

FAU Number 1107010200

New York State
Department of Health
Office of Health Insurance Programs
Division of Coverage and Enrollment

Request for Applications

Facilitated Enrollment Program

KEY DATES

RFA Release Date:	September 2, 2011
Questions Due:	September 16, 2011 by 4:00 PM ET
Letter of Interest Due:	September 16, 2011
RFA Updates Posted on or about:	September 23, 2011
Applications Due:	October 14, 2011 by 4:00 PM ET
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I. Introduction

The New York State Department of Health (SDOH) is issuing this Request for Applications (RFA) to continue the Facilitated Enrollment (FE) program. Under this procurement, \$15.3 million in annual funding is available to community based organizations and government entities for the purpose of providing facilitated enrollment services to children and adults applying for the Medicaid (MA), Family Health Plus (FHP) and Child Health Plus (CHPlus) programs.

The Facilitated Enrollment program provides multilingual application assistance to children and adults applying for government sponsored health insurance programs (MA, FHP and CHPlus). Currently, the SDOH contracts with 41 FE agencies across the state, providing application assistance in 60 languages. By contracting with organizations that are culturally and linguistically appropriate to the populations they serve, FE organizations have been successful in reaching immigrant and rural communities who previously had minimal access to the public health insurance system. The facilitated enrollment program was designed to eliminate barriers in accessing the application process by providing assistance in community based locations frequented by the target population, at times that are convenient to working families, including evenings and weekends.

This RFA is intended to continue facilitated enrollment services statewide through locally tailored programs centered in community based organizations.

II. Background

In September 1998, legislation was enacted to expand children's health insurance coverage in New York State. In addition to increasing eligibility levels, expanding the benefit package and reducing cost-sharing requirements, the legislation included a provision which created locally tailored outreach and facilitated enrollment strategies for the CHPlus and children's MA Programs. The legislative intent behind facilitated enrollment was to expand accessibility and ease the process of applying for government sponsored health insurance programs. The program was designed to provide community based alternatives to the local Department of Social Services (LDSS) for individuals to apply for health insurance.

In response to this legislation, the SDOH issued a Request for Proposals (RFP) to provide facilitated enrollment services for children in March 1999. In 1999, legislation was enacted that expanded the FE program to adults for MA and FHP. Since the initial RFP, two additional Request for Applications (RFA) were issued in 2002 and 2006, to continue the Facilitated Enrollment program. Under the most recent procurement, awards were made to 42 community based organizations for approximately \$17 million annually for the period January 1, 2007 through December 31, 2011. Facilitated enrollment services are currently offered throughout New York State through 41 community organizations and their subcontractors.

III. Overview of State Program Eligibility

A. Programs

Facilitated enrollers currently offer application assistance for the following government sponsored health insurance programs: MA, FHP and CHPlus. Below is a description of these programs.

1. Medicaid (MA)

For children, Medicaid is a free health insurance program that provides low income eligible children with complete coverage for all of their health care needs. Children enrolled in Medicaid can visit any doctors, health centers, clinics and hospitals that participate in the Medicaid program to receive health care. Most children enrolled in Medicaid must join a health plan that has its own networks of doctors, health centers and hospitals.

For adults, Medicaid is a health insurance program that offers eligible adults complete coverage for all their health care needs. The eligibility levels for parents with children under age 21 and disabled/blind individuals are higher than the eligibility levels for some adults (non-disabled/blind single adults and couples without children under the age of 21 living in their home). Additionally, blind and/or disabled adults and parents with children under age 21 whose income is over these levels may be able to participate in the Medicaid spenddown program.

Adults enrolled in Medicaid can visit Medicaid participating doctors, health centers, clinics and hospitals to receive their health care. Most adults must join a health plan that has its own network of doctors, health centers and doctors.

Applicants who are pregnant and who have income up to 200% federal poverty level (FPL) are considered eligible for MA based on the program's higher income standards for pregnant women. In most situations, these applicants will be referred to a health care provider for assessment and immediate access to care.

2. Family Health Plus (FHP)

FHP is a health insurance program for adults, ages 19 through 64, who are not income eligible for MA and who do not have private insurance. FHP offers a wide range of benefits, including regular check-ups, hospital care, emergency room care, prescription drugs and much more. It does not provide all of the benefits covered by Medicaid. Individuals enrolled in FHP are required to pay a co-payment for most medical services. All adults enrolled in FHP must join a health plan that has its own networks of doctors, health centers and hospitals.

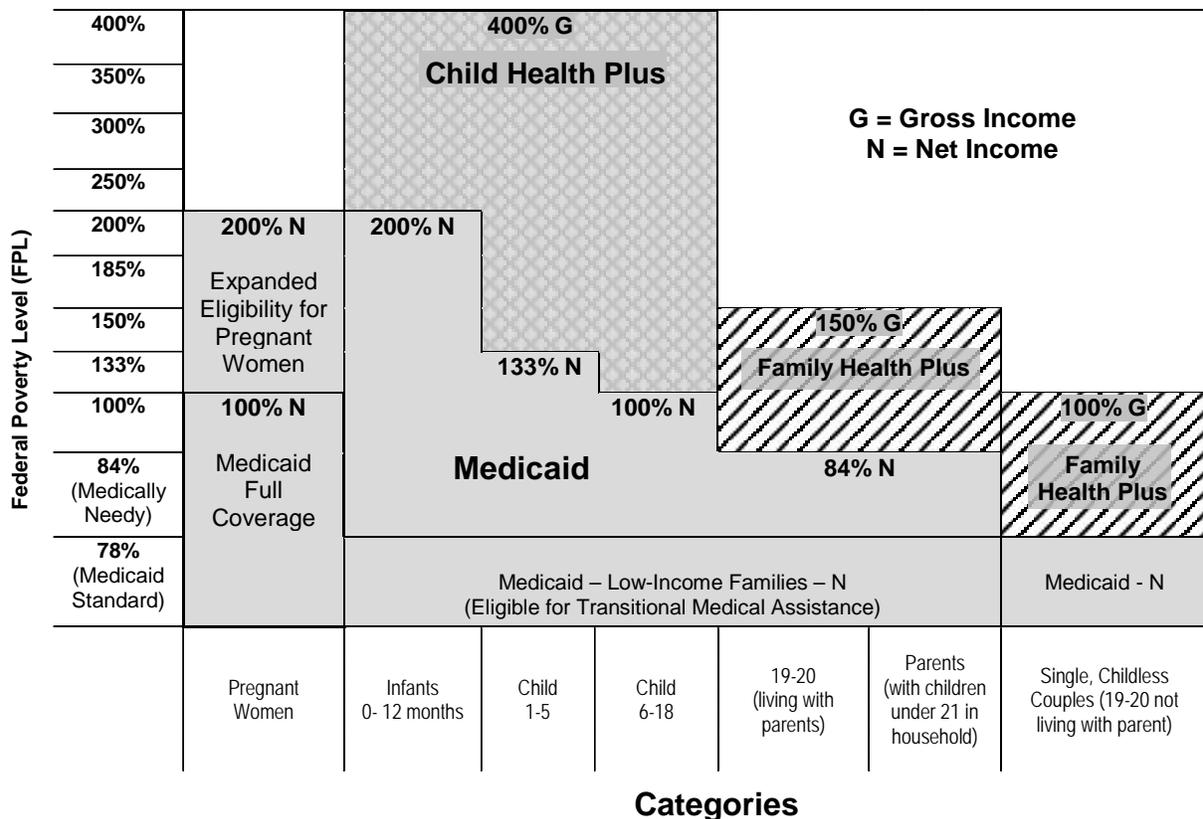
3. Child Health Plus (CHPlus)

CHPlus is a health insurance program for children under age 19 who are New York State residents who are ineligible for, Medicaid and do not have other health insurance or access to a state health benefits plan (NYSHIP). CHPlus is free for some families. Depending on income, some families may have to pay a small monthly family premium contribution ranging from \$9 to \$60 per child per month. Families with higher incomes that are above the level for subsidized coverage may pay the full monthly premium which varies by health plan. Currently, this ranges from \$133 to \$238 per child per month.

CHPlus offers a wide range of benefits including regular check-ups, hospital care, emergency room care, prescription and non-prescription drugs, routine dental care, eyeglasses and much more. It does not provide the complete package of benefits that Medicaid provides, such as long term care and non-emergency transportation. All children enrolled in CHPlus must join a health plan which has its own networks of doctors, health care centers and hospitals.

The chart below shows the income eligibility levels for the programs that will be served by facilitated enrollers.

**New York State Public Health Insurance Programs
March 1, 2011**



B. Comparison of Eligibility Requirements for Health Insurance

The programs have very similar eligibility criteria.

The following factors are considered when determining eligibility for the programs:

- New York State residency – the applicant must provide documentation of New York State residency. Documentation must be within six months of the application date;
- Age – applicant must provide documentation of their date of birth;
- Household income - the applicant must document the household income for the four weeks prior to application;
- Other health insurance – if the applicant has other health insurance, documentation showing what that coverage includes must be provided;
- U.S. Citizenship status/identity – if the applicant attests that he/she is a U.S. citizen and provides their social security number, citizenship will be verified using a data file matching process with the Social Security Administration (SSA). If the match is successful, the applicant does not need to provide proof of U.S citizenship, identity or date of birth. If the match is not successful or, for Child Health Plus, the applicant does not provide his/her social security number, the applicant must provide original citizenship and identity documentation; and
- Immigration status (if not a U.S. Citizen) – applicants must document their immigration status.

Because FHP is an expansion of the MA Program, all adult applicants are subject to certain MA requirements for eligibility in addition to those indicated above. Based on Federal and State statutes, requirements such as cooperation regarding pursuit of medical support and pursuit of potential income are required of all adult applicants, whether they are eligible for adult MA or FHP.

C. Responsibility for Eligibility Determination and Plan Enrollment

The LDSS offices are responsible for the eligibility determinations for all MA and FHP applicants. In addition, the LDSS is responsible for enrollment of MA and FHP recipients into a participating health plan, if appropriate. In designated areas, an enrollment broker (currently MAXIMUS, Inc.) may be responsible for adding the appropriate data regarding plan selection to the central file and enrollment into a health plan.

Health plans are responsible for the eligibility determination and enrollment for the CHPlus program.

D. Renewal

The MA, FHP and CHPlus programs use a mail-in renewal process. The MA and FHP programs use the same renewal application (one for upstate, one for New York City) while a separate form is used by CHPlus enrollees. Changes in enrollee circumstances are identified through a simplified renewal form that the enrollee is able to submit to the LDSS or health plan by mail. However, an individual or family may obtain assistance from a facilitator to complete the renewal form.

In New York City, individuals who can self-attest to their income also have the option to renew their MA or FHP coverage on-line using ACCESS NYC. The on-line renewal contains the same pre-printed application as the paper form which can be updated/changed as needed. Facilitated enrollers may assist consumers with completing the on-line application.

E. The Enrollment Center

In 2011, the Enrollment Center, New York Health Options, has established a consolidated call center for the MA/FHP/CHPlus programs and began processing both telephone and mail-in MA and FHP renewals for populations outside of New York City who can attest to their income at renewal. This began on June 13, 2011. Renewals for additional populations are expected to be added over time.

IV. Program Narrative/Workplan Outcomes

A. Role of Facilitated Enroller (FEs)

Facilitated enrollers provide application assistance to families and individuals applying for MA, FHP and CHPlus. Assistance includes screening individuals for the appropriate program, completing the application, collecting the required documentation, certifying that original documentation of citizenship was presented and, through the FE agency, transmitting the completed application to the appropriate entity, either the LDSS or the CHPlus health plan, in a timely manner. Facilitated enrollers should be available in various locations throughout the community where the target population frequents. This could include community centers, libraries, YMCAs, boys and girls clubs, town halls, food pantries, schools, churches, hospitals and clinics. Facilitated enrollers should be available during non-traditional hours such as early mornings, evenings and weekends, and are required to speak the language of the target community.

