TSA USE ONLY: Contract Effective Date:_____________Contract End Date: 09/30/2012

Attachment I

THE SENIOR ALLIANCE AREA AGENCY ON AGING 1-C
COMMUNITY CARE DEPARTMENT
PURCHASE OF SERVICE (POS) AGREEMENT

VENDOR INFORMATION:

Agency Name:______________________________ Federal I.D.#______________________

Address:____

President/Executive Director: ____

Contact Person (Fiscal)__________________________ Phone:______________________
Contact Person (Intake)__________________________ Phone:______________________
FAX #_______________________________________

E-Mail Address: ____

Website Address: ____
Type of Agency: _____ Public _____ Private _____ Non-Profit ______ Profit

Minority Status: Private Non-Profit organizations with minority status are those with 51% of the board and staff from minority groups. Private profit-making organizations with minority status are those with sole ownership, or at least 50% of stock held by minorities, or a partnership with at least 50% interest controlled by a minority-owned contractor.

Minority Status: _____ Yes _____No

THIS AGREEMENT is made as of (Month/Day) _____________, (Year) _______ between ____, and The Senior Alliance (TSA) Area Agency on Aging 1-C, Community Care Department (hereinafter referred to as TSA CCD), located at 3850 Second Street, Suite #201, Wayne, Michigan, 48184. The TSA CCD includes the following three programs for the elderly: *MI Choice Waiver, Care Management and Case Coordination and Support.*

STATEMENT OF FACTS:

The goal of *Care Management* and *Case Coordination & Support* is to assist frail elderly persons in obtaining services that will allow them to remain at home. One of the methods used by TSA to attain these goals is the direct purchase of services, as required by the client's care plan. The

goal of the *MI Choice Waiver* is to promote a comprehensive and coordinated service delivery system to meet the needs of those individuals who are medically eligible for institutional placement as established by the Michigan Department of Community Health under the guidelines of the Federal Home and Community-Based Services Waiver for the Elderly and Disabled.

The Vendor Agency is in the business of providing in-home support services. Accordingly, it has significant expertise and ability to provide services required by TSA CCD clients. TSA CCD desires to purchase services from vendor agencies on a unit cost reimbursement basis for client care needs.

This Agreement provides a mechanism for the creation of an individualized network of community resources on a client by client basis, through TSA CCD.

OBJECTIVES:

< To promote the mutual goal of maximizing independent functioning of eligible adults through TSA CCD.

< To maintain a climate of cooperation and consultation with and between agencies in order to achieve maximum efficiency and effectiveness among all agencies serving TSA CCD clients.

< To avoid and/or reduce service duplication and fragmentation in the service area.

< To share information and resources, and advocate for the development of comprehensive community based long-term care services in the TSA service area.

The parties to this Agreement will, whenever possible, provide technical assistance and consultation to each other on matters pertaining to actual service delivery; will share, as appropriate, the findings of research and results of service delivery; and will share relevant needs assessment information and activities so that the resources of concerned agencies may be maximized.

TERM OF AGREEMENT:

The Term of this Agreement is from ________________________ through September 30, 2012, unless terminated earlier.

SCOPE OF SERVICES:

Upon request from TSA CCD, the Vendor Agency shall provide clients with in-home and/or supportive services consistent with the standards and unit prices specified in this contract.

TSA CCD SHALL:

1. Provide comprehensive care management services to individuals who are medically eligible for institutionalization, and determined eligible for care management intervention.

   The responsibilities of TSA CCD shall include:

   a. prescreening of all individuals referred for care management intervention;

   b. client assessment, using the state mandated assessment tool (MI-CHOICE IHC) provided by the Michigan Department of Community Health (MDCH), or Office of Services to the Aging (OSA);

   c. person centered plan of care development, in consultation with the client and/or client representative and inclusive of a determination of frequency and duration of all services required under the care plan;

   d. service negotiation, including the arrangement of all health and human services as outlined in the care plan which maximizes all reimbursement sources available;

   e. care plan monitoring to track client progress through direct observational visits; and

   f. client re-assessment, and appropriate care plan modification.

2. Provide technical assistance to the Vendor Agency, as requested and available.

3. Use prescreening and assessment tools developed and required by MDCH or OSA.

4. Upon request, provide the Vendor Agency information regarding the service utilization patterns of TSA CCD clients.

5. Monitor the performance and service quality of the Vendor Agency through review of performance measures (programmatic reviews) and consumer evaluations for selected services.

