TULARE COUNTY AGREEMENT NO. _____

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

THIS AGREEMENT ("Agreement") is entered into as of _____ between the **COUNTY OF TULARE**, a political subdivision of the State of California ("COUNTY"), and Family Services of Tulare County, A California Corporation ("CONTRACTOR"). COUNTY and CONTRACTOR are each a "Party" and together are the "Parties" to this Agreement, which is made with reference to the following:

A. COUNTY wishes to utilize the services of the CONTRACTOR to provide HIV related services to assist clients in Tulare County who are at risk or living with HIV/AIDS.

B. CONTRACTOR has the experience and qualifications to provide the services COUNTY requires pertaining to the COUNTY'S Public Health Program; and

C. CONTRACTOR is willing to enter into this Agreement with COUNTY upon the terms and conditions set forth herein.

THE PARTIES AGREE AS FOLLOWS:

1. **TERM:** This Agreement becomes effective upon signatures by the Tulare County Board of Supervisors and expires at 11:59 PM on September 29, 2020. unless earlier terminated as provided below, or unless the Parties extend the term by a written amendment to this Agreement.

2. **SERVICES:** See attached **Exhibits A, A-1**

3. **PAYMENT FOR SERVICES:** See attached **Exhibits B**

4. **INSURANCE:** Before approval of this Agreement by COUNTY, CONTRACTOR must file with the Clerk of the Board of Supervisors evidence of the required insurance as set forth in the attached **Exhibit C.**

5. **GENERAL AGREEMENT TERMS AND CONDITIONS:** COUNTY'S "General Agreement Terms and Conditions" are hereby incorporated by reference and made a part of this Agreement as if fully set forth herein. COUNTY'S "General Agreement Terms and Conditions" can be viewed at http://tularecountycounsel.org/default/index.cfm/public-information/

6. **ADDITIONAL EXHIBITS:** CONTRACTOR shall comply with the terms and conditions of the Exhibits listed below and identified with a checked box, which are by this reference made a part of this Agreement. Complete Exhibits D, E, F, G, G-1, and H can be viewed at http://tularecountycounsel.org/default/index.cfm/public-information/

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

☒	**Exhibit D**	Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement
☒	**Exhibit E**	Cultural Competence and Diversity
☒	**Exhibit F**	Information Confidentiality and Security Requirements
☐	**Exhibit G**	Contract Provider Disclosures (Must be completed by Contractor and submitted to County prior to approval of agreement.)
☐	**Exhibit G1**	National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
☒	**Exhibit H**	Additional terms and conditions for federally-funded contracts
☒	**Exhibit __C_**	Insurance Requirements

7. NOTICES: (a) Except as may be otherwise required by law, any notice to be given must be written and must be either personally delivered, sent by facsimile transmission or sent by first class mail, postage prepaid and addressed as follows:

COUNTY:

TULARE COUNTY HEALTH & HUMAN SERVICES AGENCY, ATT: CONTRACTS UNIT
5957 South Mooney Blvd
Visalia, CA 93277
Phone No: 559-624-8000
Fax No: 559-713-3718

With a Copy to:

COUNTY ADMINISTRATIVE OFFICER
2800 W. Burrel Ave.
Visalia, CA 93291
Phone No.: 559-636-5005
Fax No.: 559- 733-6318

CONTRACTOR:
FAMILY SERVICES OF TULARE COUNTY
815 W. OAK STREET
VISALIA, CA 93291
Phone No: 559-732-1970

(b) Notice personally delivered is effective when delivered. Notice sent by facsimile transmission is deemed to be received upon successful transmission. Notice sent by first class mail will be deemed received on the fifth calendar day after the date of mailing. Either Party may change the above address by giving written notice under this section.

8. AUTHORITY: CONTRACTOR represents and warrants to COUNTY that the individual(s) signing this Agreement on its behalf are duly authorized and have legal capacity to sign this Agreement and bind CONTRACTOR to its terms. CONTRACTOR acknowledges that COUNTY has relied upon this representation and warranty in entering into this Agreement.

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

9. COUNTERPARTS: The Parties may sign this Agreement in counterparts, each of which is an original and all of which taken together form one single document.

