

**Warren County Health Services
Health, Human and Social Services Committee
AGENDA FOR
March 19, 2018
Information Submitted By: Patricia Auer, DPH/DPS**

Health and Human Services Committee Members: Frasier, McDevitt, Braymer, Leggett, Loeb, Diamond, Hyde, Magowan, Sokol

Committee meeting call to order by Chairperson

Motion to approve the minutes of the February 26, 2018 Health and Human Services Committee meeting.

I. Action Agenda/New Business

Request Resolution:

To amend the contract with Capital District Physicians Health Plan (CDPHP) to allow the incorporation of a Standard Clause Amendment and to authorize language that allows for future Standard Clauses to be incorporated in the contract without need for further Board of Supervisor approval as long as approved by the County Attorney.

Rationale:

Many of the new contracts have this language already, but we have had the contract with CDPHP for a long time and this was not the case at the time the original contract was authorized.

Request Resolution:

To authorize a contract agreement VNA Homecare Options, LLC in order to allow reimbursement for services to individuals who are enrolled in their Medicare Advantage Plan.

Rationale:

There is no down side to this contract as it is Department of Health approved and pays 100% of approved Medicare rates.

Request Resolution:

To ratify the action of the Chairman of the Board of Supervisors in reapproving the provider agreement for Early Intervention Services with the New York State Department of Health Early Intervention Program.

Rationale:

The application has been completed, and allows us to receive reimbursement for mandated services. It is due to the Department of Health on March 31. The April Board meeting will not occur until after that time.

This is the first time the state has requested a reapplication

Request Resolution:

To authorize a contract with Patricia Eimen to provide Occupational Therapy Services.

Request Resolution:

To authorize a contract with Lindsey Maresca to provide Occupational Therapy Services.

Rationale:

We continue to need Occupational Therapy Services in the Home Care Division and we do not want to be in a position where we are unable to accept patient referrals for those individuals requiring this service. Therapy services are billable services and revenue generating.

Request Resolution:

For Budget Amendment Please see **Attachment 5**.

Rationale:

Tawn Driscoll, Fiscal Manager, will explain the need at the meeting.

Referral/Pending Items

There are no pending items at this time.

II. Information for Discussion/Review

Report of Expenditures, Revenues, Overtime and Per Diem Use for 2017

Please see **Attachment 2**.

Revenue and Expense Comparison Report for 2017 vs 2018

Please see **Attachment 3**.

Tawn Driscoll, Fiscal Manager, will be present at the meeting to review the reports and answer any questions.

Emergency Response and Preparedness

Please see **Attachment 1** for the monthly report.

Status of Referrals

Please see **Attachment 4** for the detailed report.

Valerie Whisenant, Assistant Director of Patient Services, will provide comments at the meeting.

Rabies Program Report for 2017

Please see **Attachment 6**.

Information Item:

In January we requested to carry over funds from an Opioid Gateway Closed Grant from Adirondack Health Institute since not all the funds were expended in 2017.

Recently a program was conducted and monies were utilized to purchase food and supplies for the program attendees.

The total amount was \$413.00., Edna Frasier provided approval. The form was transmitted and per county policy, we are informing the committee.

Staffing Update

As we discussed at our last meeting staffing is always a challenge.

Since our last meeting:

WIC Program:

The **WIC Program Coordinator** retired with one week notice. It is an out of Bargaining Unit position and we anticipate it may be difficult to fill. Meanwhile Staff is adequate and knowledgeable so clinics will continue uninterrupted with more work from Public Health Staff as needed.

A **WIC Program Assistant** (Grade 5) resigned giving a 2 week notice.

The **Infant Feeding Advocate** resigned a few weeks ago, and we are in the process of ironing out job requirements with the NYSDOH WIC Program Staff. We will keep you posted. Concerns are centering around the fact that WIC staff cannot be on call after business hours, carry a cell phone and not have a mechanism for compensation.

We have requested to backfill the positions and will post as required by CSEA Contract. The WIC Assistant position has a Civil Service list, so we are hopeful we will be able to backfill from that. We will distribute the intent to fill forms at the meeting, and are seeking committee approval to backfill the openings.

Nursing Positions:

We are aware of two nurses going out on extended medical leaves in the next several weeks. We also have one nurse out on worker's comp that may or may not be back soon, and one nurse out on sick leave that is likely retiring very soon after/if she returns. Further discussion will occur at the meeting. We are seeking permission to fill 2 vacant positions.

III. Privilege of the floor to discuss any additional items to come before Committee

IV. Motion to adjourn the Health Services Meeting

Attachments:

1. Emergency Response and Preparedness Activities Report
2. Report of Expenditures, Revenues, Overtime and Per Diem Use
3. Revenue and Expense Comparison Report for 2016 vs 2017
4. Report of Referrals Status
5. Budget Amendment Request
6. Rabies Program Report

WARREN COUNTY HEALTH SERVICES BUDGET ANALYSIS

REVENUE AND EXPENDITURES FOR 2018 AS OF 3/13/2018 12:26:05 PM

FUND(S): A, CL, D, DM, EF, GI, MS, SD, V

CODE(S): 4010, 4013, 4016, 4054, 4190, 4018, 4189

EXPENSES	2018 BUDGETED	2018 YTD ACTUAL	2017 Prior Year Totals
Salaries - Regular	\$2,673,005.00	\$419,447.74	\$2,254,816.25
Salaries - Overtime	\$132,000.00	\$17,232.78	\$99,343.63
Salaries - Part Time	\$502,135.00	\$71,953.55	\$416,387.62
100's PERSONAL SERVICES	\$3,307,140.00	\$508,634.07	\$2,770,547.50
200's EQUIPMENT	\$18,967.00	\$523.95	\$70,272.53
400's CONTRACTUAL	\$6,132,117.35	\$326,967.85	\$4,899,774.77
800's EMPLOYEE BENEFITS	\$1,618,287.00	\$302,861.34	\$1,455,471.45
TOTALS	\$11,076,511.35	\$1,138,987.21	\$9,196,066.25

REVENUES	2018 BUDGETED	2018 YTD ACTUAL	2017 Prior Year Totals
	\$8,806,226.26	\$334,848.37	\$6,045,148.73

Note: Above are the current Revenues and Expenses YTD for 2018. We have accrued \$267,849 for January revenues for CHHA and MCH and are currently finalizing the billing for February.

Also reflected are the YTD totals for 2017, however the revenues and expenses are not finalized. In April, we expect to be able to bill the state for our Preschool Revenues for 2017. We also expect, in April, to receive the final values of the WIC food vouchers. At that time we will then be able to process final revenues and expenses. The total for both of these is estimated to be over \$1.3 million in additional revenues and approximately \$630,000 in expenses for WIC.

Warren County Health Services

Salaries Comparison

2017 vs 2018

as of 3/4/18 Payroll

	YTD	YTD	YTD 18v17	% Change	Total Budget	Total Actual
	2018	2017			2018	2017
Total of All Depts						
Regular Salaries	\$419,447.74	\$393,712.78	\$25,734.96	6.54%	\$2,673,005.00	\$2,254,816.25
Overtime Salaries	\$17,232.78	\$20,285.87	-\$3,053.09	-15.05%	\$132,000.00	\$99,343.63
Part Time Salaries	\$71,953.55	\$73,430.18	-\$1,476.63	-2.01%	\$502,135.00	\$416,387.62
TOTALS	\$508,634.07	\$487,428.83	\$21,205.24	4.35%	\$3,307,140.00	\$2,770,547.50
% current YTD Salary to Total Budget	15.38%	17.59%				

Source: Detail G/L report for all Salary Category from 1/1/XX-3/4/XX

Overall, total salaries are \$21,205.24 more than total 2017 Salaries due to the annual negotiated contracted increases. Overtime and Part time salaries are slightly lower YTD for 2017 compared to 2018. We have lost a few per diem nursing staff and continue to recruit. Overall salaries are up slightly by 4.35% compared to 2017. At this time, we currently are 15.38% of the 2018 budget where in 2017, we were 17.59% of the final budget.

**Warren County Health Services
Revenue and Expense Comparison 2018 vs 2017
as of 3/13/18 G/L**

EXPENSES	2018 YTD Actual as of 3/13/18 G/L	2017 YTD as of 3/15/17 G/L (3/22/17 mtg)	Variance
Salaries - Regular	\$419,447.74	\$393,712.78	\$25,734.96
Salaries - Overtime	\$17,232.78	\$20,285.87	(\$3,053.09)
Salaries - Part Time	\$71,953.55	\$73,430.18	(\$1,476.63)
100's PERSONAL SERVICES	\$508,634.07	\$487,428.83	\$21,205.24
200's EQUIPMENT	\$523.95	\$176.27	\$347.68
400's CONTRACTUAL	\$326,967.85	\$245,349.07	\$81,618.78
800's EMPLOYEE BENEFITS	\$302,861.34	\$326,896.05	(\$24,034.71)
TOTALS	\$1,138,987.21	\$1,059,850.22	\$79,136.99

REVENUES	2018 YTD ACTUAL	2017 Prior Year to Date Totals	Variance
	\$334,848.37	\$334,398.69	\$449.68

Notes:

Salaries: (please see previous page) Overall are \$21,205.24 or 4.35% above 2017 as of the 3/4/18 payroll date. Full time salaries are above 2017. YTD salaries while part time and overtime salaries are below 2017. This increase correlates with the annual negotiated contract salary increases. Overall, 2018 salaries are 15.38% of budget while this time last year we were at 17.59% of budgeted total salaries.

Contractual expenses: Expenses at this time for 2018 are above 2017 by \$81,619. This is primarily related to Rent expense. In 2018, Rent expense for all departments is reflected, where in 2017 at this time, the rent had yet to be paid.

Employee Benefits: Employee benefits are below last year by \$24,035 and correlates with the the nursing position shortages that we have experienced during the year therefore allowing us to hire per diem employees.

Revenues:

Overall revenues at this time are consistant with revenues in 2017.

ATTACHMENT #1
BT ACTIVITY SHEET
BP1 - 7/1/17 - 6/30/18

Page 1

Topic Color Codes

Red/Chempack; Green/SNS; Blue/Mass Fatality; Black/Training;
 Purple/Special Needs; Orange/Drill; Black/Pan Flu

2/1/18	Meeting	EPR Meeting w/Nursing homes/LTC and Homecare Agencies	Dan, J'nelle	Special Needs
2/6/18	Webinar	IHANS Certification Training	J'nelle	Training
2/13/18	Meeting	Regional Public health Coordinators Meeting	Dan	Training
2/13/18 thru 2/15	In-Person	ICS 300 Training	J'nelle, Pat	Training
2/15	In-Person	Health Emergency Preparedness Coalition Meeting (mandatory)	Dan	Training
2/21	Webinar	MCM ClinOps about April 3 rd Exercise	J'nelle	
2/21	In person	Tabletop exercise @ Glens Falls Hospital	J'nelle	Drill
2/21	Conference Call	ServNY Monthly Volunteer Registry Call	Dan	
3/6/18	Inservice	CDMS training for all Public Health Staff	Dan, J'nelle (PH Staff)	Training
3/6/18	Meeting	April 3 rd Exercise Overview w/ Acting Commissioner of Social Services	Dan, J'nelle	
3/7/18		Completed and submitted EPR annual	Dan	
3/13/18	Meeting	Regional Public health Coordinators Meeting	Dan, J'nelle	
3/21/18	In-Person	Tabletop exercise @ Glens Falls Hospital	Dan, J'nelle	Drill
3/21/18	Conference Call	ServNY Monthly Volunteer Registry Call	Dan	
3/21/18	Webinar	CDMS Refresher ClinOps	J'nelle	
3/29/18	Education	CDMS Refresher Training with PH Staff	Dan, J'nelle	Training

Warren County Public Health Rabies Program

Based on 2017 Animal Bite Reports

Town	Different Address Owner/Victim <small>*Follow-up by WCPH ACO</small>		Same Address Owner/Victim <small>*Follow up by Public Health</small>		Out of Town Owner <small>*Follow Up by Public Health</small>		Strays Follow Up by Public Health <ul style="list-style-type: none"> • Vet's Office • Victim Watching • Victim Treated Rabies PEP • Euthanized Animal needs to be captured and taken to Animal Hospital. Public Health to check after confinement					
	Cats	Dogs	Cats	Dogs	Cats	Dogs	Vet	Victim Watched	Treated with PEP	Refused PEP	Euthanized	ACO Capture
Bolton		1	1	1								
Chester	1	6	1	4				1c				
Glens Falls	4	25	12	21		4	2c		2c, 1d	2d		
Hague		2		1								
Horicon		1		2		1	1c					
Johnsburg	1	4	3	1		1						
Lake George	1	6	2	5		3	1c		1c	1d		
Lake Luzerne		5	3	7	1	2	1c					
Queensbury	2	34	11	35	2	6	1c	1c	1c, 1d	2d	1c	1c, 1d
Stony Creek		4										
Thurman		1	1	1								
Warrensburg	1	4	2	10		1						
Totals	10	93	36	88	3	18	6	3	7	6	1	2

Total Bites for cats and dogs occurring in 2017 in Warren County were 273.

Attachment #6

Warren County Request to Host Meeting or Conference

Name of Department: Health Services- Division of Public Health

Name of Meeting/Conference: Keeping the Opioid Gateway Closed

Date: March 13, 2018

Location: Glens Falls Hospital Auditorium A&B

Purpose: 1. To increase awareness of how opioid use for acute pain may lead to addiction
2. To educate attendees on alternative therapies for pain, instead of opiates

Contact Person: (If other than Department Head) Ginelle Jones, Assistant Director

Phone No.: 518-761-6580

Number of People attending:

4 County Employees

0 State Employees

0 Volunteers

40 Others (specify) Providers, GFH Snuggery, OBGYNs, Physical Therapists, Dentists, Council of Prevention, NAS Committee, nurses, and speaker panel

Cost to County (please include amounts): * Fully Funded by AHI Grant

Room rental \$ 0

Food/beverage \$ 350- Catered by The Tavern / \$7.95/head

Supplies \$ 30

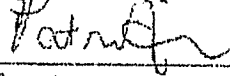
Other (specify) \$ 33

Total Cost: \$ 413

Staff time- Preparation-

Public Health Nurse (\$27.70 /hr) and Sr. Account Clerk (\$17.67/hr)

Dept Head Approval:


Signature

3/14/18
Date:

Committee Chairman Approval:


Signature

3/14/18
Date



We're Searching for Volunteers

**Warren County Public Health is looking for
Volunteers for a mock exercise!**

When: April 3rd, 9:30AM – 11:30AM

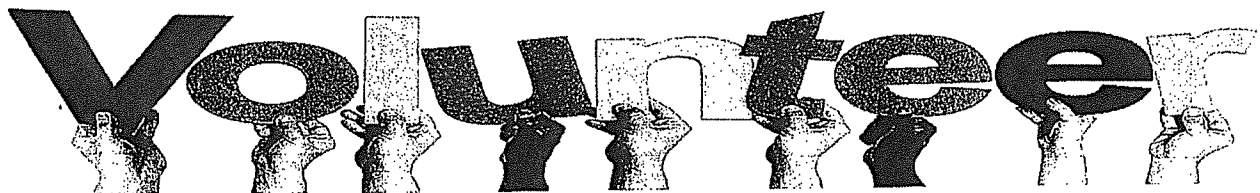
**Where: Warren County Human Services Building –
1340 U.S. 9, Lake George**

What: A mock vaccination exercise to test the counties throughput capabilities in case of a real emergency!

****Please Note, participation in this exercise is all simulated, there will be no vaccination or medication given.**

All Participants will be entered into our drawing for a starter emergency preparedness bag (2 winners will be drawn!)

For more information or to participate, please contact Dan Durkee or J'nelle Oxford at Warren County Public Health – 518-761-6580



RESOLUTION REQUEST FORM NO. 4

Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: 03/19/2018

- (a) Purpose of Contract Change: To amend the contract with CDPHP (Capital District Physicians Health Plan) to allow the incorporation of the Standard Clause Amendment and to authorize language that allows for further Standard Clause Amendments to be incorporated into the contact without need for further Board of Supervisor approval in a form approved by the County Attorney
- (b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: on file
- (c) Name of Contractor: Capital District Physicians Health Plan, Inc.
- (d) Address of Contractor: 500 Patroon Creek Blvd., Albany, NY 12206
- (e) Contractor's Contact Person and Telephone Number: Brooke Klingbeil, 518-641-3887, fax: 518-641-3505, email: Brooke.klinbeil@cdphb.com
- (f) Commencement Date of Amendment: 03/19/2018
- (g) Termination Date of Extension: per terms of current agreement
- (h) Payment Provisions: per terms of current agreement
 - i) lump sum amount
 - ii) hourly rate amount
 - iii) total amount not to exceed
 - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount OR Capital Project OR Capital Reserve Project Number and Title and Amount:
Not applicable



500 Patroon Creek Blvd.
Albany, NY 12206-1057

Fax:

Phone:

FACSIMILE TRANSMITTAL

January 09, 2018

TO::	FW: Standard Clause Amendment
FAX NUMBER:	5187616562
FROM:	Klingbeil, Brooke
TOTAL PAGES:	16

From: Klingbeil, Brooke
Sent: Tuesday, January 09, 2018 11:12 AM
To: 5187616562@fax.cdphp.com
Subject: Standard Clause Amendment

Hi Valerie,

Here is the Standard Clause Amendment that we need signed and sent back. Please fax it back to 518-641-4010 when completed.

Thank you,
Brooke Klingbeil
Provider Relations Specialist
Capital District Physicians' Health Plan, Inc.
500 Patroon Creek Blvd | Albany, NY 12206
Telephone: (518) 641-3887
Fax: (518) 641-3505
Email: Brooke.Klingbeil@cdphp.com<mailto:Brooke.Klingbeil@cdphp.com>

?Please consider the environment before printing this e-mail.

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500 Patroon Creek Blvd.
Albany, NY 12206-1057
www.cdphp.com

September 20, 2017

Warren Co Health Services Dept
Frederick Monroe, Chairman, Board of Supervisors
1340 State Route 9
Lake George, NY 12845

Dear Provider:

As you may be aware, the New York State Department of Health (DOH) recently issued a new version of the *Standard Clauses for Managed Care Provider/IPA/ACO Contracts*, which is included as an attachment to your current agreement. DOH has directed all health maintenance organizations, including CDPHP®, to amend all contracts with participating providers to include the April 1, 2017 version of that attachment. DOH permits no variation from its terms. Consequently, CDPHP is unable to accept any changes to the Standard Clauses. The Standard Clauses can be found online at:

http://www.health.ny.gov/health_care/managed_care/hmoipa/docs/standard_clauses_revisions.pdf

The only substantive changes to the Standard Clauses are: (1) the deletion of references to Family Health Plus; and (2) Section B.8 has been updated to include references to additional New York managed care laws.

Please review and sign the enclosed amendment. This amendment includes: (1) the revised version of the Standard Clauses; (2) DOH-required language regarding the incorporation of the Standard Clauses into the Agreement; and (3) language to specify that signatures are no longer required for regulatory amendments going forward.

Please return the following by October 20, 2017:

- Signed amendments in their entirety

Documents can be sent via fax to (518) 641-4010 or by mail to 500 Patroon Creek Blvd., Albany, NY 12206, Attn: Healthcare Network Strategy. If you have any questions regarding this mailing, please contact the Healthcare Network Strategy Department at (518) 641-4290.

Sincerely,

A handwritten signature in black ink that reads "Denise Corcoran". The signature is written in a cursive style with a long horizontal flourish at the end.

Denise Corcoran
Senior Vice President, Healthcare Network Strategy
CDPHP®

Enclosures (2)

Capital District Physicians' Health Plan, Inc.
Capital District Physicians' Healthcare Network, Inc.
CDPHP Universal Benefits, Inc.

AMENDMENT

to

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.
CDPHP ANCILLARY PROVIDER AGREEMENT

This amendment (hereinafter "Amendment") is made and entered into by and between CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC., a not-for-profit corporation duly organized and existing under the laws of the State of New York and certified under Article 44 of the Public Health Law of the State of New York having as a principal office for the transaction of business 500 Patroon Creek Boulevard, Albany, New York 12206-1057 and its Affiliates (collectively, "CDPHP"), and Warren Co Health Services Dept (hereinafter "Provider").

WHEREAS, CDPHP and Provider have previously entered into a CDPHP Ancillary Provider Agreement which is currently in effect (the "Agreement"); and

WHEREAS, pursuant to the revised New York State Department of Health Provider Contract Guidelines for Article 44 MCOs, IPAs and ACOs effective April 1, 2017, health maintenance organizations are required to amend all participating provider agreements to include the revised New York State Department of Health Standard Clauses for Managed Care Provider/IPA/ACO Contracts, without modification.

NOW, THEREFORE, in consideration of the premises set forth herein and other good and valuable consideration the receipt and adequacy of which is hereby acknowledged by the parties, the parties agree as follows:

FIRST: The parties agree to the following:

1. Schedule D (New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts) to the Agreement shall be deleted and replaced with a new Schedule D, attached hereto.
2. Section 2.1 of Article II of the Agreement shall be deleted in its entirety and replaced with the following:

The "New York State Department of Health Standard Clauses for Managed Care Provider/IPA/ACO Contracts", attached to the Agreement as Schedule D are expressly incorporated into this Agreement and are binding upon the Article 44 plans and providers that contract with such plans, and who are a party to this Agreement. In the event of any inconsistent or contrary language between the Standard Clauses and any other part of the Agreement, including but not limited to appendices, amendments, and exhibits, the parties agree that the provisions of the Standard Clauses shall prevail, except to the extent applicable law requires otherwise and/or to the extent a provision of the Agreement exceeds the minimum requirements of the Standard Clauses.

3. Section 8.3 of Article VIII of the Agreement shall be deleted in its entirety and replaced with the following:

Amendments. Amendments to this Agreement shall be of no force or effect unless in writing and signed by the respective parties hereto, with the following exceptions: (1) any amendment to this Agreement required by state or federal legislative, regulatory or other legal authority, as reasonably determined by

CDPHP, shall be effective and deemed a part of this Agreement thirty (30) days after Provider receives written notice thereof from CDPHP via mail, email and/or a posting on CDPHP's website; and (2) CDPHP shall notify Provider in writing of any proposed amendment to the CDPHP Affiliates Schedule to add a new Affiliate. Any amendment to add a new Affiliate shall become effective thirty (30) days after Provider receives written thereof from CDPHP via mail, email and/or a posting on CDPHP's website, unless Provider provides written notice of termination of this Agreement within such thirty (30) day period. Notwithstanding the provisions of Article VI of this Agreement, termination in accordance with this Section G shall become effective ninety (90) days after the date of receipt of the notice of termination. Any material amendments to this Agreement, including changes in risk-sharing, shall require the prior approval of and be submitted to the Commissioner at least thirty (30) days in advance of their anticipated execution, pursuant to Title 10 *New York Codes, Rules and Regulations* § 98-1.8(b).

SECOND: In the event of any conflict between the terms and provisions of this Amendment and those of the Agreement, the terms and provisions of this Amendment shall control and supersede, and shall take priority over, those of the Agreement, but only to the extent of any such conflict.

THIRD: Except as specifically modified by this Amendment, the Agreement shall remain unchanged and in full force and effect.

FOURTH: Provider's Authority to Contract: By my signature on this Amendment on behalf of the Provider listed below, I represent and warrant that I have the authority of the shareholders/partners/members of said entity to sign on their behalf, and agree to indemnify and hold harmless CDPHP from any claim that such authority did not exist.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Agreed:

WARREN CO HEALTH SERVICES
DEPT

CAPITAL DISTRICT PHYSICIANS'
HEALTH PLAN, INC.

Signature

Denise Corcoran
Senior Vice President,
Healthcare Network Strategy

Print Name / Title

Date

Date

SCHEDULE D
to
CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.
CDPHP ANCILLARY PROVIDER AGREEMENT

NEW YORK STATE DEPARTMENT OF HEALTH STANDARD CLAUSES
FOR MANAGED CARE PROVIDER/IPA/ACO CONTRACTS

April 1, 2017

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement " or "this Agreement ") the Article 44 plans and providers that contract with such plans, and who are a party agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, such clauses must be included in IPA/ACO contracts with Providers, and Providers must agree to such clauses

A. Definitions For Purposes Of This Appendix

"Managed Care Organization" or "MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer a comprehensive health services plan, or a health and long term care services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of contracting for the delivery or provision of health services by individuals, entities and facilities licensed and/or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment. Under these arrangements, such health care Providers and suppliers will provide their service in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of Health Care Services which are licensed, registered and/or certified as required by applicable federal and state law.

B. General Terms And Conditions

1. This agreement is subject to the approval of the New York State Department of Health (DOH) and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by DOH for approval or, alternatively, to terminate this Agreement if so directed by DOH, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403 (6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.
2. Any material amendment to this Agreement is subject to the prior approval of DOH, and any such amendment shall be submitted for approval in accordance with the appropriate procedures and timelines described in Sections III and VII of the New York State Department of Health Provider Contract Guidelines for MCOs and IPA/ACOs. To the extent the MCO provides and arranges for the provision of

comprehensive Health Care Services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH, as may be required by the Medicaid Managed care contract between the MCO and DOH.

3. Assignment of an agreement between an MCO and (1) an IPA/ACO, (2) an institutional network Provider, or (3) a medical group Provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA/ACO and (1) an institutional Provider or (2) a medical group Provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.
4. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA/ACO's Providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, contract, or DOH or DFS guidelines or policies and (b) has provided to the Provider at least thirty days in advance of implementation, including but not limited to: quality improvement/management; utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data; member grievances; and Provider credentialing.
5. The Provider or, if the Agreement is between the MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees, and shall require its Providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition
6. If the Provider is a primary care practitioner, the Provider agrees to provide twenty-four (24) hour coverage and back-up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.
7. The MCO or IPA/ACO that is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA/ACO's own acts or omissions, by indemnification or otherwise, to a Provider
8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007, Chapter 237 of the Laws of 2009, Chapter 297 of the Laws of 2012, Chapter 199 of the Laws of 2014, Part H, Chapter 60, of the Laws of 2014 and Chapter 6 of the Laws of 2015 with all amendments thereto
9. To the extent the MCO enrolls individuals covered by the Medical Assistance Program, this Agreement incorporates the pertinent MCO obligations under the Medicaid Managed Care contract between the MCO and DOH as set forth fully herein, including:
 - a. The MCO will monitor the performance of the Provider or IPA/ACO under the Agreement and will terminate the Agreement and/or impose other sanctions if the Provider's or IPA/ACO's performance does not satisfy the standards set forth in the Medicaid Managed Care contract.
 - b. The Provider or IPA/ACO agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA/ACO's performance.

- c. The Provider or IPA/ACO agrees to be bound by the confidentiality requirements set forth in the Medicaid Managed Care contract between the MCO and DOH.
- d. The MCO and the Provider or IPA/ACO agree that a woman's enrollment in the MCO's Medicaid Managed Care product is sufficient to provide services to her newborn, unless the newborn is excluded from the enrollment in Medicaid Managed Care or the MCO does not offer a Medicaid Managed Care product in the mother's county of fiscal responsibility.
- e. The MCO shall not impose obligations and duties on the Provider or IPA/ACO that are inconsistent with the Medicaid Managed Care contract or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.
- f. The Provider or IPA/ACO agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.
- g. The Provider or IPA/ACO agrees, pursuant to 31 U.S.C. §1352 and CFR Part 93, that no federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA/ACO for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of any Member of Congress in connection with the award of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. The Provider or IPA/ACO agrees to complete and submit the "Certification Regarding Lobbying," Appendix attached hereto and incorporated herein, if this Agreement exceeds \$100,000. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any federal contract, the asking of any federal grant, the making of any federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement, and the Agreement exceeds \$100,000 the Provider or IPA/ACO shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.
- h. The Provider or IPA/ACO agrees to disclose to the MCO, on an ongoing basis, any managing employee who has been convicted of a misdemeanor or felony in relation to the employee's involvement in any program under Medicare, Medicaid or a Title XX services program (block grant programs).
- i. The Provider or IPA/ACO agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES).
- j. The Provider or IPA/ACO agrees to disclose to the MCO complete ownership, control, and relationship information.
- k. The Provider or IPA/ACO agrees to obtain for the MCO ownership information from any subcontractor with whom the Provider has had a business transaction totaling more than \$25,000 during the 12-month period ending on the date of the request made by DOH, Office of the Medicaid Inspector General (OMIG) or the United States Department of Health and Human Services (DHHS). The information requested shall be provided to the MCO within 35 days of such request.
- l. The Provider or IPA/ACO agrees to have an officer, director or partner of the Provider execute and deliver to DOH a certification, using a form provided by DOH through OMIG's website, within five (5) days of executing this agreement, stating that:
 - o The Provider or IPA/ACO is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred

- or prescribed by the Provider. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.
- All claims submitted for payment by the Provider/IPA/ACO are for care, services or medical supplies that have been provided.
 - Payment requests are submitted in accordance with applicable law.
- m. The Provider or IPA/ACO agrees to require that an officer, director or partner of all subcontractors if they are not natural persons, or the subcontractor itself if it is a natural person, execute a certification, using a form provided by DOH through OMIG's website, before the subcontractor requests payment under the subcontract, acknowledging that:
- The subcontractor is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the subcontractor. This includes 18NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.
 - All claims submitted for payment by the subcontractor are for care, services or medical supplies that have been provided.
 - Payment requests are submitted in accordance with applicable law.
10. The parties to this Agreement agree to comply with all applicable requirements of the federal Americans with Disabilities Act.
11. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA's Providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act, the HIV confidentiality requirements of Article 27-F of the Public Health Law, and Mental Hygiene Law §33.13.
12. Compliance Program. The Provider agrees that if it claims, orders, or is paid \$500,000 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any MCO under the Medicaid Managed Care Program, that it shall adopt and implement a compliance program which meets the requirements of New York State Social Services Law § 363-d(2) and 18 NYCRR § 521.3.
13. Compliance Program Certification. The Provider agrees that if it is subject to the requirements of Section B (12) of this Appendix, it shall certify to DOH, using a form provided by OMIG on its website, within 30 days of entering into a Provider Agreement with the MCO, if they have not so certified within the past year that a compliance program meeting the requirements of 18 NYCRR §521.3 and Social Services Law § 363-d(2) is in place. The Provider shall recertify during the month of December each year thereafter using a form provided by OMIG on OMIG's website

C. Payment; Risk Arrangements

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA/ACO, insolvency of the MCO or IPA/ACO, or breach of this Agreement, shall Provider bill; charge; collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA/ACO) acting on

his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, Provider will not bill DOH or the City of New York for covered services within the Medicaid Managed Care benefit package as set forth in the Agreement between the MCO and DOH. This provision shall not prohibit the Provider, unless the MCO is a Managed Long Term Care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person, provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the Provider. However, with respect to enrollees eligible for medical assistance or participating in Child Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.
3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA/ACO must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law §4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology, or payment policy indexing scheme.
4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210 into any contracts between the contracting entity (Provider, IPA/ACO, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.
5. The parties agree that, where required by Public Health Law §4903, a claim for certain continued, extended, or additional health care services cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided within the required timeframes and under the circumstances described in Public Health Law §4903.
6. The parties agree to follow Section 3224-a of the Insurance Law providing timeframes for the submission and payment of Provider claims to the MCO.