THE VENDOR AGENCY SHALL:

1. Accept and serve on a priority basis TSA CCD clients referred by TSA CCD. Where openings do not exist in the Vendor Agency caseload, the Vendor Agency agrees to negotiate alternative arrangements with TSA CCD staff in order to meet the needs of each client.

2. Follow TSA CCD pre-screening criteria when referring individuals who may be eligible for TSA CCD intervention.

3. Accept the comprehensive assessment as completed by TSA CCD staff and refrain from conducting duplicative assessment or re-assessment activities.

4. Provide service delivery as prescribed in the directions received from TSA CCD staff during service requisition.

5. Provide TSA CCD staff with regular, on-going feedback, regarding clients referred to it for services.

6. Inform TSA CCD staff of the appropriate Vendor Agency contact person to be notified in service and/or care plan development and modification.

7. Immediately notify TSA CCD staff if, for any reason, the Vendor Agency is unable to provide service to the client as negotiated, or if a service that was agreed to is not provided.

8. Comply with all Operating Standards for Service Programs as established by the OSA, MDCH and/or TSA.

9. Participate in mandatory meetings scheduled by TSA.

10. Indemnify and hold harmless TSA, MDCH, & OSA against expense or liability of any kind arising out of service delivery performed by the Vendor Agency, and immediately notify TSA CCD staff if the Vendor Agency becomes involved in, or is threatened with, litigation related to any TSA CCD client.

11. Maintain in effect at all times during the course of this Agreement, insurance coverage as indicated and required by the MDCH, OSA and/or TSA. Further, the Vendor Agency shall submit at the beginning of this Agreement and annually thereafter, Certificates of Insurance listing TSA as an Insured.

12. Protect client confidentiality by following the Health Insurance Portability and Accountability Act (HIPAA) standards for the privacy of individually identifiable information and all protected health information.

    a. Comply with all legal limitations that exist on both the Vendor Agency and TSA CCD staff regarding the disclosure of information about a client, including, but not limited to, treating all communications received from the client as confidential, whether oral or written, and records derived from those communications.

    b. Recognize that the disclosure of information to others <u>does not</u>, by itself, abrogate a client's expectation of privacy as protected by law. Inform those to whom disclosure is made that they have a duty to maintain the confidentiality of the disclosure. TSA CCD staff and Vendor Agency shall be permitted, however, to share information for the purpose of better serving the client based on the general release of information obtained from the client in writing by TSA CCD staff at the time of the initial assessment.

13. Accept and share any information that may be necessary to better serve the client, which may be viewed as confidential, upon receipt of a copy of the general release of information signed by the client, and avoid requiring the client to sign any additional release.

14. Be duly incorporated and provide TSA with verification of incorporation.

15. Not assign, transfer, share or subcontract any of its duties or any of the services that it will render under the Agreement to any third party or any independent contractor without the prior written approval of TSA.

16. Refrain from imposing restraints, including but not limited to financial penalties and/or threats of legal action, on the ability of the workers it employs to work directly for TSA clients or another agency for TSA clients.

17. Comply with the Family and Medical Leave Act of 1992 and the Americans with Disabilities Act of 1990, and amendments thereto, and all other state and federal laws as applicable to employers, public facilities, and providers of goods and services.

18. Comply with Occupational Safety and Health Administration (OSHA) and/or Michigan Occupational Safety and Health Administration (MI-OSHA) regulations governing use of toxic substances, etc.

19. Comply with all other applicable federal and state civil rights and other statutes and regulations.

20. Establish an accessible record keeping system to verify information reported and make information available for review by authorized representatives of MDCH, OSA, and/or TSA.

21. Have on file at all times the following:

    Personnel Records;
    Staff Development Records;
    Certification and/or License, if applicable;
    Tax exempt status documentation, if applicable;
    Independent financial audit, annually;
    Equal Opportunity statement;
    Annual Internal evaluation;
    Liability insurance;
    Individual client records;
    Individual client accounts;
    Payroll records;
    Financial records; and
    Any other record(s) required by TSA during the Agreement.