THE PARTIES, having read and considered the above provisions, indicate their agreement by their authorized signatures below.

FAMILY SERVICES OF TULARE COUNTY

Date: 08/13/18

By _____
Print Name Caity Meader
Title Executive Director

Date: 8.13.18

By _____
Print Name Stephanie Burrage
Title CFO

(Pursuant to Corporations Code section 313, County policy requires that contracts with a Corporation be signed by both (1) the chairman of the Board of Directors, the president or any vice-president (or another officer having general, operational responsibilities), and (2) the secretary, any assistant secretary, the chief financial officer, or any assistant treasurer (or another officer having recordkeeping or financial responsibilities), unless the contract is accompanied by a certified copy of a resolution of the corporation's Board of Directors authorizing the execution of the contract. Similarly, pursuant to California Corporations Code section 17703.01, County policy requires that contracts with a Limited Liability Company be signed by at least two managers, unless the contract is accompanied by a certified copy of the articles of organization stating that the LLC is managed by only one manager.)

COUNTY OF TULARE

Date: _____

By _____
Chairman, Board of Supervisors

ATTEST: MICHAEL C. SPATA
County Administrative Officer/Clerk of the Board
of Supervisors of the County of Tulare

By _____
Deputy Clerk

Approved as to Form
County Counsel
By _____ 8/14/18
Deputy
Matter # 20181052

EXHIBIT A

HIV Care Program

Organization Name: Family Services of Tulare County
Address: 815 W. Oak, Visalia CA 93291
Telephone: (559) 741-7310

HIV Care Program Funding
Services are being funded by the Health Resources and Services Administration (HRSA) Ryan White Part Band Part B Supplemental funds, CFDA # 93.917, using a *Single Allocation Model to* consolidate program funds into a single contract in each service area. The OA created the new *HIV Care Program* which utilizes the HRSA service categories to support the types of services that the *stand-alone* programs once provided. Your allocation for care and support services is awarded via the new HIV Care Program MOU under the Master Agreement contract.

The HIV Care Program is a two-tiered approach to service prioritization and delivery and is based upon the following HRSA-defined service categories:

1. Tier One: HIV Care Program prioritizes the HRSA category Outpatient/Ambulatory Medical Care

2. Tier Two: Tier Two services reduce the risk of treatment failure by supporting access to, and maintenance in Tier One care.

The allowable services for the HIV Care Program you will provide are outlined below:

Tier One Services	
Outpatient/Ambulatory Medical Care	Includes the provision of professional diagnostic and therapeutic services rendered by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or other health care professional who is certified in their jurisdiction to prescribe Antiretroviral (ARV) therapy in an outpatient setting. Settings include clinics, medical offices, and mobile vans where clients generally do not stay overnight. Emergency room services are not considered outpatient settings. Services include diagnostic testing, early intervention and risk assessment, preventive care and screening, practitioner examination, medical history taking, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, education and counseling on health issues, well-baby care, continuing care and management of chronic conditions, and referral to and provision of specialty care (includes all medical subspecialties). Primary medical care for the treatment of HIV infection includes the provision of care that is consistent with the Public Health Service's (PHS) guidelines. Such care must include access to ARV and other drug therapies, including prophylaxis and treatment of opportunistic infections and combination ARV therapies.

Case Management Services (non-medical)	Includes the provision of advice and assistance in obtaining medical, social, community, legal, financial, and other needed services. Non-medical case management does not involve coordination and follow-up of medical treatments.
Emergency Financial Assistance	Is the provision of short-term payments to agencies or the establishment of voucher programs to assist with emergency expenses related to essential utilities, housing, food (including groceries, food vouchers, and food stamps), and medication, when other resources are not available. NOTE: Part A and Part B programs must allocate, track, and report these funds under specific service categories as described under 2.6 in Division of Service Systems (DSS) Program Policy Guidance No. 2 (fonnally Policy No. 97-02).
Medical Transportation Services	Are conveyance services provided, directly or through voucher, to a client so that he or she may access health care services? Medical transportation is classified as a support service and is used to provide transportation for eligible Ryan White HIV/AIDS Program clients to core medical services and support services. Medical transportation must be reported as a support service in all cases, regardless of whether the client is transported to a medical core service or to a support service.
Mental Health Services	Are psychological and psychiatric treatment and counseling services for individuals with a diagnosed mental illness. These services are conducted in a group or individual setting, and provided by a mental health professional licensed or authorized within the State to render such services. This typically includes psychiatrists, psychologists, and licensed clinical social workers.
Health Insurance Premium and Cost Sharing Assistance	Is the provision of financial assistance for eligible individuals living with HIV to maintain a continuity of health insurance or to receive medical benefits under a health insurance program. This includes premium payments, risk pools, co-payments, and deductibles.
Housing Assistance	Provide short term housing assistance through a partial rent subsidy program. The rent subsidy amount will be allocated based on county fair market rent value, of the eligible client's monthly rent.
Food Bank	Provide non-perishable food assistance through food bank program, to eligible client's monthly.