7. The parties agree to follow Section 3224-b(a) of the Insurance Law requiring an MCO to accept and initiate the processing of all claims submitted by physicians that conform to the American Medical Association's Current Procedural Technology (CPT) codes, reporting guidelines and conventions, or to the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (HCPCS).
8. The parties agree to follow Section 3224-b(b) of the Insurance Law prohibiting an MCO from initiating overpayment recovery efforts more than 24 months after the original payment was received by a health care Provider, except where: (1) the plan makes overpayment recovery efforts that are based on a reasonable belief of fraud or other intentional misconduct or abusive billing; (2) for the Medicaid Managed Care and Family Health Plus programs, the overpayment recovery period for such programs is six years from date payment was received by the health care Provider with written notice 30 days prior to engaging in overpayment recovery efforts. Such notice must state the patient's name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.
9. The parties agree to follow Section 3224-c of the Insurance Law providing that claims cannot be denied solely on the basis that the MCO has not received from the member information concerning other insurance coverage.
10. The parties agree that this contract does not waive, limit, disclaim, or in any way diminish the rights that any Provider may have pursuant to Section 3238 of the Insurance Law to the receipt of claims payment for services where preauthorization was required and received from the appropriate person or entity prior to the rendering of the service.
11. The parties agree that for a contract involving Tier 2 or 3 arrangements as described in Section VII.B of the Guidelines, the contract must:
 - a. Provide for the MCO's ongoing monitoring of Provider financial capacity and/or periodic Provider financial reporting to the MCO to support the transfer of risk to the Provider; and
 - b. Include a provision to address circumstance where the Provider's financial condition indicates an inability to continue accepting such risk; and
 - c. Address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting underfunding of the deposit to be maintained by the MCO; and
 - d. Include a provision that the Provider will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH.
12. The parties agree that for any contract involving an MCO and IPA/ACO, the contract must include provisions whereby:
 - a. The parties expressly agree to amend or terminate the contract at the direction of DOH (applies to Tier 1, Tier 2, and Tier 3);
 - b. The IPA/ACO will submit annual financial statements to the MCO, as well as any additional documents required by the MCO as necessary to assess the IPA/ACO's progress towards achieving value based payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO (applies to Tier 2 and Tier 3); and
 - c. IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH (applies to Tier 2 and Tier 3); and
 - d. The parties agree that all Provider contracts will contain provision prohibiting Providers, in the event of a default by the IPA/ACO, from demanding payment from the MCO for any covered services rendered to the MCO's enrollees for which payment was made by the MCO to the IPA/ACO pursuant to the risk agreement (applies to Tier 2 and Tier 3).

D. Records; Access

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA/ACO if applicable) for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee's medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA/ACO if applicable) expressly acknowledges that the Provider shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.
2. When such records pertain to Medicaid reimbursable services, the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.
3. The parties agree that medical records shall be retained for a period of six years after the date of service, and in the case of a minor, for three years after majority or six years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.
4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time of service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA/ACO or to third parties. If the Agreement is between an MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees to require the Providers with which it contracts to agree as provided above. If the Agreement is between an IPA/ACO and a Provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

E. Termination and Transition

1. Termination or non-renewal of an agreement between an MCO and an IPA/ACO, institutional network Provider, or medical group Provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA/ACO and an institutional Provider or medical group Provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination by the MCO may be effected on less than 45 days' notice provided the MCO demonstrates to the satisfaction of DOH, prior to termination, that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days' notice of its decision to not renew this Agreement.
3. If this Agreement is between an MCO and an IPA/ACO, and the Agreement does not provide for automatic assignment of the IPA/ACO's Provider contracts to the MCO upon termination of the MCO/IPA/ACO contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA/ACO's Providers agree, that the IPA/ACO Providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever occurs first. This provision shall survive termination of this Agreement regardless of the reason for the termination.
4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA/ACO insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract or Medicaid Managed Care contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. For purposes of this clause, the term "Provider" shall include the IPA/ACO and the IPA/ACO's contracted Providers if this Agreement is between the MCO and an IPA/ACO. This provision shall survive termination of this Agreement.
5. Notwithstanding any other provision herein, to the extent that the Provider is providing Health Care Services to enrollees under the Medicaid Program, the MCO or IPA/ACO retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.
6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA/ACO agrees to require all participating Providers of its network to assist in the orderly transfer of enrollees to another Provider.

F. Arbitration

1. To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation and copies of all decisions.

G. IPA-Specific Provisions

1. Any reference to IPA/ACO Quality Assurance (QA) activities within this Agreement is limited to the IPA/ACO's analysis of utilization patterns and quality of care on its own behalf and as a service to its contractual Providers.

RESOLUTION REQUEST FORM NO. 3

Request for New Contract

DEPARTMENT NAME: Health Services

DATE: 03/19/2018

- (a) Is this a Result of a Bid or Request for Proposal? No
- (b) Purpose of Contract: To authorize a contract with VNA Homecare Options, LLC to allow for reimbursement of services provided to individuals enrolled in Medicare advantage insurance plan in a form approved by the County Attorney
- (c) Name of Contractor: VNA Homecare Options, LLC
- (d) Address of Contractor: 1050 W. Genesee Street, Syracuse, NY 13204
- (e) Contractor's Contact Person and Telephone Number: Mary Kate Rolf, President/CEO 315-477-4663
- (f) Has or will the Contract be provided, if so, please attach: Yes
- (g) Commencement Date of Contract: per terms of agreement
- (h) Termination Date of Contract: per terms of agreement
- (i) Payment Provisions: per terms of contract agreement
- i) lump sum amount -
 - ii) hourly rate amount
 - iii) total amount not to exceed
 - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (j) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount: OR Capital Project OR Capital Reserve Project
Number, and Title, and Amount:
A4010.1610 Health Services Revenue

VNA HOMECARE OPTIONS, LLC
PROVIDER AGREEMENT

THIS AGREEMENT (“Agreement”) made the 1st day of January 2018 (“Effective Date”) by and between VNA Homecare Options, LLC, 1050 W. Genesee Street, Syracuse, NY (hereinafter “Plan”) and County of Warren dba Warren County Health Services, 1340 State Route 9, Lake George, NY 12845 (hereinafter “Provider”).

WHEREAS, Plan is a New York State limited liability company; and

WHEREAS, Plan is authorized by New York State Department of Health (“DOH”) to operate a Managed Long Term Care Plan to eligible participants (“MLTC Plan”); and

WHEREAS, Plan has been approved, or is anticipated to be approved, by the Centers for Medicare and Medicaid Services (“CMS”) to participate in a Medicare Advantage Plan (the “MA Program”); and

WHEREAS, Plan has entered or will enter into agreements with CMS and DOH (“Program Contracts”) to operate an MLTC Plan and MA Program, as applicable; and

WHEREAS, pursuant to said Program Contracts, Plan is obligated to provide, either directly or through subcontracts, certain medical and health related services; and

WHEREAS, Provider wishes to provide the Covered Services described herein to Plan Enrollees pursuant to the terms and conditions of this Agreement, Plan’s Provider Handbook, and in accordance with the Program Contracts.

NOW, THEREFORE, the parties hereto agree as follows:

1. **Definitions.** As used in this Agreement, the following terms shall have the indicated meanings:

“Clean Claim” shall mean a claim for Covered Services, submitted in a format designated by Plan or mutually agreed upon between the parties that contain all the data elements required by applicable law and, to the extent appropriate by Plan to process and adjudicate the claim.

“Enrollee” shall mean an individual covered by a Member Agreement with Plan and who is thereby entitled to receive the Covered Services which Plan provides under a Program.

“Covered Services” shall mean the medical and health related services and social and environmental supports to which an Enrollee is entitled under the applicable Program, including all attachments thereto.

“Governmental Authority” means the United States of America, the States, or any department or agency thereof having jurisdiction over Plan, a Provider or their respective Affiliates, employees, subcontractors or agents, including but not limited to CMS and DOH.

(Initial) VNAHCO _____

(Initial) Provider _____

VNA HOMECARE OPTIONS, LLC
PROVIDER AGREEMENT

"Ineligible Person" means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non-procurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in any state medical assistance programs, including New York State Medicaid or CHIP, or state procurement or non-procurement programs.

"Medically Necessary" or **"Medical Necessity"** shall mean those Covered Services that are determined by a Physician to be essential to the health of an Enrollee in accordance with professional standards accepted in the medical community. The Medical Director shall make the final determination of whether a service is Medically Necessary, subject to Plan's grievance procedures and compliance with the applicable Program Contract.

"Member Agreement" shall mean the executed agreement between Plan and the applicable Enrollee for the provision of Covered Services.

"Personnel" shall mean physicians, nurses, or other professionals registered, licensed, or certified under Title VIII of the New York State Education Law, and any other individuals who are employees or independent contractors of Provider providing Covered Services pursuant to this Agreement.

"Plan Provider" shall mean a licensed or certified health care professional, professional organization or institution that contracts with Plan to provide Covered Services to Enrollees.

"Plan's Provider Handbook" shall mean the description, entitled "Provider Manual" and prepared by Plan, of certain requirements, policies and procedures of Plan generally applicable to all Plan Providers and which supplements, is made part of and incorporated into this Agreement in its entirety.

"Program" shall mean those federal, state or other programs under which Plan arranges to provide prepaid health services to Enrollees on a contractual basis and in accordance with New York State, Medicare, and Medicaid rules and regulations, if applicable.

"Program Contracts" shall mean the contracts entered into by and between Plan DOH and/or CMS under which the Plan agrees to provide prepaid health services to Enrollees in accordance with the rules and regulations set forth therein. Program Contracts may be amended by the Plan from time to time to add or delete Programs. Program Contracts shall include the contract itself and all attachments, exhibits, schedules or appendices to such contract, as they may be

(Initial) VNAHCO _____

(Initial) Provider _____

VNA HOMECARE OPTIONS, LLC
PROVIDER AGREEMENT

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amended from time to time, and the Program Contracts are hereby incorporated by reference in their entirety as if specifically and fully set forth herein.

2. Term and Termination.

2.1 *Initial Term.* The initial term of this Agreement shall be for one (1) year commencing on the date first above written (“Initial Term”) unless earlier terminated as set forth below.

2.2 *Renewal Terms.* This Agreement shall be automatically renewed for additional one (1) year terms on or before the anniversary of the Effective Date of this Agreement, (each a “Renewal Term”) unless either party gives to the other prior written notice of its intent not to renew at least sixty (60) days before the end of the Initial or any subsequent Renewal Term.

2.3 *Termination for Cause.* A party may terminate this Agreement for material breach by the other party of any of the terms or provisions of this Agreement by providing the other party at least sixty (60) days prior notice specifying the nature of the material breach. During the first thirty (30) days of the notice period, the breaching party may cure the breach to the reasonable satisfaction of the non-breaching party.

2.4 *Immediate Termination.* Plan may terminate this Agreement upon the occurrence of any of the following: (a) Plan is notified of a situation in which Provider may cause imminent harm to an Enrollee or has caused harm to an Enrollee; (b) there has been a determination that Provider has committed fraud or abusive billing; or (c) there has been a determination by a Governmental Authority that impairs Provider’s ability to render services.

2.5 *Transition of Care.* To ensure that a transition is undertaken in an orderly manner that maximizes Enrollee safety and continuity of care, upon expiration or termination of this Agreement for any reason except for immediate termination, Provider shall continue providing Covered Services to Enrollees and cooperate with Plan for the transition of Enrollees to other Plan Providers. The terms and conditions of this Agreement shall apply to any such post termination activities. The transition of care provisions in this Agreement shall survive expiration or termination of this Agreement.

2.6 *Notification to Members.* Upon expiration or termination of this Agreement, Plan will communicate such expiration or termination to Enrollees as required by and in accordance with federal and state law and Program requirements. Provider shall obtain Plan’s prior written approval of Provider communications to Enrollees regarding the termination of this Agreement.

3. Scope of Services.

3.1 *Covered Services.* Provider agrees to make available to Plan Enrollees those Covered Services as set forth on Appendix A, attached hereto. Any services or other activities

(Initial) VNAHCO _____

(Initial) Provider _____

VNA HOMECARE OPTIONS, LLC
PROVIDER AGREEMENT

performed by Provider in accordance with the terms of this Agreement will be consistent and will comply with the Plan’s contractual obligations under the Program Contracts.

3.2 *Location of Services.* This Agreement applies to Covered Services provided at Provider’s service locations as set forth on Appendix A.

3.3 *Additional Locations.* In the event Provider begins providing services at other service locations, or under other Taxpayer Identification Number(s), those additional Taxpayer Identification Numbers, or locations will become subject to this Agreement only upon the written agreement of the parties. This applies to cases when Provider adds the location itself (such as through new construction or through conversion of a free-standing location to provider-based), and when Provider acquires, merges or comes under common ownership with an existing provider that was not already under contract with Plan.

3.4 *Merger or Acquisition of Provider.* In the event Provider acquires or is acquired by, merges with, or otherwise becomes affiliated with another provider of health care services that is already under contract with Plan to participate in the MLTC Plan and/or MA Program, the payment rates for each of Provider’s locations specified in this Agreement and the payment rates for the other provider will be (a) the rates set forth in the other agreement, or (b) the rates set forth on Appendix A to this Agreement, as decided by Plan with written notice to Provider.

3.5 *No Assignment or Transfer.* Provider will not transfer all or some of its assets to any other entity during the term of this Agreement, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Provider, without the express written agreement of Plan. This shall also apply to arrangements under which another provider leases space or employees from Provider after the Effective Date of this Agreement, so that Covered Services that were subject to this Agreement as of the Effective Date of this Agreement are rendered instead by another provider after the lease takes place.

3.6 *Health Care Services.* This Agreement shall not dictate the quality of the health care services provided by Provider, or govern Provider’s determination of what care to provide its patients, even if those patients are Enrollees of the Plan. The decision regarding what care is to be provided remains with Provider and their patients and physicians, and not with Plan or any payor.

4. **Compensation and Billing.**

4.1 *Compensation.* In consideration of the Covered Services to be rendered by Provider hereunder, Plan agrees to make payment to Provider in accordance with Plan’s Provider Handbook, and Appendix A, attached hereto and incorporated by reference.

4.2 *Billing and Payment.* Plan shall pay all Clean Claims which it deems complete and accurate in accordance with the payment policies and procedures set forth in Plan’s

(Initial) VNAHCO _____

(Initial) Provider _____

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Provider Handbook. Clean Claims will be paid within forty-five (45) days (thirty (30) days for electronic claims) of receipt of such claim, unless a shorter timeframe is required under applicable law. Submissions for claims for services rendered should be made no later than ninety (90) days from the date of service or ninety days (90) from receipt of Primary Payor Explanation of Payment (“EOP”). Provider agrees to accept Plan’s payment, together with any co-payment, deductible or coinsurance for which Enrollee is responsible as payment in full for the Covered Services rendered.

4.3 *Claims Submission and Review.* In addition to the policies and procedures set forth in the Plan’s Provider Handbook, the following shall apply to the submission and review of claims:

a. Provider shall submit all claim forms and bills for services rendered pursuant to this Agreement directly to Plan as set forth in Plan’s Provider Handbook. In no event shall Provider issue claims or bills to Enrollees for services provided hereunder. In the event that the claim forms or bills are not complete and accurate, Plan shall so notify Provider within thirty (30) days of Plan’s receipt of such claim, setting forth the reasons for Plan’s inability to process and pay the claim as submitted and requesting any information necessary to process the claim, if applicable. Claims shall be submitted on such forms and in such manner determined by Plan. Plan may, from time to time, modify claim submission forms and/or processes on no less than thirty (30) days written notice to Provider.

b. Claims for non-emergency Covered Services for which there is no record of authorization or referral will be denied. Provider may submit a copy of authorization or referral within sixty (60) days of the notice of denial for payment reconsideration.

c. If Provider does not seek correction of a given claim payment or denial by giving notice to Plan within twelve (12) months after the claim was initially processed, it will have waived any right to subsequently seek such correction.

4.4 *Overpayments.* Provider shall repay overpayments within sixty (60) days of written or electronic notice of the overpayment. Provider will promptly report any credit balance that it maintains with regard to any claim overpayment under this Agreement, and will return the overpayment to Plan within sixty (60) days after posting it as a credit balance. Recovery of overpayments may be accomplished by offsets against future payments.

4.5 *Enrollee Eligibility.* Plan will provide Enrollees with identification cards indicating their enrollment in the MLTC Plan or MA Program. Enrollees shall present their identification cards when seeking Covered Services from Provider. Plan shall furnish Provider with access to Enrollee eligibility information through electronic or other means. Should CMS retroactively disenroll an individual, Plan shall not be responsible for payments to Provider and shall be permitted to recover payments made to Provider for services rendered on or after the date of an individual’s ineligibility. Provider may obtain payment directly from such individuals or other

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responsible third party for services provided on or after the date on which the individual became ineligible, but shall not seek any recovery from Plan.

4.6 *Hold Harmless.* Provider hereby agrees that in no event including, but not limited to, nonpayment by Plan, Plan's determination that services were not Medically Necessary, Plan's insolvency, or Plan's breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Enrollee, or persons other than Plan acting on any Enrollee's behalf, for amounts that are the legal obligation of Plan. The parties agree that this provision: (a) shall be construed for the benefit of Enrollees; (b) does not prohibit collection of permitted Enrollee cost-sharing amounts; and (c) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and Enrollees or persons acting on their behalf.

4.7 *Coordination of Benefits.* Provider will cooperate with Plan in the coordination of benefits between Plan and third party payers where applicable to any Enrollee. Provider shall maintain, and shall require Personnel to maintain, adequate records reflecting collection of any coordination of benefits proceeds by Provider or Personnel regarding Enrollees, and the amounts thereof. Provider will make records regarding collections of coordination of benefits proceeds available to Plan and any appropriate federal, state, county, or city regulatory agency, and shall, upon request, provide copies of said records to any appropriate federal, state, county, or city regulatory agency without charge. This section shall survive the termination of this Agreement.

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4.8 *Communication with Patients.* Nothing in this Agreement is intended to limit Provider's right or ability to communicate fully with a patient (or client as the case may be) or patient's physician regarding the patient's health condition and treatment options. Provider is free to discuss all treatment options without regard to whether or not a given option is a Covered Service.

5. Representations and Responsibilities of Provider.

Provider, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

5.1 *Corporate Authority and Structure.*

a. Provider is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

b. Provider has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Provider have been duly and validly authorized by all action necessary under its organizational documents and applicable

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corporate law. This Agreement has been duly and validly executed and delivered by Provider and (assuming the due authorization, execution and delivery of this Agreement by Plan) constitutes a valid and binding obligation of Provider, enforceable against Provider in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

c. Provider represents and warrants that it has the authority to enter this Agreement on behalf of itself, and to the extent that Provider is a health care facility or professional entity, on behalf of health care professionals who render services on behalf of Provider during the term of this Agreement. Provider shall list all such health care professionals Appendix B and incorporated herein, and promptly notify Plan of any deletions or additions to that list so that it remains current at all times during the term of this Agreement. Accordingly, all references to Provider in this Agreement shall include all such health care professionals who shall be, and Provider shall ensure is, bound by the terms of this Agreement

d. The execution, delivery and performance of this Agreement by Provider do not and will not violate or conflict with (a) the organizational documents of Provider, (b) any material agreement or instrument to which Provider is a party or by which Provider or any material part of its property is bound, or (c) applicable law.

e. Provider has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement. Provider will maintain, without material restriction, all such registrations, permits, licenses, and other approvals and consents which are necessary to lawfully perform its obligations under this Agreement for the term of this Agreement.

f. Provider has been given an opportunity to review the Program Contract, and Plan's standards, policies, and procedures as set forth in Plan's Provider Handbook.

g. Each submission of a claim by Provider pursuant to this Agreement constitutes the representation and warranty by it to Plan that (i) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of the claim, (ii) the charge amount set forth on the claim is for the appropriate amount and (iii) the claim is a valid claim.

5.2 *Provision of Health Care Services.* Provider shall provide to Enrollees all Covered Services authorized under the terms of the MLTC Plan or MA Program. All Covered Services shall be provided in accordance with this Agreement, the Program Contracts and the policies of Plan as set forth in Plan's Provider Handbook. Notwithstanding any other provision in

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this contract, Provider remains responsible for ensuring that any service provided pursuant to this Agreement complies with all pertinent provisions of federal, state, and local statutes, rules and regulations.

a. *Prior Authorization.* Except for Emergency Services or where prior authorization is not required by Plan's Provider Handbook, Provider shall obtain prior authorization for Covered Services in accordance with Plan's Provider Handbook. Except where not permitted by applicable law or the MLTC Plan or MA Program, Plan may deny payment for Covered Services where Provider fails to meet Plan's requirements for prior authorization.

b. *Referrals.* Provider shall not refer Enrollees to other health care providers, including other Plan Providers, for Covered Services without the approval of Plan, except (a) in case of an Emergency, (b) when Enrollee self-referral is permitted by the MLTC Plan or MA Program, or (c) as permitted in Plan's Provider Handbook provisions regarding utilization management. When making a referral to another health care provider, Provider shall furnish the other provider complete information on treatment procedures and diagnostic tests performed prior to such referral, which may include providing copies of the medical records.

c. *Non-Covered Services.* Every time Provider provides items or services to an Enrollee that are not Covered Services, before providing the items or services Provider shall (a) inform Enrollee of the specific items or services that are not Covered Services and that they will not be paid for by Plan, and (b) obtain Enrollee's written agreement to pay for such specific items or services after being so advised. Provider shall contact Plan for a coverage determination in any case where Provider is unsure if an item or service is a Covered Service.

5.3 *Confidentiality.* Provider will obtain any Enrollee consents required in order to authorize Provider to provide access to requested information or records as contemplated in any section of this Agreement, including copies of Provider's medical records relating to the care provided to Enrollee. Provider further agrees:

a. That all individual identifiable information relating to Enrollees obtained by Provider shall be confidential pursuant to the requirements set forth in New York State Public Health Law, the New York State Social Services Law, the Patient Protection and Affordable Care Act codified in 42 U.S.C. §1396a(a)(7), §1902(a)(7) of the Federal Social Security Act and regulations promulgated thereunder, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and shall be used or disclosed by Provider only for a purpose directly connected with the performance of Provider's obligations under this Agreement.

b. That medical records of all Enrollees shall be confidential and shall be disclosed to and by other persons within Provider's organization, only as necessary to provide health care and quality, peer, or complaint and appeal review of health care under the terms of this

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Agreement and in accordance with HIPAA and any other confidentiality required by applicable statutes or regulations.

c. That the provisions of this section shall survive the termination of this Agreement and shall bind Provider so long as Provider maintains any individually identifiable information relating to Plan Enrollees.

5.4 *Non-Discriminatory Access and Treatment.* Provider shall comply with all applicable federal and state non-discrimination laws, and Covered Services provided to Enrollees by Provider or Personnel shall be performed in the same manner, on the same basis and in accordance with the same standards offered to all of the other patients of Provider and said Personnel, and shall be available and accessible to all Enrollees. Neither Provider nor any of Personnel shall unlawfully differentiate or discriminate in the treatment of Enrollees or in the quality of the Covered Services delivered to Enrollees on the basis of race, color, religion, creed, sex, age, marital status, veteran status, national origin, disability, sexual orientation or source of payment.

5.5 *Compliance and Evaluation.* Provider shall participate in and comply with Plan's quality assurance and utilization review programs, Plan's Compliance and Training programs, Plan's Enrollee grievance procedures, and the monitoring and evaluation by Plan of Provider's performance of services pursuant to this Agreement and Plan's Provider Handbook, as may be amended from time to time.

5.6 *Personnel.* Provider is responsible for ensuring at all times during the term of this Agreement that its employees and any and all individuals or entities subcontracted by Provider to render services in connection with this Agreement adhere to the requirements of this Agreement, and are properly licensed, credentialed, or authorized under federal and state law to perform Covered Services. The use of employees, affiliates, or other providers to render services in connection with this Agreement will not limit Provider's obligations and accountability under this Agreement with regard to the provision of Covered Services. This obligation shall include the performance of regular exclusion and debarment checks on all personnel, including contractors and agents, who will be compensated for providing services in connection with this Agreement to ensure that no excluded individual or entity participates in performance under this Agreement.

5.7 *Credentialing.* In the event that Provider employs or engages licensed health care professionals/providers, Provider shall either provide copies of all such credentials/licenses to Plan or shall permit Plan to review and approve Provider's credentialing process and audit the same on an ongoing basis. Provider shall adhere to the Credentialing policies and procedures set forth in the Plan's Provider Handbook.

5.8 *Participation in Programs.* Provider agrees Plan may amend this Agreement and Plan's Provider Handbook from time-to-time as necessary to include additional Medicaid and/or Medicare Programs applicable to Plan's beneficiaries. Provider agrees that Provider will

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participate in all new Programs for which Provider is qualified as determined by Plan pursuant to applicable federal and state laws, rules and regulations.

5.9 *Provision of Encounter Data.* Provider shall provide to Plan, and shall require all Personnel to provide to Plan, all encounter data regarding Covered Services rendered to Enrollees by Provider and Personnel. Encounter data will be provided in the format and according to the time frames established by Plan from time to time in order to comply with regulations of CMS and DOH.

5.10 *Compliance Plan.* Provider shall, and will cause its employees, agents and contractors to, read, acknowledge and adhere to Plan's Compliance Program, a copy of which shall be made available to Provider. Provider shall ensure that any compliance program required and/or adopted shall be in conformity with that of the Plan.

6. Representations and Responsibilities of Plan.

Plan, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

6.1 *Corporate Authority and Structure.*

a. Plan is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

b. Plan has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Plan have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Plan and (assuming the due authorization, execution and delivery of this Agreement by Provider) constitutes a valid and binding obligation of Plan, enforceable against Plan in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

c. The execution, delivery and performance of this Agreement by Plan do not and will not violate or conflict with (a) the organizational documents of Plan, (b) any material agreement or instrument to which Plan is a party or by which Plan or any material part of its property is bound, or (c) applicable law.

d. Plan has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

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6.2 *Administrative and Other Services.* Plan shall be ultimately responsible for all administration and management of the Programs, including but not limited to the following:

a. Payment of claims. As described in further detail in Plan’s Provider Handbook and on Appendix A of this Agreement, Plan will pay Provider for rendering Covered Services to Enrollees. Unless otherwise required by federal or state law, Provider shall follow the procedures set forth in Plan’s Provider Handbook. Plan may change its payment policies from time to time, which shall not constitute an amendment to this Agreement.

b. Implementation of Quality Assurance and Utilization Review. Plan and Provider acknowledge that Plan shall implement and have ultimate responsibility for the quality assurance and utilization review programs for the Plan participation as set forth in Plan’s Provider Handbook.

c. Provider Related Services. Plan shall be responsible for all provider relations and orientation for Personnel, including provider relations meetings, consultations and other programs.

d. Enrollee Services. Plan shall provide to Enrollees all services of Plan that are not Covered Services, including processing of complaints and grievances and preparation and dissemination of new Enrollee packets and other written materials given to Enrollees to explain the health care services provided by Plan and the procedures for receiving same.

6.3 *Contracting Responsibilities.* Plan shall oversee and be accountable to CMS for all Medicare contract functions and responsibilities.

7. Medicare Advantage. The specific terms and conditions required by CMS to be incorporated into all agreements between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions shall be referred to as the “Medicare Advantage Addendum” and is attached to this Agreement as Appendix C. In the event of any inconsistent or contrary language between the Medicare Advantage Addendum and any other part of this Agreement, including but not limited to appendices, amendments and Exhibits, the parties agree that with respect to the MA Program the provisions of the Medicare Advantage Addendum shall prevail, except to the extent applicable law requires otherwise and/or to the extent a provision of this Agreement exceeds the minimum requirements of the Medicare Advantage Addendum.

8. New York State Standard Clauses. The New York State Department of Health Standard Clauses for Managed Care Provider/IPA/ACO Contracts (the “Standard Clauses”) attached to this Agreement as Appendix D, are expressly incorporated into this Agreement and are binding upon the parties to this Agreement. In the event of any inconsistent or contrary language between the Standard Clauses and any other part of this Agreement, including but not limited to

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appendices, amendments and exhibits, the parties agree that the provisions of the Standard Clauses shall prevail, except to the extent applicable law requires otherwise and/or to the extent a provision of this Agreement exceeds the minimum requirements of the Standard Clauses.

9. Records, Access & Audits.

9.1 *Maintenance.* Provider shall, and shall cause its subcontractors to, maintain operational, financial and administrative records, contracts, books, files, data, information, and other documentation related to the Covered Services provided to Enrollees, claims filed, quality and cost outcomes, quality measurements and initiatives, and other services and activities conducted under this Agreement (collectively, "Records"). Provider shall ensure that such Records are kept in accordance with applicable federal and state laws and Program requirements, generally accepted accounting principles (as applicable) and prudent record keeping practices and are sufficient to enable Plan to enforce its rights under this Agreement, including this section, and to determine whether Provider and its subcontractors and their respective employees are performing or have performed Provider's obligations in accordance with this Agreement. Provider shall, and shall cause its subcontractors to, maintain such Records for ten (10) years. Records that are under review or audit shall be retained until the completion of such review or audit if that date is later than the time frame indicated above.

9.2 *Access & Audit.* Plan shall have the right to monitor, inspect, evaluate and audit Provider and its subcontractors. In connection with any monitoring, inspection, evaluation or audit, Provider shall, and shall cause its subcontractors to, provide Plan with access to all Records, personnel, physical facilities, equipment and other information necessary for Plan or its auditors to conduct the audit. Within three business days of Plan's written request for Records, or such shorter time period required for Plan to comply with requests of Governmental Authorities, Provider shall, and shall cause its subcontractors to, collect, compile, and prepare all such Records and furnish such Records to Plan in a format reasonably requested by Plan. Copies of such Records shall be at no cost to Plan.

9.3 The requirements of this Agreement regarding Records, access and audit shall survive expiration or termination of this Agreement.

10. Compliance. In performing this Agreement, Provider shall comply with all federal and state laws and Program requirements. Provider shall (a) cooperate with Plan with respect to Plan's compliance with federal and state laws and Program requirements, including downstream requirements that are inherent to Plan's responsibilities under federal and state laws and MA Program requirements, and (b) not knowingly take any action contrary to Plan's obligations under federal and state laws and Program requirements.

10.1 *Fraud, Waste and Abuse.* Provider shall comply with federal and state laws designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of federal

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criminal law, the False Claims Act (31 USC §§ 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act).

10.2 *Accreditation.* Provider shall comply with policies and procedures required for Plan to obtain or maintain its accreditation from accreditation bodies, including the National Committee for Quality Assurance or Utilization Review Accreditation Commission.

10.3 *Compliance Program/Reporting.* OIG publishes compliance program guidance for health care firms available at <http://oig.hhs.gov/fraud/complianceguidance.asp>. Provider shall, and shall require its employees and its subcontractors and their employees to, comply with Plan compliance program requirements, including Plan’s compliance training requirements, and to report to Plan any suspected fraud, waste, or abuse or criminal acts by Plan, Provider, other providers, their respective employees or subcontractors, or by Enrollees.

10.4 *Acknowledgement of Federal Funding.* Claims, data and other information submitted to Plan pursuant to this Agreement may be used, directly or indirectly, for purposes of obtaining payments from Federal or State governments under Federal Health Care Programs, and payments that Provider receives under this Agreement may be, in whole or in part, from federal funds.

a. Provider shall, upon request of Plan, certify, based on its best knowledge, information and belief, that all data and other information directly or indirectly reported or submitted to Plan pursuant to this Agreement is accurate, complete and truthful.

b. Provider shall not claim payment in any form, directly or indirectly, from a Federal Health Care Program for items or services covered under this Agreement, except for wrap around payments made directly by Governmental Authorities to certain qualified providers, such as federally qualified health centers (“FQHCs”) or rural health clinics (“RHCs”) where applicable.

10.5 *Ineligible Persons.* Provider warrants and represents as of the Effective Date and throughout the term of the Agreement and the duration of post expiration or termination transition activities described in this Agreement, that none of it, its principals or any individual or entity it employs or has contracted with to carry out its part of this Agreement is an Ineligible Person.

10.6 *Compliance Audit.* Plan shall be entitled to audit Provider with respect to compliance issues, including their compliance programs, and require them to address compliance issues through education, counseling or corrective action plans. Provider shall cooperate with Plan with respect to any such audit, including by providing Plan with Records and site access within such time frames as requested by Plan.

11. **Status of the Parties.**

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11.1 *Independent Contractor.* The relationship of Provider to Plan shall be that of an independent contractor. Provider agrees, and represents to Plan, that it shall comply with all applicable laws, rules and regulations of the Internal Revenue Service, The New York State Department of Taxation, and all applicable unemployment insurance, worker's compensation and disability programs required by governmental authorities having jurisdiction.