B. Role and Responsibilities of FE Agencies

Attachment 1 provides an overview of responsibilities to be undertaken by FE agencies approved to provide facilitated enrollment services as well as the LDSS, health plans and SDOH. This section provides specific requirements for FE agencies and their facilitated enrollers.

1. Provide Access to Facilitated Enrollment Services

- Provide an efficient and cost effective facilitated enrollment process in each county of FE agencies' service area in a manner approved by SDOH. Additional information regarding productivity and budget constraints are provided in Section VIII. A of this RFA.
- Place sufficient numbers of facilitated enrollers at sites that are accessible and convenient to the population being served to assure timely access by applicants. Sites should include a range of locations and types that attract as many adults and families as possible. Facilitated enrollers should be designated to target vulnerable and hard-to-reach populations (e.g., non-English speaking). FE agencies should provide SDOH with a list of the facilitated enrollment sites at which it intends to offer facilitated enrollment, including the days, hours and language capabilities during which facilitated enrollers will be available at the site. FE agencies should update the list as sites or times change. If approved by SDOH, the FE agencies may offer facilitated enrollment at additional sites not provided on the list, or if circumstances warrant, may modify the previously approved sites as needed.
- Have facilitated enrollers available during non-traditional hours such as early mornings, evenings and weekends. Applicants will need to know the patterns in the community to determine the best hours of operation. For example, in some communities, early morning hours may be better than evening hours.
- Have facilitated enrollers available who have language capabilities reflective of the community. Facilitated enrollers should be culturally and linguistically representative of the populations being served.

2. Have Facilitated Enrollers Assist With and Complete the Application

- Explain the Access New York Health Care application and assist the applicant in completing it. A copy of the most current version of the Access New York Health Care application is found in Attachment 2 of this document. Facilitated enrollers will screen applicants to assess their potential eligibility for health coverage using the Health Insurance Screening Worksheet. A copy of the screening worksheet is included as Attachment 3 of this document.

- Explain the documentation requirements and advise applicants how to obtain such documentation in accordance with the documentation checklist found in the Access New York Health Care application.
- Follow up with applicants to ensure that the application and required documentation are complete.
- Provide assistance to applicants who choose to send their application and documentation to the LDSS or CHPlus plan on their own by verifying necessary original documents demonstrating U.S. citizenship and identity.

3. Have Facilitated Enrollers Provide Education on Managed Care

- Educate eligible applicants about managed care and how to access benefits in a managed care environment. This includes the distribution of SDOH approved information materials describing MA, FHP and CHPlus.
- Distribute New York State's health insurance information materials in English and other appropriate languages. These include brochures and information developed by SDOH to explain health insurance coverage options available through the MA, FHP and CHPlus programs and various other public programs.
- Counsel all applicants eligible to participate in a managed care plan on the selection of a participating health plan, describe the important role of a primary care provider (PCP) and the benefits of preventive health care.
- Agree to operate as neutral parties in the health plan selection process to assure that each applicant is allowed to make an informed decision on health plan selection.
- Understand any specific health needs of the applicant and make suggestions to help the applicant select the appropriate plan to meet current health care needs. The facilitator should inquire about existing provider relationships such as the primary care provider (PCP) and use health plan provider directories (paper or on-line) to help applicants maintain their provider relationship where possible. Facilitated enrollers should recommend that applicants confirm with the health plan that the information included in the provider directory is current.

4. Have Facilitated Enrollers Provide Additional Information as Required by SDOH

- Provide all applicants with information about the right to appeal to the LDSS regarding eligibility determinations and health plans about benefit decisions. Information regarding the right to file appeals/complaints will be discussed

with all applicants. Information on this subject will also be included in all pre-enrollment education material.

- Verbally inform each MA and/or FHP eligible household containing an individual under the age of 21 or a pregnant woman about the availability of services under the Child/Teen Health Program.
- Provide information on other State programs such as Healthy New York or the Bridge Plan for individuals with pre-existing conditions, for which applicants may be eligible.
- Distribute additional materials as instructed by SDOH.

5. Have Facilitated Enrollers Provide Additional Information for MA and FHP Applicants

- Provide applicants with general counseling on the potential for MA spenddown, when appropriate. An applicant whose income is above MA levels but who has on-going medical needs, may reduce the income to below MA guidelines by deducting the amount of the monthly medical expenses. In this instance, when an applicant appears to be eligible for both FHP and MA spenddown, the facilitator will provide the applicant with an overview of both programs, and will refer interested applicants to the LDSS for a full assessment of their alternatives.
- Advise adult applicants on the need to pursue available support, including an overview of current child support enforcement policies and pursuit of medical support from non-custodial parents, when appropriate. This includes determining when Section IV-D requirements apply, determining the initial willingness of the applicant to cooperate and implications regarding cooperation, and determining whether the applicant is claiming “good cause” for not pursuing support. The facilitated enroller will assist the LDSS by determining whether the applicant is willing to cooperate in pursuing third party medical support available from an absent parent or spouse. While eligibility for children is not affected by compliance with Section IV-D requirements, adults who fail to cooperate with child support enforcement requirements, absent good cause, will not be eligible for either MA or FHP.
- Provide referral to the LDSS those applicants who indicate they are blind or disabled and who do not appear MA eligible. The facilitated enroller will provide the applicant with information about the potential benefit of a full MA assessment by the LDSS. FE agencies have the option to assist the individual in completing Supplement A of the Access New York Health Care application for this population.

- Provide general guidance on an applicant's need to pursue other sources of income prior to applying for MA or FHP. Applicants who appear eligible for certain benefits, such as unemployment insurance or worker's compensation, and have not applied for these potential sources of income, are required to provide evidence that they are pursuing such financial supports prior to having the application completed. If applicable, the facilitated enroller will not submit an application to the LDSS until proof of such action is provided.

6. Process Applications

- Ensure that all applications completed directly by the FE agency or the subcontractor are reviewed for quality and completeness prior to being submitted to the LDSS or CHPlus health plan following the FE agency's internal quality assurance review procedures.
- Submit completed applications with required documentation directly to the appropriate CHPlus health plan or LDSS responsible for processing the application and determining eligibility. Applications submitted to the LDSS must follow the process and timeframes established in the standard protocol between the FE agency and the LDSS/Human Resources Administration (HRA). Please note, there is one protocol for New York City and one for the rest of the state. The protocol describes the process/steps to be followed between the FE agency and the LDSS/HRA to process completed applications, specifically, that all signed MA and FHP applications to the appropriate LDSS for determinations of eligibility within 15 business days. In addition to timeframes, the protocol addresses forms and procedures for the delivery and processing of completed applications in accordance with SDOH administrative directives (ADMs). If awarded funding, an applicant is required to submit a signed FE agency/LDSS/HRA protocol to the SDOH before final contract approval and the FE agency's commencement of facilitated enrollment services. The protocol is found in Attachment 4 of this document.
- Comply with LDSS established procedures for transmitting the MA or FHP applicant's managed care plan choice directly to the appropriate LDSS or enrollment broker in accordance with county protocols. This includes working with entities contracting with SDOH as enrollment brokers for MA in areas where the enrollment broker is responsible for enrollment processing. A list of counties that use MAXIMUS, currently the state's Enrollment Broker contractor, is found in Attachment 5 of this document.
- Follow-up, if necessary, on each application with the appropriate CHPlus health plan or LDSS/HRA to ensure that applications are being processed in accordance with applicable time-frames, and that the applicants are enrolled in a timely manner.

7. Have Facilitated Enrollers Provide Assistance at Renewal

Renewal applications may be submitted by mail for all three programs and, in NYC, MA and FHP applications may be submitted on-line using Access NYC. Therefore the role of facilitated enroller and FE agencies is minimal. However, enrollees may seek assistance with completion of their renewal forms and collection of any required documentation to ensure that the renewal occurs within the required timeframe. FE agencies may submit the renewal to the appropriate CHPlus plan or LDSS according to established protocols, or return it to the enrollee for submission. It is anticipated that FE assisted upstate renewal applications will be submitted to the Enrollment Center, New York Health Options.

8. Provide Technical Assistance and Ongoing Training

- Assure that all facilitated enrollers participate in SDOH sponsored training programs, or other training approved by SDOH, including use of the “train-the-trainer” approach. Currently, Basic, Refresher and Self-employment training modules are provided. Slides of some of the training modules are also available on the training contractor’s website, <http://www.bsc-cdhs.org/fet/>.
- Provide regularly scheduled sessions for program information, updates, on-going training and technical support. Attendance at these sessions may be all-inclusive (e.g. both facilitated enrollers and quality review staff), or particular to the topics addressed. Conference calls, distribution of written materials, and memos are not acceptable substitutes for in person attendance at these meetings, but are appropriate as additional methods for information dissemination.

9. Comply with SDOH Application Reporting Requirements

- Provide specific information on the progress of each application using the Internet based reporting system Health Commerce System (HCS) for the FE Program. The required information should be continually updated to ensure timely and accurate tracking of applications, including the dates and dispositions of applications as they are processed. In particular, the FE agency should ensure, per SDOH contract requirements, that the HCS accurately reflects the end-of-the month status of all applications by the fifth business day following the end of the month.

Data to be collected and maintained for each application includes:

- Specific enroller identifier;
- Date of initial encounter with family;
- Date of completed application;
- Date application submitted for determination;

- Type of eligibility determination;
 - Number of applicants;
 - Date informed of eligibility determination; and
 - Any other data SDOH deems necessary to monitor FE agency performance.
- Cooperate with SDOH monitoring activities, including unannounced site visits.

10. Monitor the Productivity and Accuracy of Facilitated Enroller

- Monitor all program activities, including facilitated enroller productivity and accuracy as defined in the FE agency's quality review procedures approved by SDOH, to ensure that productivity meets the required standards set by the SDOH (e.g. apps per facilitated enroller FTE week). The FE agency shall monitor their staff and all subcontractors. If, after a few months of technical assistance and training, a facilitated enroller fails to meet required productivity levels, the FE agency should make appropriate staff and subcontractor changes.
- Monitor HCS data to determine the number of applications submitted per facilitated enroller FTE week ("apps per FTE week"). SDOH views this measure cumulatively throughout the year, and also monthly as a trend analysis. For 2010, the cumulative "apps per FTE week" measure ranged statewide from 5.4 to 19.6. Two-thirds of current grantees were above 9.3 applications per facilitated enroller FTE week in 2010.
- Monitor the quality of information collected by each facilitated enroller on applications, such as whether any documentation or information is missing, to check the accuracy of an individual facilitated enroller. The FE agency in their quality review procedures should ensure that no more than 3% of applications contain errors affecting eligibility and no more than 8% have any errors. The quality review procedures should also have steps to improve the productivity and accuracy of underperforming or poorly performing facilitated enrollers.
- Monitor each facilitated enroller to ensure that applications are submitted to the FE agency in a timely manner to ensure that MA and FHP applications are submitted to the LDSS within 15 business days.
- Develop subcontracts that include provisions to enforce improved productivity. SDOH will not continue to reimburse agencies for substandard performance.

11. Conduct Outreach and Information Dissemination

- The SDOH will provide outreach material for the facilitated enrollers to use, such as brochures and fliers. An FE agency may choose to develop its own material to meet the needs of its individual community. However, all publicity

and educational materials must be submitted by the FE agencies to SDOH for review and approval, prior to use to assure that enrollment information is accurate and comprehensive.

- Provide information and assist potential applicants in locations approved by SDOH. An emergency room is not an approved location. Agencies are also prohibited from telephone cold-calling, door-to-door solicitations at the homes of prospective applicants and offering incentives of any kind to join a plan where the incentive is greater than \$5.00.
- A limited amount of funds for FE may be used for outreach activities that result in increased enrollment into health insurance programs. Agencies that receive \$300,000 or less under their facilitated enrollment contract may spend up to 10% of their funds on outreach. Agencies receiving over \$300,000 may use no more than \$30,000 of the funds on outreach activities. The State may waive these limits as determined necessary.
- SDOH conducts broad outreach activities on an ongoing basis. SDOH will widely advertise available programs. FE agencies may want to specifically target outreach efforts to hard to reach populations and inform the public about availability of sites where persons and families can obtain assistance in applying for available programs. For example, advertising schedules that include information on the health insurance programs and FE locations via flyers, mailings, posters, or paid advertising would be considered an appropriate use of this funding.