Additional Requirements

Family Services of Tulare County is also contractually obligated to HIV Care Program Scope of Work which is included in the contract between County of Tulare and the California Department of Public Health, included as Exhibit A-1.

Exhibit A-1
HIV Care Program
Scope of Work

1. HCP Services

The HIV care services to be provided under HCP are HRSA-defined service categories. For a listing of HRSA service category definitions, and the specific services included in each category, please refer to the HRSA website at www.hab.hrsa.gov. Additional information can be found in the *HCP and Budget Guidelines.*

CDPHIOA will not require local utilization of HRSA's "75 percent (Core services) /25 percent (Support services)" requirement for prioritization of services.

HCP is a two-tiered approach to service prioritization and delivery and utilizes the HRSA-defined service categories, both the Core and Support service categories.

HCP prioritizes service provisions as follows:

Tier One: *Outpatient/Ambulatory Medical Care,* as defined by HRSA. Services include, but are not limited to, primary medical care, laboratory testing, medical history taking, health screening, and prescribing and managing medications. Contractors must ensure that Tier One medical services are provided for all population groups in their geographic region *via* all HIVIAIDS or other funding sources before allocating HCP funds to Tier Two services.

Tier Two: HRSA-defined Core and Support service categories that (1) assist with access to Tier One care, (2) support maintenance in Tier One care, and (3) reduce the risk of treatment failure and/or HIV transmission. HCP funds may be allocated for any Tier Two service only after Contractors have ensured Tier One services are adequately provided in their geographic region via all HIVIAIDS or other funding sources.

The following HRSA service categories are included in Tier Two of HCP:

- *Mental Health Services*
- *Medical Case Management Svcs (Includes Treatment Adherence)*
- *Case Management (Non-Medical)*
- *Oral Health Care*
- *AIDS Pharmaceutical Assistance*
- *Substance Abuse Services-*
  - *Outpatient and Residential*
- *Health Education/Risk Reduction*
- *Home Health Care*
- *Hospice Services*
- *Outreach Services*
- *Emergency Financial Assistance*
- *Food Bank/Home-Delivered Meals*
- *Housing Services*
- *Legal Services*
- *Treatment Adherence Counseling*
- *Health Insurance Premium and Cost Sharing Assistance*
- *Home- and Community-Based Health Services*
- *Linguistic Services*
- *Medical Transportation Services*
- *Psychosocial Support Services*
- *Medical Nutrition Therapy*
- *Early Intervention Services*
- *Referral for Health Care/Supportive Services*
- *Rehabilitation Services*
- *Respite Care*
- *Child Care Services*

Exhibit A-1
HIV Care Program
Scope of Work

A. The Contractor shall:

1. Provide comprehensive, ongoing medical services to individuals with HIV/AIDS. Services must be based on the HRSA service category, *Outpatient/Ambulatory Medical Care* or, if these services are not funded by HCP under Tier One, the Contractor must demonstrate and document the availability of primary medicalcare for HIV-infected persons within each population group in the service area.

2. Provide Tier Two HRSA Core and Support services as necessary, and as funds permit, to ensure access to Tier One care, maintenance in Tier One care, and reduce the risk of treatment failure or HIV transmission.