22. Submit to TSA a monthly bill by the 8th of each month for services ordered and delivered to clients on billing forms provided. Each bill shall have corresponding documentation in the client's records regarding service activity. Where applicable, documentation of material costs shall be included with the monthly bill.

    Vendor Agency shall be reimbursed usually within 45 days of the official AAA 1-C report due date (the 8th of the month) for services provided. If the information submitted is received after the 8th of the month, incomplete or inaccurate, payment will be delayed until the necessary corrections are submitted by the Vendor Agency and approved for payment by TSA.

    Bills not received within SIXTY DAYS of the month that services were rendered WILL NOT BE HONORED.

    Exception: For services provided in September, bills received after November 8th WILL NOT BE HONORED.

23. Allow TSA CCD access to reports and records noted in this Agreement for the purpose of assessment.

24. Provide a 10% local match for services under Care Management and Case Coordination & Support, and maintain records to document the local match for audit purposes. There is no match requirement for MI Choice Waiver services.

25. Maintain program records for a minimum of six years.

26. Submit missed visit logs on a monthly basis.

27. Utilize the internet-based software, Vendor View, to communicate with TSA regarding service authorizations, messages and other topics.

ACCESS TO RECORDS:

TSA, OSA, Centers for Medicare & Medicaid Services (CMS), MDCH or any of their authorized representatives, shall have the right of access to any book, document, papers, or other records of the Vendor Agency which are pertinent to this Agreement, in order to make audits, examinations, excerpts, and transcripts, so long as such is in conformity with the Privacy Act.

TERMINATION:

a. This Agreement may be terminated upon thirty (30) days written notice by either party hereto.

b. Vendor Agency agrees to submit its final bill to TSA CCD for services rendered under this

Agreement by the 8th day of the month following termination of the Agreement.

c. Upon termination of this Agreement, TSA CCD shall remove the Vendor Agency's name from the list of approved service vendors.

This Agreement will be reviewed annually, and amended if necessary, for the purpose of focusing terms to more specifically address the agreed upon interactions between the parties. Periodic review will include amending the Agreement to appropriately reflect pertinent agreements that may be developed between TSA CCD and other federal, state, and local agencies. This Agreement incorporates by reference the following Exhibits:

EXHIBIT A:
Exhibit A includes the Vendor Agency's assurance that its employees meet the minimum Operating Standards for Service Programs developed by the MDCH, OSA, and/or TSA.

EXHIBIT B:
Exhibit B includes the assurance that the Vendor Agency will comply with Section 504 of the Rehabilitation Act of 1973, as amended.

EXHIBIT C:
Exhibit C includes the assurance that the Vendor Agency will comply with the Department of Health and Human Services Regulations under Title VI of the Civil Rights Act of 1964, Michigan Persons with Disabilities Civil Rights Act of 1976, and the Elliott-Larsen Civil Rights Act of 1976.

EXHIBIT D:
Exhibit D includes the Subcontractor Enrollment Agreement for MI Choice Waiver which is to be completed and signed by a Vendor Agency official.

EXHIBIT E:
Exhibit E includes the Signature Authorization Form. Please complete with name and signature(s) of those authorized to submit reimbursement requests to TSA.

EXHIBIT F:
Exhibit F includes the Business Associate Agreement which is to be completed and signed by a Vendor Agency official.

EXHIBIT G:
Exhibit G includes a statement that the Vendor Agency is not suspended or debarred from receiving federal funds.

Vendor Agency signature on all Agreements and Assurances is binding for the Term of this Agreement. All signatures obtained on this Agreement must be original signatures. Copies or faxes of signed POS Bid Agreements will not be accepted.

SIGNATURES:

TSA	**Vendor Agency**
______________________________	______________________________
Signature of TSA Representative	Signature of Vendor Agency Representative
Lydia Gold	______________________________
Typed Name	Typed Name
Director of Operations	______________________________
Title	Title
______________________________	______________________________
Date	Date

THE SENIOR ALLIANCE
AREA AGENCY ON AGING 1-C
PURCHASE OF SERVICE INFORMATION -- BID AGREEMENT

Use this form for the following services:

- Adult Day Health
- Chore Services
- Community Living Supports
- Counseling Services
- Environmental Accessibility Adaptations
- Home Delivered Meals
- Homemaker
- Non-Medical Transportation
- Nursing Facility Transition
- Personal Care
- Personal Emergency Response Systems
- Private Duty Nursing
- Respite Care Provided Inside of the Home
- Respite Care Provided Outside of the Home
- Specialized Medical Equipment and Supplies
- Training