11.2 *Responsibility.* Each party shall be responsible for its own acts or omissions and those of its employees and agents. Provider shall maintain a policy of general and professional liability insurance, or a qualified self-insurance program, covering all acts performed by its employees or agents, with amounts of coverage not less than \$1,000,000 per incident and \$3,000,000 in the aggregate.

11.3 *Indemnity*

a. Plan shall not be liable under any contract (i) for obligations of Provider, or (ii) for any act or omission of Provider or its officers, directors, employees, agents, volunteers, or Personnel. Further, Provider agrees to defend, indemnify and hold harmless Plan and its affiliates and each of their respective officers, directors, employees and agents from and against any and all judgments, liabilities, claims, demands, lawsuits, losses, damages, costs, expenses and injuries or death to persons and damage to property (including costs, expenses, court costs, and reasonable attorneys' fees on account thereof) arising from, or relating to any act, omission, fault, negligence, or misconduct by Provider, its officers, directors, employees, agents, volunteers, or Personnel in connection with this Agreement.

b. Provider shall not be liable under any contract (i) for obligations of Plan, or (ii) for any act or omission of the Plan or its affiliates or their respective officers, directors, employees, agents, volunteers, or Personnel. Further, Plan agrees to defend, indemnify and hold harmless Provider and its affiliates and each of their respective officers, directors, employees and agents from and against any and all judgments, liabilities, claims, demands, lawsuits, losses, damages, costs, expenses, and injuries or death to persons or damage of property (including costs, expenses, court costs, and reasonable attorneys' fees on account thereof) arising from, or relating to any act, omission, fault, negligence, or misconduct by Plan, its officers, directors, employees, agents, volunteers, or Personnel in connection with the Agreement.

12. Dispute Resolution.

a. *Provider Administrative Review and Appeals.* Where applicable, Provider shall exhaust all Plan's review and appeal rights in accordance with Plan's Provider Handbook before seeking any other remedy. Where required by applicable laws or Program requirements, administrative reviews and appeals shall be subject to and resolved in accordance with such laws or Program requirements.

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b. Except as prohibited by federal or state Law, all claims and disputes between Plan and Provider related to this Agreement must be submitted to arbitration within one year of the act or omission giving rise to the claim or dispute, except for claims based on fraud, which must be brought within the State statute of limitation governing fraud claims. The failure to initiate arbitration within the foregoing time period will constitute waiver of such claims and disputes.

c. *Negotiation.* Before a party initiates arbitration regarding a claim or dispute under this Agreement, the parties shall meet and confer in good faith to seek resolution of the claim or dispute. If a party desires to initiate the procedures under this section, the party shall give notice (a "Dispute Initiation Notice") to the other providing a brief description of the nature of the dispute, explaining the initiating party's claim or position in connection with the dispute, including relevant documentation, and naming an individual with authority to settle the dispute on such party's behalf. Within 20 days after receipt of a Dispute Initiation Notice, the receiving party shall give a written reply (a "Dispute Reply") to the initiating party providing a brief description of the receiving party's position in connection with the dispute, including relevant documentation, and naming an individual with the authority to settle the dispute on behalf of the receiving party. The parties shall promptly make an investigation of the dispute, and commence discussions concerning resolution of the dispute within 20 days after the date of the Dispute Reply. If a dispute has not been resolved within 30 days after the parties have commenced discussions regarding the dispute, either party may submit the dispute to arbitration subject to the terms and conditions herein.

d. *Arbitration.* Except as barred or excepted by this Agreement, all claims and disputes between the parties shall be resolved by binding arbitration in New York, New York. The arbitration shall be conducted through the American Arbitration Association ("AAA") pursuant to the AAA Commercial Arbitration Rules then in effect, subject to the following: Arbitration shall be commenced by completing and filing with AAA a Demand for Arbitration form in accordance with the Commercial Arbitration Rules setting forth a description of the dispute, the amount involved and the remedy sought, and sending notice of the demand to the opposing party. The arbitration shall be held before a single arbitrator, unless the amount in dispute is more than \$1 million, in which case it will be held before a panel of three arbitrators. In a case with a single arbitrator, the parties shall select the arbitrator by agreement within 30 days of the date the Demand for Arbitration is filed, and if the parties are unable to agree on the selection of an arbitrator within such time, AAA shall select an independent arbitrator. In the case of a panel, within 30 days of the date the Demand for Arbitration is filed each party shall select an arbitrator, and the two arbitrators shall select the third arbitrator, and if the two arbitrators are unable to agree on the selection of a third arbitrator within such time, AAA shall select an independent third arbitrator. The arbitrator or panel may not certify a class or conduct class based arbitration. The decision of the arbitrator or panel shall be final and binding on the parties. The award of the arbitrator or panel may be confirmed or enforced in any court having jurisdiction. Each party shall assume its own costs related to the arbitration, including costs of subpoenas, depositions, transcripts, witness fees, and attorneys' fees. The compensation and expenses of the arbitrator and administrative fees or costs of the arbitration

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shall be borne equally by the parties. The New York State Commissioner of Health is not bound by arbitration or mediation decisions.

13. General.

13.1 *Governing Law / Venue.* This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of New York, except where federal law applies, without regard to principles of conflict of laws. Each of the parties hereby agrees and consents to be subject to the exclusive jurisdiction and venue of the appropriate state or federal court located in Onondaga County, New York, in any suit, action, or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Agreement.

13.2 *Assignment.* Provider may not assign, delegate or transfer this Agreement, in whole or in part, without the prior written consent of Plan. Plan may assign this Agreement, in whole or in part, to any purchaser of the assets or successor to the operations of Plan.

13.3 *Non-waiver.* No waiver of any term or condition of this Agreement by either party shall be deemed a continuing or further waiver of the same term or condition or a waiver of any other term of this Agreement.

13.4 *Invalidity.* In the event that any portion of this Agreement shall be determined to be invalid or unenforceable, the remainder of this Agreement shall be deemed to continue to be binding upon the parties hereto in the same manner as if the invalid or unenforceable provision were not a part of this Agreement.

13.5 *Amendment/Modification.* This Agreement may be amended by a written instrument duly executed by the parties hereto. In addition, Plan may amend this Agreement on ninety (90) days written notice by sending Provider a copy of the amendment. Provider's signature is not required to make the amendment effective. However, if the amendment is not required by law or regulation and would impose a material adverse impact on Provider, then Provider may terminate this Agreement on sixty (60) days written notice to Plan by sending a termination notice within thirty (30) days after receipt of the amendment.

13.6 *Notice.* Any notice required or allowed to be given hereunder, shall be deemed to have been given upon deposit in the mail, certified or registered, with return receipt requested, and addressed to the party at the address first listed herein, attention Executive Director, or as otherwise provided herein.

13.7 *Entire Agreement.* This Agreement contains the entire agreement between the parties and contains all of the agreements between them with respect to the subject matter hereof and supersedes any and all other agreements, either oral or in writing, between the parties hereto with respect to the subject matter hereof.

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13.8 *Authorization.* The execution and performance of this Agreement by each party has been duly authorized and is consistent with all laws, resolutions or corporate actions, and this Agreement constitutes the valid and enforceable obligations of each party in accordance with its terms.

13.9 *Counterparts.* This Agreement may be executed simultaneously in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one in the same instrument.

[Signature page to follow]

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Appendix A

Program, Covered Services, and Rates

A. Programs

MEDICARE ADVANTAGE; MLTC PLAN

B. Covered Services

All applicable Medicare Services

C. Rates & Billing Procedures

100 % of Medicare Rates.

There is no retroactive component to this rate as it applies to this contract. The rate is effective the date of the contract, unless it is changed by mutual agreement by both parties with an amendment to this contract; and the new rate will be effective on the date of said amendment.

D. **Location of Services.** This Agreement applies to Covered Services provided at Provider's service locations as set forth below subject to the terms and conditions set forth in Section 3 of the Agreement. If the service location is not listed on this Appendix A, this Agreement should nevertheless be understood as applying to the actual service locations that existed when this Agreement was executed.

Lake George: 1340 State Route 9, Lake George, NY 12845

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Appendix B

List of Health Care Professionals

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Appendix C

MEDICARE ADVANTAGE ADDENDUM

The provisions of this Addendum apply to health care services rendered by Provider to Medicare Advantage (“MA”) Beneficiaries covered under a health benefits plan pursuant to Plan’s contract (“MA Contract”) with the Centers for Medicare and Medicaid Services (“CMS”). With respect to such MA Beneficiaries, the provisions of this Addendum shall prevail over any provision in the Agreement which may conflict or appear inconsistent with any provision in this Addendum.

1.1 COMPLIANCE/ACCOUNTABILITY

- a. Compliance with Requirements of CMS. Provider shall comply, and shall require any of his/her subcontractors to comply, with any and all applicable Medicare laws, regulations and CMS instructions with respect to the provision of health care services and all other activities relating to MA Beneficiaries. Further, Provider agrees that any Covered Services provided by Provider or his/her subcontractors to MA Beneficiaries will be consistent with and will comply with the Medicare Advantage contractual obligations of Plan. Provider must have a provider agreement with CMS that permits it to provide services under original Medicare, and shall maintain such agreement throughout the term of this Agreement. Provider shall give prompt notice to Plan of his/her debarment, suspension or exclusion from any government program including Medicare and Medicaid.
- b. Exclusion from Federal Health Care Program. Provider may not employ, or subcontract with an individual, or have persons with ownership or control interests, who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare, or social services programs under Title XX of the Social Security Act, and thus have been excluded from participation in any Federal health care program under section 1128 or 1128A of the Act (or with an entity that employs or contracts with such an individual) for the provision of healthcare; utilization review; medical social work; or administrative services.
- c. Delegation/Accountability/Oversight. If Plan has delegated activities to Provider, then Plan will provide the following information to Provider and Provider shall provide such information to any of his/her subcontracted entities:
 - 1. A list of delegated activities and reporting responsibilities;
 - 2. Arrangements for the revocation of delegated activities;

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- 3. Notification that the performance of the contracted and subcontracted entities will be monitored by Plan;
- 4. Notification that the credentialing process must be approved and monitored by Plan; and
- 5. Notification that all contracted and subcontracted entities must comply with all applicable Medicare laws, regulations and CMS instructions.

Plan may revoke any delegation, including, if applicable, the delegated responsibility to meet CMS reporting requirements, and thereby terminate the MA Addendum if CMS, or Plan, determines that Provider has not performed satisfactorily. Such revocation shall be consistent with the termination provisions of this MA Addendum. Performance of Provider shall be monitored by Plan on an ongoing basis as provided for in this MA Addendum. Provider further acknowledges that Plan shall oversee and is accountable to CMS for the functions and responsibilities described in the Medicare Advantage regulatory standards and ultimately responsible to CMS for the performance of all services. Further, Provider acknowledges that Plan may only delegate such functions and responsibilities in a manner consistent with the standards set forth under 42 CFR §422.504(i)(4).

- d. Subdelegation. If Provider carries out any of his/her obligations or duties under the Agreement through a subcontracted arrangement, and such arrangement has been approved by Plan if so required, such arrangement shall be in writing, shall contain: (1) an agreement by the subcontractor to comply with all of Provider's obligations in the agreement and this MA Addendum; (2) a prompt payment provision as negotiated by Provider and the subcontractor; (3) a provision setting forth the term of the subcontract (preferably one (1) year or longer); and (4) dated signatures of all the parties to the subcontract.
- e. Credentialing. Provider shall cooperate with Plan's credentialing and recredentialing process. The credentials of medical professionals affiliated with Provider will be reviewed by Plan; or the credentialing process will be reviewed and approved by Plan, and Plan must audit the credentialing process on an ongoing basis, all in a manner consistent with the requirements as set forth in 42 CFR § 422.504(i)(4). To the extent that Plan has delegated selection of the providers, contractors, or subcontractor to Provider, Plan retains the right to approve, suspend, or terminate any such arrangement.
- f. Policies and Procedures. Provider shall comply with all of Plan's policies and procedures required for compliance with the Medicare program and any other federal or state laws, including but not limited to, the decisions, rules and regulations

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established by Plan’s utilization review and quality assessment programs, and shall cooperate with and participate in all internal and external peer review organizations (“PRO”) review processes, independent quality review and improvement organizations activities. Medical necessity decisions regarding MA Beneficiaries will be made in compliance with CMS guidelines, and the applicable terms of the Agreement.

- g. Consulting with Plan Providers. Plan shall consult with Plan Providers regarding its medical policies, quality improvement program and medical management programs and ensure that practice guidelines and utilization management guidelines: (1) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (2) consider the needs of the enrolled population; (3) are developed in consultation with participating physicians; (4) are reviewed and updated periodically; and (5) are communicated to Plan Providers and, as appropriate, to MA Beneficiaries. Plan also agrees to ensure that decisions with respect to utilization management, MA Beneficiary education, coverage of Covered Services, and other areas in which the guidelines apply are consistent with the guidelines.
- h. CMS Notice of Discharge and Appeal Rights. Provider agrees to comply with all CMS regulations in their issuance of any and all notices required to be provided to Medicare Beneficiaries to inform them of their rights as a patient, including their discharge and appeal rights.
- i. Grievance/Appeal. Provider shall cooperate and comply with Plan’s Grievance/Appeal Process, including procedures for expedited review of initial determination and reconsideration upon the request of an MA Beneficiary in accordance with Medicare laws. Provider agrees to cooperate with Plan in meeting its obligations regarding MA Beneficiary appeals, grievances and expedited appeals, including gathering and forwarding to Plan, in a timely manner that will permit Plan to meet CMS required time frames for disposition of grievances and appeals, all information requested by Plan in connection with the investigation and resolution of all appeals and grievances and compliance with appeals decisions.
- j. Regulatory Amendment. Provider may amend the Agreement or this Addendum to comply with the requirements of state and federal regulatory authorities and shall provide Provider with a copy of any such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Provider will not be required.
- k. Illegal Remunerations. Both parties specifically represent and warrant, to the best of their knowledge, that activities to be performed under this Agreement are not

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considered illegal remunerations (including kickbacks, bribes or rebates) as defined in 42 USCA § 1320(a)-7b.

- l. Approval of Marketing Materials. Both parties agree to comply, and to require any of their subcontractors to comply, with all applicable federal and state laws, regulations, CMS instructions, and marketing activities under this Agreement, including but not limited to, the Medicare Marketing Guidelines.
- m. Training, Education and Communications. In accordance with, but not limited to 42 CFR §§ 422.503(b)(4)(vi)(c)&(d), Provider agrees and certifies that he/she, as well as his/her employees, subcontractors, downstream entities, related entities and agents who provide services, to or for MA Beneficiaries or to or for Provider, shall participate in applicable compliance training and education required by applicable law, and must be made a part of the orientation for a new employee, new first tier, downstream or related entity and for all new appointments of a chief executive, manager, or governing body member. Both parties agree that Plan or its designee may make such compliance training, education and lines of communication available to Provider in either electronic, paper or other reasonable medium. Provider shall be responsible for documenting applicable employee's, subcontractor's, downstream entity's, related entity's and/or agent's attendance and completion of such training. Upon notice, Provider shall provide such documentation to Plan, unless otherwise not required by CMS regulation. In addition, the training requirement set forth herein is not required for providers or suppliers who have met the fraud, waste and abuse certification requirements through enrollment into the Medicare program, as those providers and/or suppliers are deemed to have met that portion of the fraud waste and abuse training required by CMS.
- n. Data Reporting.
 - 1. Data Reporting Submissions. Provider agrees to provide to Plan all information necessary for Plan to meet their data reporting and submission obligations to CMS, including but not limited to, data necessary to characterize the context and purpose of each encounter between a Medicare Advantage Beneficiary and Provider ("Risk Adjustment Data"), and data necessary for Plan to meet its reporting obligations under 42 CFR §§ 422.516 and 422.310.
 - 2. Risk Adjustment Data. Provider's Risk Adjustment Data shall include all information necessary for Plan to submit such data to CMS as set forth in 42 CFR § 422.310 or any subsequent or additional regulatory provisions. Provider's failure to submit his/her Risk Adjustment Data accurately, completely and truthfully, in the format described in the 42 CFR § 422.310 or

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any subsequent or additional regulatory provisions, may result in denials and/or delays in payment of Provider's claims.

- 3. Risk Adjustment Data Validation Audits. Plan and Provider are required in accordance with 42 CFR § 422.310(e) to submit a sample of medical records for MA Beneficiaries for the purpose of validation of risk adjustment data. Accordingly, Plan or its designee, shall have the right to obtain copies of such documentation on at least an annual basis. Provider agrees to provide the requested medical records to Plan, or Plan's designee, within fourteen (14) calendar days from receipt of a written request. Such records shall be provided to Plan, or its designee, at no additional cost.
- 4. Accuracy of Risk Adjustment Data. Provider further agrees to certify, to the best of his/her knowledge, information and belief, the accuracy, completeness, and truthfulness of Provider generated Risk Adjustment Data that Plan is obligated to submit to CMS. Within thirty (30) days after the beginning of every Fiscal Year or as required by CMS while this Medicare Advantage Addendum is in effect, Provider agrees to give Plan a certification in writing, that certifies to the accuracy, completeness, and truthfulness of Provider's Risk Adjustment Data submitted to Plan during the specified period, to the best of his/her knowledge, information and belief.

1.2 ACCESS TO RECORDS/FACILITIES

- a. Maintenance of Records. Provider shall create and maintain all medical and other records and information relating to health care services in accordance with all applicable state and federal laws and shall comply with all federal and state laws regarding the confidentiality and disclosure of MA Beneficiaries' health records, medical records, treatment information that identifies a particular MA Beneficiary and other health and patient information. Provider shall maintain all MA Beneficiary records in an accurate and timely manner and ensure timely access by MA Beneficiaries to the records and information that pertain to such MA Beneficiaries. Provider agrees to maintain such records and information for ten (10) years following the expiration or termination of this Agreement or completion of an audit by CMS, whichever is later.
- b. Access to Records/Facilities.
 - 1. Provider shall permit Provider, Plan, Department of Health, United States Department of Health and Human Services, the United States Comptroller General, CMS, and any other regulatory, state or federal agency with authority over Plan or Provider, timely access to audit, evaluate, inspect and

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copy all pertinent books, contracts, medical records, financial records, patient care documentation, encounter data and other records of Provider, or his/her first tier, downstream and related entities, including but not limited to subcontractors or transferees, that pertain to any aspect of services performed under the Agreement. Such right of audit, evaluation, inspection and copying shall extend for at least ten (10) years following the expiration or termination of this Agreement or completion of an audit by CMS, whichever is later, or such longer period of time as may be required by CMS. Further, Provider shall, upon request, provide a copy of an MA Beneficiary's medical records or financial and statistical records relating to services rendered to MA Beneficiaries to the aforementioned organizations or agencies. For the purpose of conducting the above activities, Provider shall make available his/her premises, physical facilities and equipment, and records relating to MA Beneficiaries, including access to Provider's computer and electronic systems and any additional relevant information that CMS may require. Provider acknowledges that failure to allow HHS, the Comptroller General or their designees the right to timely access under this section can subject Provider to a fifteen thousand dollar (\$15,000) penalty for each day of failure to comply.

- 2. Each party agrees to abide by all federal and state laws applicable to that party regarding confidentiality and disclosure for health records, medical records, other health information, and enrollee information. Provider shall provide such records and information only to authorized individuals and in accordance with state and federal law, and Provider shall not release original medical records except in accordance with federal or state laws. Both parties acknowledge that HHS, the Comptroller General or its designee have the right, to audit and/or inspect Provider's premises to monitor and ensure compliance with the CMS requirements for maintaining the privacy and security of protected health information (PHI) and other personally identifiable information of MA Beneficiaries.

1.3 MA BENEFICIARY ACCESS

- a. Nondiscrimination. Provider shall not discriminate against any patient based on race, sex, age, religion, place of residence, HIV status, source of payment, MA membership, color, sexual orientation, marital status, or any factor related to health status, including, but not limited to, a medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability or on any other basis otherwise prohibited by state or federal law. Further, Provider shall comply with Title VI of the Civil Rights Act of

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1964; the Americans with Disabilities Act; the Age Discrimination Act of 1975; other laws applicable to recipients of federal funds; and all other applicable laws, rules and regulations.

- b. Direct Access. Provider agrees that, as mandated by state and federal law, Plan allows direct access for mammography screenings, influenza vaccinations and to women's health specialists for routine and preventive health care services for female MA Beneficiaries. Provider agrees to comply with all of Plan's policies with regard to direct access in such specific circumstances. No MA Beneficiary expenses shall apply to influenza or pneumococcal vaccines.
- c. Cultural Competency. Provider shall ensure that Covered Services rendered to MA Beneficiaries, both clinical and non-clinical, are accessible to all MA Beneficiaries, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities. Provider must provide information regarding treatment options in a cultural-competent manner, including the option of no treatment. Provider must ensure that individuals with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.
- d. Health Assessment. To the extent applicable, Provider agrees to cooperate with Plan's procedures approved by CMS to conduct an initial health assessment of all new MA Beneficiaries within ninety (90) days of the effective date of their enrollment.
- e. Identifying Complex and Serious Medical Condition. Provider shall cooperate with Plan's policies for identifying MA Beneficiaries with complex or serious medical conditions for chronic care improvement initiatives; and assessment of those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and establishment and implementation of a treatment plan appropriate to those conditions, with an adequate number of direct access visits to specialists to accommodate the treatment plan. To the extent applicable, Provider agrees to assist in the development and implementation of the treatment plans and/or chronic care improvement initiatives.
- f. Access. Provider agrees to provide Covered Services consistent with Plan's: (1) standards for timely access to care and member services; (2) policies and procedures that allow for individual medical necessity determinations; and (3) policies and procedures for Provider's consideration of MA Beneficiary input in the establishment of treatment plans. Provider shall provide access to health care services twenty-four (24) hours a day, seven (7) days a week, or at such times as

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Covered Services are typically provided by similar providers, to assure availability, adequacy and continuity of care to MA Beneficiaries, and by making arrangements with covering Providers to treat MA Beneficiaries when Provider is not available.

- g. Standards of Care. All health care services shall be provided in accordance with professionally recognized standards of health care.

1.4 MA BENEFICIARY PROTECTIONS

- a. Hold Harmless. Provider agrees that in no event, including but not limited to nonpayment by Plan, insolvency of Plan, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against MA Beneficiaries or persons (other than Plan) acting on an MA Beneficiary's behalf for health care services provided pursuant to the Agreement. This provision does not prohibit Provider from collecting copayments, coinsurance or deductibles as specifically provided in the evidence of coverage, or fees for non-covered health care services delivered on a fee-for-service basis to MA Beneficiaries. Nor does this Agreement prohibit Provider and an MA Beneficiary from agreeing to continue services solely at the expense of the MA Beneficiary, as long as Provider has informed the MA Beneficiary in advance, and in writing, consistent with the terms of the Agreement, that Plan may not cover or continue to cover such specific service or services. This advance notice does not apply to services not covered due to a statutory exclusion from the Medicare Advantage Program.

Provider further agrees that for MA Beneficiaries who are dual eligible enrollees for Medicare and Medicaid, Provider will not bill the MA Beneficiaries for cost sharing that is not the MA Beneficiaries' responsibility and such MA Beneficiaries will not be held liable for Medicare Parts A and B cost sharing when the State is liable for the cost sharing. In addition, Provider agrees to accept Plan's payment as payment in full or shall bill the appropriate state source.

- b. Continuation of Services. Provider agrees that in the event of Plan's insolvency, other cessation of operations, or termination of the Agreement, benefits to MA Beneficiaries will continue through the period for which the premium has been paid, and health care services shall continue to be rendered to MA Beneficiaries confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until MA Beneficiary's medically appropriate discharge or transfer, or until the course of the health care treatment has been completed, whichever is later. Provider shall be compensated for any health care service rendered pursuant to this Section in accordance with the terms of the Agreement or as the parties shall otherwise mutually agree.

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- c. Advance Directives. Provider shall comply with all of Plan's applicable written policies and procedures to implement MA Beneficiaries' rights to make decisions concerning their health care, including the provision of written information to all adult MA Beneficiaries regarding their rights under state and federal law to make decisions regarding their right to accept or refuse medical treatment and the right to execute an advance medical directive. Provider further agrees to document or oversee the documentation in a prominent part of the MA Beneficiaries' medical records whether or not the MA Beneficiary has an advance directive, that Provider will follow state and federal requirements for advance directives and that Provider will provide for education of his/her staff and the community on advance directives. Provider shall not discriminate against an MA Beneficiary based on whether or not the MA Beneficiary has executed an advanced directive.
- d. Survival of Agreement. Provider agrees that: (1) the hold harmless and continuation of care provisions shall survive the termination of the Agreement, and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and an MA Beneficiary or persons acting on their behalf that relates to liability for payment for, or continuation of, Covered Services provided under the terms and conditions of these clauses.

1.5 TERM AND TERMINATION

- a. Notice of Termination. Notwithstanding anything contained in the Agreement to the contrary, Provider's participation may be terminated immediately upon written notice to Provider due to: (i) Provider's loss or suspension of licensure or certification; (ii) Provider's sanction by Medicare or exclusion from Medicare participation; or (iii) Provider's entering into a private contract with any Medicare beneficiary. Provider's participation as an MA Provider may be terminated by Plan upon thirty (30) days prior written notice due to failure to cooperate and comply with any of the provisions of this Addendum. If the Agreement contains any provision permitting termination of the Agreement without cause, notice of such termination shall be given by either party in accordance with the applicable provision of the Agreement, but in no case shall the notice period be less than sixty (60) days prior to the termination date. If Plan decides to terminate this MA Addendum, Plan shall give Provider written notice, to the extent required under CMS regulations, of the reasons for the action and set forth Provider's right to appeal the action and the process and timing for requesting a hearing.
- b. Provider Termination/Suspension. If Provider is the subject of a notice of suspension, limitation or restriction on his/her authority to operate in any jurisdiction or is excluded from or voluntarily opts out of the Medicare program, Provider shall not render any services to MA Beneficiaries during such period of suspension,

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exclusion or nonparticipation in the Medicare program or violate the terms of such suspension, limitation, restriction or exclusion; and, further, Provider agrees to notify Plan of such suspension, limitation or restriction in accordance with the Agreement. Any MA Beneficiary seeking or requiring health care services from Provider during such period of suspension, exclusion or non-participation in the Medicare program shall be referred by Provider to another Plan Provider for such health care services.

- c. Termination for Medicare Exclusion. Provider acknowledges that this MA Addendum shall be terminated if Provider, or a person or entity with ownership or control interest in Provider, is excluded from participation in Medicare under §1128A of the Social Security Act or from participation in any other Federal health care program.

1.6 PAYMENT

- a. Payment. For the provision of health care services to MA Beneficiaries, Provider shall be paid in accordance with the payment arrangement for MA Beneficiaries as set forth in the Agreement. Payment and incentive arrangements (if any) are set forth in the Agreement. Provider shall ensure that any payment and incentive arrangements it has with subcontractors are specified in a written agreement.
- b. Prompt Payment of Claims. Provider agrees to comply with the claims submission time frames as described in the Agreement. Plan shall comply with the payment time frames as described therein and shall comply with Medicare laws with regard to untimely payment of claims for health care services rendered to MA Beneficiaries, including the penalty provisions thereof. In the event Provider or a third party is delegated for claims payment, Provider or such third party agrees to comply with all applicable laws regarding the timeliness of claims payment for health care services rendered hereunder, including the penalty provisions thereof. Provider agrees that it or such third party shall be responsible for all interest payments due and owing as a result of Provider's failure to make such timely payments.
- c. Federal Funds. Provider acknowledges that Plan is receiving federal funds and that payments to Provider hereunder may, to the extent reimbursed by Plan, in whole or in part, come from Federal Funds, and that Provider and Plan are subject to certain laws applicable to individuals and entities receiving federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 and any other regulations applicable to recipients of federal funds.

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1.7 MISCELLANEOUS

- a. Inconsistencies. In the event of an inconsistency between terms of this MA Addendum and the terms and conditions set forth in the Agreement, the terms and conditions of this MA Addendum shall govern. Except as set forth herein, all other terms and conditions of the Agreement remain in full force and effect.
- b. Interpret According to Medicare Laws. Provider and Plan intend that the terms of the Agreement and this MA Addendum as they relate to the provision of Covered Services under the Medicare Advantage Program shall be interpreted in a manner consistent with applicable requirements under Medicare law.

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APPENDIX D

NEW YORK STATE DEPARTMENT OF HEALTH
STANDARD CLAUSES
FOR MANAGED CARE PROVIDER/IPA/ACO CONTRACTS

APPENDIX
Revised 04/01/2017

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement" or "this Agreement") the Article 44 plans and providers that contract with such plans, and who are a party agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, such clauses must be included in IPA/ACO contracts with Providers, and Providers must agree to such clauses.

1. Definitions for Purposes of this Appendix

"Managed Care Organization" or "MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer a comprehensive health services plan, or a health and long term care services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of contracting for the delivery or provision of health services by individuals, entities and facilities licensed and/or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment. Under these arrangements, such health care Providers and suppliers will provide their service in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of Health Care Services which are licensed, registered and/or certified as required by applicable federal and state law.

2. General Terms and Conditions

- a. This agreement is subject to the approval of the New York State Department of Health (DOH) and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by DOH for

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approval or, alternatively, to terminate this Agreement if so directed by DOH, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403 (6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.

- b. Any material amendment to this Agreement is subject to the prior approval of DOH, and any such amendment shall be submitted for approval in accordance with the appropriate procedures and timelines described in Sections III and VII of the New York State Department of Health Provider Contract Guidelines for MCOs and IPA/ACOs. To the extent the MCO provides and arranges for the provision of comprehensive Health Care Services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH, as may be required by the Medicaid Managed Care contract between the MCO and DOH.
- c. Assignment of an agreement between an MCO and (1) an IPA/ACO, (2) an institutional network Provider, or (3) a medical group Provider that serves five percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA/ACO and (1) an institutional Provider or (2) a medical group Provider that serves five percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.
- d. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA/ACO's Providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, contract, or DOH or DFS guidelines or policies and (b) has provided to the Provider at least thirty days in advance of implementation, including but not limited to:
 - quality improvement/management;
 - utilization management, including but not limited to precertification procedures, referral process or protocols, and reporting of clinical encounter data;
 - member grievances; and
 - Provider credentialing.
- e. The Provider or, if the Agreement is between the MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees, and shall require its Providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.

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- f. If the Provider is a primary care practitioner, the Provider agrees to provide twenty-four (24) hour coverage and back-up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.
- g. The MCO or IPA/ACO that is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA/ACO's own acts or omissions, by indemnification or otherwise, to a Provider.
- h. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007, Chapter 237 of the Laws of 2009, Chapter 297 of the Laws of 2012, Chapter 199 of the Laws of 2014, Part H, Chapter 60, of the Laws of 2014 and Chapter 6 of the Laws of 2015 with all amendments thereto.
- i. To the extent the MCO enrolls individuals covered by the Medical Assistance Program, this Agreement incorporates the pertinent MCO obligations under the Medicaid Managed Care contract between the MCO and DOH as set forth fully herein, including:
 - i. The MCO will monitor the performance of the Provider or IPA/ACO under the Agreement and will terminate the Agreement and/or impose other sanctions if the Provider's or IPA/ACO's performance does not satisfy the standards set forth in the Medicaid Managed Care contract.
 - ii. The Provider or IPA/ACO agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA/ACO's performance.
 - iii. The Provider or IPA/ACO agrees to be bound by the confidentiality requirements set forth in the Medicaid Managed Care contract between the MCO and DOH.
 - iv. The MCO and the Provider or IPA/ACO agree that a woman's enrollment in the MCO's Medicaid Managed Care product is sufficient to provide services to her newborn, unless the newborn is excluded from the enrollment in Medicaid Managed Care or the MCO does not offer a Medicaid Managed Care product in the mother's county of fiscal responsibility.