12. Have Facilitated Enrollers Follow SDOH Appeal/Complaint Process

SDOH and its LDSS partners have policies and procedures for applicants to file appeals/complaints with SDOH or LDSS at any time. Facilitated enrollers will be responsible for informing applicants of their right to file appeals/complaints, and should inform applicants of the process for filing appeals.

13. Maintain Confidentiality Requirements

- Maintain the confidentiality of information contained on the Access New York Health Care application, and additional information provided by applicants, as well as information contained on supporting documentation. Eligibility information for MA, FHP and CHPlus is also confidential.
- Information may be shared by the FE agencies, subcontractors conducting FE, and the programs and agencies identified in this RFA, provided that the applicant has given appropriate written authorization on the application and provided the release is for the purposes of determining eligibility or evaluating the success of the program. There can be no further disclosure of MA

Confidential Data (MCD) without prior, written approval of the SDOH MA Confidential Data Review Committee (MCDRC). The FE agency will require that any approved agreement or contract with a subcontractor or others contains a statement that the subcontractor or other party may not further disclose MCD without the prior written approval of the MCDRC.

If an applicant is awarded funding, the grantee is required to:

- Submit to SDOH a completed and signed “Certification Regarding State and Federal Confidentiality Requirements for Facilitated Enrollment Agency” form found in Attachment 6.
- Maintain a file of completed “Certification Regarding State and Federal Confidentiality Requirements for Facilitated Enrollment Subcontractors” signed by each facilitator at the time of hire, and submit copies to SDOH.
- Ensure upon termination of the FE Program contract with SDOH that program data reporting is complete, and certify that any electronic or paper copies of MCD collected in connection with this contract are destroyed.
- Under the Health Insurance Portability and Accountability Act (HIPAA), successful grantees must comply with the Federal HIPAA Business Associate Agreement which is Appendix H of the SDOH Grant Contract in Attachment 7 of this document. HIPAA Privacy Rule was enacted to provide protection for and limit the disclosure of a person’s protected health information. Protected health information is defined as information that relates to a past, present or future health condition, health care service or payment information for such a service that identifies the individual involved. As a Business Associate, a FE agency will comply with the HIPAA privacy regulations. An FE agency will safeguard protected health information from intentional and unintentional use or disclosure. Therefore, it is critical that all documents containing protected health information, including applications and documentation, be kept in a secured location accessed only by authorized personnel, such as in a locked room, cabinet or drawer. Staff should only have access to the minimum information needed to do their jobs. Furthermore, all staff, volunteers, and consultants with access to protected health information will be trained in, and comply with the HIPAA privacy regulations. For additional information about the HIPAA privacy requirements and access to the governing statute and regulations, applicants should refer to the Department of Health and Human Services website <http://www.hhs.gov/ocr/privacy/> .

V. Responsibilities of Other Agencies working with the contracted FE Agency

A. Local Social Services Districts/Enrollment Broker

The LDSSs/enrollment broker will work with State contracted FE agencies. The LDSS/enrollment broker shall coordinate the application and enrollment process with the FE agency working in their communities. The HRA in New York City and LDSSs in other counties will have responsibility for MA eligibility determinations and enrollment of applicants into managed care plans

The responsibilities of the LDSS in the facilitated enrollment process will include the following:

- Working with the FE agencies, in compliance with the standard written protocol for FE detailing operations and practices for families and individuals applying for MA and FHP specifically the receipt and processing of Access NY Health Care applications and renewals. This includes processes to notify the agencies and, if appropriate, the applicant, of the need for additional documentation when necessary and of the final eligibility determination.
- Providing prompt feedback to the FE agencies on incomplete or incorrect applications so that problems can be addressed in a timely fashion.
- Providing information when needed to the agencies to assist facilitated enrollers in determining a health care provider's participation in FHP or MA managed care.
- Accepting completed applications from FE agencies, and processing MA and FHP applications in accordance with established protocols and prescribed timeframes. In addition, LDSSs will provide notices of eligibility decisions to applicants, the FE agency and their selected health plan.
- Accepting and processing FHP and MMC enrollment forms received from the FE agencies, and completing enrollment after eligibility has been established in the Prepaid Capitation Plan Subsystem. In some areas of the State, this is the responsibility of the enrollment broker.
- Assisting individuals and families who apply for FHP and MA at the LDSS. In these cases, the LDSS will be responsible for eligibility determinations and counseling about health plan and primary care physician selection. The LDSS or enrollment broker, depending on the county, will be responsible for the entry of individual enrollment form data and/or transmitting that data to SDOH's Prepaid Capitation Plan Subsystem. Should an child be determined ineligible for MA at the LDSS due to excess income, the LDSS/HRA screen eligible for CHPlus, the

LDSS/HRA is responsible for sending a copy of the completed application, documentation and budget to the CHPlus health plan selected by the applicant.

- SDOH has contracted with an enrollment broker in some boroughs/counties of the State to conduct certain enrollment, outreach and educational activities for MA and FHP. The enrollment broker will assist in specific portions of the enrollment process, such as the receipt and data entry of plan selection information from the facilitator, and notification to the applicable plan of the new enrollee's information. Other potential roles for the enrollment broker, including enrollment counseling to families and/or individuals and assisting in plan and PCP selection, may be added.

B. CHPlus Health Plan

The responsibilities of the CHPlus health plans in the facilitated enrollment process include the following:

- Accepting and processing Access NY Health Care applications from FE agencies.
- Providing feedback to the FE agencies on incomplete or incorrect applications.
- Providing material about the health plan, including provider directories, to the FE agencies.
- Sending completed application and documentation copies to the LDSS/HRA if the CHPlus plan finds an applicant to be Medicaid eligible.

C. New York State Department of Health (SDOH)

SDOH retains responsibility for ensuring that the FE agencies' policies and procedures related to enrollment and outreach are appropriate to meet the needs of applicants, and are in accordance with State and Federal laws, regulations, policies, and procedures. Prior to commencement of facilitated enrollment, SDOH will:

- Conduct a review to assure that FE agencies have established policies and procedures approved by SDOH regarding the handling of applications, communications, contact persons, quality assurance procedures, and interactions with LDSSs/HRA and plans, if applicable;
- Review schedules of facilitated enrollment sites, times and staffing;
- Establish and monitor the payment process for facilitated enrollment;
- Provide initial and limited ongoing training to all FE agencies and their subcontractors;

- Review the standard written protocol between FE agencies and LDSSs/HRA which details FHP and MA operations and practices to assure that the unique needs and concerns of FE agencies and LDSSs/HRA are addressed;
- Review the agency's internal quality assurance monitoring procedures; and
- Assess the FE agencies' plan selection processes to assure that facilitated enrollers are trained and able to present applicants with unbiased information regarding plan selection.

SDOH will monitor and evaluate FE agency performance in accordance with the terms and conditions contained in their FE contract with SDOH. SDOH may, at its discretion, conduct targeted reviews to assess the performance of FE agencies, including reviews for incomplete or erroneous applications. If an agency is found to be out of compliance with the terms and conditions, SDOH may terminate an agency's FE contract.

VI. Who May Apply

A. Eligible Entities

Under Public Health Law § 2511(9) and Social Services Law §369-ee(4), the Commissioner may contract with community based organizations (CBOs) and local governments that can effectively target FE efforts in geographic regions of the State where there are uninsured individuals. CBOs must be not-for-profit organizations. Examples of CBOs include, but are not limited to, child advocacy organizations, community service agencies, rural health networks, health care providers, perinatal networks and school-based health centers. Local government agencies are also eligible to apply.

Since FE is a community based program, we encourage applications to be locally designed for communities in which the CBO is located, with facilitated enrollers located in those sites that best reach the target population. Based on past experience, SDOH discourages applicants from submitting an application covering the entire state as it may be difficult for the agency to manage and oversee multiple subcontractors and staff in a large geographic area. The SDOH prefers that entities propose to cover either an entire county or group of counties and populations that are culturally similar to the populations served by the agency. Applicants are expected to provide facilitated enrollment services to the entire geographic area they propose to serve, even if the individual applying for health insurance coverage is of a different cultural background than the agency generally serves. For example, an agency primarily serving a Hispanic population is required to assist a Korean individual in applying for health insurance coverage.

Health plans are not eligible to submit applications under this RFA, since they may participate in FE through their contractual arrangement with the SDOH as a health plan.

B. Preferred Characteristics of Applicants

Since 1999, the State has invested significant resources in the FE Program. SDOH has developed and supported a statewide infrastructure of application assistance that has been successful in reaching uninsured New Yorkers. In addition, SDOH has devoted, and continues to devote significant resources to training facilitated enrollers. Based on experience, SDOH has identified many of the characteristics of a successful FE operation. Thus, the following are the preferred requirements for applicants.

1. The applicant should demonstrate knowledge of, an understanding of and experience working with the target population. This should include how it will reach the target population.

Applicants should describe the population to be served, and to the extent possible, the level of under or uninsured in the population. Applicants should describe in detail their past accomplishments and experience in working with the target population.

Current grantees should describe specific approaches that have been successful in their efforts to enroll their target population. Lessons learned from these experiences should be included in the description (e.g. use of specific outreach materials, unusual FE locations).

New applicants should present information from comparable challenges and solutions in service provision to their target population.

2. The applicant should demonstrate an appropriate capacity and organizational structure to undertake the proposed activities, including evidence of an adequate staffing level, a dedicated program manager and a high level of staff retention.

- **Proposed staffing level is adequate to support a successful FE Program**

- a. Program Manager

Applicants should include a dedicated program manager who is responsible for the overall operation of the FE Program. The SDOH prefers that the manager dedicates 100% of his/her time to this project and be responsible for all communication with the department. This is because past experience shows that a project with a dedicated program manager is more successful than one that does not employ a dedicated program manager. An applicant proposing less than a full time program manager should define the manager's other responsibilities and, explain how and by whom, the

additional oversight of the program will be provided. Applicants should describe all funding for the program manager.

FE agencies may employ facilitated enrollers directly at their agency or through a subcontract with another CBO. Historically, grantees have been most successful in their FE efforts if staff were directly hired rather than through subcontractors. Applicants should define their staffing levels and that of each subcontractor.

Program experience shows that facilitated enrollers working full time on the FE Program are generally more successful than part time facilitated enrollers. The knowledge and experience needed to be a successful facilitated enroller is difficult to achieve and retain without a full time commitment to the job responsibilities. As such, the SDOH prefers that projects employ full time facilitated enrollers. However, the SDOH will consider positions less than full time equivalents (FTEs) if the applicant supplies a justification. A duplication of effort between the FE agency's other programs or staff providing similar services for another program will be unacceptable and SDOH reserves the right to withhold funding, in whole or part, or terminate the contract.

b. Quality Review Staff

The FTE level of quality review staff should be adequate to support the proposed volume of applications to be processed. For some applicants with fewer FTE facilitated enrollers, quality review may be solely conducted by the program manager. Those with a larger number of FTE facilitated enrollers, or who will handle a high volume of completed applications each week, may establish staff positions dedicated to this activity. Applicants should define how they will ensure adequate staffing to process the projected number of applications.

Based on 2010 data, the mean number of applications one FTE facilitated enroller completes weekly is 10.7. Currently, it takes an average of 5 days for a completed application to be reviewed, processed and submitted to either a CHPlus health plan or the LDSS.

c. Support Staff

Applicants should also identify other support staff necessary to successfully implement and operate the FE Program. Such staff may be grant funded or provided in-kind. Applicants should identify the staff positions which will be responsible for the following program activities: data entry into the SDOH Health Commerce System (HCS); collection of completed applications from enrollment sites and their submission to health plans and LDSS; and, clerical support (telephones, photocopying, appointment scheduling, etc.).