VENDOR INFORMATION

Name of Vendor Agency:____

Vendor Agency
Address:____

Telephone:_________________________________ Fax:_________________________________

Administrator/President: Name:_______________________________ Title:________________

Contact Person (to request services): Name:______________________ Title:________________

Type of Agency: Public___ Private___ Profit____ Non-profit______

Verification of Incorporation Attached:________ Proof of Insurance Attached:_____

BACKGROUND

State the purpose of the vendor agency, history of providing the proposed service, and the number and qualifications of staff available to provide the service: (provide attachments if necessary)

SERVICE: _________________________________ UNIT COST: ______________

Cost included in unit:____

Capacity (units per week):____

Geographic boundaries of service area:____

Effective Date of Agreement will be the date of the AAA 1-C Authorizing Official's signature. Unit cost will remain in effect until a new Agreement is executed.

CERTIFICATION

______________________________	______________________	______________
Signature of Vendor Representative	**Title**	**Date**
______________________________	<u>**Director of Operations**</u>	______________
Signature of TSA Representative	**Title**	**Date**

THE SENIOR ALLIANCE
AREA AGENCY ON AGING 1-C
PURCHASE OF SERVICE INFORMATION -- BID AGREEMENT

DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES

Name of Vendor Agency:____
Vendor Agency Address:___________________________ _________________________________
Telephone: _____________________________________ Fax:_____________________________
Administrator/President: Name: ____________________________________ Title:____________
Contact Person (to request services): Name: __________________________ Title:____________
Type of Agency: Public_______ Private______ Profit______ Non-Profit_______
Verification of Incorporation attached:______ Proof of Insurance attached:_______

BACKGROUND

State the purpose of the vendor agency, history of providing the proposed service, and the number and qualifications of staff available to provide the service: (provide attachments if necessary)

BIDDING INFORMATION

1. Provide a complete listing (catalog) of products available and cost for each product:
   - Raised Grab Bars
   - Toilet Seats
   - Shower Attachments
   - Liquid Diet Supplements
   - Incontinence Products
   - Variety of Medicine Boxes
2. Capacity (units per week)
3. Geographic boundaries of service area:

Effective Date of Agreement will be the date of the AAA 1-C Authorizing Official's signature. Prices will be in effect until a new Agreement is executed.

CERTIFICATION

___________________________________	______________________	_______________
Signature of Vendor Representative	**Title**	**Date**
___________________________________	**Director of Operations**	_______________
Signature of TSA Representative	**Title**	**Date**

THE SENIOR ALLIANCE
AREA AGENCY ON AGING 1-C
PURCHASE OF SERVICE INFORMATION -- BID AGREEMENT

ENVIRONMENTAL MODIFICATIONS/ENVIRONMENTAL AIDS

Name of Vendor Agency:____

Vendor Agency Address:____

Telephone: __________________________ Fax:______________________

Administrator/President: Name:_______________________________ Title:________________

Contact Person(to request services): Name:______________________ Title:________________

Type of Agency: Public ____ Private____ Profit____ Non-Profit______

Verification of Incorporation attached: ________ Proof of Insurance attached: _______

BACKGROUND

State the purpose of the vendor agency, history of providing the proposed service, and the number and qualifications of staff available to provide the service: (provide attachments if necessary)

BIDDING INFORMATION

Note: Bids will be solicited per job.

1. Service: List the types of jobs the vendor agency is able to perform (or attach information):

   Unit Rate:

2. Capacity (units per week)
3. Geographic boundaries of service area:

Effective Date of Agreement will be the date of the AAA 1-C Authorizing Official's signature. Prices will be in effect until a new Agreement is executed.