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- v. The MCO shall not impose obligations and duties on the Provider or IPA/ACO that are inconsistent with the Medicaid Managed Care contract or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.
- vi. The Provider or IPA/ACO agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.
- vii. The Provider or IPA/ACO agrees, pursuant to 31 U.S.C. §1352 and CFR Part 93, that no federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA/ACO for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of any Member of Congress in connection with the aware of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. The Provider or IPA/ACO agrees to complete and submit the "Certification Regarding Lobbying," Exhibit 1 attached hereto and incorporated herein, if this Agreement exceeds \$100,000. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement, and the Agreement exceeds \$100,000 the Provider or IPA/ACO shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.
- viii. The Provider or IPA/ACO agrees to disclose to the MCO, on an ongoing basis, any managing employee who has been convicted of a misdemeanor or felony in relation to the employee's involvement in any program under Medicare, Medicaid or a Title XX services program (block grant programs).
- ix. The Provider or IPA/ACO agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES).

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- x. The Provider or IPA/ACO agrees to disclose to the MCO complete ownership, control, and relationship information.
- xi. The Provider or IPA/ACO agrees to obtain for the MCO ownership information from any subcontractor with whom the Provider has had a business transaction totaling more than \$25,000 during the 12-month period ending on the date of the request made by DOH, Office of the Medicaid Inspector General (OMIG) or the United States Department of Health and Human Services (DHHS). The information requested shall be provided to the MCO within 35 days of such request.
- xii. The Provider or IPA/ACO agrees to have an officer, director or partner of the Provider execute and deliver to DOH a certification, using a form provided by DOH through OMIG’s website, within five (5) days of executing this agreement, stating that:
 - The Provider or IPA/ACO is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the Provider. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.
 - All claims submitted for payment by the Provider/IPA/ACO are for care, services or medical supplies that have been provided.
 - Payment requests are submitted in accordance with applicable law.
- xiii. The Provider or IPA/ACO agrees to require that an officer, director or partner of all subcontractors if they are not natural persons, or the subcontractor itself if it is a natural person, execute a certification, using a form provided by DOH through OMIG’s website, before the subcontractor requests payment under the subcontract, acknowledging that:
 - The subcontractor is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the subcontractor. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and

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claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.

- All claims submitted for payment by the subcontractor are for care, services or medical supplies that have been provided.
 - Payment requests are submitted in accordance with applicable law.
- j. The parties to this Agreement agree to comply with all applicable requirements of the federal Americans with Disabilities Act.
- k. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA's Providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act, the HIV confidentiality requirements of Article 27-F of the Public Health Law, and Mental Hygiene Law § 33.13.
- l. Compliance Program. The Provider agrees that if it claims, orders, or is paid \$500,000 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any MCO under the Medicaid Managed Care Program, that it shall adopt and implement a compliance program which meets the requirements of New York State Social Services Law § 363-d(2) and 18 NYCRR § 521.3.
- m. Compliance Program Certification. The Provider agrees that if it is subject to the requirements of Section B (12) of this Appendix, it shall certify to DOH, using a form provided by OMIG on its website, within 30 days of entering into a Provider Agreement with the MCO, if they have not so certified within the past year that a compliance program meeting the requirements of 18 NYCRR §521.3 and Social Services Law § 363-d(2) is in place. The Provider shall recertify during the month of December each year thereafter using a form provided by OMIG on OMIG's website.

3. Payment and Risk Arrangements

- a. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA/ACO, insolvency of the MCO or IPA/ACO, or breach of this Agreement, shall Provider bill; charge; collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA/ACO) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract and this Agreement, for the period covered by the

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paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, Provider will not bill DOH or the City of New York for covered services within the Medicaid Managed Care benefit package as set forth in the Agreement between the MCO and DOH. This provision shall not prohibit the Provider, unless the MCO is a Managed Long Term Care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person, provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.

- b. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the Provider. However, with respect to enrollees eligible for medical assistance or participating in Child Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.
- c. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA/ACO must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law §4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology, or payment policy indexing scheme.

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- d. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210 into any contracts between the contracting entity (Provider, IPA/ACO, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.
- e. The parties agree that, where required by Public Health Law §4903, a claim for certain continued, extended, or additional health care services cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided within the required timeframes and under the circumstances described in Public Health Law §4903.
- f. The parties agree to follow Section 3224-a of the Insurance Law providing timeframes for the submission and payment of Provider claims to the MCO.
- g. The parties agree to follow Section 3224-b(a) of the Insurance Law requiring an MCO to accept and initiate the processing of all claims submitted by physicians that conform to the American Medical Association's Current Procedural Technology (CPT) codes, reporting guidelines and conventions, or to the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (HCPCS).
- h. The parties agree to follow Section 3224-b(b) of the Insurance Law prohibiting an MCO from initiating overpayment recovery efforts more than 24 months after the original payment was received by a health care Provider, except where: (1) the plan makes overpayment recovery efforts that are based on a reasonable belief of fraud or other intentional misconduct or abusive billing; (2) for the Medicaid Managed Care and Family Health Plus programs, the overpayment recovery period for such programs is six years from date payment was received by the health care Provider with written notice 30 days prior to engaging in overpayment recovery efforts. Such notice must state the patient's name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.
- i. The parties agree to follow Section 3224-c of the Insurance Law providing that claims cannot be denied solely on the basis that the MCO has not received from the member information concerning other insurance coverage.
- j. The parties agree that this contract does not waive, limit, disclaim, or in any way diminish the rights that any Provider may have pursuant to Section 3238 of the Insurance Law to the receipt of claims payment for services where preauthorization

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was required and received from the appropriate person or entity prior to the rendering of the service.

k. The parties agree that for a contract involving Tier 2 or 3 arrangements as described in Section VII.B of the Guidelines, the contract must:

- i. Provide for the MCO’s ongoing monitoring of Provider financial capacity and/or periodic Provider financial reporting to the MCO to support the transfer of risk to the Provider; and
- ii. Include a provision to address circumstance where the Provider’s financial condition indicates an inability to continue accepting such risk; and
- iii. Address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting underfunding of the deposit to be maintained by the MCO; and
- iv. Include a provision that the Provider will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH.

l. The parties agree that for any contract involving an MCO and IPA/ACO, the contract must include provisions whereby:

- i. The parties expressly agree to amend or terminate the contract at the direction of DOH;
- ii. The IPA/ACO will submit both quarterly and annual financial statements to the MCO, as well as any additional documents required by the MCO as necessary to assess and ensure the IPA/ACO’s progress towards achieving value based payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO; and
- iii. The IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH; and
- iv. The parties agree that all Provider contracts will contain provision prohibiting Providers, in the event of a default by the IPA/ACO, from demanding payment from the MCO for any covered services rendered to the MCO’s enrollees for which payment was made by the MCO to the IPA/ACO pursuant to the risk agreement.

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4. Records and Access

- a. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA/ACO if applicable) for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee's medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA/ACO if applicable) expressly acknowledges that the Provider shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.
- b. When such records pertain to Medicaid reimbursable services, the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.
- c. The parties agree that medical records shall be retained for a period of six years after the date of service, and in the case of a minor, for three years after majority or six years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.
- d. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time of service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA/ACO or to third parties. If the Agreement is between an MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees to require the Providers with which it contracts to agree as provided above. If the Agreement is between an

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IPA/ACO and a Provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

5. Termination and Transition

- a. Termination or non-renewal of an agreement between an MCO and an IPA/ACO, institutional network Provider, or medical group Provider that serves five percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA/ACO and an institutional Provider or medical group Provider that serves five percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination by the MCO may be effected on less than 45 days' notice provided the MCO demonstrates to the satisfaction of DOH, prior to termination, that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.
- b. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal; and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days' notice of its decision to not renew this Agreement.
- c. If this Agreement is between an MCO and an IPA/ACO, and the Agreement does not provide for automatic assignment of the IPA/ACO's Provider contracts to the MCO upon termination of the MCO/IPA/ACO contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA/ACO's Providers agree, that the IPA/ACO Providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever occurs first. This provision shall survive termination of this Agreement regardless of the reason for the termination.
- d. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA/ACO insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract or Medicaid Managed Care contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. **For purposes of this clause, the term "Provider" shall include the IPA/ACO and the IPA/ACO's contracted Providers if this**

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Agreement is between the MCO and an IPA/ACO. This provision shall survive termination of this Agreement.

- e. Notwithstanding any other provision herein, to the extent that the Provider is providing Health Care Services to enrollees under the Medicaid Program, the MCO or IPA/ACO retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.
- f. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA/ACO agrees to require all participating Providers of its network to assist in the orderly transfer of enrollees to another Provider.

6. Arbitration

To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation and copies of all decisions.

7. IPA/ACO-Specific Provisions

Any reference to IPA/ACO Quality Assurance (QA) activities within this Agreement is limited to the IPA/ACO's analysis of utilization patterns and quality of care on its own behalf and as a service to its contractual Providers.

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EXHIBIT 1 TO APPENDIX D

CERTIFICATION REGARDING LOBBYING

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

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds \$100,000, the Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

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 pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

DATE: _____

TITLE: _____

ORGANIZATION: _____

NAME: (Please Print) _____

SIGNATURE: _____

(Initial) VNAHCO _____

(Initial) Provider _____

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IN WITNESS THEREOF, the parties hereto have executed this Agreement on the date first above written.

PLAN:

VNA Homecare Options, LLC

By: _____
Mary Kate Rolf, President / CEO

Date: _____

PROVIDER:

County of Warren dba Warren County
Health Services

By: _____

Name/Title: _____

Date: _____

(Initial) VNAHCO _____

(Initial) Provider _____

RESOLUTION REQUEST FORM NO. 4

Request for Extending, Rescinding or Amending Resolution

DEPARTMENT NAME: Health Services

DATE: 03/19/2018

- (a) Purpose of Contract Change: To ratify the Chaiman of the Board of Supervisors action to reapprove the Provider Agreement for Early Intervention services with New York State Department of Health Early Intervention Program
- (b) Resolution Number, or Numbers if Amended, which Authorized the Original Contract: on file
- (c) Name of Contractor: New York State Department of Health Bureau of Early Intervention Provider Approval and Due Process Unit
- (d) Address of Contractor: Empire State Plaza – Corning Tower Rm. 287, Albany, NY 12237-0660
- (e) Contractor's Contact Person and Telephone Number: Darcy Alheim, email: Darcy.Alheim@health.ny.gov
- (f) Commencement Date of Amendment: 04/01/2018
- (g) Termination Date of Extension: per terms of agreement
- (h) Payment Provisions: Per New York State Early Intervention Program set rates
- i) lump sum amount
 - ii) hourly rate amount
 - iii) total amount not to exceed
 - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc.
- (i) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount **OR** Capital Project **OR** Capital Reserve Project Number and Title and Amount:
- A4054.0060.1604 Early Intervention Revenues
A4054.0060.3278 Early Interventon

**** send completed document via email to:**
eiprovideragreement@health.ny.gov

NYS Department of Health

Bureau of Early Intervention

Provider Approval and Due Process Unit

Early Intervention Provider Agreement: Notification/Re-Approval

Caldwell, Diane

From: doh.sm.EIP.Provider.Agreement <EIPProviderAgreement@health.ny.gov>
Sent: Tuesday, March 06, 2018 1:08 PM
Subject: URGENT (Completion Required): Early Intervention Agreement
Attachments: Provider Agreement (rev 2018).pdf

Importance: High

This document only pertains to your EI Re-Approval and should not be shared.

IT IS IMPORTANT THAT YOU COMPLETE THIS ASAP.

Your DOH Early Intervention Re-Approval Application has been received.

Attached you will find the updated *Early Intervention Provider Agreement (revised 2018)*. After carefully reading the pdf fillable Agreement, type in your information, then save the document to your files. Once saved, you should then print out the Agreement and sign it. Please keep a copy of the Agreement for your records. Where your signature is required, please sign in ink.

*If you are currently an approved individual, with a business name associated with it, you must record your name as <Last Name, First Name> for <Business Name>.

You may either return:

- **the entire completed Agreement or**
- **pages 1 and 2 (if maintaining an Appendix 1) and the Authorization/Signature Page.**

Early Intervention Provider Agreement (effective 2018)

This Provider Agreement is entered into by and between the New York State Department of Health (hereinafter referred to as the "Department"), and

Warren County Health Services
<NYS Provider ID/State ID> 314 (hereinafter referred to as the "Provider"). Provider acknowledges that this agreement is made by and between the Department and Provider, as Provider is currently organized and constituted or presented. The Department reserves the right to terminate this agreement should the Provider reorganize or otherwise substantially change the character of its corporate or other business structure or presentation.

Purpose of Agreement

The purpose of this Agreement is to set forth the terms and conditions for participation in the Early Intervention Program (EIP) and to establish the obligations, expectations and relationship between the Department, municipalities within the State and the Provider.

Providers intending to receive service authorizations for early intervention services directly from a Municipality and payment from the Municipality for such services rendered must complete and comply with the attached **Appendix 1- Payee Provider Agreement/Service Authorizations and Payment**. Appendix 1 sets forth the terms and conditions for such authorizations and payment.

Definitions

When used herein, the following terms shall have the following meanings:

- "Applied behavior analysis" or "ABA" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
- "Early Intervention Official" or "EIO" shall mean an appropriate municipal official designated by the chief executive officer of a municipality and an appropriate designee of such official.
- "Early Intervention Program" or "EIP" means the program established pursuant to Title II-A of Article 25 of the Public Health Law.
- "Family/Caregiver Support Group" is the provision of early intervention services to a group of parents, caregivers (foster parents, day care staff, etc.) and/or siblings of eligible children for the purposes of enhancing their capacity to care for and/or enhance the development of the eligible child and providing support, education, and guidance to such individuals relative to the child's unique developmental needs.
- "Group Developmental Intervention Visit" shall mean the provision of early intervention services by appropriate qualified personnel to eligible children in a group which may also include children without disabilities, at an approved Provider's site or in a community-based setting.
- "Home and Community Based Individual/Collateral Visits" shall mean the provision by appropriate qualified personnel of services to an eligible child and/or parent or other designated caregiver at the child's home or any other natural environment in which children under three years of age are typically found (including day care centers other than those located at the same premises as the Provider, and family day care homes).
- "Municipality" shall mean a county outside of the City of New York or in the case of a county located within the City of New York. For purposes of this agreement, "Municipality" shall further mean the Municipality in which the Provider renders evaluations, service coordination or early intervention services to children residing in such Municipality.
- "Office/Facility-Based Individual/Collateral Visits" shall mean the provision by appropriate qualified personnel of services to an eligible child and/or parent or other designated caregiver at an approved Provider's site (including day care centers located at the same premises as the Provider).

- "Parent-Child Group" is a group comprised of parents or caregivers, children, and a minimum of one appropriate qualified Provider of early intervention services at an early intervention Provider's site or a community-based site (e.g., day care center, family day care, or other community settings).
- "Provider" shall mean an agency or individual approved in accordance with 10 NYCRR § 69-4.5 to deliver service coordination, evaluations and screenings and/or services in the EIP.
 - "Agency Provider" shall mean an entity which employs qualified personnel as defined in 10 NYCRR §69-4.1(ak), and may contract with individual providers or other agency providers which are approved by the Department, for the provision of early intervention program evaluations and screenings, service coordination, and/or early intervention services.
 - "Individual Provider" shall mean a person who holds a state-approved or recognized certificate, license or registration in one of the disciplines set forth in 10 NYCRR § 69-4.1(ak) and who either receive service authorizations for early intervention services from a Municipality and/or are under contract with an agency provider.
- "Services" shall mean those early intervention services as defined in 10 NYCRR 69-4.1(l) that the Provider identified in the Provider's application to the Department as being able to provide, either directly or for Agency Providers through employees and/or contracts with Individual Providers or other Agency Providers.
- "Service authorization" shall mean approval by a municipality relating to specific services contained in a child's Individualize Family Service Plan (IFSP) and includes the following details: the provider of record; the type of service; whether it is a facility based or home and community based service; whether it is a basic or extended service; how many times per week the service can be provided; the rendering provider; and the diagnosis for the child.
- "Service Coordination Services" shall mean assistance provided by a service coordinator to enable an eligible child and the child's family to receive the rights, procedural safeguards and services that are authorized to be provided under the EIP.
- "State" shall mean the State of New York.

Now, therefore, the Department and Provider agree as follows:

I. Appendix

The Provider cannot receive service authorizations from a Municipality and claim for early intervention services rendered unless requested by the provider and approved by the Department in this agreement. The following appendix, when checked, shall be incorporated and made a part of this agreement as if fully set forth herein:



Appendix 1- Payee Provider Agreement/Service Authorizations and Payment

II. Role of Department, Municipalities and Providers in the Early Intervention Program

Pursuant to Public Health Law (PHL) § 2550, the Department is the lead agency responsible for the administration of the Early Intervention Program in this State. Each individual Municipality and the city of New York is responsible for the local administration of the program, which includes but is not limited to, accepting referrals of children potentially eligible for program services, assigning initial service coordinators, participating in IFSP meetings, ensuring that early intervention (EI) services contained in an IFSP are appropriately delivered, and reimbursing providers for services not covered by Medicaid or commercial insurance according to rates set by the Department pursuant to regulations. PHL authorizes the Department to contract with a fiscal agent that will handle provider claiming and payment. The Provider hereby understands and agrees that the claims submitted shall be accurate and complete, and shall reflect the actual service rendered. The Provider further understands and agrees that, pursuant to PHL § 2557(3) and (3-a), PHL § 2552(1) and 10 NYCRR § 69-4.12, both the Department and the Municipality are authorized to monitor and audit evaluators, service coordinators and Providers of services within the Municipality. Provider understands and agrees that certain provisions within this Agreement that require notice to the Municipality or includes the Municipality with respect to obligations or requirements, are designed to acknowledge the Municipality's role in the local administration of the Early Intervention Program and in the oversight of Providers in the delivery and payment for evaluations and services provided to children within such Municipality.

III. Provider Responsibilities

- A. Provider shall comply with all applicable provisions of law, rule and regulation when participating in the Early Intervention Program, including but not limited to PHL §2550 et seq, 10 NYCRR SubPart 69-4, Part C of the Individuals with Disabilities Education Act and its regulations at 34 CFR Part 303, and the Family Educational Rights and Privacy Act (FERPA) and its regulations at 34 CFR Part 99.
- B. Agency Provider understands and hereby agrees that it is responsible for and shall ensure that its employees and Individual Providers under contract with such Agency Provider comply with the provisions of applicable law and regulations, and with the terms of this Agreement when delivering evaluations or services on behalf of the Agency Provider.
- C. Provider hereby agrees that Provider can and shall deliver services in the areas of the State identified by the Provider to the Department as part of this agreement but the Provider is not prohibited from providing services in additional areas of the State. Provider shall only conduct evaluations and deliver the services for which Provider is approved by the Department to deliver.
- D. Provider understands and hereby agrees that nothing in this Agreement or Appendix 1 of this Agreement shall be deemed to require or otherwise hold the Department responsible for making payment to the Provider for evaluations or services rendered under the EIP. Provider understands and agrees that reimbursement for evaluations and services is governed by PHL §2557 and §2559. In accordance with those sections, Providers who receive direct service authorizations from a Municipality shall, in the first instance and where applicable, seek reimbursement under a health insurance policy, plan or contract, including under the medical assistance program or the child health insurance program, prior to seeking reimbursement from a Municipality for services rendered to a child who has health insurer or health maintenance organization coverage. Payments will be made by insurers and the Medicaid Program directly to the Provider and remittance advices will be submitted by the third-party payers to the Department's state fiscal agent (SFA) with claims adjudication information. The SFA will inform the Provider of denied claims and will work with the Provider to address any denials resulting from inaccurate or incomplete information required for payment (for example, missing diagnostic or procedural codes.) Pursuant to PHL §2557, approved costs, other than those reimbursable under a health insurance policy, plan or contract, including under the medical assistance program or the child health insurance program, for evaluations and services shall be a charge upon the Municipality wherein an eligible child resides. Provider shall not seek or be entitled to reimbursement directly from the Department for evaluations or services rendered to eligible children under the EIP.
- E. Provider understands and hereby agrees that the Provider cannot be involved in any activity relating to the provision of evaluations or services rendered under the EIP if the Provider is excluded from Medicaid or Medicare.
- F. Agency Provider understands and hereby agrees that the Agency Provider must verify that a person is not excluded from Medicaid or Medicare at the time of hire or upon entering into contract and at least verify every thirty (30) days that current employees and contractors used by the Agency Provider have not been excluded.
- G. Provider understands and hereby agrees that nothing in this Agreement shall be construed as guaranteeing to Provider a specific number of evaluation assignments or service authorizations. Provider understands and agrees that the Provider may not be assigned any evaluations or provided with any service authorizations in the EIP, and/or that service authorizations may be modified at any time in accordance with PHL, for reasons including but not limited to the eligible child has progressed under the EIP and the IFSP team determines that a service should be reduced or is no longer needed. Provider further understands that payment for evaluations and services under the EIP is subject to funds being appropriated and made available therefor.
- H. Provider understands and hereby agrees that all sites are under the control of the Provider and will be maintained in compliance with all applicable laws and regulations and implement a policy for addressing health, safety and sanitation issues that conforms with standards established by the Department and where applicable, in conformance with the American with Disabilities Act. Provider further understands that all sites under the control of the Provider must be approved by the Department prior to rendering EIP services at each site.

IV. Personnel

- A. Provider hereby affirms that Provider can deliver services on a twelve-month basis and provides flexibility in hours of service delivery, which includes but is not limited to, rendering services outside of standard business and/or operating hours. This includes but is not limited to service delivery on weekend and evening hours in accordance with eligible children's IFSPs.
- B. Provider shall maintain a statement from a health care provider which documents that the Provider, and employees and Individual Providers under contract with an Agency Provider, has no diagnosed disorder or condition that would preclude him/her from providing services. Such statement shall be obtained prior to the provision of services and updated on an annual basis thereafter.
- C. Provider shall maintain proof from a health care provider that the Provider, and/or employees and Individual Providers under contract with an Agency Provider, meet the following requirements, prior to provision of services:
 - measles, mumps, and rubella titer and/or vaccine; and annual Mantoux/PPD or chest X-ray with the exception of EI Providers who are also licensed day care providers by the NYC Bureau of Day Care. NYC Bureau of Day Care Providers must demonstrate that upon commencement of work, a record of testing performed for tuberculosis infection, and further testing at any time, if required by the NYC Bureau of Day Care.
 - have the following recommended vaccines or has documented refusal, prior to the provision of EI Provider services: Hepatitis B vaccine, Tetanus immunization within the past 10 years, Diphtheria, Pertussis, Varicella, and Influenza.
- D. In accordance with Social Services Law (SSL) §424-a and §495, Agency Provider shall conduct a Staff Exclusion List (SEL) check of potential hires through the New York State Justice Center for the Protection of People with Special Needs (Justice Center) prior to conducting a Statewide Central Register (SCR) of Child Abuse and Maltreatment check. The Agency Provider is responsible for initiating this process with the state's Justice Center.
- E. Providers shall, in accordance with Social Services Law (SSL) § 424-a, ensure that Statewide Central Register Database Check Form LDSS-3370 is completed and submitted to the SCR for: (i) any person who is being actively considered for employment, and who will have the potential for regular and substantial contact with children who receive early intervention services; and (ii) any prospective Individual Provider providing goods and services who will have the potential for regular and substantial contact with children who receive services. Agency Provider shall complete the SCR database check and must receive an acceptable response from the SCR prior to authorizing or allowing any person or Individual Provider to have any unsupervised contact with a child receiving early intervention services. If any person about whom the Agency Provider has made an inquiry is found to be the subject of an indicated report of child abuse or maltreatment, such Agency Provider must, in accordance with SSL § 424-a, determine, on the basis of information it has available and in accordance with guidelines developed and disseminated by the NYS Office of Children and Family Services for child care services, whether to hire, retain or use the person as an employee, volunteer or contractor or to permit the person providing goods or services to have access to children being served by the Agency Provider. Whenever such person is hired, retained, used or given access to children in the EIP, such Agency Provider must maintain a written record, as part of the application file or employment or other personnel record of such person, of the specific reason(s) why such person was determined to be appropriate and acceptable as an employee, volunteer, contractor or provider of goods or services with access to children being served the Agency Provider.
- F. If Agency Provider denies employment or determines not to retain or utilize such person, Agency Provider shall comply with the requirements contained in SSL § 424-a.
- G. Provider shall review and become familiar with the Department's guidance and written policies and procedures for the provision of EI services, including but not limited to guidance regarding referral, eligibility, evaluations, provision of services, record keeping and claiming. Agency Providers shall ensure that its employees and Individual Providers under contract with such Agency Providers are familiar with such guidance, policies and procedures.
- H. Agency Providers shall only utilize qualified personnel as defined in 10 NYCRR §69-4.1 as appropriate for the provision of authorized services, and shall ensure that such qualified personnel maintain current

registration, certification or licensure in the area for which they are providing services on behalf of the agency.

- I. Individual Providers shall demonstrate proficiency in early childhood development and only render services within the scope of practice for which they are licensed and currently registered, or certified, as applicable, and within the areas in which the Individual Provider has been trained and educated, and with which he or she is familiar and competent.
- J. Agency Providers shall assign a speech language pathologist to provide services to a child when a speech service is authorized in a child's IFSP; the Agency Provider shall not assign a certified teacher when speech services are authorized in the child's IFSP and requested by the service coordinator.
- K. Provider, employees and independent contractors (including Service Coordinators) utilized by a Provider Agency to deliver services shall demonstrate continued professional development related to their professional field of practice, including but not limited to family-centered services, child outcomes, quality improvement and on state and municipal policies and procedures of the early intervention program, including participation in Department-sponsored training. Provider shall participate in a minimum of ten clock (10) hours of professional development activities per year. Such professional development activities are not restricted to Department sponsored training and may include other professional activities necessary for licensure and activities identified by the Provider to increase the Provider's professional skills and knowledge. Activities may include but are not limited to formal continuing education courses/workshops, formal academic study, independent study, mentoring, and in-service training programs. Activities may also include Department sponsored training, Municipal sponsored training, webcasts, and webinars which may be provided particularly during periods of introduction of a new policy and procedure. Provider will maintain documentation of professional development activities and make such documentation available upon request to the Department and/or Municipality.
- L. Agency Providers will, before utilizing a student/intern, a physical therapy assistant or an occupational therapy assistant for the provision of EI provider services, notify the Municipality, service coordinator and parent that the Agency Provider intends to have a student/intern, a physical therapy assistant or an occupational therapy assistant provide services under the supervision of a licensed practitioner; provide the Municipality, service coordinator and parent a written plan for how the supervising practitioner will assume professional responsibility for the services provided under his or her direction and how the need for continued services will be monitored; and have agreement from the Municipality, service coordinator and parent prior to the provision of services by a student/intern, a physical therapy assistant or an occupational therapy assistant.
- M. Agency Providers shall maintain, using the Department's electronic database, a contemporaneous list of their employees and Individual Providers under contract with such Agency Provider which reflects the current staff available to provide EI services.
- N. Provider shall be familiar with and comply with all applicable Medicaid rules and regulations. Provider shall not engage in any act which constitutes an unacceptable practice under the Medical Assistance Program as enumerated in Title 18 of the New York Code of Rules and Regulations Section 515.2(a) and (b) (1) through (b) (15), (17) and (18). Agency Providers shall not utilize employees or Individual Providers or vendors, who have been excluded from participation in the Medical Assistance Program. Agency Providers shall ensure that they do not employ, or are affiliated with, any individual or agency, which has been excluded from either the Medicare or the Medicaid program. Providers shall routinely but no less than every thirty (30) days review federal and state databases to determine if employees, prospective employees, and contractors (Individuals and other Agency Providers), have been excluded or terminated from participation in the Medical Assistance Program.
- O. Provider shall provide their own equipment and supplies including toys necessary to conduct their business. Provider understands that it is not the responsibility of the Department or Municipalities to supply such equipment, supplies or toys. Provider shall comply with applicable health and safety standards, including those related to use of toys, equipment and supplies.
- P. Provider shall obtain access to the Department's electronic database for at least one person for the purpose of managing EI information necessary to conduct business utilizing the electronic database.

V. **Services**

- A. Provider shall use informed clinical opinion, observation and ongoing assessment in collaboration with the family/caregiver and additional team members to prioritize identified family/caregiver areas of concern. Provider shall be an active participant in the development of integrated family & child focused goals and outcomes for the IFSP. As a licensed and/or certified professional focused on their field of practice, Provider shall encourage families and caregivers to collaboratively identify priorities as they relate to a child's participation in everyday activities; observe families/caregivers and their children to engage in activities when clinically appropriate; collaboratively document child and family strengths, accomplishments, interests and needs which will assist a family to be an informed advocate for their child/children and active member of the IFSP team; and inform an IFSP team, if the provider is unable to attend an IFSP meeting.
- B. Provider shall render services in conformance with the child's and family's IFSP, including but not limited to functional outcomes, the duration specified, location and frequency of such service.
- C. Provider understands and agrees that the use of aversive intervention in any form is strictly prohibited when providing EIP services. Aversive intervention is defined in 10 NYCRR § 69-4.9 to mean an intervention that is intended to induce extreme or excessive and/or non-therapeutic pain or discomfort to a child for the purpose of modifying or changing a child's behavior, limiting a child's free range of movement, or eliminating or reducing maladaptive behaviors, including but not limited to the following: contingent application of noxious, painful, intrusive stimuli or activities; any form of noxious, painful, or intrusive spray (including water or other mists), inhalant, or tastes; contingent food programs that include the denial or delay of the provision of meals or intentionally altering staple food or drink to make it distasteful; movement limitation used as punishment, including but not limited to helmets and mechanical restraint devices; physical restraints; blindfolds; and white noise helmets and electric shock.
- D. Provider shall work collaboratively with the family to identify strategies/activities and the necessary services and supports to achieve IFSP outcomes including but not limited to developing and enhancing the family's capacity to support their child's learning and development between visits; building on the interests and strengths of the child and family; and determining the intensity, and method for each service to be reasonable and not burdensome to the family.
- E. Provider shall use a child developmental approach in intervention strategies, incorporating evidence-based child development practices with necessary adaptations to foster and promote age appropriate development.
- F. Provider shall use an individualized approach, including consideration and respect for cultural and religious, lifestyle, ethnic, and other individual and family characteristics.
- G. Provider shall be an active participant in the development and implementation of a transition plan for a child transitioning from the EIP.

VI. **Documentation and Recordkeeping**

- A. When required by the Department, Provider shall utilize a standardized reporting format when reporting on services delivered in the EIP.
- B. Provider shall maintain documentation necessary to support claiming to third party payors (Medicaid and commercial insurers), the Municipality and State. In instances where corrections are made to documentation required to support claiming, the rendering provider shall leave his or her original writing intact, strike through the mistake with a single line, make a legible correction and clearly write his or her initials and date correction was made next to the correction. Provider shall not use white-out in an EI record.
- C. Provider shall maintain contemporaneous session notes, utilizing a Department standardized form when required by the Department, following each child and family contact, which shall include the information required in 10 NYCRR 69-4.26(c) including: the recipient's name, date of service, type of service provided, time the Provider began delivering therapy to child and end time, brief description of the recipient's progress made during the session as related to the outcome contained in the IFSP, name, title, and signature of the person rendering the service, date the session note was created, and signature of the

parent or caregiver which documents that the service was received by the child on the date and during the period of time as recorded by the Provider.