- **Evidence of high level of staff retention**

FE productivity is directly proportional to the experience of the staff. Current contractors who apply should supply the turnover rate in their program, including any subcontractors (if applicable) for the previous two years. New applicants should submit comparable information for the average length of employment for staff on another SDOH grant program, other grant or for their organization as a whole.

3. The applicant should demonstrate their commitment to actively engage in and conduct FE activities.

Applicants should discuss how this program relates to the broader mission statement of the organization as a whole.

- Applicants and their subcontractors should have a known presence in the community. Applicants should demonstrate how they and their subcontractors are a resource to their community.
- Applicants should discuss the support of their board of directors and executive director for the FE program. Applicants should identify the executive level person(s) who has been, and/or will be, responsible for the successful operation of the FE program and clearly define (1) that person's level of involvement with the FE program; and, (2) the lines of authority and responsibility between that person and the director of the FE program. Similarly, county governments should discuss the support of their local structures such as the County Executive and the high level staff responsible for the overall success of the program.
- Applicants should describe their process for responding to requests for information from SDOH. Applicants should indicate the dedicated program manager as the point of contact for SDOH, and guarantee timely responses to SDOH inquiries. Applicants should describe current and past experience in responding to SDOH inquiries.
- Historically, grantees have shown the ability to resolve temporary operational problems (such as an unexpected support staff shortage or a physical site problem) because of overall agency support and collaboration. Applicants should provide an example relative to the FE program that demonstrates an atmosphere of internal collaboration and support. New applicants should provide a description of how their agency works collaboratively to support its individual activities.

4. Applicants should demonstrate that facilitated enrollers will be representative of the cultural and language diversity of the population to be served.

They should provide services in locations and at times that are convenient for and accessible to the target population. The legislative intent behind FE is to have

convenient, community based sites, staffed by facilitated enrollers who are culturally and linguistically representative of the population being served.

5. Applicants should demonstrate their ability to schedule interviews promptly and submit applications that are complete and timely to LDSS/CHPlus health plans.

- Current grantees should provide specific details on their appointment scheduling process. These details should include the average wait time for an interview appointment, how the agency services walk-in applicants, and any outreach the agency employs to minimize “no shows” (e.g. reminder postcards, phone calls the day in advance). In addition, they should describe the processes and timeframes for handling applications in a timely manner. Current grantees should indicate the average number of days to complete the following processing steps: initial interview to submission of the application for quality review; and, receipt of application for quality review to submission to LDSS/health plan for determination.
- New applicants should present information based on a comparable activity which demonstrates promptness in customer assistance and an ability to handle multi-step processing efficiently. This could include information as diverse as patient wait times or the number of days from order receipt to shipment of goods.

6. Applicants should demonstrate past experience and current working relationships with LDSS, health plans and subcontracting agencies, if applicable.

Applicants should demonstrate an existing working relationship with the LDSS and health plans. If subcontractors are used, they should also describe the history of their working relationship with these organizations. If an applicant does not have a history of working with such organizations, they should describe the concrete steps that will be taken to quickly establish such relationships.

7. Applicants should demonstrate that ongoing training and technical assistance will be provided to facilitated enrollment staff.

Current grantees should include information on their training and technical assistance efforts with FE staff, including regularly scheduled meetings and in-service topics. This information should include the process of training new staff. New applicants should describe the method that they will use to conduct frequent and regularly scheduled communication with all FE staff.

8. Applicants should demonstrate the ability to develop and implement a quality assurance plan for monitoring performance of facilitated enrollers.

Applicants should describe a plan for monitoring the number of applications taken and appropriate processing of the applications of each facilitated enroller hired directly by

the applicant and hired by subcontractors, if applicable. This should include a plan for correcting non- and under-performance and the quality assurance standards utilized to ensure complete, timely and highly accurate applications. Applicants will be required to submit their quality review procedures for approval by SDOH. All data collection and reporting systems used to monitor performance will include the capacity to transmit data electronically to SDOH.

9. Applicants should demonstrate the ability to meet administrative requirements including timely vouchers and budget modification requests and report submissions and contract execution timeframes.

Applicants should describe the process of how they will be able to execute their contract within 30 days of receipt from SDOH. This is to ensure that FE services are available on January 1, 2012. If it is unlikely that your agency will be able to meet this timeframe, applicants should explain the circumstances creating this delay, and define the expected amount of time required for completion of the contract process. Applicants should discuss their past compliance with such DOH requirements, including reasons for failure to comply. During a contract period, vouchers should be submitted monthly to SDOH 30 days after the end of the reporting period. Proposed budget modifications must be submitted to SDOH not less than 30 days prior to implementation and approved prospectively. At no time will retroactive budget modifications be considered.

10. Applicants should demonstrate that the administrative structure is cost effective and efficient.

The proposed program budget and administrative structure should be cost effective and efficient. While administrative costs should be adequate to support the program, they cannot be excessive in proportion to the amount of funding dedicated to direct FE activity. Preference will be given to those with administrative costs that most reflect these criteria. Information to assist applicants in budget preparation is included in Section VIII. A of this RFA.

VII. Administrative Requirements

Applicants for this RFA will need to submit an application describing how they will address the needs of the target population. Applicants will also need to submit budgets reflecting the costs associated with providing FE for the population. This section provides general information regarding the process for applicants applying to provide FE services.

A. Issuing Agency

This RFA is issued by the NYS DOH, Office of Health Insurance Programs, Division of Coverage and Enrollment, Facilitated Enrollment Program. The

SDOH is responsible for the requirements specified herein and for the evaluation of all applications.

B. Amendments

SDOH reserves the right to amend this RFA at any time prior to the application due date by issuing written addenda. Amended information regarding the RFA will be posted on the Department of Health's website at <http://www.health.ny.gov/funding/>. Agencies who submitted a letter of interest will be notified by electronic mail that an amendment has been posted.

C. Question and Answer Phase:

All substantive questions about this RFA must be submitted in writing via mail to:

Gabrielle Armenia - Director, Bureau of CHPlus Enrollment
Division of Coverage and Enrollment
Office of Health Insurance Programs
New York State Department of Health
Corning Tower Room 1619
Empire State Plaza
Albany, New York 12237-0004

Submission is also acceptable via fax (518) 473-5273 or e-mail to:

chpferfa@health.state.ny.us

Each inquiry should cite the RFA section and paragraph to which it refers. Written questions will be accepted until the date posted on the cover sheet of this RFA.

Questions of a technical nature can be addressed to Mary Dillon in writing to the above address or fax, or via telephone by calling (518) 474-5449.

Questions of a technical nature are limited to questions about how to prepare your application (e.g., formatting) rather than relating to the substance of the application.

Prospective applicants should note that all questions and clarifications, including exceptions relating to the terms and conditions of the SDOH contract, are to be raised prior to the submission of the application.

Questions and answers, as well as any updates and/or modifications, will be posted on the Department of Health's website at <http://www.health.ny.gov/funding/> by the date posted on the cover sheet of this RFA. Prospective applicants that wish to receive this information via mail must request so in writing.

D. Applicant Conference and Letter of Interest

1. An Applicant Conference will not be held for this program.
2. Non-Mandatory Letter of Interest

All potential applicants are requested to submit a non-binding Letter of Interest, to be received by SDOH by close of business on the date posted on the cover sheet of this RFA, at the address listed below in Section VII.E. Attachment 8 should be used as a template for submission of the Letter of Interest.

E. How to File an Application

Applications must be **received** at the following address by the date and time posted on the cover sheet of this RFA. Late applications will not be accepted*.

Gabrielle Armenia, Director, Bureau of CHPlus Enrollment
Division of Coverage and Enrollment
Office of Health Insurance Programs
New York State Department of Health
Corning Tower Room 1619, Empire State Plaza
Albany, New York 12237-0004

* It is the applicant's responsibility to see that applications are delivered to the address above prior to the date and time specified. Late applications due to a documentable delay by the carrier may be considered at the Department of Health's discretion.

Applicants shall submit one (1) signed original and seven (7) copies of their application (8 complete sets in all). Applicants should also submit one (1) electronic copy of the application and all attachments on a compact disc (CD) with copy/read permissions only. All attachments or forms that require applicant information should be kept and submitted electronically in their original format, either Microsoft Word or Excel. The electronic version of these attachments can be downloaded off the SDOH website at <http://www.health.ny.gov/funding/>. The eight hardcopy sets and CD of the complete application should be clearly labeled with the name and number of the RFA as listed on the cover of this document. Applications submitted via fax or e-mail will not be accepted. Failure to submit the correct number of applications and the CD will result in a point deduction from the applicant's score.

Prior to SDOH's application approval date, an applicant may withdraw its submitted application by sending a written withdrawal request, signed by the applicant's authorized agent, to the above address.

F. SDOH Reserved Rights

The SDOH reserves the right to:

1. Reject any or all applications received in response to this RFA.
2. Withdraw the RFA at any time, at the Department's sole discretion.
3. Make an award under the RFA in whole or in part.
4. Disqualify any applicant whose conduct and/or proposal fails to conform to the requirements of the RFA.
5. Seek clarifications and revisions of applications.
6. Use application information obtained through site visits, management interviews and the state's investigation of an applicant's qualifications, experience, ability or financial standing, and any material or information submitted by the applicant in response to the agency's request for clarifying information in the course of evaluation and/or selection under the RFA.
7. Prior to application opening, amend the RFA specifications to correct errors or oversights, or to supply additional information, as it becomes available.
8. Prior to application opening, direct applicants to submit proposal modifications addressing subsequent RFA amendments.
9. Change any of the scheduled dates.
10. Waive any requirements that are not material.
11. Award more than one contract resulting from this RFA.
12. Conduct contract negotiations with the next responsible applicant, should the Department be unsuccessful in negotiating with the selected applicant.
13. Utilize any and all ideas submitted with the applications received.
14. Unless otherwise specified in the RFA, every offer is firm and not revocable for a period of 60 days from the bid opening.
15. Waive or modify minor irregularities in applications received after prior notification to the applicant.

16. Require clarification at any time during the procurement process and/or require correction of arithmetic or other apparent errors for the purpose of assuring a full and complete understanding of an offerer's application and/or to determine an offerer's compliance with the requirements of the RFA.
17. Negotiate with successful applicants within the scope of the RFA in the best interests of the State.
18. Eliminate any mandatory, non-material specifications that cannot be complied with by all applicants.
19. Award grants based on geographic or regional considerations to serve the best interests of the state.
20. If the SDOH does not receive an application to provide services for a particular county of the state, SDOH may request that the applicant with the highest score in a contiguous county expand its coverage to this additional area.

G. Term of Contract

Any contracts resulting from this RFA will be effective only upon approval by the New York State Office of the Comptroller. It is expected that contracts resulting from this RFA will have the following time period, January 1 through December 31, 2012, with the option of four (4) additional one year renewals, contingent on program performance and the availability of funding.

H. Payment and Reporting Requirements of Grant Awardees

1. The Department may, at its discretion, make an advance payment to not for profit grant contractors in an amount not to exceed 25 percent.
2. The grant contractor will be required to submit monthly vouchers and required reports of expenditures to the State's designated payment office:

Bureau of Child Health Plus Enrollment
Facilitated Enrollment Program
NYS Department of Health
Corning Tower, Room 1621
Albany, NY 12237

Grant contractors shall provide complete and accurate billing vouchers to the Department's designated payment office in order to receive payment. Billing vouchers submitted to the Department must contain all information and supporting documentation required by the Contract, the Department and the State Comptroller. Payment for vouchers submitted by the CONTRACTOR shall only be rendered electronically unless payment by paper check is expressly authorized

by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epunit@osc.state.ny.us or by telephone at 518-486-1255.

CONTRACTOR acknowledges that it will not receive payment on any vouchers submitted under this contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

Payment of such vouchers by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law.

3. The grant contractor will be required to submit the following periodic reports:

- Progress report no later than 30 days following the end of the reporting period;
- Monthly expenditure report; and
- Annual equipment inventory.