3. Develop and implement a system of service delivery that offers comprehensive, ongoing health and support services to individuals with HIV/AIDS, that actively seeks individuals who know their HIV status but are not accessing services, that reaches out to people who are HIV positive but unaware of their HIV status, and that is coordinated and integrated with other service delivery systems as appropriate.

4. Advisory and/or focus groups will meet at least annually to provide input to the Contractor on issues such as needs assessment, service delivery plans, and comprehensive planning.The Contractor shall maintain minutes and/or documentation of the advisory or focus group meetings.

   The advisory and/or focus group, should be made up of representatives from state, federal, and local programs that provide health services and education and prevention services; non-profit and for-profit community-based agencies; staff from other key points of entry into medical care, who either provide services to individuals with HIV/AIDS, or who may have contact with HIV positive individuals who are not in care or not aware of their HIV status; individuals with HIV, and their advocates, etc. The advisory group provides information to the Contractor regarding health services delivery and the needs of individuals with HIV/AIDS living within the community.

5. Ensure the protection of the clients privacy and confidentiality at all times. In addition, federal law requires that individuals have a right of access, to inspect, and obtain a copy of their protected health information (PHI) in a designated record set, for as long as the health information is maintained by a CDPH health plan, CDPH providers, or business associates. There are limited exceptions to an individual's right of access PHI (45 C.F.R. s 164.524).

6. Ensure that any subcontracted agencies have the organizational and administrative capabilities to support the program services and activities.

The Contractor is responsible for quality assurance and utilization review activities for subcontracted HIV care services.

7. Ensure that any subcontracted agencies have appropriate facilities and resources, including an adequate physical plant and appropriate supplies and equipment available for the provision of services and practical support functions.

8. Develop and maintain working relationships, and coordinate an integrated system of service delivery, with entities who provide key points of entry into medical care, including but not limited to emergency rooms, substance abuse treatment programs, detoxification centers, adult and juvenile detention facilities, California Department of Corrections and Rehabilitation, Transitional Case Management Program (TCMP) for incarcerated populations, sexually transmitted disease (STD) clinics, HIV counseling and testing sites, mental health programs, homeless shelters, health care points of entry specified by the State, federally qualified health centers, migrant health centers, community health centers, health services for the homeless, family planning grantees, comprehensive hemophilia diagnostic and treatment centers, and non-profit and for profit private entities that provide comprehensive primary care services to populations at risk for HIV. The coordinated, integrated system of care must be informed by HIV epidemiological data and other data sources and should include leveraged resources. The Contractor shall keep documentation of these working relationships.

9. Ensure that case management services that link available community support services to appropriate specialized medical services shall be provided for individuals residing in rural areas as appropriate.

10. Ensure HIV care services will be provided in a setting that is accessible to low-income individuals with HIV disease. Facilities must also be accessible for hearing-, vision-, and mobility-impaired persons in accordance with the federal Americans with Disabilities Act (ADA).

11. Provide targeted prevention coordinated with all state and federal programs to low-income individuals with HIV disease and to inform such individuals of the services available under Ryan White Part B.

12. To the maximum extent practical, ensure that HIV related health care and support services delivered pursuant to a program established with assistance provided under Ryan White Part B will be provided without regard to the ability of the individual to pay for such services and without regard to the current or past health condition of the individual with HIV disease.

13. Ensure that services provided to women, infants, children, and youth are tracked and reported (see Data Collection, subheading F).

14. Ensure that services provided under this contract are in accordance with the program policy guidance issued by Division of Service Systems (DSS), HIV/AIDS Bureau (HAB) (see www.hab.hrsa.gov), CDPH/OA's *HCP and Budget Guidelines.*

15. Ensure that the Ryan White HIV/AIDS Program funds do not comprise more than sixty percent (60%) of any subcontracted agency's total budget, Ryan White HIV/AIDS Program funds are intended to provide additional funding to those areas negatively affected by HIV disease and cannot be used to supplant local HIV-related budgets.

16. Ensure that clients are eligible for services in accordance with the program policy guidance issued by OSS, HAB (see www.hab.hrsa.gov).