- D. Provider understands and hereby agrees that all 'make-up' sessions must be consistent with Department regulations and guidance, occur in conformance with the IFSP and session notes created for 'make-up' sessions must accurately state that the session is in place of a previously scheduled session, and reflect the date/time that the 'make-up' session occurred. Provider further understands and hereby agrees that Provider risks non-payment for inaccurate claims.
 - E. Original session notes must be maintained in accordance with the requirements of 10 NYCRR § 69-4.26. In situations where an Individual Provider is rendering services to a child and family under an authorization to such Provider by a Municipality or when the Individual Provider is rendering services as a contractor to an Agency Provider, the Individual Provider shall maintain the original session notes. A Municipality or Agency Provider may request or require submission of copies of such Individual Provider's session notes. Original EI records generated by qualified personnel who are employees of a Municipality or Agency Provider shall be retained by the respective Municipality or Agency Provider.
 - F. Provider shall make periodic progress notes summarizing the effectiveness of the service and the progress being made toward outcomes included in the child's and family's IFSP. Progress notes shall be made at a minimum frequency of twice during the IFSP yearly cycle - for six-month IFSP reviews and for the annual IFSP review. The Department may direct that the progress notes be made in a certain format or manner. Progress notes shall be included in the child's record and shall be available upon request by the service coordinator, Municipality, or Department.
 - G. Provider shall maintain records that document the performance of services required to be completed by Provider on behalf of eligible children and their families, including but not limited to: parental consents for provision of evaluations and services; reports, session notes, progress notes, and other documentation related to evaluations or service delivery; a copy of the IFSP; service authorizations; physicians orders and/or prescriptions for services provided and other documents as may be required in regulation.
 - H. Provider shall maintain accurate and complete records that support claiming for actual services rendered. Provider shall only submit claims for payment that accurately reflect the service provided by qualified personnel authorized to provide the service on the date such service is provided and which shall be consistent with the child's IFSP.
 - I. Provider shall maintain complete records and data that support information necessary for the Department to report annually through the Part C Annual Performance Report (Part C- APR). Information/data will include but is not limited to timely IFSP, timely services, and transition steps and services. The Department may direct that information be made in a certain format or manner.
 - J. Provider shall retain EI records pertaining to a child and family for a minimum of six years from the date that care, services, or supplies were provided to the child and family. Individual Providers who are licensed, registered, or certified under state education law must retain child and family records for the period of time set forth in the laws and regulation that apply to their profession.
- VII. Notifications**
- A. Provider shall make reasonable efforts to notify the child's parent/family/caregiver prior to the date and/or within one hour prior to the time on which a EI provider service is to be delivered, of any temporary inability to deliver such service due to circumstances such as illness, emergencies, hazardous weather, or other circumstances which impede the provider's ability to deliver the service. If circumstances prevent such notification prior to a visit, notification should be provided as soon as possible following the missed visit. Provider shall also make reasonable efforts to notify the child's parent/family/caregiver if the Provider will be more than fifteen (15) minutes late for a scheduled session, due to uncontrollable circumstances.
 - B. Provider shall make reasonable efforts to notify the Department and municipality (s) within five (5) business days of any prolonged closure or unavailability to provide EI services to children located in a specific municipality
 - C. Provider shall notify the child's parent and service coordinator at least five (5) business days prior to any scheduled absences due to vacation, professional activities, or other circumstances, including the dates for

which the Provider will be unable to deliver services to the child and family in conformance with the IFSP and the date on which services will be resumed by such Provider. Missed visits may be rescheduled and delivered to the child and family by such Provider, as clinically appropriate, agreed upon by the parent and in conformance with the child's and family's IFSP.

- D. Provider shall notify the child's service coordinator and early intervention official (EIO) of the intent to permanently terminate the delivery of early intervention program services to a child and the child's family, for any reason, at least thirty (30) calendar days prior to the date on which the Provider intends to cease providing services.
- E. Provider shall notify the child's service coordinator within twenty-four (24) hours of the child's absence from more than three (3) consecutive scheduled sessions for the delivery of services, indicating the reason for said absence, if known.
- F. Provider shall notify the service coordinator and the Municipality within two (2) business days, when a parent voluntarily withdraws their child from early intervention services with a Provider, for any reason.
- G. Provider shall notify the Department, in writing, within five (5) calendar days, in the event Provider becomes a party to any litigation, investigation or transaction that may reasonably be considered to have a material impact on Provider's ability to perform under this Agreement.
- H. Individual Providers shall notify the Department within two (2) business days if their license is suspended, revoked, limited or annulled, regardless of whether the suspension or limitation is stayed.
- I. Provider shall notify the Department immediately upon becoming aware that the, Medicare or Medicaid certification of Provider, or any employee or Individual Provider under contract with the Agency Provider is restricted, suspended or temporarily and/or permanently revoked by any regulatory authority.

VIII. Mandated Reporting

- A. Providers shall report or cause to be reported suspected cases of child abuse and/or maltreatment to the SCR whenever they believe that there is reasonable cause to suspect that a child, made known to them in their official capacity as a Provider under the EIP, is or has been abused or maltreated.
- B. Provider shall develop and maintain policies and procedures regarding the reporting of suspected child abuse and/or maltreatment. Agency Providers shall ensure that its employees and Individual Providers under contract with such Agency Provider are aware of the Agency Provider's policies and procedures in this regard.

IX. Confidentiality

- A. Provider shall preserve the confidentiality of all electronic and/or hard-copy data and information, both historical and current data, that is shared, received, collected, or obtained in relation to services provided in the EIP, in accordance with applicable law and regulations, including but not limited to FERPA and 10 NYCRR § 69-4.17.
- B. Provider shall keep child records secure, whether records are stored in a business location, an Individual Provider's home or at a secure location outside the Provider's home. Provider shall have a written policy on confidentiality and meet all confidentiality requirements of the EIP, including physical security.
- C. Provider shall prevent the disclosure, redisclosure or release of such data or information, except as expressly authorized by law. Provider shall not use such data or information for personal benefit.
- D. Provider agrees to develop and maintain specific procedures ensuring the protection of health history information related to an individual who has been diagnosed as having AIDS or HIV-related illness or HIV infection or laboratory tests performed on an individual for HIV-related illness.
- E. Agency Provider agrees to comply with the confidentiality and disclosure requirements set forth in and in Part 403 of New York State Social Service Law and Section 2782 of Public Health Law, and ensure that staff, to whom confidential HIV-related information is disclosed as a necessity for providing services, are fully informed of the penalties and fines for redisclosure in violation of State law and regulations.

- F. The Provider fully agrees that any disclosure of confidential HIV-related information shall be accompanied by a written statement as follows:

This information has been disclosed to you from confidential records, which are protected by State law. State law prohibits you from making any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of State law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

X. Marketing

- A. Provider shall comply with the provisions of 10 NYCRR § 69-4.5(e).
- B. Provider shall not represent themselves as, or claim to be, an officer or employee of the State or Municipality by reason of this Agreement.
- C. Provider shall ensure that marketing and advertising materials adhere to the Department's Marketing Standards for Early Intervention Service Providers and adequately inform parents or guardians of children less than three years of age who are suspected of having a disability or are at risk of disability about the EIP.

XI. Auditing, Monitoring, Due Process

- A. Provider shall cooperate with any announced or unannounced fiscal audit, programmatic monitoring and/or quality improvement monitoring by the Department, Municipality or its respective designee. Provider shall maintain and make available to the Department and Municipality upon request, complete financial records and clinical documentation related to the provision of services to permit a full fiscal audit by appropriate State and municipal authorities.
- B. Provider shall make available such records or documents that are requested on the date and time of the visit, and shall provide access to the facility for facility based Providers.
- C. Provider shall render diligently to the Department and the Municipality any and all cooperation, without additional compensation, that may be required as part of an investigation, mediation, or hearing.
- D. Provider shall demonstrate full and faithful cooperation with any investigation, audit or inquiry conducted by the Department, Municipality or State or Federal governmental agency or authority that is empowered directly or by designation to compel attendance of witnesses and to examine witnesses under oath, or conducted by a governmental agency that is a party in interest to the transaction, that is subject of the investigation, audit or inquiry.
- E. Provider shall render diligently to the Municipality and Department any and all cooperation, without additional compensation, that may be required to defend the Municipality and/or Department against any claims, demand, or action that pertain to Provider that may be brought against the Municipality and/or the Department in connection with services rendered by or on behalf of Provider to children under the Early Intervention Program and/or the terms and provisions of this Agreement.
- F. Provider shall implement to the satisfaction of the Department, corrective actions deemed necessary by the Department or its designee to bring the Provider into compliance with applicable State and Federal statutes and regulations governing the EIP. Provider shall further implement, to the satisfaction of the Municipality, any corrective actions as may be required by Municipality after an audit or monitoring of the Provider by the Municipality in accordance with PHL § 2557(3-a), PHL § 2552(1) and 10 NYCRR § 69-4.12.
- G. Provider understands and hereby agrees that payment by the Municipality may be withheld or suspended if upon audit or monitoring by the Department or Municipality it is found that the Provider, and/or employees or Individual Providers under contract with an Agency Provider, did not provide the services claimed for, the services were not provided in conformance with a child's IFSP, the rendering provider was not qualified by licensure, certification or registration to deliver the services, and/or the services were not provided in conformance with law or regulation or this Agreement.

XII. EI Model Specific Responsibilities

A. Service Coordination

- A1. Provider, and employees and Individual Providers under contract with an Agency Provider, who deliver service coordination services, shall, in accordance with 10 NYCRR §§ 69-4.4 and 69-4.5(xi) demonstrate continued professional development on state and local policies and procedures of the EIP, including participation in Department-sponsored training. Provider shall maintain documentation of continuing education/training and make such documentation available upon request to the Department and Municipality.
- A2. Provider shall ensure that they, their employees and independent contractors utilized by the Provider Agency demonstrate participation in on-going training including but not limited to introductory service coordination, advanced service coordination, evaluation, and IFSP training sponsored or approved by the Department of Health, when Provider is approved for service coordination services.
- A3. Provider, and employees and Individual Providers utilized by an Agency Provider who deliver service coordination services on behalf of the Agency Provider shall complete introductory service coordination training sponsored or approved by the Department of Health prior to rendering service coordination services and participate in a minimum of one (1) professional development activity totaling a minimum of 1 1/2 clock hours directly related to service coordination per calendar year. Such activity is not limited to Department sponsored training but can include other professional development activities which focus on enhancing skills necessary for service coordinators to increase their competency to provide service coordination activities.
- A4. Provider shall render all service coordination activities as set forth in applicable law and regulations and as specified in the child's IFSP.
- A5. Provider of initial and/or ongoing service coordination services shall document all activities (billable and non-billable) related to the performance of their duties which includes the following information: recipient's name; date of service; a description of the specific service coordination activity performed; name, date of contact, and purpose of contact for providers or others contacted on behalf of the child and family as necessary to implement the IFSP; start and end time for each contact; and name, title and signature of the service coordinator, as applicable. The Department may require that the Provider document such activities using a standard form or format.
- A6. Provider shall provide Service Coordination as authorized by the Municipality when authorized for initial service coordination, and when authorized for on-going service coordination for a child/family, up to the limit of units of service coordination prescribed in the IFSP and indicated on the service authorization. Provider shall provide additional units of service only if authorized in accordance with a fully executed amendment to the IFSP, which shall include signatures of the Parent (s) and EIO/designee and IFSP team members.
- A7. Provider shall prepare and submit reports and/or data regarding Service Coordination activities as requested by the Department or Municipality in a manner and format as may be requested by the Department or Municipality.
- A8. Provider shall be reasonably accessible to the child's evaluator, other Providers of EI services, the Department and the Municipality during standard business hours.
- A9. The Provider shall be reasonably available to the parent in a manner that does not limit service access to daytime and/or weekday hours and does not limit access to a specific location. The Provider shall ensure that accessibility for service coordination are available to families in non-traditional schedules and through a variety of methods and locations. Provider shall be responsible for informing families of changes to their contact number, email address, and the specific times and places of their accessibility.
- A10. Provider shall communicate with the family about the purpose of Early Intervention, provide all information to the family in the family's dominant language or other mode of communication unless clearly not feasible to do so, and shall ensure that the family has received or has access to the

current version of Early Intervention Steps: A Parent's Basic Guide to the Early Intervention Program, the parent's handbook that provides information about the program upon referral to the EIP.

- A11. Provider shall describe the rationale for services in natural environments. Provider shall describe each step of the IFSP process, including its purpose, and what service delivery might look like.
- A12. Provider shall collaboratively balance listening to the family with sharing information and shall use open-ended questions that encourage the family to share their thoughts and concerns. Provider shall discover family preferences for sharing and receiving information as well as the family's teaching and learning strategies they prefer to use with their child.
- A13. Provider shall review with the EI family the EIP procedural safeguards/due process rights upon initial contact with the family and whenever the family may disagree with an eligibility decision or with the early intervention official/designee decision regarding services for their child/family.
- A14. Provider shall assist families to obtain the services and/or assistance they need.
- A15. Provider shall inform the family that services must be at no cost to families, use of Medicaid and/or third party insurance for payment of services is required under the EIP, that any deductible or co-payments is not the responsibility of the family; the use of third party insurance for payment of early intervention services will not be applied against lifetime or annual limits specified in their insurance policy, if such policy is subject to New York State law and regulation; and that the Municipality/Department/service coordinator will not obtain payment from their insurer, if such policy is not subject to New York State law and regulation and if the insurer is therefore not prohibited from and will apply payment for early intervention services to the annual and lifetime limits specified in their insurance policy. Provider shall collect, from the family, information on any insurance policy, plan or contract under which an eligible child has coverage.
- A16. Provider shall review all options for evaluation and screening with the family from the list of approved evaluators including location, types of evaluations performed, and settings for evaluations (e.g., home vs. at the evaluation agency). Upon selection of an evaluator by the family, the Provider shall ascertain from the family any needs the family may have in accessing the evaluation. Provider shall at the family's request, assist the family in arranging of the evaluation after the family selects from the list of approved evaluators.
- A17. Provider shall contact the family to ensure that the family has received information concerning alternative approved evaluators and ascertain from the family any needs the family may have in accessing the evaluation, if the family has accessed an approved evaluator prior to contact by the initial service coordinator.
- A18. Provider, upon receipt of the results of the evaluation, may with parental consent and the approval of the early intervention official, require additional diagnostic information regarding the condition of the child, provided that such information is not unnecessarily duplicative or invasive to the child according to guidelines of the Department of Health. One such example is that such information may assist the IFSP team to determine the appropriate type, location, frequency or duration of the EI provider service.
- A19. Provider shall prior to obtaining written parental consent for additional diagnostic information, provide the family with a written explanation which shall include: diagnostic information requested; reasons for obtaining the information, and use of the information; location of diagnostic testing; source of payment and that no costs shall be incurred by the parent; a statement that the information shall not be used to refute eligibility; and a statement that the meeting to formulate the Individualized Family Service Plan shall be held within the 45 day time limit.
- A20. The Provider shall, with parent consent, notify the Office for People with Developmental Disabilities' regional developmental disabilities services office of the potential eligibility of a child for programs or services available under that Office, if the Provider, in consultation with the evaluator, identifies the child as potentially eligible for programs or services offered by or under such office.

- A21. Provider shall, upon the determination of a child as ineligible for EIP services, inform the family of the right to due process procedures as set forth in 10 NYCRR § 69-4.17 and shall inform the family of other services which the family may choose to access and for which the child may be eligible and offer assistance with appropriate referrals.
- A22. Provider shall collect from the family a written referral from a primary care provider as documentation, for eligible children, of the medical necessity of EIP services in order to support private insurance claiming.
- A23. Provider shall assist the family in preparing for the meeting to develop the IFSP, including facilitating their understanding of the child's multidisciplinary evaluation and identifying their resources, priorities, and concerns related to their child's development.
- A24. Provider shall inform the family of the opportunity to select an ongoing service coordinator, who may be different from the initial service coordinator, at the Individualized Family Service Plan meeting or at any other time after the formulation of the IFSP.
- A25. Provider shall ensure that the IFSP, including any amendments thereto, is implemented in a timely manner within thirty (30) days of parent consent to the IFSP, or if the projected date for the initiation of a service is greater than thirty (30) days of parent consent to the IFSP, not later than thirty (30) calendar days after the projected date for initiation of the service.
- A26. Provider shall in consultation with the service Provider and the family/caregiver continuously seek the appropriate services and situations necessary to benefit the development of the child for the duration of the child's EIP eligibility, including providing appropriate referrals for families to access social and mental health services.
- A27. When notified by a Provider or by otherwise becoming aware of a child's absence from more than three (3) scheduled sessions for the delivery of services, Provider shall contact the child's parent/family to ascertain the reason for any absences and immediately notify the EIO regarding the absences, reason for such absences and whether there is a need to modify an existing IFSP.
- A28. Provider shall early in the relationship with the family, have conversations about what they want for their child's future once they transition from the EIP.
- A29. Provider shall identify transition issues and discuss steps to prepare the family for choices/options at different transition points and to prepare the child for participating in the new setting when transition occurs. Provider shall ensure that the family understands the timeframe for transition from the EIP and when transition planning should occur.
- A30. Provider shall, together with the IFSP team, develop a transition plan as part of the IFSP process which includes the outcomes and activities to prepare the child and family for success after early intervention.
- A31. When applicable, Provider shall notify the local Committee on Preschool Special Education (CPSE) of a child's potential transition to CPSE services utilizing Department-standardized forms, procedures, and timelines in accordance with applicable law and regulations.
- A32. Provider understands and agrees that, in accordance with PHL § 2552, a Municipality may request that the parent/family select a new service coordinator or require that the service coordinator select a new Provider of services if the Municipality finds that the service coordinator or Provider, as applicable, has not been performing his or her responsibilities as required or that services have not been provided in accordance with the child's IFSP.

B. Evaluations & Screenings

- B1. Provider shall only provide evaluation and screening services as authorized in accordance with their licensure, registration or certification. Agency Providers shall only use qualified personnel who are licensed, certified or registered in the area for which they are providing evaluation services for the provision of core/multidisciplinary evaluations and/or supplemental evaluations

- B2. Provider shall provide evaluations in accordance with a service authorization issued by the Municipality or service coordinator. If the parent selects an approved Provider to conduct the evaluation prior to the designation of an initial service coordinator, the Provider shall immediately notify the EIO of such selection and shall begin the evaluation no sooner than four (4) business days of the EIO's receipt of written notice from the Provider. The Provider shall obtain parental consent to conduct the evaluation prior to the initiation of the evaluation.
- B3. Provider shall when conducting a multidisciplinary evaluation include qualified personnel who have sufficient expertise in child development, and include at least one qualified personnel in the area of the child's suspected delay or disability. The primary area of concern must be included as part of the core evaluation. No evaluation may be performed by telephone, in whole or in part.
- B4. Provider shall when conducting a family assessment include qualified personnel who are trained in the use of professionally accepted methods and procedures to assist the family in identifying their concerns, priorities, and resources related to the development of their child.
- B5. Provider shall ensure that they and, if applicable, their employees who provide Evaluation & Screening services complete continuing professional and clinical education relevant to early intervention services, and in-service training sponsored by the Department regarding evaluation and eligibility, within six (6) months of becoming an employee of the Agency Provider or within six (6) months of the start date of the Agreement, whichever is later. Provider or employees of an Agency Provider who render evaluations and screenings shall also participate in a minimum of one (1) professional development activity totaling a minimum of 1 1/2 clock hours per year related to the provision of evaluation & assessments to children under the age of 5 years old. Such activity is not limited to Department sponsored training but can include other professional development activities which focus on enhancing skills necessary for evaluators to increase their competency to provide evaluation activities. Provider shall have the training and competency to administer a particular evaluation tool prior to conducting an EI evaluation utilizing such tool. Agency Providers shall ensure that its employees who conduct evaluations have the training and competency to administer a particular evaluation tool prior to conduct an unsupervised evaluation.
- B6. Provider shall ensure that they and, if applicable, all employees and Individual Providers under contract to provide evaluations for an Agency Provider, have access to the Department's guidance regarding evaluations and eligibility criteria for the early intervention program, prior to conducting an evaluation or screening and that it is implemented appropriately.
- B7. Provider shall have availability and competency to screen, evaluate, and assess infant and toddler development using appropriate methods and procedures, both formal and informal.
- B8. Provider shall utilize evaluation and assessment procedures that are responsive to the cultural, ethnic, religious and linguistic background of the family. Tests and other evaluation materials and procedures shall be administered in the dominant language or other mode of communication of the child, unless it is clearly not feasible to do so. If such an evaluation is not possible, Provider should not accept the evaluation assignment or must document the attempts to locate a bilingual evaluator and notify the service coordinator of their inability to provide the evaluation in the dominant language or other mode of communication of the child and receive further direction from the service coordinator before proceeding with the evaluation. The service coordinator may, after discussion with and consent by the parent, request that the evaluation be reassigned to another Provider or Provider Agency.
- B9. Agency providers shall only use qualified personnel who are licensed, certified or registered in the area for which they are providing evaluation services for the provision of core/multidisciplinary evaluations and/or supplemental evaluations.
- B10. Provider shall adhere to recognized standards of practice for their respective disciplines when conducting evaluations and utilizing and scoring standardized assessment instruments.
- B11. Provider shall, when conducting a multidisciplinary evaluation include the core components of a developmental assessment of all domains (physical development, cognitive development,

- communication development, social or emotional development, and adaptive development); a review of pertinent records, parent interview, and, at the option of the family, a family assessment.
- B12. Provider shall use the most recent edition of a standardized test instrument as soon as practicable (e.g., when the standardized instrument has become widely available, including the availability of training, if required by test developers) when conducting evaluations for the purpose of determining a child's initial or ongoing eligibility for the EIP. Standardized test instruments must be administered, scored and interpreted according to the tool's manual.
- B13. Provider understands that no single procedure or instrument may be used as the sole criterion or indicator of eligibility. Provider shall utilize information from a variety of appropriate sources, including but not limited to standardized instruments and procedures, when appropriate or possible; observations of the child; parent interviews; informed clinical opinion; and any other sources of information about the child's developmental status available to the team conducting the child's evaluation.
- B14. Provider shall consider the parent's input regarding the preferred natural environment/setting for the evaluation and should conduct an evaluation in a setting conducive to ensuring accurate results. After the evaluation, the family should be asked whether they believe their child's response was optimal, and the family's response shall be included in the evaluation summary and report.
- B15. Provider shall immediately notify the Parent, the Service Coordinator and EIO/M, prior to initiation of the Evaluation if the Provider reasonably believes that the Provider cannot provide an evaluation within a sufficient time frame so that it can be accomplished within forty-five (45) days necessary to schedule an IFSP (due to workload or scheduling issues).
- B16. Provider shall provide the family a single point of contact and phone number for the evaluation process.
- B17. Provider shall describe to the family each step of the evaluation process, including its purpose, and what the evaluation might look like, including process, rules and procedures that Providers must follow.
- B18. Provider shall discuss how information gathered from the family is used in planning and conducting the evaluation. Provider shall help the family decide how they want to participate in their child's evaluation. The child's parent shall have the opportunity to be present and participate in the performance of evaluation and assessments, unless the parent's circumstances prevent the parent's presence.
- B19. Provider shall provide evaluation results in layman's terms/user friendly language in a manner which is understandable to family and caregivers. Provider shall discuss screening, evaluation, and assessment information with families in understandable language and in the context of the child's strengths. Provider shall ensure that parents are afforded the opportunity to discuss the evaluation results with evaluators, including any concerns they have with the evaluation process.
- B20. Provider shall ensure that when conducting a multidisciplinary evaluation, the Evaluator prepares an evaluation report and written summary and submits the summary, and upon request the report, to the following individuals within sufficient time to ensure completion of the IFSP within forty-five (45) days of a child's referral to the EIP: the child's parent(s); the EIO; and the initial service coordinator. Provider shall ensure that the multidisciplinary report is coordinated by qualified personnel who conducted the child's evaluation.
- B21. Provider shall ensure that Provider creates one integrated multidisciplinary report according to a state-standardized form and that the evaluation report and summary include the names, titles, and qualifications of the persons performing the evaluation and assessment; a description of the assessment process; the child's responses to the procedures and instruments used as part of the evaluation process, the family's belief about whether the responses were optimal; the developmental status of the child in each of the five developmental domains, including the unique strengths and needs in each area; documentation of how clinical opinion was used by the persons performing the evaluation and assessing the child's developmental status and potential eligibility for

the EIP; and measures and/or scores that were used, if any; and an explanation of these measures or scores. The evaluation report shall also include diagnostic information and the International Classification of Disease (ICD) codes related to the child's eligibility, where appropriate.

- B22. Provider shall ensure that when a diagnosis is made during the evaluation, one or more persons who conducted the evaluation are qualified under the NYS Education Law to render the diagnosis. A diagnosis shall not be rendered by an evaluation team member unless they are qualified by their profession to render such diagnosis.
 - B23. Provider shall fully document the basis for Provider's eligibility determination and provide such information and documentation that may be requested by the Municipality or the Department within the timeframes specified.
 - B24. Provider shall ensure that if the results of the multidisciplinary evaluation indicate the child is not eligible for the EIP, the team's evaluation report will clearly document reasons why the child is not eligible. If a child is not eligible for the EIP but has a developmental delay and the evaluation team believes the child should receive services or supports outside of the EIP, the evaluation team should inform the family of options for services and community resources that will promote the child's development
 - B25. Provider shall submit any additional documentation or explanation requested by the Municipality, service coordinator or Department regarding any evaluation, within five (5) business days of the request.
 - B26. Provider understands and agrees that all evaluations must be completed in accordance with applicable law and regulations in order to receive payment for the same.
 - B27. Provider shall participate in IFSP meetings in accordance with the requirements of 10 NYCRR § 69-4.11.
 - B28. Provider understands and agrees that if the EIO determines that the Provider has not complied with PHL and/or regulations pertaining to an evaluation, the EIO may require that the Provider immediately submit additional documentation to support the eligibility determination and no later than five (5) business days, or if the documentation provided continues to be inconsistent with PHL or regulations, the EIO can require that the parent select another Provider to conduct a multidisciplinary evaluation to determine whether the child meets eligibility for EIP services.
- C. Home/Community-Based and Office/Facility-Based Individual/Collateral Visits
- C1. Provider shall provide home/community-based individual/collateral services in accordance with a service authorization issued by the Municipality or service coordinator.
 - C2. Provider shall assist families in learning ways that the family can report more effectively on their observations and understanding (assessment) of their child's skills, behaviors and interests. Provider shall document a family's observations and assessments into the child's session notes. Family observations and assessments should be encouraged but not required.
 - C3. Provider shall apply knowledge of current research and evidenced based practices to the development and implementation of strategies, therapy and interventions with the child and family.
 - C4. Provider shall work collaboratively with family/caregivers to seek opportunities to adapt learning experiences and therapeutic strategies to reflect individual characteristics of the child and family, and to identify and implement, as appropriate, strategies that enhance and promote the child's participation in natural learning opportunities across both child and family routines and community settings.
 - C5. Provider and family/caregivers shall collaboratively identify toys, materials, interactions and locations that are available, of interest to, and motivating for the child and family.

- C6. Provider and family/caregivers shall collaboratively identify and incorporate family identified resources, concerns and priorities which shall result in individualized strategies promoting the outcomes identified by the family, therapeutic outcomes and outcomes identified in an IFSP. Provider shall be aware of and acknowledge new family concerns or interests.
- C7. Provider shall assist the family in learning how to communicate with their child.

D. Group Developmental Intervention

- D1. Provider shall provide group developmental intervention services in accordance with a service authorization issued by the Municipality or service coordinator.
- D2. Provider shall only utilize qualified personnel as defined by 10 NYCRR § 69-4.1(ak) when assigning a substitute in situations where the usual group leader is absent.
- D3. Provider shall provide EI services in a safe, developmentally appropriate environment which has adequate space for the group-size, a physical environment and facilities conducive to learning and reflective of the different stages of development of each child. Providers should incorporate, when possible, Universal Design for Learning principles into the creation of learning environments that support all children, including children with disabilities, when designing a learning environment. Provider agrees that it shall only provide Group developmental services in a location that has been included in Provider's application to the Department.
- D4. Provider shall support a child's positive behavior through well-organized classrooms, consistent schedules, well-designed learning areas, established routines, and sensitive and appropriate guidance strategies.
- D5. Provider shall engage in ongoing adaptations of the environment to meet the needs of individual children, including varying teaching strategies which can influence a child's ability to participate.
- D6. Provider shall have clear curricular goals and learning outcomes and where appropriate individualized learning objectives for children and modification of instructional materials as indicated on the child's IFSP.
- D7. Provider shall promote supportive interventions within the classroom which minimize the need for a child to be pulled out of the group for an individualized intervention.
- D8. Provider shall foster a collaborative partnership with all persons involved with the child including the child's family, caregivers and other Providers and will create an individualized learning experience reflective of the individual child's social and cultural experience, child's interests, abilities, and developmental progress. Provider shall inform the child's family on a regular basis about their child's progress and experience in the group developmental setting.

E. Parent-Child Groups and Family/Caregiver Support Groups

- E1. Provider shall provide parent-child groups and family/caregiver support group services in accordance with a service authorization issued by the Municipality or service coordinator.
- E2. Provider shall assist parents to understand their child's needs and identify community resources to meet family and child needs and to understand the emotional impact of having a child with disabilities.
- E3. Provider shall assist the family to learn multiple strategies for communicating with their child.
- E4. Provider shall assist the family to be confident in their parental skills and in their ability to care for a child with disabilities.
- E5. Provider shall assist the family to communicate with the team who works with his/her child and family and to develop skills as an advocate for the child.
- E6. Provider shall assist the family to do things with and for their child that will help enhance their child's development.

- E7. Provider shall assist the family to learn how to communicate with their child.
 - E8. Provider shall assist the family to learn how to understand and manage their child's behavior.
 - E9. Provider shall assist the family to develop skills to cope with stressful situations.
 - E10. Provider shall assist the family to enhance their own ability to modify family routines, such as mealtimes or bedtime, bathing and dressing to accommodate the family needs as well as the developmental and emotional needs of their child and to improve the family's quality of life.
- F. Providers Using Applied Behavior Analysis (ABA) in the Delivery of ABA Early Intervention Provider Services
- F1. Provider understands and hereby agrees that "Applied behavior analysis" or "ABA" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
 - F2. Agency Provider understands and hereby agrees to only utilize qualified personnel as defined in 10 NYCRR §69-4.1 as appropriate for the provision of early childhood ABA services and such employees and Individual Provider have been trained, educated, and are familiar with and competent in the delivery of such services.
 - F3. Provider understands and hereby agrees that Provider shall maintain and implement written policies and procedures for the delivery of ABA services which are in conformance with nationally recognized, evidence-based practices for the delivery of such services. Such written policies and procedures shall be: reviewed at least annually by the Provider and updated as necessary to maintain conformance with evidence-based practices for delivery of ABA services; and made available for review for monitoring purposes and upon request by the Department and/or its agent and the Municipality.
 - F4. Provider shall be responsible for developing individual child ABA plans in collaboration with the child's family and Agency Provider, as appropriate, qualified personnel; directing the implementation of individual child ABA plans and the ongoing monitoring, systematic measurement, data collection, and documentation of child progress; modifying individual child ABA services as necessary to promote progress towards goals, generalization of learning; and, where applicable, transitioning of the child from receiving services in home- and facility-based settings to receiving services and participating in other community settings.
 - F5. Provider shall provide assistance, training, and support as needed by parents/caregivers to assist them in follow-through activities specified in the child's ABA plan to enhance child development, behavior, and functioning.

XIII. Additional Provider Responsibilities

- A. Provider understands and agrees that nothing herein shall be deemed to create an "employee" and "employer" relationship between the Department and the Provider, or between the Municipality and the Provider. The relationship of the Provider to the Department or Municipality shall be that of an Independent Contractor for whom no federal or state income tax will be deducted by the Municipality in payment for services provided, and for whom no retirement benefits, workers' compensation protection, survivor benefit insurance, group life insurance, vacation and sick leave, liability protection, and similar benefits available to the State or Municipal employees will accrue.
- B. Provider shall be responsible for the services for which Provider is approved to deliver and, with respect to Agency Providers, shall only utilize employees and/or Individual Providers and/or another Agency Provider when approved by the Department as an Agency Provider. Agency Provider understands and agrees that when utilizing Individual Providers or another Agency Provider to deliver authorized services, the Agency Provider may only utilize Individuals and Agencies approved by the Department and shall remain responsible for the services for which it is authorized to deliver that were rendered by the Individual Provider and/or the other Agency Provider, including but not limited to all claims for payment related to such services, and in ensuring that the Individual Provider and/or the other Agency Provider complied with all applicable rules and regulations in relation to such services.