All payment and reporting requirements will be detailed in Appendix C of the final grant contract.

I. Vendor Responsibility Questionnaire

The New York State Department of Health recommends that vendors file the required Vendor Responsibility Questionnaire online via the New York State VendRep System. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at http://www.ocs.state.ny.us/vendrep/vendor_index.htm or go directly to the VendRep system online at <https://portal.osc.state.ny.us>.

Vendors must provide their New York State Vendor Identification Number when enrolling. To request assignment of a Vendor ID or for VendRep System assistance, contact the Office of the State Comptroller's Help Desk at 866-370-4672 or 518-408-4672 or by email at ciohelpdesk@osc.state.ny.us.

Vendors opting to complete and submit a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the Office of the State Comptroller's Help Desk for a copy of the paper form.

Applicants should complete and submit the Vendor Responsibility Attestation (Attachment 9).

J. General Specifications

1. By signing the "Application Form" each applicant attests to its express authority to sign on behalf of the applicant.
2. Contractor will possess, at no cost to the State, all qualifications, licenses and permits to engage in the required business as may be required within the jurisdiction where the work specified is to be performed. Workers to be employed in the performance of this contract will possess the qualifications, training, licenses and permits as may be required within such jurisdiction.
3. Submission of an application indicates the applicant's acceptance of all conditions and terms contained in this RFA, including the terms and conditions of the contract. Any exceptions allowed by SDOH during the Question and Answer Phase (Section VII.C.) must be clearly noted in a cover letter attached to the application.
4. An applicant may be disqualified from receiving awards if such applicant or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.
5. Provisions Upon Default
 - a. The services to be performed by the Applicant shall be at all times subject to the direction and control of SDOH as to all matters arising in connection with or relating to the contract resulting from this RFA.
 - b. In the event that the Applicant, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFA, the Department acting for and on behalf of the State, shall thereupon have the right to terminate the contract by giving notice in writing of the fact and date of such termination to the Applicant.
 - c. If, in the judgment of SDOH, the Applicant acts in such a way which is likely to or does impair or prejudice the interests of the State, the Department acting on behalf of the State, shall thereupon have the right to terminate any contract resulting from this RFA by giving notice in writing of the fact and date of such termination to the Contractor. In such case the Contractor shall receive equitable compensation for such services as shall, in the judgment of the State Comptroller, have been satisfactorily performed by the Contractor up to the date of the termination of this agreement, which such compensation shall not exceed the total cost incurred for the work which the Contractor was engaged in at the time of such termination, subject to audit by the State Comptroller.

K. Appendices Included in SDOH Grant Contracts

The following will be incorporated as appendices into any contract(s) resulting from this RFA. Attachment 7 includes the model grant contract which will be used for successful grantees for the Facilitated Enrollment program.

- APPENDIX A: Standard Clauses as required by the Attorney General for all State Contracts
- APPENDIX A-1: Agency Specific Clauses
- APPENDIX A-2: Program Specific Clauses
- APPENDIX B: Budget
- APPENDIX C: Payment and Reporting Schedule
- APPENDIX D: Workplan
- APPENDIX E : Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or the Workers' Compensation Board, of coverage for:

Workers' Compensation, for which one of the following is incorporated into this contract as **Appendix E-1**:

- **CE-200** - Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage is Not Required; OR
- **C-105.2** - Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the **U-26.3**; OR
- **SI-12** - Certificate of Workers' Compensation Self-Insurance, OR **GSI-105.2** -- Certificate of Participation in Workers' Compensation Group Self-Insurance

Disability Benefits coverage, for which one of the following is incorporated into this contract as **Appendix E-2**:

- **CE-200** - Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage is Not Required; OR
- **DB-120.1** - Certificate of Disability Benefits Insurance OR
- **DB-155** - Certificate of Disability Benefits Self-Insurance

NOTE: Do not include the Workers' Compensation and Disability Benefits forms with your application. These documents will be requested as a part of the contracting process should you receive an award.

APPENDIX G: Notices
APPENDIX H: Federal Health Insurance Portability and Accountability Act ("HIPPA") Business Associate Agreement ("Agreement")
APPENDIX X: Modification Agreement Form

VIII. Completing the Application

This section describes the content and format requirements for applications, the qualitative competitive scoring criteria to be used, and information to assess the viability and feasibility of an organization's ability to successfully implement and accomplish the goals and objectives of their proposal.

A. Application Content

Respond to each of the statements and questions listed below. Number/letter your narrative to correspond to each element in the order presented. Be specific and complete in your responses. Do not leave any element blank. If appropriate, indicate if the element is not relevant to your agency or application.

1. GRANT APPLICATION COVER SHEET

A completed grant application cover sheet (Attachment 10) should be included with the application. The grant application checklist (Attachment 11) is provided for the applicant to ensure that all of the requested information is included with the application.

2. PROGRAM SUMMARY

Applicants should provide a one-page summary of the proposed FE Program. Topics to be briefly described include the target area and an identification of the target population to be served, including an estimated number of under and uninsured in this population (Please see Attachment 12 for population information by county). The applicant should present a broad overview of its enrollment strategy, identify the types of sites to be used and subcontractor agencies, if applicable, and describe how it will manage each step of the process from outreach through application assistance to submission of an application to the LDSS/HRA and/or health plan.

3. SERVICE AREA AND STATEMENT OF NEED

Applicants should describe the target area they propose to serve. For all areas of the state except New York City, the applicant should include the county(ies) they plan to serve. For New York City applicants, the proposal should include the borough and/or zip codes that the project will serve if the proposal does not cover an entire borough. The proposal should include a description of the size and demographics of the target population. Applicants proposing to serve multiple counties should submit one budget for the entire project, specifying how many facilitated enrollers will be dedicated to each county.

Additionally, the following should be included:

- A description of the community and populations that will be targeted, including the cultural and language characteristics of the area.
- An explanation how the applicant's participation in the FE Program will address an unmet community need and why the applicant is uniquely qualified to provide facilitated enrollment services.

4. APPLICANT ORGANIZATION

The following information should be provided regarding the applicant organization:

- The organization's mission, organizational structure, the services the organization provides and the role it will play in the proposed program.
- Current and past experience as a contractor, including funds received and services provided (during the last five years) and the organization's compliance with contractual requirements including vouchering, reporting and responsiveness to the organization providing the funding.
- A Statement demonstrating the support of the applicant's board of directors, if applicable, to the program's success and the organization's commitment to the community and the target population.
- The staff retention rate for the applicant and each proposed subcontractor, if applicable. For new applicants without prior experience in the FE Program, provide the average staff retention rate or the average amount of time similarly salaried staff have remained in a working relationship at the applicant's organization. Comparable information should be provided for each proposed subcontractor agency.

- The proportion of time that the dedicated program manager will be devoted to the FE Program (this can include FE services), the person's other responsibilities, if applicable, and who will be responsible if that person is not devoted 100% to the FE program. Include all parties responsible for communication with SDOH. This should include a detailed description of the program manager's responsibilities. At a minimum, this includes overall program responsibility, responsibility for day-to-day operations, supervision, detailed knowledge of FE Program rules and regulations, knowledge of data systems or separate staff that report to the manager for this program that will carry out data responsibilities, and compliance with contractual requirements.
- The proportion of time and level of involvement expected from the executive level person(s) and board of directors for the successful operation of the FE program. Define the proposed line of authority and responsibility between the executive level person(s) and the director of the FE program. Similarly, county governments should discuss the support of their local structures such as the County Executive and the high level staff responsible for the overall success of the program.

5. ENROLLMENT STRATEGY AND EXPERIENCE OR RELATIONSHIPS WITH ENROLLMENT ENTITIES (LDSSs/HRA and CHPlus Health Plans)

An explanation of the enrollment strategy including:

- The approaches that will be undertaken to reach children and adult populations. In particular, applicants should identify strategies that will be implemented to reach vulnerable and hard to reach populations. Applicants are to include the availability of bilingual materials, if appropriate.
- The number of individuals that the applicant proposes will be employed by the applicant as facilitated enrollers and by subcontractor(s), if applicable, and justification for that number. Provide the number of quality review, support and other staff that the applicant proposes for the FE Program. Discuss all employees' qualifications, prior experience working with target population and language capabilities.
- Applicants should describe, for each subcontractor, their prior experience working with the subcontractor and why, based on their experience, they believe the subcontractor will successfully enroll children and adults and/or the rationale for a new subcontractor to participate in the program. A letter of intent from each subcontractor describing the proposed role it will play should be included with the application.

- Give the estimated number of applications the applicant proposes will be submitted per month to the appropriate program. Explain how the estimate was derived. Current FE agency applicants should also include projected level of productivity in terms of applications submitted per facilitated enroller per FTE week. New applicants, where possible, should base their projections on prior experience assisting their target population in applying for benefits including health insurance and any other means tested program.
- The steps that will be taken to assist an applying family or individual in completing an application and obtaining necessary documentation and following through to enrollment.
- The availability of staff to provide original documentation certification services to individuals applying to MA/FHP/CHPlus through other than a FE agency.
- The applicant's current or planned internal program procedures and timeframes for handling applications including wait times for appointments, completion of applications, quality reviews and submission of applications to appropriate entity (LDSS/HRA and/or CHPlus health plan) for an eligibility determination.
- A description of the applicant's experience working with health plans and/or LDSSs/HRA or a proposed plan for developing such relationships. Successful enrollment is, in part, dependent on the development and adherence to steps established between the FE agency and the external entities that complete the enrollment process (i.e., LDSS for MA and FHP, and the health plans for CHPlus).
- A statement indicating that facilitated enroller(s) will present potential enrollees with unbiased information and assistance for plan selection.
- A statement that the agency will comply with established procedures for transmitting MMC or FHP managed care plan choices to an enrollment broker or the appropriate LDSS.
- A statement that the agency will complete and comply with the standard protocols for each applicable LDSS(s)/HRA.

6. IDENTIFICATION OF PROPOSED LOCATIONS AND SCHEDULES

Include:

- A detailed description of the potential locations where FE will occur and how these locations will enhance accessibility for enrollment assistance in the proposed target area. Describe what languages will be spoken and how those locations are designed to reach the intended populations.
- A schedule of expected days and hours of operation including weekend and evening hours and how this schedule supports the proposed number of applications to be submitted per month.
- A statement indicating that the applicant will update sites in the SDOH FE Program site directory on a real time basis.
- A completed form listing the proposed locations and schedules (Attachment 13) should be included with the application.

7. QUALITY ASSURANCE, TRAINING, OUTREACH AND REPORTING

Include:

- A proposed schedule of frequent and regular communication between the applicant, its subcontractor(s), if applicable, and facilitated enrollers.
- A plan for monitoring the number of applications taken and appropriate processing of the applications of each facilitated enroller hired directly by the applicant and hired by subcontractors, if applicable. This should include a plan for correcting non- and under-performance.
- A statement demonstrating that the applicant will not fund non- or under-performing subcontractors at the original agreed upon amount. Also, include a description of how subcontracting arrangements would be adjusted.
- A detailed description of the quality assurance standards that will be implemented by the applicant to ensure complete, timely and highly accurate applications.
- A statement demonstrating that the agency will establish quality review procedures that will be approved by SDOH.

- A statement demonstrating that program staff will undergo training and adhere to the official SDOH FE Program training curriculum.
- A plan to provide ongoing training and technical assistance to all facilitated enrollers.
- A demonstration that current data collection and reporting systems will be accommodated to include the capacity to transmit data electronically to SDOH. Applicants should include a commitment that all required reports will be handled electronically, and that data entry will occur within the timeframe stated in the SDOH contract.
- A statement demonstrating that if awarded funding, the applicant agrees that confidential data must not be disclosed, except to an organization listed on the signed application, without prior written approval of the MA Confidential Data Review Committee, consistent with Section IV. C. 13. Grantees will be required to submit the form in Attachment 6 signed by its organization prior to contract execution. Attachment 6 will also need to be completed by facilitated enrollers prior to them taking any applications.