CERTIFICATION

____________________________________	____________________	______________
Signature of Vendor Representative	**Title**	**Date**
____________________________________	**Director of Operations**	______________
Signature of TSA Representative	**Title**	**Date**

THE SENIOR ALLIANCE
AREA AGENCY ON AGING 1-C
PURCHASE OF SERVICE -- BID AGREEMENT *AMENDMENT*

Use this form for the following services only when amending the original bid agreement:

Adult Day Health
Chore Services
Community Living Supports
Counseling Services
Environmental Accessibility Adaptations
Home Delivered Meals
Homemaker
Non-Medical Transportation
Nursing Facility Transition
Personal Care
Personal Emergency Response Systems
Private Duty Nursing
Respite Care Provided Inside of the Home
Respite Care Provided Outside of the Home
Specialized Medical Equipment and Supplies
Training

VENDOR INFORMATION

Name of Vendor Agency: ____________________

Vendor Agency Address: ____________________

Telephone: ____________________ Fax: ____________________

Administrator/President: Name: ____________________ Title: ____________________

Contact (to request services): Name: ____________________ Title: ____________________

AMENDMENT SUMMARY

SERVICE: ____________________ **UNIT COST:** ____________________

SERVICE: ____________________ **UNIT COST:** ____________________

Cost included in unit: ____________________

____

Capacity (units per week): ____________________

Geographic boundaries of service area: ____________________

Effective Date of Agreement will be the first of the month following the date of the AAA 1-C Authorizing Official's signature. Unit cost will remain in effect until a new Agreement (or amendment) is executed.

CERTIFICATION

____________________ ____________________ ____________________

Signature of Vendor Representative **Title** **Date**

____________________ **Director of Operations** ____________________

Signature of TSA Representative **Title** **Date**

EXHIBIT A

THE SENIOR ALLIANCE
AREA AGENCY ON AGING 1-C
ASSURANCE OF COMPLIANCE WITH SERVICE STANDARDS

Any service funded by TSA must be in compliance with appropriate standards of the Michigan Department of Community Health (MDCH), Office of Services to the Aging (OSA) and AAA 1-C. This includes service definitions, unit definitions, and service standards for operation.

On behalf of ______________________________________, (hereafter called the Vendor Agency), I
(Vendor Agency Name)

HEREBY ASSURE that all persons involved in implementing the proposed bid agreement have read the MDCH, OSA and TSA service standards, including the general standards and the specific standards for each of the services for which funds are being requested as found on TSA's website, http://www.aaa1c.org in the Doing Business with TSA section. I further assure on behalf of the Vendor Agency that it is completely in compliance with all such standards for the following services and that it shall maintain compliance with these standards throughout the term of this Agreement (list all services for which funding is requested):

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

I further assure that the Vendor Agency possesses and shall maintain insurance coverage as required by MDCH in the Service Standards/Definitions and that proof of insurance with TSA identified as an Insured is attached as an appendix to this Agreement. The Vendor Agency understands that service purchasing cannot begin until such time as TSA has in its possession such Certificate of Insurance for all required insurance coverage and that it is to provide a new certificate annually.

This assurance is given in consideration of, and for the purpose of obtaining, federal and/or state funds through a Purchase of Service arrangement with TSA. The Vendor Agency recognizes and agrees that any approved financial assistance will be extended based on assurances made in this Agreement and that TSA shall have the right to seek enforcement of all such assurances.

The assurances provided in this Agreement are binding on the Vendor Agency, its successors, transferees, and assignees.

___________________________________	____________________	______________
Signature of Vendor Representative	**Title**	**Date**
___________________________________	**Director of Operations**	______________
Signature of TSA Representative	**Title**	**Date**

EXHIBIT B

THE SENIOR ALLIANCE (TSA)
AREA AGENCY ON AGING - 1-C

MICHIGAN OFFICE OF SERVICES TO THE AGING
ASSURANCE OF COMPLIANCE WITH SECTION 504
OF THE REHABILITATION ACT OF 1973, AS AMENDED

The undersigned recipient of funds (hereinafter called the Recipient) from the Michigan Department of Community Health (MDCH) and the Michigan Commission and Office of Services to the Aging (OSA) hereby agrees and assures that it shall comply with Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), all requirements imposed by the applicable Health and Human Services regulations (45 C.F.R. Part 84), and all guidelines and interpretations issued pursuant thereto at all times while it receives such funding.

Pursuant to 45 C.F.R. § 84.5(a), the Recipient provides this assurance in consideration and for the purpose of obtaining any and all grants, loans, contracts (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other financial assistance extended by OSA after the date of this assurance, including payments or other assistance made after such date of application(s) for financial assistance that were approved before such date. The Recipient recognizes and agrees that such financial assistance will be extended in reliance on the representations and assurances made in this Agreement and that MDCH, OSA or TSA shall have the right to enforce this assurance through lawful means. This Agreement is binding on the Recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below as authorized to sign this Agreement on behalf of the Recipient.