17. Ensure that no more than ten percent (10%) of the allocation is used for non-direct service functions such as:

    a. Routine contract administration and monitoring activities, including the preparation of applications for these funds, the receipt and disbursal of program funds, the development and establishment of reimbursement and accounting systems, the preparation of routine programmatic and financial reports, and compliance with contract conditions and audit requirements;

    b. All activities associated with the Contractor's subcontract award procedures, including the development of request for proposals, contract proposal review activities, negotiation and awarding of subcontracts, grievance process, monitoring of subcontracts through telephone consultation or onsite visits, reporting on subcontracts and funding reallocation activities.

18. In addition, ensure that no more than ten percent (10%) of the allocation is used for all subcontracted agencies' non-direct service (administrative) functions without prior written consent from OA.

19. Conduct assessment of HIV/AIDS service needs for the geographic service area at least once every three years. Review assessment annually and, if needed, update it. Ensure that no more than five percent (5%) of the allocation is utilized to plan, conduct, and evaluate the needs assessment process. Needs assessment activities may not be billed to CDPH/OA more than once during a three year contract period.

20. Ensure that client service providers who provide Medi-Cal reimbursable services are certified as providers for purposes of Medi-Cal billing (see www.medi-cal.ca.gov) and have the ability to bill other third-party payers for covered services.

21. Ensure that funds are payer of last resort by ensuring that client service providers bill all other third-party payers, including Medi-Cal, before invoicing HCP.

22. Ensure that funds are not utilized to make payments for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to that item or service:

    a. Under any State compensation program, under an insurance policy, or under any Federal or State health benefits program; or

    b. By an entity that provides health services on a prepaid basis.

23. Ensure that funds are not used to:

    a. Make cash payment to intended recipients of services;

    b. Purchase or improve (other than minor remodeling) any building or other facility; or

    c. Pay for automobile parts, repairs, or maintenance, pet care or supplies, funeral expenses, etc. (see www.hab.hrsa.gov).

24. Ensure that all approved subcontracted agency invoices are paid within 45 days of receipt.

25. Ensure that no funds are carried over into subsequent contract years.

26. Ensure compliance with the federal HRSA Ryan White Program, CDPH/OA's HCP and Budget Guidelines, CDPH/OA Policy Letters, Management Memoranda, AIDS Regional Information and Evaluation System (ARIES) Policy Notices, and other program guidelines issued by CDPH/OA.

27. Administer Ryan White Part B funds appropriately, maintain records and invoices using standard accounting practices, coordinate federal and state data reporting, and arrange for fiscal audits.

28. Annually evaluate the cost-effectiveness of the mechanisms used to deliver comprehensive care.

29. When issuing statements, press releases, requests for proposals, bid solicitations, and other documents describing projects or programs funded in whole or in part with Federal money, the Contractor shall clearly state the percentage of the total costs of the program or project which will be financed with Federal money, the dollar amount of Federal funds for the project or program, and percentage and a dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

30. Ensure that Management Memoranda responses are accurate, complete and received on or before the required response date.

31. Ensure compliance with the following requirements regarding imposition of charges for services, for those providers who charge for services:

    a. In the case of individuals with an income less than or equal to one hundred percent (100%) of federal poverty guidelines (FPG) (see www.aspe.hhs.gov/poverty), the provider will not impose charges on any such individual for the provision of services under the contract;

    b. In the case of individuals with an income greater than one hundred percent (100%) of the FPG, the provider:

        i. Will impose charges on each such individual for the provision of such services and
        ii. Will impose charges according to a schedule of charges that is made available to the public;

    c. In the case of individuals with an income between the FPG in Columns A and B (see table below), the provider will not, for any calendar year, impose charges exceeding the percentage in Column C of the client's annual gross income:

Column A: Client's income is greater than	Column B: Client's income does not exceed	Column C: Charges are not to exceed
100% of FPG	200% of FPG	5% of the client's annual gross income
200% of FPG	300% of FPG	10% of the client's annual gross income
300% of FPG	-	10% of the client's annual gross income

32. Participate in any state-mandated meetings, trainings, WebEx conferences, Webinars, teleconferences, and/or other conferences to be determined.

33. Take steps to ensure that people with limited English proficiency can meaningfully access health and social services. For detailed information on the specific responsibilities of Contractors regarding linguistic competence, see the Office of Civil Rights (OCR) website at: http://www.hhs.gov/ocr/lep/revisedleo.html.