8. READINESS/WORKPLAN

Include a readiness workplan using the form in Attachment 14. SDOH intends to fund applications that can begin providing FE services no later than three months after the contract is executed. An applicant should include a statement that, if awarded funding, the applicant will sign and submit the grant contract to SDOH within 30 days of contract receipt (refer to Attachment 7). If it is unlikely that an applicant will be able to meet this timeframe, applicants should explain the circumstances creating this delay, and define the expected amount of time required for completion of the contract process. Applicants should discuss their past compliance with such SDOH requirements, including reasons for failure to comply. The workplan form lists the major activities and expected outcomes/deliverables. The applicant should include timeframes and responsible parties. The applicant may list additional activities and deliverables. The workplan should provide the timeframes in weeks and months, e.g., Week One, Month One, rather than list specific dates and months.

9. FACILITATED ENROLLMENT BUDGET AND JUSTIFICATION

SDOH is making available up to \$15.3 million, contingent on funding availability, to organizations to support FE activities. The maximum base award for applicants applying to serve only one county is listed in the table on page 35 of this document. Applicants proposing to serve more than one

county/borough may receive an award up to the amount listed below for each additional county to be served.

For example, if the applicant proposes to serve Albany, Schenectady, and Rensselaer counties, the base award for Albany County is \$200,000 plus an additional \$60,000 for Schenectady and another \$60,000 for Rensselaer making the total maximum award to serve all three counties \$320,000.

County/Borough	Maximum Base Award Per Single County	Maximum Add-On Per Additional County
Allegany, Broome, Cayuga, Cattaraugus, Chautauqua, Chemung, Chenango, Cortland, Delaware Genesee, Herkimer, Jefferson, Lewis, Livingston, Madison, Niagara, Ontario, Oneida, Orleans, Oswego, Otsego, Schoharie, Schuyler, Seneca, Steuben, St. Lawrence, Tioga, Tompkins, Wayne, Wyoming, and Yates	\$150,000	\$60,000
Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Sullivan, Ulster, Warren, and Washington	\$200,000	\$60,000
Erie, Monroe, Onondaga, and Westchester	\$300,000	\$60,000
Nassau, Suffolk	\$300,000	\$300,000
Bronx, Kings, Queens, New York, Richmond	\$500,000	\$100,000

Only one budget for each applicant will be evaluated regardless of how many counties the applicant proposes to serve. The budget justification should identify the costs that are specific to a particular county/borough. For example, if there are certain sites or facilitated enrollers dedicated to a particular county, that information should be included in the budget justification.

Applicants should present budgets that are fiscally sound and programmatically responsible. The vast majority of personnel funding should be devoted to facilitated enrollers and quality assurance reviewers. Non-personnel service funds should be used for direct support of the program. The applicant should describe any organizational governance which dictates personnel expenditures (e.g. governmental wage rates, union contracts, salary is determined or limited by an agency wide rate). Applicants should discuss how it will address future COLAs and fringe benefit rate increases in an environment of level funding.

Applicants should submit proposed budgets with their applications using the forms in Attachments 15A and 15B. All applicants should submit each proposed cost by a specific line item that also includes an attached written justification for each proposed cost. As stated previously, applicants proposing to serve more than one county/borough must identify the costs that are specific to a particular county/borough. For example, if there are certain sites or facilitated enrollers dedicated to a particular county, that information should be included in the budget justification. In the event that an awardee does not receive funding for one or more of the counties they propose to serve, specific costs identified for those counties will be removed and the funding award amount will be reduced accordingly.

Proposed budgets should include allowable costs, and to assist applicants in their budget preparation, we are providing the following guidelines:

Personnel Services

- The majority of the funds should be allocated to personnel services, primarily to support facilitated enrollers and quality assurance staff. Past experience with facilitated enrollment grantees reflect an average salary and fringe benefits for a facilitated enroller are approximately \$39,327 upstate and \$38,485 in New York City for an average of \$38,645.

Non-Personnel Services

- Past experience with facilitated enrollment grantees reflect that approximately 13% of a grantee's total budget is allocated to non-personal services.
- Budgets may not include an overhead/indirect rate.
- Rent should be within fair market value.
- Items such as equipment, utilities, travel, office supplies, printing, photocopying, postage, telephone, training, conferences, audit, and insurance should be itemized and justified. Explain how the cost was calculated and how each item is essential to the operation of the FE Program. Non-personnel items that cannot be justified as integral to the operation of the FE Program will not be allowed.
- Outreach expenses may be up to \$30,000 for agencies proposing budgets over \$300,000 in funding and 10% of the total proposed budget for agencies receiving \$300,000 or less.

- If subcontractors are to be utilized, a proposed budget should be provided for each subcontractor, itemizing all proposed expenses as described above. The subcontractor form in Attachment 15B should be completed for each subcontractor.
- The SDOH may, if funding is available, provide successful non-profit applicants with an advance payment up to 25% of the approved amount in the contract. Terms for repayment of the advance will be included in the contract resulting from this procurement. Please note that additional advance payments will not be available in subsequent grant years.

a. FE Agency Budget

i. Personnel Services

This section should list all personnel proposed for the FE Program. This should include each individual's title, annual salary, the percentage of a full time equivalent (FTE) for each position to be supported by the grant, the dollars proposed for grant support. Use the form in Attachment 15A.

ii. Non-Personnel Services

This section should list all proposed non-personnel services. As stated in the budget guidelines above, items such as equipment, utilities, travel, office supplies, printing, photocopying, postage, telephone, training, conferences, audit, insurance should be listed separately.

iii. Subcontractor(s)

If applicants propose subcontractor(s), they should include a total proposed budget amount for each.

b. Subcontractor Budget

For each proposed subcontractor, a detailed proposed budget should be submitted using Attachment 15B following the budget guidelines described above.

c. Budget Justification

Every line item listed on budget forms in Attachment 15A and 15B should be justified. The line item written justification should explain how the cost was calculated and detail why it is essential to operating a FE Program. For subcontractors proposing to serve more than one county/borough, the budget justification needs to note costs that are specific to a particular county/borough. For example, if there are certain sites or facilitated

enrollers dedicated to a particular county, that information should be included in the budget justification. In the event that an awardee does not receive funding for one or more of the counties they propose to serve, specific costs identified for those counties will be removed and the funding award amount will be reduced accordingly.

ADDITIONAL SUBMISSIONS TO SDOH PRIOR TO CONTRACT APPROVAL

Prior to final contract approval, grantees will be required to submit:

- Completed Attestation and hard copy Vendor Responsibility Questionnaire, where appropriate (Attachment 9).
- Signed “Certification Regarding State and Federal Confidentiality Requirements for Facilitated Enrollment Agency,” (Attachment 6).
- Proposed final FE Program workplan and 12-month line item budget and justification (Attachments 14, 15A and 15B).
- Signed protocols with the LDSS(s)/HRA in the county(s) that the grantee will be serving. The grantee should also provide quality review procedures. The protocols should be submitted to SDOH for approval prior to final contract approval to perform FE activities. Attachment 4 includes the standard written protocol between an FE agency and LDSS/HRA.
- Specific facilitated enrollment site schedule (county/borough, name and address of site, languages spoken, and days and times). Refer to Attachment 13.
- Written assurance to comply with applicable Americans with Disabilities Act (ADA) standards to assure that facilitated enrollment sites, services, programs, and activities are readily accessible to and usable by individuals with disabilities, including but not limited to, people with visual, auditory, cognitive or mobility disabilities. Agencies may not discriminate against an individual with a disability, as defined in Title II of the ADA (42USC §12131 -12134 and the regulations contained in 28 CFR Part 35) and section 504 of the Rehabilitation Act of 1973, in providing services, programs, or activities.

B. Application Format

Applicants should conform to the format described below. Applications should not exceed sixteen (16) double-spaced pages, (not including the cover sheet, program summary, workplan form, budget forms and justification, and attachments) using a 12-pitch type font or larger with one-inch margins on all sides. Pages

should be numbered consecutively, including all attachments. The cover sheet, program summary, workplan, budget and budget justification, and all attachments are **not included** in the sixteen page limitation. Please submit only requested information in attachments and do not add attachments that are not requested.

Failure to follow these guidelines will result in a deduction of up to five (5) points.

The point value assigned to each section, as listed in the chart below, is an indication of the relative weight that will be given when scoring applications.

Criteria	Maximum Score (Points)
The application was received by the date and time posted on the cover sheet of this RFA.	Pass/Fail
1. Grant Application Cover Sheet	Not Scored
2. Program Summary	Not Scored
3. Statement of Need	5
4. Applicant Organization	15
5. Enrollment Strategy and Experience and Relationship with Enrollment Entities	30
6. Proposed Locations and Schedules (Attachment 13)	10
7. Quality Assurance, Training, Outreach and Reporting	15
8. Readiness/Workplan (Attachment 14)	5
9. Facilitated Enrollment Budget (Attachments 15A and 15B)	20
10. Formatting	- 5

C. Review and Award Process

Applications meeting the guidelines set forth above will be reviewed and evaluated competitively by the NYSDOH Division of Coverage and Enrollment, Bureau of Child Health Plus Enrollment. Any cost incurred in response to this RFA is the obligation of the applicant and not the responsibility of the SDOH.

Applications will be reviewed based on the criteria included in this RFA and each section of the application will be reviewed based on the criteria and scoring described in Section VIII. B of this document.

Upstate Award Process

Applicants must receive a satisfactory score of at least 65 points to receive funding. The applicant with the highest scoring proposal in a particular county will receive funding up to the maximum base award specified in the table below. In the event of a tie score, the applicant who scored highest on their Enrollment Strategy and Experience will receive the award.

Applicants proposing to serve more than one county may increase their award for each additional county they propose to serve. The additional amount is included in the chart below in the column titled, “Maximum Add-On Per Additional County.” For example, if the applicant proposes to serve Albany and Schenectady counties and is the highest scoring proposal in each of those counties, the base award for Albany County is \$200,000 plus an additional \$60,000 for Schenectady county, resulting in the total maximum award for the two counties \$260,000. Applicants proposing to serve more than one county should consider their “base award” as the county where their main office is located.

County	Maximum Base Award Per Single County	Maximum Add-On Per Additional County
Allegany, Broome, Cayuga, Cattaraugus, Chautauqua, Chemung, Chenango, Cortland, Delaware Genesee, Herkimer, Jefferson, Lewis, Livingston, Madison, Niagara, Ontario, Oneida, Orleans, Oswego, Otsego, Schoharie, Schuyler, Seneca, Steuben, St. Lawrence, Tioga, Tompkins, Wayne, Wyoming, and Yates	\$150,000	\$60,000
Albany, Clinton, Columbia, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Orange, Putnam, Rensselaer, Rockland, Saratoga, Schenectady, Sullivan, Ulster, Warren, and Washington	\$200,000	\$60,000
Erie, Monroe, Onondaga, and Westchester	\$300,000	\$60,000
Nassau and Suffolk	\$300,000	\$300,000
Bronx, Kings, Queens, New York, and Richmond	\$500,000	\$100,000

SDOH expects to fund only one application per county, with the exception of Long Island, where multiple awards may be made. Due to the geographic proximity of Nassau and Suffolk counties, it is the expectation that an applicant proposing to cover either Nassau or Suffolk county will have the capacity to serve consumers that live in the other county.

SDOH will rank applications by county and award funding to the highest scoring proposal in each county. Applicants should submit one budget for the entire project, regardless of how many counties they propose to serve. Specific budgets for each county are not required. The budget justification should identify any costs that are specific to a particular county. For example, if there are certain sites or facilitated enrollers dedicated to a particular county, that information should be included in the budget justification.

If the SDOH does not receive an application to provide services for a particular county or if an application for a particular county does not receive a satisfactory score of at least 65, SDOH may request that the applicant with the highest score in a contiguous county expand its coverage to this additional area. Additional funding will be provided in accordance with the maximum funding for an additional county as found

in the table on page 40 of this document. If an applicant does not agree to add to its service area, the next highest scoring applicant in a contiguous county will be contacted.