This assurance obligates the Recipient for the period during which federal financial assistance is extended to it by MDCH and OSA, or, where the assistance is in the form of real or personal property, for the period provided for in 45 C.F.R. § 84.5(b).

______________________	______________________
Name of Vendor Agency	**President, Chairperson of Board, or Comparable Official**
______________________	______________________
Vendor Agency Address	**Title**
______________________	______________________
Date	**Signature**

EXHIBIT C

THE SENIOR ALLIANCE (TSA), AREA AGENCY ON AGING 1-C
ASSURANCE OF COMPLIANCE WITH CIVIL RIGHTS ACTS

Assurance of Compliance with the Department of Health, Education, and Welfare Regulations under Title VI of the Civil Rights Act of 1964, Michigan Persons with Disabilities Civil Rights Act of 1976, and the Elliott-Larsen Civil Rights Act of 1976.

The Vendor Agency identified below who receives funds from the Michigan Office of Services to the Aging (OSA) agrees that it shall comply with Title VI of the Civil Rights Act of 1976 (P.A. 453, Section 209) and with requirements imposed by or pursuant to the Regulations of the Department of Health and Human Services (HHS) (45 CFR Part 80) issued pursuant to Title VI that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Vendor Agency receives federal or state financial assistance from TSA, and hereby gives assurance that it shall immediately take any measures necessary to effectuate such compliance.

If any real property or structure thereon is provided or improved with the aid of federal or state financial assistance extended to the Vendor Agency for the period during which said property or structure is used for a purpose for which federal or state financial assistance is extended, the Vendor Agency further certifies that it has no commitments or obligations which are inconsistent with compliance of these and any other pertinent federal or state regulations and policies, and that any other agency, organization or party which participates in this project shall have no such inconsistent commitments or obligations, and all activities shall not run counter to the purpose and intent of the assurances in this Agreement.

The assurances in this Agreement are given in consideration and for the purpose of obtaining any and all federal or state grants, loans, contracts, property, discounts, or other federal or state financial assistance extended after the date hereof to the Vendor Agency by TSA, including installment payments after such date on account of applications for federal or state financial assistance which are approved before such date. The Vendor Agency recognizes and agrees that such federal or state financial assistance will be extended in reliance on the representations and assurances in this Agreement. TSA, OSA, and/or HHS shall have the right to seek judicial enforcement of this Agreement. This Agreement is binding on the Vendor Agency, its successors, transferees, and assignees, and the person whose signature appears below who is authorized to sign this Agreement on behalf of the Vendor Agency.

______________________________ **Name of Vendor Agency**	______________________________ **President, Chairperson of Board, or Comparable Official**
______________________________ **Agency Address**	______________________________ **Title**
______________________________ **Date**	______________________________ **Signature**

EXHIBIT D

THE SENIOR ALLIANCE AREA AGENCY ON AGING 1-C HOME & COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY & DISABLED **SUBCONTRACTOR ENROLLMENT AGREEMENT** Michigan Department of Community Health	TSA Use Only Eligibility Begin Date:

This form is to be completed by all vendors who wish to receive payment from The Senior Alliance (TSA), the Medicaid-enrolled organized health care delivery system, for services provided under the Home & Community Based Services Waiver for the Elderly & Disabled. An original payment agreement must be submitted for **each** business location and for **each** eligible vendor.

COMPLETION INSTRUCTIONS **PLEASE TYPE OR PRINT CLEARLY**

Item #1: Individual persons must enter their last name, first name, and middle initial. All other applicants (e.g., a licensed business/vendor) must enter the complete business name as licensed and/or certified.

Item #3: If the applicant is employed/contracted by a business, or in a partnership, enter the name of the business you are employed by, affiliated or contracted with, or in partnership with.

Item #4: Proof of the EIN number (federal tax number) is REQUIRED.

Item #5: Vendors must attach a copy of their license/certification, as applicable.

Item #6: The SSN is required for an individual and is confidential and to be used only for the administration of the program.

