) Abide by the terms of the statement; and

(2) Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

E. Notifying the Department within ten days after receiving notice under subparagraph D(2) from an employee or otherwise receiving actual notice of such conviction;

SAMPLE

F. Taking one of the following actions, within 30 days of receiving notice under subparagraph D(2), with respect to any employee who is so convicted:

(1) Taking appropriate personnel action against such an employee, up to and including termination; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency; and

(3) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs A, B, C, D, E, and F.

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

1.____
(Street address)

____
(City, county, state, zip code)

2.____
(Street address)

____
(City, county, state, zip code)

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

False certification or violation of the certification shall be grounds for suspension of payment, suspension or termination of grants, or government-wide Federal suspension or debarment, 45 C.F.R. 82.510.

______________________________ ______________________________
Signature Title

______________________________ ______________________________
Agency/Organization Date

(Certification signature should be same as Contract signature).

SAMPLE

APPENDIX C

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

Certification for Contracts, Grants, Loans and Cooperative Agreements

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

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

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any Federal, state or local government agency, a Member of Congress, a Member of the General Assembly, an officer or employee of Congress, an officer or employee of the General Assembly, an employee of a Member of Congress, or an employee of a Member of the General Assembly in connection with the awarding of any Federal or state contract, the making of any Federal or state grant, the making of any Federal or state loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal or state 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.

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

Notwithstanding other provisions of federal OMB Circulars A-122 and A-87, costs associated with the following activities are unallowable:

Paragraph A.

(1) Attempts to influence the outcomes of any Federal, State, or local election, referendum, initiative, or similar procedure, through in kind or cash contributions, endorsements, publicity, or similar activity;

(2) Establishing, administering, contributing to, or paying the expenses of a political party, campaign, political action committee, or other organization established for the purpose of influencing the outcomes of elections;

(3) Any attempt to influence: (i) The introduction of Federal or State legislation; or (ii) the enactment or modification of any pending Federal or State legislation through communication with any member or employee of the Congress or State legislature (including efforts to influence State or local officials to engage in similar lobbying activity), or with any Government official or employee in connection with a decision to sign or veto enrolled legislation;

(4) Any attempt to influence: (i) The introduction of Federal or State legislation; or (ii) the enactment or modification of any pending Federal or State legislation by preparing, distributing or using publicity or propaganda, or by urging members of the general public or any segment thereof to contribute to or participate in any mass demonstration, march, rally, fundraising drive, lobbying campaign or letter writing or telephone campaign; or

(5) Legislative liaison activities, including attendance at legislative sessions or committee hearings, gathering information regarding legislation, and analyzing the effect of legislation, when such

SAMPLE

activities are carried on in support of or in knowing preparation for an effort to engage in unallowable lobbying.

The following activities as enumerated in Paragraph B are excepted from the coverage of Paragraph A:

Paragraph B.

(1) Providing a technical and factual presentation of information on a topic directly related to the performance of a grant, contract or other agreement through hearing testimony, statements or letters to the Congress or a State legislature, or subdivision, member, or cognizant staff member thereof, in response to a documented request (including a Congressional Record notice requesting testimony or statements for the record at a regularly scheduled hearing) made by the recipient member, legislative body or subdivision, or a cognizant staff member thereof; provided such information is readily obtainable and can be readily put in deliverable form; and further provided that costs under this section for travel, lodging or meals are unallowable unless incurred to offer testimony at a regularly scheduled Congressional hearing pursuant to a written request for such presentation made by the Chairman or Ranking Minority Member of the Committee or Subcommittee conducting such hearing.
(2) Any lobbying made unallowable by subparagraph A(3) to influence State legislation in order to directly reduce the cost, or to avoid material impairment of the organization's authority to perform the grant, contract, or other agreement.
(3) Any activity specifically authorized by statute to be undertaken with funds from the grant, contract, or other agreement.

Paragraph C.

(1) When an organization seeks reimbursement for indirect costs, total lobbying costs shall be separately identified in the indirect cost rate proposal, and thereafter treated as other unallowable activity costs in accordance with the procedures of subparagraph B(3).
(2) Organizations shall submit, as part of the annual indirect cost rate proposal, a certification that the requirements and standards of this paragraph have been complied with.
(3) Organizations shall maintain adequate records to demonstrate that the determination of costs as being allowable or unallowable pursuant to this section complies with the requirements of this Circular.
(4) Time logs, calendars, or similar records shall not be required to be created for purposes of complying with this paragraph during any particular calendar month when: (i) the employee engages in lobbying (as defined in subparagraphs A & B) 25 percent or less of the employee's compensated hours of employment during that calendar month, and (ii) within the preceding five-year period, the organization has not materially misstated allowable or unallowable costs of any nature, including legislative lobbying costs. When conditions (i) and (ii) are met, organizations are not required to establish records to support the allow ability of claimed costs in addition to records already required or maintained. Also, when conditions (i) and (ii) are met, the absence of time logs, calendars, or similar records will not serve as a basis for disallowing costs by contesting estimates of lobbying time spent by employees during a calendar month.
(5) Agencies shall establish procedures for resolving in advance, in consultation with OMB, any significant questions or disagreements concerning the interpretation or application of this section. Any such advance resolution shall be binding in any subsequent settlements, audits or investigations with respect to that grant or contract for purposes of interpretation of this Circular; provided, however, that this shall not be construed to prevent a contractor or grantee from contesting the lawfulness of such a determination.

Paragraph D.

Executive lobbying costs. Costs incurred in attempting to improperly influence either directly or indirectly, an employee or officer of the Executive Branch of the Federal Government to give consideration or to act regarding a sponsored agreement or a regulatory matter are unallowable.

SAMPLE

Improper influence means any influence that induces or tends to induce a Federal employee or officer to give consideration or to act regarding a federally sponsored agreement or regulatory matter on any basis other than the merits of the matter.

Signature Title

Agency/Organization Date
(Certification signature should be same as Contract signature.)

APPENDIX D

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services
Certification for Contracts, Grants, Loans and Cooperative Agreements

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

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

Signature Title

Agency/Organization Date
(Certification signature should be same as Contract signature).

SAMPLE