SDOH will not fund activities that are duplicative of efforts funded through other grant programs or resources.

New York City Award Process

In New York City, initially, all applications will be ranked according to score by borough. The applicant with the highest scoring proposal in each of the five boroughs will receive funding up to a maximum of \$500,000 as found in the table on page 40 of this document. Applicants must receive a satisfactory score of at least 65 points to receive funding. In the event that a satisfactory proposal is not received for a particular borough, SDOH may request that the applicant with the highest scoring proposal in a contiguous borough expand its coverage to this additional area. Additional funding will be provided in accordance with the maximum funding amount for an additional borough or \$100,000 as found in the table on page 40 of this document.

If an applicant is the highest scoring proposal in more than one borough, an additional \$100,000 may be awarded for each additional borough the applicant proposes to serve. For example, if the applicant was the highest scoring proposal in Bronx and Kings, the maximum award would be \$600,000, \$500,000 for the “base” borough of Bronx and an additional \$100,000 to serve Kings.

Once one award has been made in each of the five boroughs, all remaining proposals will be ranked according to score, regardless of the borough to be served. Subsequent awards will be made according to score until available funding is exhausted. In the event of a tie score, the applicant who scored the best on their Enrollment Strategy and Experience will receive the award.

D. Funding Methodology

It is anticipated that the total funding available will be up to \$15.3 million per year, contingent upon available funding, and that between 36 and 48 organizations covering all counties/boroughs of the state will be awarded funding. Half of the available funding will be reserved for New York City and half of the funds will be reserved for the rest of the state. To the extent possible, funds will be provided such that FE services are available in each county of the State.

In the event that more money is requested than is available, funding requests will be reduced by the same percentage across all successful applicants. SDOH reserves the right to revise all award amounts as necessary due to changes in the availability of funding.

In the event that New York City or the upstate region has facilitated enrollment services available in all counties/boroughs and there is additional money left in that region, SDOH reserves the right to distribute the remaining funds to the other region or to award more than one grant in an upstate county.

This is a re-solicitation of the existing Facilitated Enrollment Grant administered by SDOH. Organizations that are currently funded by SDOH to provide FE must respond to this RFA if they wish to continue to provide these services.

Funds under this solicitation are intended to supplement, enhance and expand but not supplant existing resources and services aimed at helping consumers apply for, enroll in, or maintain public health insurance coverage.

Once an award has been made, applicants may request a debriefing of their application. Please note the debriefing will be limited only to the strengths and weaknesses of the subject application and will not include any discussion of other applications. Requests must be received no later than ten (10) business days from date of award or non-award announcement.

In the event unsuccessful applicants wish to protest the award resulting from this RFA, applicants should follow the protest procedures established by the Office of the State Comptroller (OSC). These procedures can be found on the OSC website at http://www.osc.state.ny.us/agencies/gbull/g_232.htm.

IX. Attachments

The electronic version of these attachments can be downloaded off the SDOH website at <http://www.health.ny.gov/funding/>

- Attachment 1: Facilitated Enrollment Program Tasks by Responsible Party
- Attachment 2: Access New York Health Care Application
- Attachment 3: Health Insurance Screening Worksheet
- Attachment 4: Standard Facilitated Enrollment Protocols
- Attachment 5: List of Counties Using the Enrollment Broker
- Attachment 6: Certification Regarding State and Federal Confidentiality Requirements for Facilitated Enrollment Agency and Certification Regarding State and Federal Confidentiality Requirements for Facilitated Enrollment Subcontractors

- Attachment 7: Standard Grant Contract Boilerplate
- Attachment 8: Letter of Interest
- Attachment 9: Vendor Responsibility Attestation
- Attachment 10: Grant Application Cover Sheet
- Attachment 11: Application Checklist for Facilitated Enrollment Program
- Attachment 12: Uninsured Population Estimate by County
- Attachment 13: Facilitated Enrollment Locations and Schedules
- Attachment 14: Workplan Form
- Attachment 15A: Facilitated Enrollment Budget Form– FE Agency Only
- Attachment 15B: Facilitated Enrollment Budget Form - Subcontractor Only

**FACILITATED ENROLLMENT PROGRAM
REQUEST FOR APPLICATIONS**

ATTACHMENTS

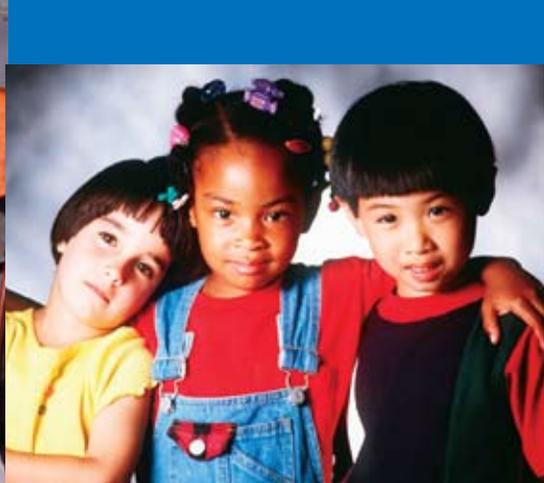
ATTACHMENT 1

FACILITATED ENROLLMENT PROGRAM TASKS BY RESPONSIBLE PARTY

Contractor	Facilitated Enroller	LDSS	Health Plan	SDOH
<ul style="list-style-type: none"> ▪ Application assistance ▪ Check all applications for completeness and accuracy ▪ Forward complete and accurate applications to CHPlus health plan and/or LDSS for eligibility determinations following protocols ▪ Ensure follow-up with incomplete and/or incorrect applications ▪ Verify birth and immigration documentation, as requested ▪ Conduct community outreach and education ▪ Publicize enrollment opportunities ▪ Cooperate with SDOH monitoring efforts ▪ Develop and implement site schedule that includes evening and weekend hours convenient locations and staffed by Facilitated enroller who are culturally and linguistically representative of the target population 	<ul style="list-style-type: none"> ▪ Screen for eligibility for MA, FHP and CHPlus ▪ Assist applicants in completing application ▪ Explain required documentation ▪ Assist applicants in obtaining required documentation ▪ Verify birth and immigration documentation as requested ▪ Explain requirement, if applicable, to select a health plan ▪ Provide applicants with standard health plan information in English and Spanish ▪ Assist in selection of health plan/PCP ▪ Assist in completion of managed care enrollment forms, when necessary ▪ Provide a copy of the application to the applicant ▪ Cooperate with SDOH monitoring efforts ▪ Educate all eligible applicants about managed care 	<p style="text-align: center;">Facilitated Enrollment Process</p> <ul style="list-style-type: none"> ▪ Confirm receipt of facilitator assisted applications with FE agency following agreed upon protocols ▪ Notify FE agency of necessary follow-up following agreed upon protocols ▪ Determine eligibility for all MA/FHP/CHPlus applicants <ul style="list-style-type: none"> – Complete referral forms (TPHI, IV-D) – Categorical/full financial eligibility using MABEL – Make CIN assignment (if applicable) ▪ Enter enrollment data into PCP subsystem ▪ Notify MA/FHP/CHPlus applicants of determinations ▪ Notify FE agency of determinations following agreed upon protocols ▪ Coordinate with FE agency regarding renewals ▪ Process managed care enrollment forms after health plan has been selected and eligibility established 	<ul style="list-style-type: none"> ▪ Determine eligibility for all CHPlus applicants ▪ Notify all CHPlus applicants of eligibility determinations ▪ Notify FHP applicants of plan enrollment ▪ Notify FE agency of determinations ▪ Complete/confirm PCP assignments. ▪ Send welcome letter and member handbook/contract to all new enrollees as appropriate ▪ Issue member cards ▪ Notify LDSS/FE agency of any known changes in enrollee circumstances that would affect coverage 	<ul style="list-style-type: none"> ▪ Design of application for MA, FHP and CHPlus in conjunction with pertinent groups ▪ Arrange for training of Facilitated enroller and counties in facilitated enrollment requirements and policies ▪ Provide ongoing assistance to Facilitated enroller and counties throughout implementation ▪ Monitor work of Facilitated enroller and facilitated enrollment activities of counties ▪ Review and approve facilitator policies and procedures regarding application/enrollment process ▪ Review and approve protocols between FE agency and LDSSs, and FE agency internal operating protocols ▪ Review and approve FE agency internal operating protocols ▪ Review and approve program expenditures

Continued List from Previous Page

Contractor	Facilitated Enroller	LDSS	Health Plan	SDOH
<ul style="list-style-type: none"> ▪ Accountability for expenditures ▪ Comply with SDOH data submission and tracking requirements 	<ul style="list-style-type: none"> ▪ Submit completed application, required documentation and plan enrollment form to FE agency for quality check ▪ Follow-up on each application, as appropriate ▪ Assist in renewal, as appropriate ▪ Provide applicants with information regarding rights and complaints, as appropriate 	<p>Standard LDSS Role</p> <ul style="list-style-type: none"> ▪ Screen for eligibility for MA, FHP and CHPlus ▪ Assist in completing single application ▪ Explain required documentation ▪ Assist in obtaining required documentation ▪ Verify birth and immigration documentation, as requested ▪ Explain requirement (if applicable) to select a health plan ▪ Provide standard health plan information ▪ Assist in selection of health plan ▪ Assist in completion of county managed care enrollment forms, when necessary ▪ Provide a copy of the application to applicant ▪ Make eligibility determinations ▪ Complete referral forms (TPHI, IV-D) ▪ Categorical/full financial eligibility using MABEL; Make CIN assignment, if applicable ▪ Enter enrollment data into PCP subsystem ▪ Provide notice of eligibility to applicant ▪ Maintain enrollment data ▪ Cooperate with SDOH monitoring efforts 		



Health
Insurance
APPLICATION

access
NY

for Children,
Adults and
Families

health care



INSTRUCTIONS

CONFIDENTIALITY STATEMENT All of the information you provide on this application will remain confidential. The only people who will see this information are the Facilitated Enrollers and the State or local agencies and health plans who need to know this information in order to determine if you (the applicant) and your household members are eligible. The person helping you with this application cannot discuss the information with anyone, except a supervisor or the State or local agencies or health plans which need this information.

PURPOSE OF THIS APPLICATION Complete this application if you want health insurance to cover medical expenses. This application can be used to apply for Medicaid, Family Health Plus, Child Health Plus, the Family Planning Benefit Program, or for assistance paying your health insurance premiums. You can apply for yourself and/or immediate family members living with you.

IF YOU NEED HELP COMPLETING THIS APPLICATION DUE TO A DISABILITY, CALL YOUR LOCAL DEPARTMENT OF SOCIAL SERVICES. THEY WILL MAKE EVERY EFFORT TO PROVIDE REASONABLE ACCOMMODATIONS TO ADDRESS YOUR NEEDS.

PLEASE READ the entire application booklet before you begin to fill out the application. If you are applying ONLY for children or if you are a pregnant woman applying alone, you must complete only **Sections A through G and Sections I and J**. Other applicants must complete all sections.

If you are 65 years old or older, certified blind, certified disabled, or institutionalized and applying for coverage of nursing home care, you must **also complete Supplement A**. The supplement includes questions about your resources, such as money in the bank or property you own.

Whenever you see the words **SEND PROOF** on the application refer to the “Documentation Needed When You Apply for Health Insurance” section for a listing of acceptable supporting documents.

HOW TO GET HELP When applying for public health insurance, you **DO NOT** need to visit your local department of social services or a Facilitated Enroller for an interview, but you **MAY** come in or contact a Facilitated Enroller for help filling out this application. **You can get a list of Facilitated Enrollers where you got this application, or by calling 1-800-698-4543. ALL HELP IS FREE.**

[\(1-877-898-5849 TTY line for the hearing impaired\)](#)

SECTION A Applicant's Information

We need to be able to contact the people applying for health insurance. The home address is where the people applying for health insurance live. The mailing address, if different, is where you want us to send health insurance cards and notices about your case. You can also tell us if you want someone else to get information about your case and/or to be able to discuss your case.