VENDOR INFORMATION

1. Vendor's Name (See Instructions)	2. Professional Title, If Applicable
3. Employer's Name (See Instructions)	4. EIN Number (See Instructions)
5. State License Number (See Instructions)	6. Applicant's Social Security Number

7. Mailing Address (No. & Street)	P.O. Box

City	State	Zip Code	Phone Number ( )

MEDICAL ASSISTANCE (MEDICAID) VENDOR PAYMENT AGREEMENT CONDITIONS

1. All information furnished on this payment agreement form is true and complete.
2. I consent that, upon request and at a reasonable time and place, I will permit authorized agents of the State of Michigan or the federal government to inspect, and copy, any records related to my delivery of goods or services to, or on behalf of, a participant under the Medicaid Program.
3. I am not currently suspended, terminated, or excluded from any state Medicaid Program or by the U.S. Department of Health and Human Services.
4. I agree to accept the Michigan Medicaid payment as payment in full for the services rendered. Except for patient liability as determined by the Michigan Medicaid Program including applicable co-payments, I will not seek nor accept additional or supplemental payment from the participant, his/her family, or representative(s).
5. I may be prosecuted under applicable federal or state criminal and civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data, other acts of misrepresentation, or conspiracy to engage therein.
6. I agree to comply with the MDCH's policies and procedures for the Medical Assistance Program and the Home and Community Based Services for the Elderly and Disabled contained in manuals, manual updates, provider bulletins, and other program notifications.

As a condition of receiving payment from the Michigan Medicaid Program for services provided to an eligible participant, I certify and agree to all of the conditions listed above. I certify that the undersigned has the authority to execute this agreement.

IMPORTANT: FACSIMILE SIGNATURES WILL NOT BE ACCEPTED

Applicant's Signature	Date	Title

The Michigan Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs, or disability.

EXHIBIT E

THE SENIOR ALLIANCE, AREA AGENCY ON AGING 1-C
SIGNATURE AUTHORIZATION FORM

Please Print or Type

Vendor Agency: ________________________________Vendor Federal ID#: ___________________

Agency Address: ____

City, State, Zip: ____

Telephone: ____

The following persons are hereby authorized to sign and submit requests for reimbursement and related correspondence to The Senior Alliance. On behalf of the vendor specified above, I understand that this authorization remains in force only in relation to the vendor specified above. I understand that only I, or other persons designated by the vendor, may change the names on this list and hereby pledge to do so, if and when the need arises, in a timely manner.

AUTHORIZED NAME (please print)	SIGNATURE
____________________________________	_____________________________________
____________________________________	_____________________________________
____________________________________	_____________________________________
____________________________________	_____________________________________
____________________________________	_____________________________________

____________________________________ _____________________________________

Signature of Designated Official **Date of Signature**

____________________________________ _____________________________________

Printed Name of Designated Official **Title of Designated Official**

EXHIBIT F

THE SENIOR ALLIANCE AREA AGENCY ON AGING 1-C COMMUNITY CARE DEPARTMENT BUSINESS ASSOCIATE AGREEMENT

VENDOR INFORMATION

Agency Name:_________________________ Federal ID or SSN:____________________

Address:____

President/Executive Director:____

Type of Agency: _____Public _____Private _____Non-profit _____Profit

This Agreement is made as of (Month/Day)__________, (Year)________between____________ ________________________________, hereinafter referred to as Business Associate, and The Senior Alliance (TSA) Area Agency on Aging 1-C, Community Care Department (hereinafter referred to as TSA CCD), located at 3850 Second Street, Suite 201, Wayne, Michigan, 48184.

Obligations and Activities of Business Associate:

- Business Associate shall, consistent with Health Insurance Portability and Accountability Act (HIPAA), not to use or disclose Protected Health Information (PHI) other than as permitted or required by the Agreement or as required by law.
- Business Associate shall use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement.
- Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.
- Business Associate shall report to TSA CCD any use or disclosure of the PHI not provided for by this Agreement of which it becomes aware.
- Business Associate shall ensure that any agent, including a subcontractor, to whom it provides or receives PHI, or which creates PHI on behalf of Business Associate or TSA CCD, agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information.
- Within 10 business days of a request by TSA CCD, Business Associate shall provide access to PHI in a Designated Record Set to TSA CCD or, as directed by TSA CCD, to an individual who is the subject of the PHI, in order to meet the requirements under 45 C.F.R. § 164.524.
- Business Associate shall make any amendment(s) to PHI in a Designated Record Set that TSA CCD directs, or agrees to, pursuant to 45 C.F.R. § 164.526 or at the request of TSA CCD or an individual who is the subject of the PHI, within 10 business days.
- Business Associate shall make internal practices, books, records, policies, and procedures relating to PHI and PHI itself, which is created or received by or from Business Associate in connection with services provided on behalf of TSA CCD available to TSA CCD or to the Secretary of Health and Human Services within 10 business days of request.
- Business Associate shall document any disclosure of PHI and information related to such disclosures as would be required for TSA CCD to respond to a request by an individual who is the subject of the PHI for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.
- Within 10 business days, Business Associate shall provide TSA CCD, or an individual who is the subject of PHI, information collected regarding disclosures of PHI to permit TSA CCD to respond to a request by such individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