- C. Agency Provider shall be responsible for the acts and omissions of Individual Providers and/or other Provider Agencies utilized by the Provider Agency for the provision of services as it is for the acts and omissions of persons directly employed by it.
- D. Provider shall maintain continued compliance with all applicable provisions of the Federal and State Labor Standards.
- E. Provider shall maintain continued compliance with all applicable provisions of the Federal Internal Revenue Code, 20 NYCRR-Taxation and Finance, and all rules promulgated there under, including withholding provisions and timely deposits of employee taxes and unemployment insurance taxes, as applicable.
- F. Provider shall operate and provide services in compliance with the provisions of the Civil Rights Act of 1964, as amended; with 44 CFR Part 7, entitled "Nondiscrimination in Federally Administered Programs"; and with 45 CFR Parts 84 and 85, entitled "Non-Discrimination on the Basis of Handicap in Program Activities Receiving or Benefiting from Federal Financial Assistance".
- G. Provider shall operate, hire, subcontract and provide services without regard to race, creed, color, national origin, sex, age, disability, sexual orientation, genetic predisposition or carrier status or marital status.
- H. Provider shall not have religious worship, instruction, or proselytizing as part of or in connection with the provision of early intervention Provider services, nor shall any of the funds provided under this Agreement be used for such purposes.
- I. Provider shall operate, hire and subcontract in compliance with the provisions of Article 15 of the New York State Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions.
- J. Agency Provider shall, in the event that the Agency Provider files for bankruptcy or reorganization under Chapter seven or Chapter Eleven of the United States Bankruptcy Code, disclose such action to the Department within (7) seven days of filing. This Agreement shall not be assigned by the Provider or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of and attempts to do so are null and void.
- K. Indemnification:
 - i. Provider shall be solely responsible and answerable in damages for any and all accidents and/or injuries to persons (including death) or property arising out of or related to the services to be rendered by the Provider or its employees or Individual Providers under contract, pursuant to this AGREEMENT. The Provider shall indemnify and hold harmless the Department and its officers and employees and Municipalities and its officers and employees from claims, suits, actions, damages and costs of every nature arising out of the provision of services pursuant to this AGREEMENT and under the EIP.
 - ii. The Provider is an independent contractor and may neither hold itself out nor claim to be an officer, employee or subdivision of the Department or Municipality nor make any claims, demand or application to or for any right based upon any different status.

This provision shall survive the termination of this Agreement. This Agreement shall be deemed terminated immediately upon the Provider's failure to comply.

XIV. Terms and Termination

This Agreement shall be effective for a five (5) year term, unless terminated pursuant to the terms hereof. Provider shall not provide services, nor hold itself out as authorized to provide such services on and after the date upon which this Agreement shall be deemed terminated.

If the Provider wishes to continue participating the EIP after the expiration of this Agreement, Provider shall notify the Department at least ninety (90) days prior to the expiration date and request that the Department enter into a new agreement with the Provider.

Amendments to this agreement may be made by the Department and shall be sent to the Provider via mail or electronically utilizing the Provider's email address. The Provider shall notify the Department within thirty (30)

calendar days of the date the Provider receives the proposed Amendment of whether it accepts the terms contained in the proposed Amendment. The Department reserves the right to terminate this Agreement if a proposed Amendment is not accepted. Oral modifications to this Agreement are prohibited.

1. Termination for Convenience by the Department:

This Agreement may be cancelled at any time by the Department giving to the Provider not less than ninety (90) days written notice that on or after a date therein specified this Agreement shall be deemed terminated and cancelled. Provider shall not render services in the EIP on and after the date specified in such notice and shall not claim for any services rendered after such termination date.

2. Termination for Convenience by Provider:

This Agreement may be cancelled at any time by the Provider, giving to the Department not less than ninety (90) days written notice that on or after a date therein specified this Agreement shall be deemed terminated and cancelled. In the event the Provider terminates the Agreement in accordance with this paragraph, Provider shall, together with any notice of termination, provide each child's Service Coordinator and the corresponding Municipality of residency of the children served with a Plan and Timetable for the orderly transition of services, and a copy of any proposed notification to parents, transporters, employees and Individual Providers utilized by an Agency Provider who deliver services. The plan and timetable for orderly transition of services must be developed in conjunction with affected municipalities and in accordance with municipal procedures. Notification to parents, transporters, employees and Individual Providers utilized by an Agency Provider shall be disseminated by the Provider upon approval by the Municipality and the Department of the proposed Plan and Timetable. The notice of termination and transition plan shall be submitted to the service coordinator(s), affected Municipalities and the Department not less than ninety (90) calendar days prior to the intended termination date of the Agreement. Provider also understands and agrees that the Provider will supply, to the best of the Provider's ability, any outstanding child/family information necessary for the Department's Part C Annual Performance Report, prior to terminating this agreement.

3. Termination for Cause:

The Department or the Provider may terminate this agreement, prior to the end of term by giving thirty (30) calendar days written notice to the other party of its intention and reason for termination. The non-terminating party may be given an opportunity to cure the reason for termination within the 30-day period. If the non-terminating party does not cure the reason for termination to the satisfaction of the terminating party, this Agreement shall terminate at the end of such 30-day period. Cause for termination may include but shall not be limited to: (a) failure to comply with the terms and conditions of this Agreement; (b) § 69-4.12 and (c) any violation of applicable laws or regulations, including an unacceptable practice under the Medical Assistance Program as enumerated in Title 18 NYCRR §515.2. Provider shall immediately provide each child's individual Service Coordinator and the corresponding Municipality of residency of the children served, with a Plan and Timetable for the orderly transition of Services, and a copy of any proposed notification to Parents, transporters, employees and independent contractors utilized by a provider agency who deliver EI provider services. The plan and timeline for orderly transition of services must be developed in conjunction with municipalities and in accordance with municipal procedures. Notification to parents, transporters, employees and independent contractors utilized by a Provider Agency shall be disseminated by the Provider Agency upon approval by the affected Municipalities and the Department of the proposed Plan and Timetable. Provider also understands and agrees that the Provider will supply, to the best of the Provider's ability, any outstanding child/family information necessary for the Department's Part C Annual Performance Report for services furnished, prior to terminating this agreement.

4. Immediate Termination by the Department:

The Department shall have the right to terminate this Agreement, in whole or with respect to any identifiable part of the Program, effective immediately in cases of imminent danger to the health and safety of Eligible Children, Parents and/or staff, or upon the filing of a petition in bankruptcy or insolvency, by or against the Provider. Such termination shall be immediate and complete, without termination costs or further obligations by the Department or Municipality to the Provider.

5. Compliance Involving Health & Safety Issues:

If the Department finds that the health or safety of a child, the child's parents or staff of the Agency Provider or Municipality is in imminent risk of danger or there exists any condition or practice or a continuing pattern of conditions or practices which poses imminent danger to the health or safety of such child, parents or staff of the Agency Provider or Municipality, in addition to any other remedies available to it, the Department may:

- (a) terminate this Agreement,
- (b) terminate one or more of the service models the Provider is authorized to deliver in the EIP,

- (c) terminate one or more service delivery methods/settings;
- (d) direct that the Municipality prohibit or limit the assignment of children to the Provider;
- (e) direct that the Municipality remove or cause to be removed some or all of the children the Provider currently serves;
- (f) direct that the Municipality suspend or limit or cause to be suspended or limited payment for services to the Provider.

6. Compliance proceedings involving approval of an individual or agency:

In accordance with 10 NYCRR § 69-4.24, the Department may, in addition to any other remedies available to it, revoke, suspend, limit this agreement and approval.

7. Notices:

All notices shall be sent by mail or email to the Provider listed within the electronic data system (currently NYEIS or any successor data system as required by the Department) as the Program Director or in the case or to an Individual Provider. The Provider is responsible for notifying the Department of any change in contact information including mailing and email addresses. All notices of termination will contain the specific date on which the Provider must cease providing Early Intervention Services.

All notices from the Provider must be sent to the Department at the following address:

New York State Department of Health
Bureau of Early Intervention
Provider Approval & Due Process Unit
ESP, Corning Tower, Room 287
Albany, New York 12237-0660

8. Severability:

It is expressly agreed that if any term or provision of this Agreement, or the application thereof to any person or circumstance, shall, to any extent, be held invalid or unenforceable, the remainder of this Agreement, or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby; and every other term and provision of this Agreement shall be valid and shall be enforced to the fullest extent permitted by law.

Appendix 1 - Payee Provider Agreement/Service Authorizations and Payment

THIS Appendix IS NOT CONSIDERED TO BE FULLY EXECUTED WITHOUT AN APPROVAL DATE FROM THE New York State Department of Health. The Provider cannot receive service authorizations from a Municipality and claim for early intervention services rendered until this Appendix is fully executed by the Department. In the event this Appendix is executed subsequent to the execution of the Agreement, the effective dates for this Appendix shall be as set forth herein.

- I. For a Provider to receive service authorizations from a Municipality for EIP services and direct payment for the services rendered from the Municipality, the Provider shall utilize the Department's electronic data system and, when indicated by the Department, establish a relationship with the Department's fiscal agent for claiming payment for service coordination, evaluations and EI Provider services. Provider shall comply with all requirements for claiming as required in applicable law and regulation, and as necessary for the fiscal agent to perform its duties, including but not limited to, the terms and conditions set forth in this Appendix.
 - a) Provider shall be responsible for monitoring the quality of the Provider's services, compliance with this Agreement, Individuals with Disabilities Education Act (IDEA), PHL, early intervention regulations and fiscal responsibilities.
 - b) Provider shall report incidents of noncompliance, fraud or abuse to appropriate payors and ensure that the appropriate State and municipal agencies are notified, as required.
 - c) Provider shall not claim or collect payment directly from the family for EI services nor require the family to pay additional costs.
 - d) Provider shall promptly notify the Department and/or its state fiscal agent and the Municipality of any duplicate or erroneous payment received from the Municipality or from any third-party payor and shall cooperate with the Department and/or its state fiscal agent and the Municipality to rectify the situation.
 - e) Provider understands that there is a specific Medicaid institutional enrollment for early intervention providers. Provider shall enroll in the Medical Assistance Program as a billing Provider for EIP services.
 - f) Provider shall certify, recertify and revalidate with Medicaid as necessary to maintain early intervention approval and maintain the Appendix 1. Agency Providers must maintain an active Medicaid status as an early intervention provider to be able to provide early intervention services.
 - g) Provider shall, for children who have coverage under an insurance policy, plan or health benefit package, including the Medicaid Assistance Program or other governmental payor, seek payment from such insurer or health plan prior to seeking payment from the Municipality, in accordance with PHL § 2559. Provider shall utilize the Department's data system and/or fiscal agent as directed by the Department in seeking payment from such insurer or health plan.
 - h) Provider shall further take the appropriate steps to secure insurer or health plan payment for services, including responding to claim denials by correcting any errors identified in claims, providing requested documentation such as that needed to support medical necessity, and the submission of Subrogation notice to each child's insurance company.
 - i) The Department and/or its fiscal agent(s) is responsible for management of all submitted Provider claims. Provider shall use uniform and consistent procedures as directed by the Department for submission of claims. Provider shall use the Department's electronic data system (or any successor data system as required by the Department) for submission of claims associated with EI children.
 - j) The Department and/or its fiscal agent(s) will assist Provider in claims submission and adjudication to third party payors, and shall manage payments owed to Provider for services not reimbursed by third party payors.
 - k) Provider shall maintain progress and session notes detailing the nature and extent of services provided and shall make them available to the Department and/or Municipality upon request for programmatic monitoring and fiscal audit purposes.

- l) Provider shall have policies and procedures in place to verify that any service authorizations issued by the Municipality are in conformity with the IFSP and to notify the service coordinator and Municipality immediately regarding any discrepancy. Provider shall further develop and implement policies and procedures to verify that services are delivered to a child in conformity with the child's IFSP.
- m) Provider shall keep an accurate record of attendance for each child for whom services are being provided such record shall be maintained in the child's record or file and may be requested at any time by the Department or Municipality.
- n) Provider shall make available and accessible to the Department and Municipality, all records and information necessary to assure the appropriateness of payments made to the Provider and to assure the Provider's compliance with all applicable statutes and regulations.
- o) Provider understands and agrees that payment will not be made for services provided by individuals who are not qualified personnel as defined in 10 NYCRR §69-4.1(ak), or for services rendered by qualified personnel who are not acting within the scope of practice authorized by his or her license, registration or certification for the provision of services authorized in a child's IFSP.
- p) Provider shall fully familiarize itself with Department's policy and guidance regarding claiming and documentation for services rendered.
- q) Agency Provider seeking to cease EIP services understands and agrees that if such Agency Provider provides services to more than fifty (50) children per year, the Agency Provider must contact the Department and/or the municipality(s) to ensure that prior to agency closure, the Agency Provider shall submit child specific information necessary for the completion of the Department's Annual Performance Report (APR).
- r) Provider shall submit all claims for early intervention services in a timely manner as required by the Department and understands that the Provider risks non-payment for late claims.
- s) Provider shall submit to the Department no less than annually in a manner and format and by the date requested by the Department, a description of the Provider's services at each site at which EI Provider services are offered. Such program description may include program models utilized at various sites, languages offered, services offered, special populations served, and other such description information. The Department shall make such program descriptions available to Service Coordinators for the purpose of assisting parents in understanding program types and options, and in selecting an evaluation site.
- t) Pursuant to PHL § 2557, when directed by the Department, Provider shall utilize the Department's fiscal agent for early intervention claims as determined by the Department. Provider shall provide such information and documentation as required by the Department and necessary for the fiscal agency to carry out its duties.
- u) Provider shall sign up for electronic funds transfer, as directed by the Department, for payment by the fiscal agent for claims not covered by third party payers.
- v) Provider shall sign up with third-party clearinghouses, at the direction of the Department, to enable the secure exchange of claim adjudication information among the fiscal agent, Provider and applicable third-party payers.

II. Additional Requirements: Provider shall not commence performing Services under this Agreement plus Appendix 1 unless and until all required insurance is in effect, and shall ensure continuous insurance coverage in the manner, form, and limits required by the Agreement.

- (1) Provider shall procure, pay the entire premium for and maintain throughout the term of this Agreement insurance in amounts and types specified herein. Unless otherwise specified by the Department and agreed to by the Provider, in writing, such insurance will be as follows:
 - i. **Commercial General Liability** insurance including contractual coverage, in an amount no less than \$1,000,000/per occurrence must be carried by the Agency Provider.
 - ii. **Commercial General Liability** insurance for Individual Providers who carry Professional Liability Insurance is not required unless the Individual Provider (1) employs others, besides themselves, and these employees have contact with children or parents, or (2) owns, rents or otherwise has control of the space where children and/or parents are provided with early intervention services by the provider.
 - iii. **Automobile Liability** insurance is required only if children who are being treated under this agreement are being transported in the subject vehicle in an amount not less than \$1,000,000 combined single limit for bodily injury and property damage occurrence. If the Provider does not transport children, the Provider is not required to carry Automobile Insurance other than that is required by New York State Law and regulations.
 - iv. **Professional Liability** insurance in an amount not less than \$1,000,000 per incident/occurrence. It is not necessary to have municipalities or the State listed as additionally insured on an individual's professional liability policy.
 - v. In the case of Agency Providers, **Worker's Compensation and Employer's Liability** insurance in compliance with all applicable New York State laws and Regulations and **Disability Benefits** insurance, if required by law. Provider shall maintain and make available upon request to the Department, the documentation required by the New York State Workers' Compensation Board of coverage or exemption from coverage pursuant to Sections 57 and 220 of the NYS Workers' Compensation Law. In accordance with Article 5-A Section 108 of NYS General Municipal Law, this Agreement shall be void and of no effect unless the Provider shall provide, upon request and maintain coverage during the term of this Agreement for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.
- (2) To have all policies providing such coverage issued by insurance companies with an A.M. Best rating of A- or better.
- (3) To furnish to the State certificates of insurance or, on request, original policies, evidencing compliance with the aforesaid insurance requirements.
- (4) To have, in the case of commercial liability insurance, said certificates or other evidence of insurance name the State of New York and Municipality as an additional insured.
- (5) To have all such certificates or other evidence of insurance provide for the State of New York and Municipality to be a certificate holder and to be notified in writing thirty (30) days prior to any cancellation, non-renewal or material change.
- (6) To have such certificates, policies or other evidence of insurance and notices mailed to the Department and Municipality at the address contained in this Agreement or at any such other address of which the Department and Municipality shall have given the Provider notice in writing.

III. Additional Requirements: Upon request of the Department, Individual Providers, Agency program director and Principals of an Agency Provider who are/will be providing direct services to EIP children shall provide the Department with all necessary information and documentation to allow for a database check from the Justice Center and the SCR, and shall upon request further submit any required fee under Section 424-a of New York State Social Services Law to perform such SCR clearance.

This page is intentionally left blank.

Agency: Notification/Re-Approval

**As Early Intervention Evaluators,
Service Coordinators, and Service Providers**

This document is to be used to notify the Department of Health of our agency's intent to continue participating in the Early Intervention Program (EIP) as an approved Agency Provider under Title II-A of Article 25 of the Public Health Law.

OR

To request to end our Early Intervention Provider Agreement and withdraw as an approved provider.

PLEASE TYPE OR PRINT USING BLACK INK

Notification

Please consider this as the 90-day notification prior to the expiration date of our current Early Intervention Provider Agreement (hereinafter referred to as Agreement) to:
(select one of the requests below)



We request to enter into a new Agreement with the Department. *(Provider must complete and return the Re-Approval Application. Please see page 2.)*

OR



We request to end our Agreement with the Department and withdraw as an EI provider, effective the day following the expiration date of our current Agreement *(Please complete the remaining area in this box and return only this page to the email or mailing address found on page 7).*

Agency Name:

Organization NPI:

EI State ID:

Authorizer's Name *(EI Program Director/CEO only)*:

Authorizer's Original Handwritten Signature:

Title:

Date:

Contact's Telephone Number: Area Code: Number:

Re-Approval Application of Currently Approved Agency Providers

This application is for the re-approval of agencies as early intervention evaluators, service providers and service coordinators for the statewide Early Intervention (EI) Program under Title II-A of Article 25 of the Public Health Law.

By way of submitting this application for re-approval, this agency is attesting to its fiscal viability and that it will meet all payment obligations for services rendered on behalf of the agency.

**PLEASE TYPE OR PRINT USING BLACK INK
(all fields required)**

1. Applicant Information

Agency Name:

DBA where applicable:

Mailing Address:

Line 1:

Line 2:

City: State: Zip+4:

Primary Email Address:

Primary Phone Number: Area Code: Number: Ext:

Organization NPI: FEIN:

EI State ID: EI Medicaid Provider ID:

EI all other services
00473785 service
coordination

2. Corporate Structure/Disclosure Requirement

(Check the box that indicates the Type of Ownership of the applicant agency)

- Sole Proprietor
- Partnership
- Professional Limited Liability Company (PLLC)
- Limited Liability Partnership (LLP)
- Not-For-Profit Corporation
- Business Corporation
- Professional Corporation (PC)
- Limited Liability Company (LLC)
- Government Subdivision

Does your agency have a parent company? Yes No

Name of Parent Company:

3. Minimum Agency Staffing Requirements

Does your Agency employ a full-time EI Program Director who meets the qualification in 10 NYCRR Section 69-4.5 (a)(4)(viii)(a)?

Yes: No:

If Yes, Name of Program Director:

Profession:

Email Address:

Is the Program Director providing services to EI children?

Yes: No:

Does your Agency employ a minimum of two employees (excluding the program director) who are recognized as qualified personnel by the Early Intervention Program, as defined in 10 NYCRR Section 69-4.1, or service coordinators meeting the qualifications in 10 NYCRR Section 69-4.4, and, each available to provide a minimum of 20 hours per week early intervention services and/or evaluations and/or service coordination which may also include the delivery of services to individuals with disabilities outside of the EI program?

Yes: No:

If yes, please identify the two employees that meet this criteria:

Name:

Profession:

License/Certification Number:

Personal Email:

Name:

Profession:

License/Certification Number:

Personal Email:

4. NYS Education Department Waiver of Corporate Practice (if applicable)

Does your Agency have a NYSED corporate practice waiver?

No:

Yes, expiration date:

5. Record of Legal Actions

Except for minor traffic violations, have you or any other Agency officer, principal, stockholder been convicted of any violation of the law (e.g., criminal, civil, or administrative charges) within the last five years?

Yes:

No:

Have you or any other Agency officer, principal, stockholder or any agency that provides health and human services in which you or any other Agency officer, principal, stockholder held an office or position ever been restricted, suspended, revoked or fined by any Federal, State or local agency?

Yes:

No:

Have you or any other Agency officer, principal, stockholder or any agency that provides health and human services in which you or any other Agency officer, principal, stockholder held an office or position ever been subject to an audit that resulted in recoupment?

Yes:

No:

Have you or any other Agency officer, principal, stockholder or any agency that provides health and human services in which you or any other Agency officer, principal, stockholder held an office or position ever had a contract terminated, suspended or restricted for failure to perform or for any other reason?

Yes:

No:

Has the applicant Agency ever been the subject of any child care enforcement actions (e.g., fines, sanctions, etc.) or had its approval, certification, or licensure restricted, revoked or suspended by the Office of Children and Family Services?

Yes:

No:

Have you or any other Agency officer, principal, stockholder ever been restricted, suspended or excluded from participation as a Medicaid provider?

Yes:

No:

Are there any criminal, civil or administrative charges pending against you or any other Agency officer, principal, stockholder?

Yes:

No:

6. Agency Affiliations

Is the applicant Agency currently approved, certified or licensed by any of the following New York State agencies for services other than early intervention? If yes, please indicate type of service.

Department of Health

No:

Yes, Type of Service:

Certified Home Health Agency

Education Department

No:

Yes, Type of Service:

Diagnostic and Treatment Agency

Office of People with Developmental Disabilities

No:

Yes, Type of Service:

Office of Mental Health

No:

Yes, Type of Service:

Office of Children and Family Services

No:

Yes, Type of Service:

Has the applicant Agency ever been the subject of any enforcement actions (e.g., fines, sanctions, etc.) or had its approval, certification or licensure restricted, revoked or suspended by any of the above State agencies?

No:

Yes, Type of Action:

To answer statements 7 through 9 locate your agency's listing in the *Central Directory of Early Intervention Services and Resources*, found at https://health.ny.gov/community/infants_children/early_intervention/service_providers/.

According to the webpage "Information for Service Providers" the Directory was last updated on:

Dec. 11, 2017 (record the date highlighted in yellow)

7. Available Personnel

I certify that the Agency has the qualified personnel (QP) listed in the Central Directory available to provide EI services.

Yes:

If no, using the box below, please indicate what QP are no longer available.

8. Service Models

I certify that the Agency has the service model(s) listed in the Central Directory available to provide EI services.

Yes:

If no, using the box below, please indicate what service model(s) are no longer available.

9. Languages

I certify that the Agency has the language(s) listed in the Central Directory available to provide EI services.

Yes:

If no, using the box below, please indicate what language(s) are no longer available.

10. Professional Development

I certify that the employees and Individual Providers under contract with our Agency demonstrate continued professional development on state and local policies and procedures of the EIP, including participation in Department sponsored training(s). The Agency maintains documentation of continuing education/training and can make such documentation available upon request to the Department and Municipality.

Yes, I agree:

No, please explain:

I, the undersigned, hereby certify under penalty of perjury, that I am an Agency officer, principal, stockholder duly authorized to subscribe and submit this application and that the information contained herein and attached hereto is accurate, true and complete in all material aspects. I further acknowledge that the application will be processed pursuant to the provisions of Title II-A of Article 25 of the Public Health Law, and the pertinent regulations adopted thereto.

Name:

Title:

Authorized Original Handwritten Signature:

Date:



PLEASE KEEP A COPY OF THIS DOCUMENT AND ALL ATTACHMENTS FOR YOUR RECORDS

Your application for reapproval **CANNOT** be processed if any required information is missing. Please return ALL required documents together as one packet. Please write your agency's name or EI State ID number in the upper right corner of all submitted pages. Incomplete packets will be returned.

11. Required Attachments

1. List each officer, principal, stockholder and their percentage of ownership of the applicant agency. Also, indicate if they will be providing services to EI children.

2. List each Quality Assurance Professional (**include their name, profession, license number, years of professional experience, and email address**) employed by your agency for each particular early intervention service/profession, including service coordination, that your agency is providing, as defined in 10 NYCRR Section 69-4.5 (a)(4)(viii)(c).

3. If a Record of Legal Action is indicated in # 5, you are required to provide the following information for each action: Name of Individual, Date of Action, Type of Action, Location, and Explanation.

4. If your Agency provides EI services at a site that your agency rents, owns, leases or operates, provide the following information for each site: the name (if different from the Agency's name), site address (including county) and the type of EI service model(s) provided at that site.

Please return this document and all required attachments to the Department via email (EIPProviderAgreement@health.ny.gov) OR U.S. Mail:

**New York State Department of Health
Bureau of Early Intervention
Empire State Plaza- Corning Tower, Rm 287
Albany, NY 12237-0660**

12/15/2017

H:\23\R\PAU NYEIS Manual\4\F\AgencyNotificationReApproval

RESOLUTION REQUEST FORM NO. 3

Request for New Contract

DEPARTMENT NAME: Health Services

DATE: 03/19/2018

- (a) Is this a Result of a Bid or Request for Proposal? No
- (b) Purpose of Contract: To authorize a contract agreement with Patricia Elmen to provide Occupational Therapy services
- (c) Name of Contractor: Patricia Elmen
- (d) Address of Contractor: 46 Coolidge Avenue, Glens Falls, NY 12801
- (e) Contractor's Contact Person and Telephone Number: Patricia Elmen 518-596-3271, email: lpa703@gmail.com
- (f) Has or will the Contract be provided, if so, please attach: Please use therapist contract
- (g) Commencement Date of Contract: 4/23/18
- (h) Termination Date of Contract: Upon 30 days written notice by either party
- (i) Payment Provisions:
- i) lump sum amount – see attached rates
 - ii) hourly rate amount
 - iii) total amount not to exceed
 - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc. Paid upon receipt of required documentation for each individual patient visit)
- (j) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount: OR Capital Project OR Capital Reserve Project
Number, and Title, and Amount:

A4010.10.470 Health Services

**WARREN COUNTY HEALTH SERVICES
THERAPY RATES**

Certified Home Health Agency

Evaluation Region 1	\$55.00
Revisit Region 1	\$53.00
Evaluation Region 2	\$75.00
Revisit Region 2	\$75.00
Meetings (for all services)	\$40.00

Early Intervention Services Only

Evaluation Region 1	\$50.00
Revisit Region 1	\$50.00
Evaluation Region 2	\$57.00
Revisit Region 2	\$57.00
Extended visit Region 1 & 2 (with IFSP approval)	\$70.00
Supplemental Evaluations Regions 1 & 2	\$117.00

Preschool CPSE/Approved IEP

Basic visit Region 1	\$53.00
Basic visit Region 2	\$60.00
Group visit per child Regions 1 & 2	\$44.00

Meetings (for all services)	\$40.00
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Patricia Elmen

46 Coolidge Ave, Glens Falls, NY 12801 | 518-596-3271 | lpa703@gmail.com

Education

CERTIFICATE PROGRAM IN SENSORY INTEGRATION | CURRENT STUDENT | UNIVERSITY SOUTHERN CALIFORNIA

MASTERS HOLISTIC NUTRITION | 2010 | CLAYTON COLLEGE OF NATURAL HEALTH

BACHELOR OF SCIENCE - OT | 1994 | DOMINICAN COLLEGE

A.A.S - OTA | 1990 | HERKIMER COUNTY COMMUNITY COLLEGE

Experience

OWNER – OTR/L | IN SYNC OCCUPATIONAL THERAPY | 2017 - PRESENT

- OT private practice with focus on customized Interactive Metronome programs.

PRESIDENT | COMMUNITIES ABOUT NUTRITION | 2008 - 2011

- Founded and operated non-profit designed to provide healthy meal options to local food pantries.

OCCUPATIONAL THERAPIST | REHABCARE | 2009 - 2010

- Per-diem OT Adirondack Tri-County Nursing and Rehabilitation Center

OCCUPATIONAL THERAPIST | SARATOGA COUNTY | 2006 - 2007

- Home care consultant

OCCUPATIONAL THERAPIST | MITCHELL MARTIN CONSULTING | 1999 - 2003

- NYU Hospital, NY School for the Deaf, Sports Rehabilitation

CHIEF OF OCCUPATIONAL THERAPY | MEMORIAL SLOAN KETTERING CANCER CENTER | 1999 - 2001

- Staff hiring and training, in-service education, quality management, program development, OT services for adult and pediatric patients.

FACULTY | MARIA COLLEGE | 1994-1998

- Instructor medical science, kinesiology, OT theory courses. Student advisor, fieldwork coordination.

OCCUPATIONAL THERAPIST (COTA 1990 – 1994) | ST PETER'S HOSPITAL | 1990 – 1998

- OT for adult and pediatric services; out-patient, acute care, in-patient rehab, home care, and skilled nursing. Preschool Core Evaluation Team, staff mentor, in-service education, Rehabilitation Practice Council, program development.