B. Monitoring Activities.

The Contractor shall:

1. Conduct site visits and document/monitor the activities of subcontracted agencies to ensure contractual compliance not less than once every year. For all deficiencies cited in the contractor's monitoring report, develop a corrective plan, submit it to the State for approval, and implement the plan.

2. Provide any necessary assistance to the State in carrying out State monitoring activities and inspection rights for both contractors and subcontracted agencies, as provided in this agreement.

3. Make available to authorized State and/or federal representatives all records, materials, data information, and appropriate staff required for monitoring or inspection activities.

4. For all deficiencies cited in the State's monitoring report, develop a corrective plan, submit it to the State for approval, and implement the plan. Provide the corrective plan to the State within 30 days of receipt of the monitoring report.

C. Partner Services (PS)

The Contractor shall ensure that client service providers:

1. Inform clients of the availability of PS. Client service providers may either offer PS directly through their agency or by referral to their designated local health programs.

2. Maintain documentation when PS is offered and the outcome (i.e., the number of partners to be notified by the client and/or by the health jurisdiction). Client service providers using ARIES should document these encounters on the Basic Medical screen. Client service providers not using ARIES should document these encounters in the client medical records.

D. Reporting Requirements

HCP Contractors are required to submit quarterly financial and narrative reports to OA. The HCP Quarterly Reports are due to OA according to the following schedule:

Reporting Period	Due dates
July 1 -September 30	November15
October 1– December 31	February 15
January 1 - March 31	May 15
April 1 - June 30	August 15

1. The quarterly HCP Financial Report tracks expenditures for the Contractor and any subcontracted agency for the quarter reported. The quarterly Financial Reports shall include the administrative costs of the Contractor and each subcontracted agency, amount of funds obligated to each subcontracted agency, total expended quarterly by each subcontracted agency, percentage expended for the quarter, and total number of unduplicated clients for the quarter reported.

2. The quarterly HCP Narrative Report is an opportunity for the Contractor to describe their HCP programs, services provided, progress and accomplishments, and to identify any technical assistance needs. The quarterly Narrative Reports shall include, for the quarter reported only, descriptions of the programs, services funded with HCP funds, any general accomplishments within the programs, issues or concerns with the programs and services funded in your county, and any technical assistance and/or training needs of the contractor and/or subcontracted agency.

   Contractors may access the HCP Financial and Narrative Report formats at:
   http://www.cdph.ca.gov/programsiaids/Pages/OAHIVCareProgram.aspx

F. Data Collection

The Contractor shall ensure that client service providers:

1. Collect the HCP minimum data set. The HCP minimum dataset includes data elements required by (a) HRSA to complete the Ryan White Program Data Report (RDR), the Ryan White Program Service Report (RSR), selected HAB Quality Management (QM) indicators, and the Women, Infants, Children, and Youth Report, and (b) CDPH/OA for its development of estimates and reports (i.e., estimate of unmet need for HIV medical care, statewide epidemiologic profile, Statewide Coordinated Statement of Need) and to conduct program activities.

2. Directly enter data into ARIES within two weeks from a client's date of service. Client service providers may import data into ARIES from other data collection systems only if they obtain prior written approval from CDPH/OA; said providers may not use CDPH/OA funds to develop or maintain their import systems.

3. Electronically submit the aggregate-level RDR through HAS's Electronic Handbook (EHS). The RDR reporting period is January 1 through December 31 of the previous calendar. Submission deadlines will be announced in ARIES Policy Notices.

4. Electronically submit a Provider Report for the RSR through HAS's EHB. Unless exempted by HRSA, client service providers who provide RSR-eligible services must also upload a Client Report, which contains client-level data, as an XML data file to HAS's EHB. The RSR is due twice a year: (a) The first report includes data from the first six months of the current calendar year, and (b) The second report includes all the data from the entire previous calendar year. Submission deadlines will be announced in ARIES Policy Notices.

5. Comply with the policies and procedures outlined in ARIES Policy Notices issued by the CDPH/OA (see www.projectaries.org).