Permitted Uses and Disclosures by Business Associate:

- Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities or services for, or on behalf of, TSA CCD as specified in the TSA CCD Purchase of Service Bid Agreement, provided that such use or disclosure would not violate the Privacy Rules if done by TSA CCD or the minimum necessary policies and procedures of TSA CCD.
- Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibility of the Business Associate.
- Business Associate may use PHI to report violations of law to appropriate federal and state authorities, consistent with 42 C.F.R. § 164.502.

Obligations of TSA CCD:

- TSA CCD shall notify Business Associate on any limitation(s) in its notice of privacy practice of TSA CCD in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
- TSA CCD shall notify Business Associate of any changes in, or revocation of, permission by an individual who is the subject of PHI for the use or disclosure of PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
- TSA CCD shall notify Business Associate of any restriction to the use or disclosure of PHI that TSA CCD has agreed to in accordance with 45 C.F.R. § 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.
- TSA CCD shall refrain from requesting Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and the Privacy Rule if done by TSA CCD.

Term and Termination:

- Term: This Agreement shall become effective upon execution and remain in effect until all PHI provided by TSA CCD to Business Associate, or PHI created or received by Business Associate on behalf of TSA CCD, is destroyed or returned to TSA CCD, or, if it is not feasible to return or destroy PHI, the parties agree in writing to extend protections for all such information.
- Termination for Cause: Upon TSA CCD's knowledge of a material breach by Business Associate, TSA CCD shall have the right to either:
    1. Provide an opportunity for Business Associate to cure the breach, or end the violation and, if Business Associate does not cure the breach or end the violation within the time specified by TSA CCD, terminate this Agreement;
    2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or
    3. If neither termination nor cure is feasible, TSA CCD shall report the violation to the Secretary of Health and Human Services.
- Effect of Termination: Upon termination of this Agreement, for any reason, Business Associate shall, as directed by TSA, return or destroy all PHI received from TSA CCD, or created or received by Business Associate on behalf of TSA CCD. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI unless the parties mutually agree otherwise in writing.

Miscellaneous:

- Regulatory References: A reference in this Agreement to a section in the Privacy Rule means the section as in effect or amended.
- Amendment: The Parties agree to take such action as is necessary to amend this Agreement from time to time

as is necessary for TSA CCD to comply with the requirements of the Privacy Rules and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

- Survival: The obligations of Business Associate under section Effect of Termination, above, shall survive the termination of this Agreement.
- Interpretation: Any ambiguity in this Agreement shall be resolved to permit any Covered Entity to comply with the Privacy Rule.

SIGNATURES:

TSA	**VENDOR AGENCY**
____________________________	____________________________
Signature of TSA Representative	Signature of Vendor Agency Representative
Lydia Gold	____________________________
Printed Name	Printed Name
Director of Operations	____________________________
Title	Title
____________________________	____________________________
Date	Date

EXHIBIT G

The Senior Alliance, Area Agency on Aging 1-C

Suspended / Debarred Declaration

The Senior Alliance, Area Agency on Aging 1-C (TSA), a non-federal entity, is prohibited from contracting with or making sub-awards to parties that are suspended or debarred from receiving federal funds. By your signature below, you confirm that your organization is not suspended or debarred, or the principals of your company/agency are not suspended or debarred from receiving federal funds.

After making reasonable inquiry, I certify under penalty of perjury that neither the Vendor Agency nor its principals are suspended or debarred from receiving federal funds.

____

Vendor Agency Name

____

Address

____

Signature of Responsible Agent Date