Continuing Education/Certifications/Licensure

NYS LICENSE | 1990-PRESENT | # 00647-1

NBCOT CERTIFIED | 1994 - PRESENT | # 005930

SIPT CERTIFIED | 2002 | # 7896

CERTIFIED INTERACTIVE METRONOME PROVIDER | 2016

- Full list of extensive continuing education coursework available upon request

Patricia Elmen

46 Coolidge Ave, Glens Falls, NY 12801 | 518-596-3271 | lpa703@gmail.com

Continuing Education Experience

CERTIFICATE PROGRAM IN SENSORY INTEGRATION | USC | 2017 - PRESENT

MOCA TRAINING | SCHEDULED FEB 2018

INTERACTIVE METRONOME ADULT REHABILITATION BEST PRACTICES: MOTOR SKILLS | SCHEDULED FEB 2018

INTERACTIVE METRONOME: IM HOME CERTIFICATION | 2018

THE BRAIN IN DETAIL | 2017

NEUROMUSCULAR AND NEURODEGENERATIVE DISORDERS | 2017

THE COMPLETE AUTISM AND SPD TOOLKIT: STRATEGIES AND INTERVENTIONS | 2017

CERTIFICATE IN MINDFULNESS BASES INTERVENTION FOR CHILDREN AND TEENS | 2017

INTERACTIVE METRONOME PEDIATRIC BEST PRACTICE | 2017

INTERACTIVE METRONOME PEDIATRIC SPECIALIST COACHING PROGRAM | 2017

INTERACTIVE METRONOME: ADULT EXECUTIVE FUNCTION | 2017

CERTIFIED INTERACTIVE METRONOME PROVIDER | 2016

THE PEDIATRIC PRIMER | 2016

SELF-REGULATION IN CHILDREN | 2016

ADVANCED ADHD TREATMENT FOR CHILDREN AND ADULTS | 2016

VISUAL PROCESSING THERAPY: SPD, ADHD, AUTISM, DYSLEXIA, BRAIN INJURY | 2016

REFLEX DEVELOPMENT: TESTING AND INTEGRATION | 2016

NON-MEDICATION TREATMENTS FOR ADHD | 2015

BASICS AND BEYOND: SHOULDER TO FINGER | 2010

MASTERS HOLISTIC NUTRITION | 2005 - 2010

LOW VISION: OT INTERVENTION WITH THE OLDER ADULT | 2007

HAND WRITING WITHOUT TEARS | 2003

FEEDING THERAPY: A SENSORY MOTOR APPROACH | 2002

THREE PART TREATMENT PLAN FOR ORAL MOTOR THERAPY | 2002

NEUROBEHAVIORAL THEORY OF SENSORY INTEGRATION | 2002

SIPT ADMINISTRATION | 2002

SIPT INTERPRETATION | 2002

Continuing Education Experience Continued

SIPT CERTIFIED | 2002 | # 7896

THE ADAPTIVE RESPONSE | 2001

COMPREHENSIVE APPROACH TO TOTAL JOINT ARTHROPLASTY | 2000

CANCER REHABILITATION | 2000

FRONTIERS IN ALS | 2000

ERGONOMIC EVALUATION CERTIFICATION PROGRAM | 2000

STRESS AND DISEASE | 1999

TRAINING IN IDENTIFICATION IN CHILD ABUSE | 1999

PERSONAL TRAINER CERTIFICATION | 1998

FUNCTIONAL ASPECTS OF NEUROMOTOR TREATMENT | 1997

OT IN HOME CARE | 1996

PROBLEM SOLVING WITH THE NDT APPROACH | 1996

ADVANCED SERVICE COORDINATION TRAINING | 1996

INTERDISCIPLINARY APPROACHES TO THE FEMALE PATIENT | 1996

NDT PEDIATRIC HANDLING | 1996

INTRODUCTION TO HAND THERAPY | 1995

OSTEOPOROSIS | 1994

SENSORY EDUCATION THEORY | 1994

SENSORY EDUCATION TREATMENT | 1994

BS OT | 1991 - 1994

INVACARE WHEEL-CHAIR EQUIPMENT AND POSITIONING | 1991

MEMORY AND AGING | 1991

INTRODUCTION TO NDT AND THE ADULT HEMIPLEGIC | 1990

AAS OTA | 1988 - 1990



Healthcare Professional Liability

LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the Company)

55 Water Street, 18th Floor
New York, NY 10041

DECLARATIONS

Policy Number: AHY-891789001

Renewal Of: New

SECTION I

Item

1. Named Insured: In SYNC Occupational Therapy, PC

2. Mailing Address: Suite 44,
206 Glen Street
Glens Falls, NY 12801

3. Policy Period: From: 11/01/2017 To: 11/01/2018
12:01 A. M. Standard Time At Location of Designated Premises

4. Business or Profession: Occupational Therapist Affiliation: 3116- American Occupational Therapy Assn.

5. The Named Insured is a(n): Partnership Corporation Individual LLC
 Sole Proprietor (with employees) Professional Association Other

This policy is made and accepted subject to the printed conditions of this policy together with the provisions, stipulations and agreements contained in the following form(s) or endorsements(s): HCPL-2037 (01/14), HCPL-2038 (11/09), HCPL-8020 (Ed. 12/10), HCPL-2037-9000-NY (10/14), HCPL-9002-NY (02/10), HCPL-8101-NY (11/14), OFAC (08/09),

HCPL-8320 (01/15), HCPL-8321 (01/15), HCPL-8324NY (05/15), HCPL-8328NY (05/15)

SECTION II

Item	COVERAGE	Premium
A.	Professional Liability [X]	\$212.00
B.	General Liability []	
	Terrorism Risk Insurance Act []	
C.	Endorsements []	
TOTAL:		\$300.00
		Minimum Premium
LIMITS OF LIABILITY		
	\$1,000,000 Each Incident and Each Occurrence	\$3,000,000 Aggregate

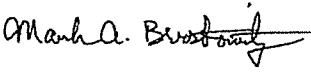
SECTION III

SUPPLEMENTARY PAYMENTS

- A. First Party Assault
- B. Licensing Board Reimbursement
- C. Wage Loss and Expense
- D. Deposition Expense
- E. First Aid Reimbursement

Representative Agent: Mercer Consumer, a service of
 Mercer Health & Benefits Administration LLC
 P.O. Box 14576
 Des Moines, IA 50306-3576

Client # 2441358

MEMORANDUM OF INSURANCE				Date Issued 11/15/2017	
Producer Mercer Consumer, a service of Mercer Health & Benefits Administration LLC P.O. Box 14576 Des Moines, IA 50306-3576 1-800-503-9230			This memorandum is issued as a matter of information only and confers no rights upon the holder. This memorandum does not amend, extend or alter the coverages afforded by the Certificate listed below.		
Insured In SYNC Occupational Therapy, PC Suite 44 206 Glen Street Glens Falls NY 12801			Company Affording Coverage Liberty Insurance Underwriters Inc		
This is to certify that the Certificate listed below has been issued to the insured named above for the policy period indicated, notwithstanding any requirement, term or condition of any contract or other document with respect to which this memorandum may be issued or may pertain, the insurance afforded by the Certificate described herein is subject to all the terms, exclusions and conditions of such Certificate. The limits shown may have been reduced by paid claims. The Memorandum of Insurance and verification of payment are your evidence of coverage. No coverage is afforded unless the premium is successfully paid in full.					
Type of Insurance	Certificate Number	Effective Date	Expiration Date	Limits	
Professional Liability Occup Thp Fm Occupational Therapist	AHY-891789001	11/01/2017	11/01/2018	Per Incident/ Occurrence	\$1,000,000
				Annual Aggregate	\$3,000,000
PROOF OF INSURANCE					
Memorandum Holder: PROOF OF COVERAGE ONLY			Should the above describe Certificate be cancelled before the expiration date thereof, the issuing company will endeavor to mail 30 days written notice to the Memorandum Holder named to the left, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives.		
			Authorized Representative Mark Brostowitz		
					

Healthcare Professional Liability



LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Company")

ENDORSEMENT NO. []

Effective Date: 11/01/2017

Policy Number: AHY-891789001

Issued To: In SYNC Occupational Therapy, PC

Return Premium \$

Additional Premium

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

COVERED OCCUPATIONS ENDORSEMENT

The business, occupation and/or profession shown in the Declarations of this policy is amended to include the following:

Occupational Therapist, FT, Owner, 1

RESOLUTION REQUEST FORM NO. 3

Request for New Contract

DEPARTMENT NAME: Health Services

DATE: 03/19/2018

- (a) Is this a Result of a Bid or Request for Proposal? No
- (b) Purpose of Contract: To authorize a contract agreement with Lindsey Maresca to provide Occupational Therapy Services
- (c) Name of Contractor: Lindsey Maresca
- (d) Address of Contractor: 6846 State Route 8, Brant Lake, NY 12815
- (e) Contractor's Contact Person and Telephone Number: Lindsey Maresca, (518)932-3677, email: Lindsey.maresca@yahoo.com
- (f) Has or will the Contract be provided, if so, please attach: Please use therapist contract
- (g) Commencement Date of Contract: 4/23/18
- (h) Termination Date of Contract: Upon 30 days written notice by either party
- (i) Payment Provisions:
 - i) lump sum amount – see attached rates
 - ii) hourly rate amount
 - iii) total amount not to exceed
 - iv) how will payments be made (i.e. monthly, quarterly, upon completion of the project, etc. Paid upon receipt of required documentation for each individual patient visit)
- (j) Where are the Funds for this Contract ? List Budget Code, (with title), Object Code (with title), and Amount: OR Capital Project OR Capital Reserve Project
Number, and Title, and Amount:

A4010.10.470 Health Services

**WARREN COUNTY HEALTH SERVICES
THERAPY RATES**

Certified Home Health Agency

Evaluation Region 1	\$55.00
Revisit Region 1	\$53.00
Evaluation Region 2	\$75.00
Revisit Region 2	\$75.00
Meetings (for all services)	\$40.00

Early Intervention Services Only

Evaluation Region 1	\$50.00
Revisit Region 1	\$50.00
Evaluation Region 2	\$57.00
Revisit Region 2	\$57.00
Extended visit Region 1 & 2 (with IFSP approval)	\$70.00
Supplemental Evaluations Regions 1 & 2	\$117.00

Preschool CPSE/Approved IEP

Basic visit Region 1	\$53.00
Basic visit Region 2	\$60.00
Group visit per child Regions 1 & 2	\$44.00

Meetings (for all services)	\$40.00
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Lindsey Maresca, MOTR/L

6846 State Route 8
Brant Lake, New York 12815
(518) 932-3677
lindsey.maresca@yahoo.com

PROFESSIONAL EXPERIENCE

Occupational Therapist- Center for Disability Services NY-Education and Article 28 Services- Prospect Center
March 2016-February 2018

- Sensory Integration
- Fine motor
- Aquatic Therapy (education and outpatient)
- ADL training
- MOVE trained
- Vocational education training
- Adapted dining

EDUCATION

Quinnipiac University - Hamden, Connecticut

BSHS, May 2014 and MOT, January 2016

- Fieldwork Level I
 - Fall 2011- Hippotherapy in Durham, CT
 - Fall 2011- YMCA (Preschool) in Southington, CT
 - Fall 2012- Elim Park (SNF) in Cheshire, CT
 - Spring 2013- Green Acres School District in North Haven, CT
 - Fall 2013- Skane School in Bridgeport, CT
 - Spring 2014- Middlesex Healthcare Center in Middlesex (SNF), CT
 - Fall 2014- Bridgeport Hospital (Acute Mental Health) in Bridgeport, CT
 - Spring 2015- Advanced Therapy Solutions in Wethersfield, CT
 - Spring 2015- Gaylord Hospital (Acute Rehab)in Wallingford, CT
- Fieldwork Level II
 - Summer 2014- Community, Work, and Independence (CWI) in Glens Falls, NY- I had experience observing and performing individual treatment sessions. At the end of the twelve weeks I was responsible for the treatment of my own caseload of thirteen clients. I had the opportunity to observe and assist with assessments, dining, and trainings. I was given experience in assessment write-ups, revision of treatment plans and treatment reviews. I was also able to present in and attend ISP meetings. I had the opportunity to assist in training OPWDD dining. I was responsible for the inventory of adaptive dining equipment.
 - Summer 2015- Chestnut Terrace Rehabilitation in East Providence, RI- I had the experience of working with older adults in a skilled nursing facility providing rehabilitation to long term and short term patients. I had the experience of working with and getting trained on PAMs. I gained experience with collaborating with the rehabilitation team in treatments and during meetings. I had opportunities with home evaluations. I was also a team member involved in presenting the idea of "Muffin Meals" to administration for residents who were unable to utilize utensils to enjoy the same meals as other residents, not just sandwiches for finger foods.
 - Fall 2015- Reece School in Harlem, NY- I had experiences observing and performing individual and group OT sessions with children in the school ages 7-13. I had opportunities to treat students according to their IEP's. I had experiences interacting with children who experienced emotional and behavioral challenges as well as academic challenges. Sensory integration, and Handwriting Without Tears practice incorporated with this fieldwork experience.

To: Licensee/Registrant

- ◆ Please review the Registration Certificate below to be sure the information on it is correct.
- ◆ If any of the information is not correct, please contact us at OPREGFEE@mail.nysed.gov or (518) 474-3817, Ext. 410.
- ◆ If the information is correct, sign above the Licensee/Registrant block and please destroy any previous Registration Certificates you may have, as certificates with incorrect information are not valid and should not be kept.
- ◆ Should your address or name change, please notify us as described on the reverse and a new certificate will be issued.

UPON RECEIPT OF THIS REGISTRATION CERTIFICATE YOUR PREVIOUSLY ISSUED REGISTRATION CERTIFICATE IS NULL AND VOID. PLEASE DESTROY THE PREVIOUSLY ISSUED REGISTRATION CERTIFICATE.

SEE BACK FOR IMPORTANT INFORMATION

The University of the State of New York
Education Department
Office of the Professions
REGISTRATION CERTIFICATE
Do not accept a copy of this certificate

License Number: 020418-1

Certificate Number: 9285974

MARESCA LINDSEY
PO BOX 83

6826 ST RT 8
BRANT LAKE

NY 12815-0000



is registered to practice in New York State through 02/28/2019 as a(n)
OCCUPATIONAL THERAPIST

[Signature]
LICENSEE/REGISTRANT

[Signature]
EXECUTIVE SECRETARY

[Signature]
COMMISSIONER OF EDUCATION

[Signature]
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FOR THE PROFESSIONS

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PROFESSIONAL LIABILITY

LIBERTY INSURANCE UNDERWRITERS INC.

(A New York Stock Insurance Company, hereinafter the "Insurer")

ENDORSEMENT NO. []

Effective Date: 10/03/2017
Policy Number: AHY-841040002
Issued To: Lindsey Maresca

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

U.S. ECONOMIC AND TRADE SANCTIONS ENDORSEMENT

Whenever coverage provided by this policy would be in violation of any U.S. economic or trade sanctions such as, but not limited to, those sanctions administered and enforced by the U.S. Treasury Department's Office of Foreign Assets Control ("OFAC"), such coverage shall be null and void.

Similarly, any coverage relating to or referred to in any certificates or other evidences of insurance or any claim that would be in violation of U.S. economic or trade sanctions as described above shall also be null and void.

Healthcare Professional Liability



limited to **Life Care Planning**, **Legal Nurse Consulting** and services provided as an expert witness.

“Educational Services” means:

1. services rendered by an **Insured** as a teacher or instructor in their **Area of Specialization**, and/or
2. services rendered by an **Insured** as an author, researcher and/or presenter of research findings when conducted solely for the purposes of dissemination of knowledge in the **Insured’s Area of Specialization**.

“Legal Nurse Consulting” means evaluation, analysis and rendering of informed opinions about medical issues, delivery of health care and/or the health outcomes as they relate to cases or issues within the medical-legal arena utilizing one’s background and experience as a licensed nursing professional.

“Life Care Planning” means the creation of a dynamic document based upon published standards of practice, comprehensive assessment, data analysis and research, which provides an organized, concise plan for current and future needs with associated cost for individuals who have experienced catastrophic injury or have chronic health care needs.

“Medical Administration” means the employment of medical knowledge and/or organizational skills, medical industry knowledge and technology to manage an office and/or practice of a healthcare service provider or providers.

“Utilization Review” means:

1. evaluations and resultant recommendations concerning professional practice patterns of others for controlling the cost of delivery of patient care;
2. determinations and/or recommendations regarding healthcare services to be provided by others to any participant in any healthcare insurance plan; or
3. determination or consultation in the determination of benefits paid by others to any participant in a healthcare insurance plan.

It is further agreed that the following have been added to Section VI. EXCLUSIONS:

This insurance does not apply:

1. to claims based on or arising out of the commingling, misappropriation or improper use of funds; or arising out of, or in way involving the gaining of any personal profit or advantage to which an **Insured** is not legally entitled;
2. to claims based upon, directly or indirectly arising out of, or in any way involving the participation in, design and/or solicitation of any structured settlement proposal;

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17. to any **Consulting Services** performed by any medical technologist, technician or aide; or any **Consulting Services** provided by any other individual who is not a licensed health care provider;
18. to authoring of books or articles if such activities are a primary source of income; or to activities as a publisher;
18. to any liability resulting from **Case Management, Consulting Services, Educational Services, Life Care Planning and/or Utilization Review** the **Named Insured** provides while their license or certification to practice is suspended, revoked or no longer valid;
19. to any notarized certification or acknowledgement of a signature without physical appearance before the **Named Insured** of the person who is, or claims to be, the person signing the instrument.

ALL OTHER TERMS AND CONDITIONS OF THE POLICY REMAIN UNCHANGED.

NOTICE

CLAIM REPORTING INSTRUCTIONS

In the event you receive notice of a **Claim, Suit, Incident or Occurrence**, you must provide written notice to Liberty Insurance Underwriters Inc. (LIUI). A claim must be reported to LIUI for assignment to a Claims Professional. Please follow the instructions below:

Please send written notice to:

MercerClaims@libertyiu.com

OR

Liberty International Underwriters
Attn: Mercer Claims
55 Water Street 23rd Floor
New York, NY 10041

If you would like to speak with someone regarding your **Claim, Suit, Incident or Occurrence**, please contact:

1-855-511-8097

Terms in bold face are defined by your policy. Please refer to your policy for relevant definitions and reporting obligations.



Healthcare Professional Liability

LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the Company)
55 Water Street, 18th Floor
New York, NY 10041

DECLARATIONS

Policy Number: AHY-841040002

Renewal Of: AHY-841040001

SECTION I

Item

- 1. Named Insured: Lindsey Maresca
- 2. Mailing Address: 6846 State Route 8,
Brant Lake, NY 12815
- 3. Policy Period: From: 10/03/2017 To: 10/03/2018
12:01 A. M. Standard Time At Location of Designated Premises
- 4. Business or Profession: Occupational Therapist Affiliation: 3116- American Occupational Therapy Assn.
- 5. The Named Insured is a(n): Partnership Corporation Individual LLC
 Sole Proprietor (with employees) Professional Association Other

This policy is made and accepted subject to the printed conditions of this policy together with the provisions, stipulations and agreements contained in the following form(s) or endorsements(s): HCPL-2037i (01/14), HCPL-2038 (11/09), HCPL-8020 (Ed. 12/10), HCPL-2037-9000-NY (10/14), HCPL-9002-NY (02/10), HCPL-8101-NY (11/14), OFAC (08/09), HCPL-8103NY (03/16),

HCPL-8320 (01/15), HCPL-8321 (01/15), HCPL-8324NY (05/15), HCPL-8328NY (05/15)

SECTION II

Item	COVERAGE	Premium
A.	Professional Liability [X]	\$68.00
B.	General Liability []	
	Terrorism Risk Insurance Act []	
C.	Endorsements [X]	\$25.00
TOTAL:		\$93.00

LIMITS OF LIABILITY

\$1,000,000 Each Incident and Each Occurrence \$3,000,000 Aggregate

SECTION III

SUPPLEMENTARY PAYMENTS

- A. First Party Assault
- B. Licensing Board Reimbursement
- C. Wage Loss and Expense
- D. Deposition Expense
- E. First Aid Reimbursement

Representative Agent: Mercer Consumer, a service of
Mercer Health & Benefits Administration LLC
P.O. Box 14576
Des Moines, IA 50306-3576

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HCPL-2037D (11/09)

LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Company")

MEDICAL PROFESSIONAL LIABILITY OCCURRENCE INSURANCE POLICY - INDIVIDUAL

THIS IS AN OCCURRENCE POLICY. PLEASE REVIEW THE POLICY CAREFULLY.

The Company agrees with the **Named Insured**, in consideration of the payment of the premium, and in reliance upon the statements in the Declarations and in the Application and subject to the Limit of Liability, exclusions, conditions and other terms of this policy, as follows:

I. COVERAGES

A. COVERAGE A, PROFESSIONAL LIABILITY COVERAGE

The Company will pay on behalf of the **Insured** all sums which the **Insured** shall become legally obligated to pay as **Damages** because of **Bodily Injury** or **Property Damage** caused by an **Incident** or **Personal and Advertising Injury** offense, to which this insurance applies in the operation of the business or conduct of the profession of the **Named Insured** as specified in the Declarations; which occurs during the **Policy Period**.

B. COVERAGE B, GENERAL LIABILITY COVERAGE

If indicated by a specific premium in the Declarations, the Company will pay on behalf of the **Insured** all sums which the **Insured** shall become legally obligated to pay as **Damages** because of **Bodily Injury**, **Property Damage** or **Personal and Advertising Injury** to which this insurance applies in the operation of the business or conduct of the profession of the **Named Insured** as specified in the Declarations, caused by an **Occurrence** during the **Policy Period**. This coverage specifically includes the following extensions:

1. Contractual Liability: **Bodily Injury** or **Property Damage** resulting from any **Incidental Contract** relating to the operation of the **Named Insured's** business, except if such injury or damage occurred prior to the execution of the **Incidental Contract**;
2. Host Liquor Liability: **Bodily Injury** or **Property Damage** arising out of the giving or serving of alcoholic beverages at functions incidental to the **Named Insured's** business;
3. Damage To Premises Rented To You: **Property Damage** to structures or portions thereof rented to or leased to the **Named Insured**, including fixtures permanently attached thereto, if such **Property Damage** arises out of fire. Solely as respects Damage To Premises Rented To You coverage, all of the exclusions of the policy, other than Exclusions 6, 12 and 13 and the Nuclear Energy Liability Exclusion (Broad Form) are deleted;

As respects coverage(s) provided by this insurance, the Company shall have the right and duty to defend any **Suit** against the **Insured** seeking **Damages** on account of such **Bodily Injury**, **Property Damage**, **Personal and Advertising Injury**, even if any of the allegations of the **Suit** are groundless, false or fraudulent, but the Company shall not be obligated to pay any claim or judgment or continue to defend any **Suit** after the applicable limit of the Company's liability has been exhausted by payment of **Damages**.

The Company, at its option, shall select and assign defense counsel; however, the **Named Insured** may engage additional counsel, solely at their expense, to associate in the defense of any claim covered hereunder. **Claims Expenses** incurred by the Company shall be paid in addition to the applicable Limits of Liability. The Company shall also have the right to investigate any claim and/or negotiate the settlement thereof, as it deems expedient, but the Company shall not commit to any settlement without the **Named Insured's** written consent. If the **Named Insured** refuses to consent to any settlement recommended in writing by the Company and elects to contest the claim or continue any legal proceedings in connection with such claim, then the Company shall be

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caused by any one **Assault** by, or at the direction of, a person other than an **Insured** during the **Policy Period**, which happens on the **Insured's** workplace premises, including the ways immediately adjoining such workplace premises, while away from such workplace premises while conducting an authorized work activity, or while travelling to or from such workplace premises.

Subject to the foregoing, the total amounts payable under this extension shall not exceed \$25,000 for all **Assaults** which happen during the **Policy Period**.

This coverage does not apply to damage to any mode of transportation used by the **Insured** to go to and from the **Insured's** workplace premises, or damage to any business or personal property owned, leased or rented by any other person or business enterprise while in the **Insured's** possession.

This coverage applies as excess over any other available insurance covering such loss;

B. LICENSING BOARD REIMBURSEMENT:

Up to \$10,000 for attorney fees, and other costs, expenses or fees resulting from the investigation or defense of all proceedings before any entity responsible for regulating the **Insured's** professional conduct, arising out of an **Incident**, incurred as a result of notice or notices of proceedings first received by the **Insured** during the **Policy Period**. This payment, however, does not apply to any expenses or fees resulting from criminal proceedings.

All such proceedings arising out of the same or related **Incident** shall be:

1. considered first made during the **Policy Period** in which the earliest complaint arising out of such same or related **Incident** was made; and
2. subject to a single limit as stated above.

Subject to the foregoing, the total amounts payable under this extension shall not exceed \$25,000 for all **Incidents** of which notice or notices are first received by all **Insureds** during the **Policy Period**.

C. WAGE LOSS AND EXPENSE:

For lost wages, costs and expenses, caused by the **Insured's** attendance at the Company's request at any trial(s), hearing(s) or arbitration proceedings(s) involving a civil **Suit(s)** against such **Insured** for covered **Damages** the Company will pay up to \$500 per **Insured** per day for the **Insured's** lost wages, costs and expenses. Regardless of the number of trials, hearings or arbitration proceedings, the amount so payable for any one series of trials, hearings or arbitration proceedings arising out of the same **Incident** and/or **Occurrence** shall not exceed \$10,000. The maximum amount the Company will pay for all **Incidents** and/or **Occurrences** during the **Policy Period** shall not exceed \$25,000.

D. DEPOSITION EXPENSE:

Up to \$10,000, for all reasonable fees, costs and expenses necessary to represent the **Insured** at all depositions, which the **Insured** is required to attend, arising out of the profession indicated in the Declarations, of which notice or notices of required attendance are first received by the **Insured** during the **Policy Period**. This payment does not apply to any deposition where the **Insured** is acting as a paid expert.

E. FIRST AID REIMBURSEMENT:

Up to \$10,000, for all medical related expenses for which the **Insured** has voluntarily made payment or incurred, for first aid rendered to others because of any **Bodily Injury** covered by this policy. For purposes of this Supplementary Payment, first aid is the provision of initial care for an illness or injury until definitive medical treatment can be accessed.

This provision does not apply to **Bodily Injury** to any person defined as an **Insured** in this policy.

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- b. infringement of trademark, service mark or trade name, other than titles or slogans, by use thereof on or in connection with goods, products or services sold, offered for sale or advertised; or
 - c. incorrect description or mistake in advertised price of goods, products or services sold, offered for sale or advertised;
3. to any obligation for which the **Insured**, or any carrier as his/her insurer, may be held liable under any workers' compensation, unemployment compensation or disability benefits law, or under any similar law;
4. to **Bodily Injury** or **Personal Injury** to any employee of the **Insured** arising out of and in the course of his/her employment by the **Insured** or to any obligation of the **Insured** to indemnify another because of **Damages** arising out of such injury;
5. to **Bodily Injury** or **Property Damage** arising out of the ownership, maintenance, operation, use, loading or unloading of:
 - a. any watercraft owned or operated by or rented or loaned to any **Insured**; or
 - b. any other watercraft operated by any person in the course of his/her employment by any **Insured**.
 - c. This exclusion does not apply to any watercraft under 26 feet in length provided such watercraft is neither owned by the **Named Insured** nor being used to carry persons or property for a charge. Irrespective of this coverage, where the **Insured** is covered or protected by other insurance against any loss or claim which would otherwise have been paid by the Company under this policy there shall be no contribution or participation by this Company on the basis of excess, contributing, deficiency, concurrent, or double insurance or otherwise;
6. to any claim, action, judgement, liability, settlement, loss, defense, cost or expense in any way arising out of actual, alleged or threatened pollution, contamination or any environmental impairment resulting from seepage, discharge, dispersal, release or escape of any solid, liquid, gaseous or radioactive matter including, but not limited to, smoke, vapors, soots, fumes, acids, alkalis, chemicals or toxic matter; or waste material (including materials to be recycled, reconditioned or reclaimed); or oil or other petroleum substances or derivatives (including oil refuse or oil mixed with waste), or thermal or vibratory effect including, but not limited to, sound or noise, heat or cold, into or upon land, the atmosphere or any water course or body of water, underground water or water table supplies, whether such results directly, indirectly or in concurrence or in any sequence from the **Insured's** activities or the activities of others and whether or not such is sudden, gradual, accidental, intended, foreseeable, expected, fortuitous or inevitable and wherever or however such occurs.

But this exclusion shall not apply to **Bodily Injury** or **Property Damage** caused by heat, smoke or fumes from a **Hostile Fire** unless such fire involves:

 - a. materials which are or were at any time used for the handling, storage, disposal, processing or treatment of waste; or
 - b. any premises, site or location:
 - i. which is or was at any time used for handling, storage, disposal, processing or treatment of waste; or
 - ii. on which any **Insured** or contractors or subcontractors working directly or indirectly on any **Insured's** behalf are performing operations to test for, monitor, cleanup, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of, pollutants;
7. to **Bodily Injury** or **Property Damage** due to war, whether or not declared, civil war, insurrection, rebellion or revolution or to any act or condition **Incident** to any of the foregoing;
8. to **Bodily Injury** or **Property Damage** for which the **Insured** or the **Insured's** indemnitee may be liable:
 - a. as a person or organization engaged in the business of manufacturing, distributing, selling or serving alcoholic beverages; or

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- a. a delay in or lack of performance by or on behalf of the **Named Insured** or any contract or agreement; or
- b. the failure of the **Named Insured's Products** or work performed by or on behalf of the **Named Insured** to meet with the level of performance, quality, fitness or durability warranted or represented by the **Named Insured**;

but this exclusion does not apply to loss of use of other tangible property resulting from the sudden and accidental physical injury to or destruction of the **Named Insured's Product** or work performed by or on behalf of the **Named Insured** after such products or work have been put to use by any person or organization other than an **Insured**;

20. to **Property Damage** to the **Named Insured's Products** arising out of the use of such products or any part of such products;
21. to claims brought for the withdrawal, inspection, repair, replacement, or loss of use of the **Named Insured's Products** or work completed by or for the **Named Insured** or any property of which such products or work form a part, if such products, work or property are withdrawn from the market or from use because of any known or suspected defect or deficiency therein;
22. to claims brought against any **Insured** as a proprietor, owner, partner, manager, superintendent, or officer of any hospital, sanitarium, medical clinic, health maintenance organization, managed care facility, foster care agency, adoption agency or any other facility not specified in the Declarations or any endorsement thereto;
23. to claims arising out of the services performed by any **Insured** as a physician, surgeon, dentist, nurse midwife, chiropractor, podiatrist, osteopath, psychiatrist, cytotechnologist, or perfusionist, except for services performed as an optometric physician, or to claims brought against the **Insured** arising out of any trade, business, employment, profession or occupation other than as specified in the Declarations or any endorsement thereto;
24. to claims based on or arising out of the practice of the **Named Insured's** business or professional occupation as stated in the Declarations unless the **Insured** is properly licensed or certified by the laws of the state(s) in which the **Insured** practices or conducts business or is otherwise qualified to practice the **Named Insured's** business or professional occupation in the absence of such law;
25. to claims based on or arising out of services provided by any **Insured**, to the extent such services are not authorized or permitted by the laws of the state(s) in which such **Insured** practices or conducts business;
26. to any claims based on or arising out of any act or omission by an **Insured** with respect to hiring, termination, harassment, compensation, or the tenure, term, condition, benefits or privilege of employment of any such person;
27. to any claims made or **Suits** brought against any **Insured** alleging in whole or part:
 - a. physical assault, abuse, molestation, or habitual neglect, or licentious, immoral, amoral or other behavior that was committed or alleged to have been committed, by the **Insured** or by any person for whom the **Insured** is legally responsible; and/or
 - b. sexual assault, abuse, or molestation, or licentious, immoral, amoral or other behavior which was threatened, intended to, lead to or culminated in, any sexual act whether committed intentionally, negligently, inadvertently or with the belief, erroneous or otherwise, that the other party is consenting and has the legal and mental capacity to consent thereto, that was committed, or alleged to have been committed by the **Insured** or by any person for whom the **Insured** is legally responsible.

This exclusion applies regardless of the legal theory or basis upon which the **Insured** is alleged to be legally liable or responsible in whole or in part, for any **Damages** arising out of sexual and/or physical abuse, including but not limited to assertions of improper or negligent hiring, employment or supervision, failure to protect or warn the other party, failure to prevent the sexual abuse and/or physical abuse, failure to prevent assault and battery, failure to discharge the employee.



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- A. fees charged by an attorney(s) and/or independent adjustor(s) designated by the Company and all other fees, costs and expenses resulting from the investigation, adjustment, defense and appeal of a claim, **Suit** or proceedings arising in connection therewith, if incurred by the Company, or by the **Insured** with written consent of the Company, but does not include salary charges or expenses of regular employees or officials of the Company;
- B. all costs taxed against the **Insured** in such **Suits** and all interest on the entire amount of any judgment therein which accrues after entry of the judgement and before the Company has paid, tendered or deposited, whether in court or otherwise, the part of the judgement which does not exceed the limit of the Company's liability;
- C. premiums on appeal bonds and premiums on bonds to release attachments in such **Suits**, but not for bond amounts in excess of the applicable Limit of Liability of this policy, but the Company shall have no obligation to apply for or furnish any such bond;

"**Collapse Hazard**" includes "**Structural Property Damage**" as defined herein and **Property Damage** to any other property at any time resulting therefrom. "**Structural Property Damage**" means the collapse of or structural injury to any building or structure due to:

- A. grading of land, excavating, burrowing, filling, back-filling, tunneling, pile driving, cofferdam work or caisson work; or
- B. moving, shoring, underpinning, razing or demolition of any building or structure or removal or rebuilding of any structural support thereof.

The **Collapse Hazard** does not include **Property Damage**:

- A. arising out of operations performed for the **Named Insured** by independent contractors; or
- B. included within the **Completed Operations Hazard** or the **Underground Property Damage Hazard**; or
- C. for which liability is assumed by the **Insured** under an **Incidental Contract**;

"**Completed Operations Hazard**" includes **Bodily Injury** and **Property Damage** arising out of operations or reliance upon a representation or warranty made at any time with respect thereto, but only if the **Bodily Injury** or **Property Damage** occurs after such operations have been completed or abandoned and occurs away from premises owned by or rented to the **Named Insured**. "Operations" includes materials, parts or equipment furnished in connection therewith. Operations shall be deemed completed at the earliest of the following times:

- A. when all operations to be performed by or on behalf of the **Named Insured** under the contract have been completed; or
- B. when all operations to be performed by or on behalf of the **Named Insured** at the site of the operations have been completed; or
- C. when the portion of the work of which the **Bodily Injury** or **Property Damage** arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as part of the same project.