G. Client Service Provider/Subcontracted Agency Reporting Requirements

Comply with the State's timeline to submit to the State a Hst identifying the names and budget overview of all service provision and subcontracted agencies and total funds available to each Client Service Provider. OA's HIV Care Section will provide the required forms to complete the budget overview and all service provision information. These forms are located on the OA website. Please click on the link to access the current forms at HCP Budget Forms

H. QM Program

The Contractor shall:

1. Ensure that all client service providers have a QM program in place. The QM program should fit within the framework client service providers' other programmatic quality assurance and quality improvement activities. Client service providers may use an existing QM program (e.g., Joint Commission on Accreditation of Healthcare Organizations, Medicaid) or develop their own program. Client service providers who develop their own program should refer to the nine steps in HAS's *OM Technical Assistance Manual* for program formation. (www. hab.hrsa.gov/tools/qm).

2. Incorporate selected indicators from Groups 1 and 2 of HAB's HIV/AIDS Core Clinical Performance Measures for Adults and Adolescents (also known as HAB QM indicators) into QM programs as CDPH/OA implements selected HAB QM indicators as part of its QM and monitoring program. Specific indicators will be identified and released by OA Management Memorandum. Contractors and subcontracted agencies can monitor their progress in meeting HAB QM indicators for Groups 1 and 2 by using the Compliance Reports in ARIES as appropriate.

I. Data Encryption

The Contractor shall adhere to the Information Privacy and Security Requirements (Exhibit J). In addition to the procedures set forth in the Information Privacy and Security Requirements exhibit, Contractors must ensure that all mobile devices are equipped with encryption software, even if the Contractor or their subcontracted agencies do not store confidential information on the mobile devices.

Exhibit B - Attachment I ③
HIV Care Program
Budget Year 1 (November 30, 2016 - September 29, 2017), Year 2 (September 30, 2017-September 29, 2018), Year 3 (September 30, 2018-September 29, 2019), Year 4 (September 30, 2019-September 29, 2020)

			Year (1)			Year (2)			Year (2) Amendment			Year (3)			Year (4)			Totals	
A. Personnel		Annual Salary																	
Position Title	SOW Reference	Range	FTE	Avg. Salary	Budget	FTE	Avg. Salary	Budget	FTE	Avg. Salary	Budget	FTE	Avg. Salary	Budget	FTE	Avg. Salary	Budget		
Social Services Worker II	~~II.A.1~~	$40,638-$50,636	1.00	$45,638	$45,638	~~1.00~~	~~$45,638~~	~~$45,638~~	0.50	$47,200	$23,600	0.50	$47,200	$23,600	0.50	$47,200	$23,600	~~$ 91,276~~	116,438
Total Salaries and Wages					$45,638			$45,638			$23,600			$23,600			$23,600	~~$ 91,276~~	116,438
Fringe Benefits				Percentage			Percentage			Percentage			Percentage			Percentage			
				42.00%	$19,168		~~42.00%~~	~~$19,168~~		38.00%	$8,968		38.00%	$8,968		38.00%	$8,968	~~$ 38,336~~	46,072
Total Personnel					$64,806			$64,806			$32,568			$32,568			$32,568	~~$ 129,612~~	162,510
B. Operating Expenses	SOW Reference				Budget			Budget			Budget			Budget			Budget		
Total Operating Expenses					$0			$0			$0			$0			$0		-
C. Capitol Expenditures	SOW Reference				Budget			Budget			Budget			Budget			Budget		
Total Capitol Expenditures					$0			$0			$0			$0			$0		-
D. Other Cost	SOW Reference				Budget			Budget			Budget			Budget			Budget		
Contractors Non-Personnel Costs ①	~~II.A.1~~ 5.A.1				$12,500			~~$12,500~~			$0			$0			$0	~~$ 25,000~~	12,500
Family Services of Tulare County ②	5.A.1, Page 10				$0			$0			$10,000			$10,000			$10,000		30,000
Total Other Costs					$12,500			~~$12,500~~			$10,000			$10,000			$10,000	~~$ 25,000~~	42,500
E. Indirect Costs				Percentage	Budget		Percentage	Budget		Percentage	Budget		Percentage	Budget		Percentage	Budget		
Total Indirect Costs				11.8%	$7,650		~~11.8%~~	~~$7,650~~		14.5%	$4,732		14.5%	$4,732		14.5%	$4,732	~~$ 15,300~~	21,846
Total Costs					$84,956			~~$84,956~~			$47,300			$47,300			$47,300	~~$ 169,912~~	226,956

① Contractors Non-Personnel Costs Associated Directly with Services - includes Early Intervention Services (EIS)
② Subcontractor - Direct Service Provider, providing Food Bank/Home Delivered Meals
③ Rounding might occur.