Operations which may require further service, maintenance work, correction, repair or replacement because of any defect or deficiency, but which are otherwise complete, shall be deemed completed.

The **Completed Operations Hazard** does not include **Bodily Injury** or **Property Damage** arising out of:

- A. operations in connection with the transportation of property, unless the **Bodily Injury** or **Property Damage** arises out of a condition in or on a vehicle created by the loading or unloading thereof; or
- B. the existence of tools, installed equipment or abandoned or unused material; or
- C. operations for which the classification stated in the policy or in the Company's manual specifies "including completed operations";



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“**Occurrence**” means an accident, including continuous or repeated exposure to substantially the same general conditions, which results in **Bodily Injury** or **Property Damage**, neither expected nor intended from the standpoint of any **Insured** or **Advertising Injury**;

“**Personal and advertising injury**” means injury, including consequential **bodily injury**, arising out of one or more of the following offenses:

- A. False arrest, detention or imprisonment;
- B. Malicious prosecution;
- C. The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor;
- D. Oral or written publication, in any manner, of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;
- E. Oral or written publication, in any manner, of material that violates a person's right of privacy;
- F. The use of another's advertising idea in the **Named Insured's** advertisement; or
- G. Infringing upon another's copyright, trade dress or slogan in the **Named Insured's** advertisement;

“**Policy Period**” means, whenever used in this policy, the period from the inception date of this policy to the policy expiration date as set forth in the Declarations or its earlier termination date, if any;

“**Products Hazard**” includes **Bodily Injury** and **Property Damage** arising out of the **Named Insured's** **Products** or reliance upon a representation or warranty made at any time with respect thereto, but only if the **Bodily Injury** or **Property Damage** occurs away from the premises owned by or rented to the **Named Insured** and after physical possession of such products has been relinquished to others. Equipment specifically designed, made or altered by the **Insured** for a patient or client in the performance of the **Insured's** profession or operation of business, shall not be included in the “**Products Hazard**”;

“**Property Damage**” means:

- A. physical injury to or destruction of tangible property which occurs during the **Policy Period**, including the loss of use thereof at any time resulting therefrom; or
- B. loss of use of tangible property which has not been physically injured or destroyed provided such loss of use is caused by an **Occurrence** during the **Policy Period**; or
- C. economic loss, whether or not resulting from physical injury or damage to person or property, except if such loss was caused, or alleged to have been caused, in whole or part, by anti-trust, breach of contract, price-fixing, restraint of trade or unfair business practices by any **Insured**;

“**Suit**” includes lawsuit and/or arbitration proceedings to which the **Insured** is required to submit to or to which the **Insured** has submitted with the Company's consent;

“**Underground Property Damage Hazard**” includes **Underground Property Damage** as defined herein and **Property Damage** to any other property at any time resulting therefrom. “**Underground Property Damage**” means **Property Damage** to wires, conduits, pipes, mains, sewers, tanks, tunnels, any similar property, and any apparatus in connection therewith, beneath the surface of the ground or water, caused by and occurring during the use of mechanical equipment for the purpose of grading land, paving, excavating, drilling, burrowing, filling, back-filling or pile driving. The **Underground Property Damage Hazard** does not include **Property Damage**:

- A. arising out of operations performed for the **Named Insured** by independent contractors; or
- B. included within the **Completed Operations Hazard**; or
- C. of which liability is assumed by the **Insured** under an **Incidental Contract**.

“**Utilization Review**” means:



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of the effective date of cancellation or the date of delivery of the **Insured's** notice of intent to cancel, subject always to the retention by the Company of any minimum premium stipulated herein (or proportion thereof previously agreed upon).

The earned portion of the premium shall be computed on the customary short-rate basis unless any state law or regulation of the state shown in the mailing address of the **Named Insured** in the Declarations requires that return premium be computed on a pro-rata basis, even in the event of cancellation by the **Named Insured**.

This insurance may also be canceled, with or without the return or tender of the unearned premium, by the Company or by its authorized representative on its behalf, by sending to the **Named Insured**, by first-class registered or certified mail, at the **Named Insured's** address last known to the Company or its authorized agent, not less than ninety (90) days written notice stating the specific reason for such cancellation and when the cancellation shall be effective. In such case, the Company shall refund the paid premium less the earned portion thereof within ten (10) business days after the effective date of cancellation, subject always to the retention by the Company of any minimum premium stipulated herein (or proportion thereof previously agreed upon) in the event of cancellation either by the Company or the **Named Insured**. In case of nonpayment of premium, only thirty (30) days written notice of cancellation must be given by the Company. Minimum premium shall not apply to the return of unearned premium if cancellation is by the Company.

Cancellation by the Company shall only be effective if based on one or more of the following reasons:

- a. nonpayment of premium;
- b. the policy was obtained through material misrepresentation that was relied on by the Company, and such policy would not have been issued by the Company under the same terms and conditions if correct information had been disclosed;
- c. material failure to comply with any policy term, condition or contractual duty;
- d. the risk originally accepted has measurably increased; or
- e. loss by the Company of reinsurance which provided coverage for all or a substantial part of the risk insured.

2. NONRENEWAL

The Company will renew this policy unless written notice of the Company's intent not to renew, stating the specific reasons for nonrenewal, is mailed to the **Named Insured** not less than ninety (90) days before the policy expires. "Nonrenewal" shall include the failure of the Company to offer a renewal policy which provides types and limits of coverage substantially equivalent to those contained in the expiring policy.

3. MAILING OF NOTICE

Any notice of cancellation or nonrenewal will be mailed by first-class registered or certified mail to the **Named Insured** at the last mailing address known to the Company. Proof of mailing will be sufficient proof of notice.

F. CHANGES

The terms of this policy shall not be waived or changed, except by endorsement issued to form a part of this policy.

G. DECLARATIONS

By acceptance of this policy, the **Insured** agrees that the statements in the Declarations are the **Insured's** agreements and representations, that this policy is issued in reliance upon the truth of such representations and that this policy embodies all agreements existing between the **Insured** and the Company or any of its agents relating to this insurance.

H. OTHER INSURANCE



Healthcare Professional Liability

The Company shall be permitted but not obligated to inspect the **Named Insured's** property and operations at any time. Neither the Company's rights to make inspections, nor the making thereof, nor any report thereon shall constitute an undertaking, on behalf of or for the benefit of the **Named Insured** or others, to determine or warrant that such property or operations are safe or healthful, or are in compliance with any law, rule or regulation.

The Company may examine and audit the **Named Insured's** books and records at any time during the **Policy Period** and extensions thereof and within three years after the final termination of this policy as far as they relate to the subject matter of this insurance.

M. AUTHORIZATION

The first **Named Insured** listed in the Declarations or in any amendment thereto, agrees to act on behalf of all other **Insureds** with respect to the giving and receiving of all notices to the Company as may be required by the terms of this policy and in the receiving of any return premiums that may become due hereunder.

All **Insureds** agree that the first **Named Insured** listed in the Declarations or in any amendment thereto, is hereby designated to so act on their behalf.

N. LIBERALIZATION

If the Company adopts a revision, at any time during the **Policy Period**, which would broaden the coverage under this policy without additional premium, the broadened coverage will immediately apply to this policy.

IN WITNESS WHEREOF, the Company has caused this policy to be signed by its President and Secretary.

A handwritten signature in black ink, appearing to read "C. L. Peirce".

PRESIDENT
Christopher L. Peirce

A handwritten signature in black ink, appearing to read "Mark C. Touhey".

VICE PRESIDENT and SECRETARY
Mark C. Touhey

Healthcare Professional Liability



2. the proceeding is reported to the Company within sixty (60) days after the **Insured** receives notice of such proceeding; provided, however, that failure to give such notice shall not invalidate any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible thereafter.

ALL OTHER TERMS AND CONDITIONS OF THE POLICY REMAIN UNCHANGED.

Healthcare Professional Liability

- (3) the **Bodily Injury or Property Damage** arises out of the furnishing by an **Insured** of services, materials, parts or equipment in connection with the planning, construction, maintenance, operation or use of any **Nuclear Facility**, but if such facility is located within the United States of America, its territories or possession or Canada, this exclusion (3) applies only to **Property Damage** to such **Nuclear Facility** and any property thereof.

II. As used in this endorsement:

"**Hazardous Properties**" include radioactive, toxic or explosive properties;

"**Nuclear Material**" means **Source Material, Special Nuclear Material or By-product Material**;

"**Source Material**" "**Special Nuclear Material**" and "**By-product Material**" have the meanings given them in the Atomic Energy Act of 1954 or in any law amendatory thereof;

"**Spent Fuel**" means any fuel element or fuel component, solid or liquid, which has been used or exposed to radiation in a **Nuclear Reactor**;

"**Waste**" means any waste material:

- (a) containing **By-product Material** other than the tailings or **Wastes** produced by the extraction or concentration of uranium or thorium from any ore processed primarily for its source material content; and
- (b) resulting from the operation by any person or organization of any **Nuclear Facility** included under the first two paragraphs of the definition of **Nuclear Facility**;

"**Nuclear Facility**" means:

- (a) any **Nuclear Reactor**;
- (b) any equipment or device designed or used for (1) separating the isotopes of uranium or plutonium, (2) processing or utilizing **Spent Fuel**, or (3) handling, processing or packaging **Waste**;
- (c) any equipment or device used for the processing, fabricating or alloying of **Special Nuclear Material** if at any time the total amount of such material in the custody of the **Insured** at the premises where such equipment or device is located consists of or contains more than 25 grams of plutonium or uranium 233 or any combination thereof, or more than 250 grams of uranium 235;
- (d) any structure, basis, excavation, premises or place prepared or used for the storage or disposal of **Waste**, and includes the site on which any of the foregoing is located, all operations conducted on such site and all premises used for such operations;

"**Nuclear Reactor**" means any apparatus designed or used to sustain nuclear fission in self-supporting chain reaction or to contains critical mass of fissionable material;

"**Property Damage**" includes all forms of radioactive contamination of property.



Healthcare Professional Liability Policy

LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Company")

ENDORSEMENT NO. []

Effective Date: 10/03/2017

Policy Number: AHY-841040002

Issued To: Lindsey Maresca

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

NEW YORK AMENDATORY ENDORSEMENT

It is hereby agreed and understood that the above-referenced policy is amended as follows:

I. Section I.B. 3., COVERAGES is replaced by:

3. **Damage To Premises Rented To You: Property Damage** to structures or portions thereof rented to or leased to the **Named Insured**, including fixtures permanently attached thereto, if such **Property Damage** arises out of fire. Solely as respects Fire Legal Liability coverage, all of the exclusions of the policy, other than Exclusions 6, 10, 12 and 13 and the Nuclear Energy Liability Exclusion (Broad Form) are deleted;

II. The following is added to Section I. COVERAGES:

When the Limit of Liability with respect to the entire policy has actually been exhausted by payment of **Damages**:

- a. the Company will notify the **Insured**, in writing, as soon as practicable, that such limit has actually been exhausted and the Company's duty to defend any claim has also ended.
- b. the Company will initiate, and cooperate in, the transfer of control, to any appropriate **Insured**, of all claims which are subject to that Limit of Liability and which are reported to the Company before that Limit of Liability is exhausted. That **Insured** must cooperate in the transfer of control of said claim.
- c. the Company agrees to take such steps, as the Company deems appropriate, to avoid a default in, or continue the defense of, such claim until such transfer is completed, provided the appropriate **Insured** is cooperating in completing such transfer.
- d. the Company will take no action whatsoever with respect to any claim that would have been subject to that Limit of Liability, had it not been exhausted, if the claim is reported to the Company after that Limit of Liability has been exhausted.
- e. the **Named Insured**, and any other **Insured** involved in a claim seeking **Damages** subject to that Limit of Liability, must arrange for the defense of such claim within such time period as agreed to between the appropriate **Insured** and the Company. Absent any such agreement, arrangements for the defense of such claim must be made as soon as practicable.
- f. the **Named Insured** will reimburse the Company for expenses the Company incurs in taking those steps the Company deems appropriate in accordance with paragraph c. above.
- g. the duty of the **Named Insured** to reimburse the Company will begin on:
 - i. the date on which the applicable Limit of Liability is exhausted, if the Company sent notice; or

Healthcare Professional Liability Policy

VIII. The definition of "Assault" in Section VII. DEFINITIONS is replaced by:

"Assault" means any willful attempt or threat to inflict injury upon the person of another, when coupled with an apparent present ability to do so, and any intentional display of force such as would give the victim reason to fear or expect immediate bodily harm. Assault shall not include an action using reasonable force to protect persons or property.

IX. The following is added to Section VIII.A., CONDITIONS:

However, and notwithstanding the foregoing, with respect to a claim concerning an allegation of death or personal injury, if the Company disclaims liability or denies coverage based on the failure to provide timely notice, the injured person or claimant may maintain an action directly against the Company solely on the issue of whether the Company's disclaimer of liability or denial of coverage was proper. However, this right of the injured person or claimant to maintain such an action against the Company only applies if, within sixty (60) days following such disclaimer or denial, neither the **Insured** nor the Company:

- a. initiates an action to declare the rights of the parties under this policy; and
- b. names the injured person or other claimant as a party to the action.

Furthermore, and notwithstanding the foregoing, in case judgment against the **Insured** or the **Insured's** personal representative in an action brought to recover **Damages** for injury sustained or loss or damage occasioned during the life of this policy shall remain unsatisfied at the expiration of thirty (30) days from the serving of notice of entry of judgment upon the attorney for the **Insured**, or upon the **Insured**, and upon the Company, then an action may, except during a stay or limited stay of execution against the **Insured** on such judgment, be maintained against the Company under the terms of this policy for the amount of such judgment not exceeding the amount of the applicable Limit of Liability this policy.

X. The following is added to the first paragraph of Section VIII.C., CONDITIONS:

However, and notwithstanding the foregoing, the failure of the **Insured**, an injured person or any other claimant to give written notice to the Company of a claim within the time prescribed shall not invalidate the claim if it can be proven that it was not reasonably possible to give such notice within the time prescribed, and that notice was given as soon as was reasonably possible thereafter.

Subject to the foregoing, the failure of the **Insured**, an injured person or any other claimant to give written notice to the Company within the time prescribed shall not invalidate the claim unless failure to give timely notice to the Company prejudices the Company.

Furthermore, any notice given by or on behalf of the **Insured**, or written notice given by or on behalf of the injured person or any other claimant to any licensed New York agent of the Company, with particulars sufficient to identify the **Insured**, shall be deemed notice to the Company.

XI. Section VIII.E., CONDITIONS is replaced by:

E. CANCELLATION, NONRENEWAL, CONDITIONAL RENEWAL

2. CANCELLATION

This insurance may be canceled on the customary short-rate basis by the **Named Insured** at any time by written notice or by surrender of this insurance to the Company or its authorized representative and the Company shall refund the paid premium less the earned portion thereof within thirty (30) days of the latter of the effective date of cancellation or the date of delivery of the **Insured's** notice of intent to cancel, subject always to the retention by the Company of any minimum premium stipulated herein (or proportion thereof previously agreed upon).

Healthcare Professional Liability Policy

If the Company is obligated but fails to send the **Named Insured** a complete and timely nonrenewal notice before the policy expires, this policy will remain in full force and effect until sixty (60) days after such notice is mailed or delivered to the **Named Insured**, unless the **Named Insured** elects to cancel sooner.

If the Company is obligated but fails to send the **Named Insured** a complete and timely nonrenewal notice on or after the policy expires, this policy will remain in full force and effect for another required **Policy Period**, unless the **Named Insured** elects to cancel sooner.

However, and notwithstanding the foregoing, the Company shall not be required to send a nonrenewal notice if the **Named Insured** or the **Named Insured's** producer, if any, mails or delivers written notice to the Company stating that this policy has been replaced or is no longer desired.

If the **Named Insured** receives a notice that this policy is being nonrenewed, the notice relating thereto will also advise the **Named Insured** and the **Named Insured's** producer, if any, of the availability of loss information. Specifically, such notice will advise that, upon written request of the **Named Insured** or the **Named Insured's** producer, the Company shall mail or deliver, within ten (10) days of such request, the following loss information covering the period of time specified by New York regulation or the period of time coverage has been provided by the Company to the **Named Insured**, whichever is less:

- a. information on any and all closed claims, including the date and description of the **Incident(s)** that allegedly gave rise to the subject claim(s) and any and all payments made by the Company with regard to same;
- b. information on any and all open claims, including the date and description of the **Incident(s)** that allegedly gave rise to the subject claim(s) and any and all payments made by the Company with regard to same; and
- c. information on, and all notices of, any **Incident(s)**, including the date and description of the **Incident**.

3. CONDITIONAL RENEWAL

If the Company offers to renew this policy but such renewal is conditioned upon any:

- a. change with respect to the limits of liability;
- b. change in the type of coverage;
- c. reduction in coverage;
- d. increase in the Deductible;
- e. addition of a new exclusion; or
- f. premium increase in excess of ten percent (10%),

the Company will mail or deliver written notice stating the changed term(s). Such notice will be sent to the **Named Insured** and to the **Named Insured's** producer, if any, at the address shown on this policy. Such notice will be sent no less than sixty (60) days, but not more than one hundred twenty (120) days, before the policy expires.

If the Company is obligated but fails to send the **Named Insured** a complete and timely conditional renewal notice before the policy expires, this policy will remain in full force and effect until sixty (60) days after such notice is mailed or delivered to the **Named Insured**, unless the **Named Insured** elects to cancel sooner.

If the Company is obligated but fails to send the **Named Insured** a complete and timely conditional renewal notice on or after the policy expires, this policy will remain in full force and effect for another required **Policy Period**, unless the **Named Insured** elects to cancel sooner.



Healthcare Professional Liability

LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Company")

ENDORSEMENT NO. []

Effective Date: 10/03/2017

Policy Number: AHY-841040002

Issued To: Lindsey Maresca

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

SEPARATE AGGREGATE LIMIT OF LIABILITY ENDORSEMENT – NEW YORK

In consideration of the premium paid, it is hereby agreed and understood that Section III., LIMIT OF LIABILITY, of the above referenced policy is hereby amended by the addition of the following:

Notwithstanding the foregoing, the Limit of Liability stated in the Declarations as "Aggregate" shall apply separately to any individual domiciled in New York and defined as an **Insured** under Section II. PERSONS INSURED, Subsections A, B, C or E and any corporation or professional association domiciled in New York and defined as an **Insured** under Section II. PERSONS INSURED, Subsection D.

ALL OTHER TERMS AND CONDITIONS OF THE POLICY REMAIN UNCHANGED.



Healthcare Professional Liability

LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Company")

ENDORSEMENT NO. []

Effective Date: 10/03/2017

Policy Number: AHY-841040002

Issued To: Lindsey Maresca

Return Premium \$

Additional Premium

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

STUDENT PROFESSIONAL LIABILITY OCCURRENCE INSURANCE POLICY

SPECIFIED MEDICAL PROFESSIONAL LIABILITY OCCURRENCE INSURANCE POLICY -

STUDENT INDIVIDUAL

MEDICAL PROFESSIONAL LIABILITY OCCURRENCE INSURANCE POLICY

MEDICAL PROFESSIONAL LIABILITY OCCURRENCE INSURANCE POLICY - INDIVIDUAL

EXCLUSION OF SPECIFIED ACTIVITIES - REUSE OF PARENTERAL DEVICES AND SUPPLIES

In consideration of the premium charged, this policy shall not apply to **Bodily Injury** or **Property Damage** for, based upon, arising out of or related to any acts, errors or omissions involving **Reuse** of:

1. needles or syringes;
2. catheters or ports, including implanted ports;
3. intravenous solution, whether intended for direct intravenous administration or as a source of diluent for medication or any other substance to be administered parenterally;
4. intravenous medications intended for direct intravenous administration, including heparin or sodium chloride used for flushing venous access devices;
5. lines, including intravenous lines, tubing and any connectors thereto; or
6. any other types of parenteral device or supply used to inject medications, administer parenteral substances or withdraw blood samples;

in contravention of the instructions, warnings or recommendations of the manufacturer of such parenteral device or supply, or any standards regarding safe injection practices, intravenous therapy guidelines, infection control or any other pertinent recommendations or guidelines promulgated by

Healthcare Professional Liability



LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the "Company")

ENDORSEMENT NO. []

Effective Date: 03-OCT-2017

Policy Number: AHY-841040002

Issued To: Lindsey Maresca

Return Premium \$

Additional Premium

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

This endorsement modifies insurance provided under the following:

MEDICAL PROFESSIONAL LIABILITY OCCURRENCE INSURANCE POLICY

MEDICAL PROFESSIONAL LIABILITY OCCURRENCE INSURANCE POLICY – INDIVIDUAL

SEXUAL MISCONDUCT ENDORSEMENT – NEW YORK

SEXUAL MISCONDUCT AGGREGATE SUBLIMIT OF LIABILITY:

\$25,000

In consideration of the premium charged, the following changes are made to the policy:

- I. Solely with respect to coverage provided under this endorsement, SECTION I, COVERAGES, COVERAGE A, PROFESSIONAL LIABILITY COVERAGE is amended to include the following:

With respect to **Incidents** alleging **Sexual Misconduct** on behalf of any person(s) for whom the **Insured** is legally responsible, the Company will pay **Covered Sexual Misconduct Damages** because of **Bodily Injury** or **Personal and Advertising Injury** to which this insurance applies, subject to the **Sexual Misconduct** Aggregate Sublimit of Liability stated above. Such **Sexual Misconduct** must actually or allegedly occur:

1. in the operation of the business or conduct of the profession of the **Named Insured** as specified in the Declarations; and
2. during the **Policy Period**.

- II. Solely with respect to COVERAGE A. PROFESSIONAL LIABILITY COVERAGE, the following is added to SECTION III, LIMITS OF LIABILITY:

The **Sexual Misconduct** Aggregate Sublimit of Liability indicated above is the limit of the Company's liability for the sum of all amounts the **Insured** is legally obligated to pay as a result of **Claims** involving any act of **Sexual Misconduct** arising out of or related to the operation of the business or conduct of the profession of the **Named Insured** as specified in the Declarations, provided that **Sexual Misconduct** has not been determined to have occurred by any civil or criminal trial verdict, court ruling, regulatory ruling or legal admission, whether appealed or not.

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Healthcare Professional Liability



ALL OTHER TERMS AND CONDITIONS OF THE POLICY REMAIN UNCHANGED.

RESOLUTION REQUEST FORM NO. 12

Schedule "A"

NOTICE OF INTENT TO FILL VACANT POSITION

This notice of intent is filed whenever a department head plans to fill an *existing* funded position in their budget that is vacated due to a retirement, resignation, termination or promotion. This notice may not be used for requests to create a *new* position. For complete instructions on the procedure to be followed, see the reverse of this form.

DEPARTMENT HEAD COMPLETES THIS SECTION

Department Health Services Payroll Dept. No. 36.01
Title of Position WIC Coordinator Annual Salary \$51,934.69 Grade not applicable
Budget code and title 44013-110 Union Non-Union
This position is vacated due to: Retirement Resignation Termination Promotion Other
Employee No. 9413 3/16/18
Is this position mandated? Yes No Is the position reimbursable? Yes No
Source of reimbursement: Federal 100% State % Other %
Impact to Budget: 0

Personnel Officer has approved this form when initialed. AP 3/13/18 REN 3/13/18

COUNTY ADMINISTRATOR COMPLETES THIS SECTION

Name of Committee _____ Date _____
 The Administrator has no objection to the filling of the vacancy.
 The Administrator objects to the filling of the vacancy.

Administrator Signature W. B. M. [Signature]

SUPERVISORY COMMITTEE COMPLETES THIS SECTION

Name of Committee Health, Human + Social Ser. Date 3/19/18
 The committee has no objection to the filling of the vacancy.
 The committee objects to the filling of the vacancy.

Ranking Committee Member Signature Edna A. Frasier

PERSONNEL/HUMAN RESOURCES COMMITTEE COMPLETES THIS SECTION

Date 2/16/18
 The Personnel/Human Resources Committee has no objection to the filling of the vacancy.
 The Personnel/Human Resources Committee objects to the filling of the vacancy.

Ranking Committee Member Signature Budget Officer
Frank E. Thomas

RESOLUTION REQUEST FORM NO. 12

Schedule "A"

NOTICE OF INTENT TO FILL VACANT POSITION

This notice of intent is filed whenever a department head plans to fill an existing funded position in their budget that is vacated due to a retirement, resignation, termination or promotion. This notice may not be used for requests to create a new position. For complete instructions on the procedure to be followed, see the reverse of this form.

DEPARTMENT HEAD COMPLETES THIS SECTION

Department Health Services Payroll Dept. No. 36.01
Title of Position WIC Assistant Annual Salary \$29,747 Grade 5
Budget code and title 44013.110 Union [X] Non-Union []
This position is vacated due to: [] Retirement [X] Resignation [] Termination [] Promotion [] Other
Employee No. 12914
Is this position mandated? [] Yes [X] No Is the position reimbursable? [X] Yes [] No
Source of reimbursement: [X] Federal 100 % [] State % [] Other %
Impact to Budget: 0
Personnel Officer has approved this form when initialed. [Signature] 3/13/18

COUNTY ADMINISTRATOR COMPLETES THIS SECTION

Name of Committee _____ Date _____
[X] The Administrator has no objection to the filling of the vacancy.
[] The Administrator objects to the filling of the vacancy.
Administrator Signature [Signature]

SUPERVISORY COMMITTEE COMPLETES THIS SECTION

Name of Committee Health, Human & SS Date 3/19/18
[] The committee has no objection to the filling of the vacancy.
[] The committee objects to the filling of the vacancy.
Ranking Committee Member Signature [Signature]

PERSONNEL/HUMAN RESOURCES COMMITTEE COMPLETES THIS SECTION

Date 3/16/18
[X] The Personnel/Human Resources Committee has no objection to the filling of the vacancy.
[] The Personnel/Human Resources Committee objects to the filling of the vacancy.
Budget - ok
Ranking Committee Member Signature [Signature]

RESOLUTION REQUEST FORM NO. 12

Schedule "A"

NOTICE OF INTENT TO FILL VACANT POSITION

This notice of intent is filed whenever a department head plans to fill an *existing* funded position in their budget that is vacated due to a retirement, resignation, termination or promotion. This notice may not be used for requests to create a *new* position. For complete instructions on the procedure to be followed, see the reverse of this form.

DEPARTMENT HEAD COMPLETES THIS SECTION

Department: Health Services Payroll Dept. No: 36.00

Title of Position: Registered Professional Nurse #1 Base Salary of Position: 46,318 Grade: 19

Filling at Step # (If Known): not known

Budget code and title: A. 4010-110 Full Time Salaries Union Non-Union

This position is vacated due to: Retirement Resignation Termination Promotion Other

Employee No./Last Name: 12967 / Sullivan Date of Vacancy: 4/29/17

Is this position mandated? Yes No Is the position reimbursable? Yes No

Source of reimbursement: Federal _____ % State _____ % Other part % various depends
insurance case mix of
patients
insurance

CIVIL SERVICE STATUS AND HUMAN RESOURCES DIRECTOR APPROVAL

Competitive-active eligible list Competitive-no list (*hiring would be provisional*) Non-Competitive Other _____

Actual Impact to Budget Report will be provided monthly by Human Resources Director

Candidate's qualifications must be approved by Personnel Officer prior to hiring. 2/15/18

Human Resources Director has approved this form when initiated. 3/15/18

COUNTY ADMINISTRATOR COMPLETES THIS SECTION

The Administrator has no objection to the filling of the vacancy.

The Administrator objects to the filling of the vacancy.

Administrator Signature L.B. M. [Signature] Date 3/16/18

BUDGET OFFICER COMPLETES THIS SECTION

The Budget Officer has no objection to the filling of the vacancy.

The Budget Officer objects to the filling of the vacancy.

Budget Officer Signature Frank E. Thomas Date 3/16/18

SUPERVISORY COMMITTEE COMPLETES THIS SECTION

Name of Committee Health, Human & Social Services

The committee has no objection to the filling of the vacancy.

The committee objects to the filling of the vacancy.

In the case of an emergency, Committee Chair has no objection to the filling of the vacancy.

In the case of an emergency, Committee Chair objects to the filling of the vacancy.

Ranking Committee Member Signature Edna A. Fusco Date 3/19/18

RESOLUTION REQUEST FORM NO. 12

Schedule "A"

NOTICE OF INTENT TO FILL VACANT POSITION

This notice of intent is filed whenever a department head plans to fill an *existing* funded position in their budget that is vacated due to a retirement, resignation, termination or promotion. This notice may not be used for requests to create a *new* position. For complete instructions on the procedure to be followed, see the reverse of this form.

DEPARTMENT HEAD COMPLETES THIS SECTION

Department: Health Services Payroll Dept. No: 36.00
Title of Position: Registered Professional Base Salary of Position: 46,318 Grade: 19
Filling at Step # (If Known): Not known Nurse #30
Budget code and title: A4010-110 Full Time Salaries Union Non-Union
This position is vacated due to: Retirement Resignation Termination Promotion Other
Employee No./Last Name: 12843 / Dwyer Date of Vacancy: _____
Is this position mandated? Yes No Is the position reimbursable? Yes No
Source of reimbursement: Federal _____% State _____% Other DVT % VARIOUS
uns.

CIVIL SERVICE STATUS AND HUMAN RESOURCES DIRECTOR APPROVAL

Competitive-active eligible list Competitive-no list (*hiring would be provisional*) Non-Competitive Other _____

Actual Impact to Budget Report will be provided monthly by Human Resources Director.

Candidate's qualifications must be approved by Personnel Officer prior to hiring. 3/15/18

Human Resources Director has approved this form when initialed. 3/15/18

depends on case mix of patients insured

COUNTY ADMINISTRATOR COMPLETES THIS SECTION

- The Administrator has no objection to the filling of the vacancy.
- The Administrator objects to the filling of the vacancy.

Administrator Signature [Signature] Date 3/16/18

BUDGET OFFICER COMPLETES THIS SECTION

- The Budget Officer has no objection to the filling of the vacancy.
- The Budget Officer objects to the filling of the vacancy.

Budget Officer Signature Frank E. Thomas Date 3/16/18

SUPERVISORY COMMITTEE COMPLETES THIS SECTION

Name of Committee Health, Human + Social Services

- The committee has no objection to the filling of the vacancy.
- The committee objects to the filling of the vacancy.
- In the case of an emergency, Committee Chair has no objection to the filling of the vacancy.
- In the case of an emergency, Committee Chair objects to the filling of the vacancy.

Ranking Committee Member Signature Edna A. Fraser Date 3/19/18

RESOLUTION REQUEST FORM NO. 7

Request to Amend County Budget*

***If this is the result of a grant award, also complete and submit
Form No. 5 or 6**

DEPARTMENT NAME: Warren County Health Services-Home Care Division

DATE: March 19, 2018

- (a) **Purpose of Amendment:** To amend the 2018 budget to adjust the Health Services – Home Care Division to reflect funds received from the Adirondack Health Institute (AHI) in the amount of \$56,875.50 which must be used to support the DSRIP (New York State Delivery Systems Reform Incentive Payment Program) Project activities. The Funds will be utilized to transition the Electronic Patient Health Record System utilized by our Certified Home Health Agency from Delta Health Technologies' Encore Product to their Crescendo Product. Costs will include equipment, data processing and training.
- (b) **Appropriation Code (with title), Object Code (with title) and Amount:**
A.4010.260 Health Services- Other Equipment \$ 26,875.50
A.4010.428 Health Services-Data Processing \$10,000.00
A.4010.437 Health Services – Consulting Fees \$20,000.00

Revenue Code (with title), and Amount:

A.4010.3426 Health Services—DSRIP Engagement Funds Revenue \$56,875.50.

ATTACHMENT #5