PROFESSIONAL SERVICES CONTRACTS (EXHIBIT C)

INSURANCE REQUIREMENTS

CONTRACTOR shall provide and maintain insurance for the duration of this Agreement against claims for injuries to persons and damage to property which may arise from, or in connection with, performance under the Agreement by the CONTRACTOR, his agents, representatives, employees and subcontractors, if applicable.

A. Minimum Scope & Limits of Insurance

1. Coverage at least as broad as Commercial General Liability, insurance Services Office Commercial General Liability coverage occurrence form GC 00 01, with limits no less than $1,000,000 per occurrence including products and completed operations, property damage, bodily injury and personal & advertising injury. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.

2. Insurance Services Office Form Number CA 00 01 covering Automobile Liability of $1,000,000 per occurrence including any auto or, if the CONTRACTOR has no owned autos, hired and non-owned auto coverage. If an annual aggregate applies it must be no less than $2,000,000.

3. Workers' Compensation insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury or disease.

4. Professional Liability (Errors and Omissions) insurance appropriate to the CONTRACTOR's profession, with limit no less than $1,000,000 per occurrence or claim, $2,000,000 aggregate.

B. Specific Provisions of the Certificate

1. If the required insurance is written on a claims made form, the retroactive date must be before the date of the contract or the beginning of the contract work and must be maintained and evidence of insurance must be provided for at least three (3) years after completion of the contract work.

2. CONTRACTOR must submit endorsements to the General Liability reflecting the following provisions:

   a. *The COUNTY, its officers, agents, officials, employees and volunteers are to be covered as additional insureds as respects; liability arising out of work or operations performed by or on behalf of the CONTRACTOR including material, parts, or equipment furnished in connection with such work or operations.*

   b. *For any claims related to this project, the CONTRACTOR's insurance coverage shall be primary insurance as respects the COUNTY, its officers, agents, officials, employees and volunteers. Any insurance or self-insurance maintained by the COUNTY, its officers, agents, officials, employees or volunteers shall be excess of the CONTRACTOR's insurance and shall not contribute with it.*

   c. *CONTRACTOR hereby grants to COUNTY a waiver of any right to subrogation which any insurer of CONTRACTPR may acquire against the county by virtue of the payment of any loss under such insurance. CONTRACTOR agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the COUNTY has received a waiver of subrogation endorsement from the insurer.*

d. *Each insurance policy required by this agreement shall be endorsed to state that coverage shall not be canceled by either party, except after written notice has been provided to the County.*

3. The Workers' Compensation policy shall be endorsed with a waiver of subrogation in favor of the COUNTY for all work performed by the CONTRACTOR, its employees, agents and subcontractors. CONTRACTOR waives all rights against the COUNTY and its officers, agents, officials, employees and volunteers for recovery of damages to the extent these damages are covered by the workers compensation and employers liability.

C. Deductibles and Self-Insured Retentions

Self-insured retentions must be declared and the COUNTY Risk Manager must approve any deductible or self-insured retention that exceeds $100,000.

D. Acceptability of Insurance

Insurance must be placed with insurers with a current rating given by A.M. Best and Company of no less than A-:VII and a Standard & Poor's Rating (if rated) of at least BBB and from a company approved by the Department of Insurance to conduct business in California. Any waiver of these standards is subject to approval by the County Risk Manager.

E. Verification of Coverage

Prior to approval of this Agreement by the COUNTY, the CONTRACTOR shall file with the submitting department, certificates of insurance with original endorsements effecting coverage in a form acceptable to the COUNTY. Endorsements must be signed by persons authorized to bind coverage on behalf of the insurer. The COUNTY reserves the right to require certified copies of all required insurance policies at any time.