SECTION B Household Information

Please include information for everyone who lives with you even if they are not applying for health insurance. It is important that you list everyone who lives with you so that we can make a correct eligibility decision. Include maiden name (legal name before marriage), if this applies to the person. Also include City, State and Country of birth. If a person was born outside of the United States, just write the country of birth. We also need, for each person applying, his/her mother's full maiden name (first and last name). This information may be used to obtain proof of the applicant's birth date under certain circumstances.

- **Is this person pregnant?** If so, when is her baby due to be born? This information helps us determine the size of your family. A pregnant woman counts as two people.
- **Relationship to the person on Line 1.** Explain how each person is related to the person listed on Line 1 (for example, spouse, child, step-child, brother, sister, niece, nephew, etc.)

- **Public Health Coverage.** If you or anyone who lives with you is already enrolled or was previously enrolled in Medicaid, Family Health Plus, Child Health Plus, the Family Planning Benefit Program, or any other form of public assistance such as Food Stamps, we need to know. Also, tell us the identification number on the New York State Benefit Identification Card or plan identification card for Child Health Plus.

- **Social Security Number.** A Social Security Number should be provided for all persons applying, if the person has one. If the person does not have a Social Security Number, leave this box blank.

- **Citizenship and Immigration Status.** This information is needed only for those people applying for health insurance. Pregnant women do not have to complete this question. To be eligible for health insurance, other persons age 19 and over must be U.S. citizens or be in an eligible immigration category. We need to see either original documentation of U.S. citizenship and identity, or certified copies of these documents. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring these documents. Please note that if you are on Medicare, or receiving Social Security Disability but are not yet eligible for Medicare, it is not necessary to document citizenship or identity.

Effective July 1, 2010, citizen children who provide their Social Security Number are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

Children who are New York State residents and do not have other health insurance are eligible, regardless of their immigration status.

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

Your enrollment cannot be completed until all NECESSARY items are received. *If you need help getting any of these items, let us know.*

YOU DO NOT NEED TO SHOW US ALL OF THESE DOCUMENTS. We only need documents that apply to you or others who are applying. We will need to see original or certified copies of documents for identity and U.S. citizenship. Please contact your local department of social services or call 1-800-698-4543 to find out where you can bring identity and U.S. citizenship documents. Many local departments of social services and Child Health Plus health plans do not accept original documents by mail, so please check with them if you wish to mail these documents. Copies of other documents can be mailed with your application.

You need to provide proof of Identity, U.S. Citizenship and/or Immigration Status and Date of Birth.

Effective 7/1/10, citizen children who provide a social security number are not required to provide identity or citizenship documentation if eligible for Child Health Plus.

You can provide ONE of the following documents to prove both U.S. Citizenship, Identity and your Date of Birth:

- U.S. passport book/card **OR**
- Certificate of Naturalization (DHS Forms N-550 or N-570) **OR**
- Certificate of U.S. Citizenship (DHS Forms N-560 or N-561) **OR**
- NYS Enhanced Driver's License (EDL).

When one of the above documents is not available, ONE document from EACH of the lists below may be used to prove your citizenship and/or identity.

This list is not all-inclusive. If you do not have one of these documents, please refer to the "How to Get Help" section of the instructions.

Documents with * next to it also show date of birth

U.S. Citizenship

- U.S. Birth Certificate*
- Certification of Birth issued by Department of State (Forms FS-545 or DS-1350)*
- Report of Birth Abroad (FS-240)
- U.S. National ID card (Form I-197 or I-179)
- Native American Tribal Document*
- Religious/School Records*
- Military record of service showing U.S. place of birth
- Final adoption decree
- Evidence of qualifying for U.S. citizenship under the Child Citizenship Act of 2000

Identity

- State Driver's license or ID card with photo*
- ID card issued by a federal, state, or local government agency
- U.S. Military card or draft record or U.S. Coast Guard Merchant Mariner Card
- School ID card with a photo (may also show date of birth)
- Certificate of Degree of Indian blood or other Native American/Alaska Native tribal document with photo
- Verified School, Nursery or Daycare records (for children under 16) (may also show date of birth)
- Clinic, Doctor or Hospital records (for children under 16)*

If you do not use one of the documents that show date of birth, you must also submit one of the following:

- Marriage certificate
- NYS Benefit Identification Card

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

If you are not a U.S. Citizen

The list below contains some of the most common United States Citizenship and Immigration Services (USCIS) forms used to show your immigration status. This list is not all-inclusive. If you do not have one of these documents, please refer to the “How to Get Help” section of the instructions.

We need to see **ONE** of the following documents to prove both Immigration Status, Identity and your Date of Birth:

Documents with * next to it also show date of birth

Immigration Status/Identity

- I-551 Permanent Resident Card (“Green Card”)*
- I-688B or I-766 Employment Authorization Card*

Immigration Status, but require an additional Identity document

- I-94 Arrival/Departure Record*
- USCIS Form I-797 Notice of Action
- Evidence of Continuous U.S. Residence prior to January 1, 1972

Home Address: This address must match the home address that you write in Section A of the application. The proof must be dated within 6 months of when you signed the application.

- Lease/ letter/ rent receipt with your home address from landlord
- Utility Bill (gas, electric, phone, cable, fuel or water)
- Property tax records or mortgage statement
- Driver’s license (if issued in the past 6 months)
- Government ID card with address
- Postmarked envelope or post card (cannot use if sent to a P.O. Box)

PROOF OF CURRENT INCOME, OR INCOME YOU MIGHT GET IN THE FUTURE LIKE UNEMPLOYMENT BENEFITS OR A LAWSUIT: You must provide a letter, written statement, or copy of check or stubs, from the employer, person or agency providing the income. YOU DO NOT NEED TO SHOW US ALL OF THESE DOCUMENTS, only the ones that apply to you and the people living with you. One proof for each type of income you have is required. Provide the most recent proof of income before taxes and any other deductions. The proof must be dated, include the employee’s name and show gross income for the pay period. The proof must be for the last four weeks, whether you get paid weekly, bi-weekly, or monthly. It is important that these be current.

Wages and Salary

- Paycheck stubs
- Letter from employer on company letterhead, signed and dated
- Current signed and dated income tax return and all Schedules
- Business/payroll records

Self-Employment

- Current signed and dated income tax return and all Schedules
- Records of earnings and expenses/business records

Unemployment Benefits

- Award letter/certificate
- Monthly benefit statement from NYS Department of Labor
- Printout of recipient’s account information from the NYS Department of Labor’s website (www.labor.state.ny.us)
- Copy of Direct Payment Card with printout
- Correspondence from the NYS Department of Labor

Private Pensions/Annuities

- Statement from pension/annuity

Social Security

- Award letter/certificate
- Annual benefit statement
- Correspondence from Social Security Administration

Workers’ Compensation

- Award letter
- Check stub

Child Support/Alimony

- Letter from person providing support
- Letter from court
- Child support/alimony check stub
- Copy of NY Epicard with printout
- Copy of child support account information from www.newyorkchildsupport.com
- Copy of bank statement showing direct deposit

Veterans’ Benefits

- Award letter
- Benefit check stub
- Correspondence from Veterans Affairs

Military Pay

- Award letter
- Check stub

Income from Rent or Room/Board

- Letter from roomer, boarder, tenant
- Check stub

Interest/Dividends/Royalties

- Recent statement from bank, credit union or financial institution
- Letter from broker
- Letter from agent
- 1099 or tax return (if no other documentation is available)

Support from Other Family Members

- Signed statement or letter from family member

DOCUMENTS NEEDED WHEN YOU APPLY FOR HEALTH INSURANCE

If you pay to have care for your children or parents while you work, provide one of the following:

- Written statement from day care center or other child/adult care provider
- Canceled checks or receipts that show your payments

Proof of health insurance, provide all that apply:

- Proof of current insurance (Insurance policy, Certificate of Insurance or Insurance Card)
- Health Insurance Termination Letter
- Medicare Card (Red, White and Blue Card)

Pregnant women only: proof of pregnancy, provide one of the following:

- Presumptive Eligibility Screening Worksheet for pregnant women completed by a qualified provider that tells us the expected date of delivery
- Statement from medical professional (such as a doctor or nurse practitioner) with the expected date of delivery
- WIC Medical Referral Form that tells us the expected date of delivery

If you have medical bills in the last three months, provide all the following:

For determination of eligibility for medical expenses from the past three months:

- Proof of income for the month(s) in which the expense was incurred
- Proof of residency/home address for the month(s) in which the expense was incurred
- Medical bills for last three months, whether or not you paid them

ACCESS NY HEALTH CARE Medicaid / Family Health Plus / Child Health Plus

PLEASE READ the entire application and INSTRUCTIONS before you fill it out. Print clearly in blue or black ink. An incomplete application cannot be processed and will result in a delay of a decision on your application.

Section A Applicant's Information Please tell us who you are and how to contact you.

Legal First Name		Middle Initial	Legal Last Name	
Primary Phone # <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other		Another Phone # <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other		What Language Do You Speak? _____ Read? _____
HOME ADDRESS of the persons applying for health insurance <input type="checkbox"/> Check here if homeless		Street		Apt.#
		City	State	Zip Code County
MAILING ADDRESS of the persons applying for health insurance if different from above.		Street		Apt.#
		City	State	Zip Code
OPTIONAL: If there is another person you would like to receive your Medicaid notices, please provide this person's contact information. I want this contact person to:		Name		State
		Street		Zip Code
		City	Apt.#	Phone # <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Other
<input type="checkbox"/> Apply for and/or renew Medicaid for me <input type="checkbox"/> Discuss my Medicaid application or case, if needed <input type="checkbox"/> Get notices and correspondence	<input type="checkbox"/> Check all that apply			

Section B Household Information If you live in the household, start with yourself. If you do not, start with any adults who live in the household. List the full legal names of the persons applying for or already receiving Medicaid, Family Health Plus or Child Health Plus and list the ID Number from their Benefit Card or health plan ID card. You must provide information for household members including: parents, step-parents, and spouses. You may provide information for other household members (for example, a dependent child under the age of 21). Listing other household members may allow us to give you a higher eligibility level. Pregnant women and children under 19 may be eligible for health insurance regardless of immigration status.

	Legal First, Middle, Last Name	Date of Birth SEND PROOF	Is this person applying for health insurance?	Is this person pregnant? SEND PROOF	Is this person the parent of an applying child?	What is the relationship to the person in Box 1?	If this person has or had public health coverage in the past, check the box that applies.	Social Security Number (if you have one)	Please mark one box that indicates your current Citizenship or Immigration Status. Not needed for pregnant women SEND PROOF	*Race/Ethnic Group
01	_____ Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No What is the Due Date? / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	SELF	<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	
02	_____ Full Maiden Name (person's birth name before they were married) City of Birth State of Birth Country of Birth This Person's Mother's Full Maiden Name	/ / <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No What is the Due Date? / /	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status ____/____/____ Month Day Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	

Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible for Child Health Plus.
SEND PROOF Refer to the "Documents Needed When You Apply for Health Insurance" in the instructions on pages 1-3, "Documentation Checklist for Health Insurance", for a list of documents that prove Identity, Citizenship or Immigration Status.

Section B Household Information (Continued from previous page)

	Legal First, Middle, Last Name	Date of Birth SEND PROOF	Is this person applying for health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this person pregnant? SEND PROOF	Is this person the parent of an applying child? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the relationship to the person in Box 1?	If this person has or had public health coverage in the past, check the box that applies.	Social Security Number (if you have one)	Please mark one box that indicates your current Citizenship or Immigration Status. Not needed for pregnant women SEND PROOF	*Race/Ethnic Group
03	_____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status _____/_____/_____ Month Day Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	
	Full Maiden Name (person's birth name before they were married)	<input type="checkbox"/> Male <input type="checkbox"/> Female								
	City of Birth State of Birth Country of Birth	/ /								
	This Person's Mother's Full Maiden Name									
04	_____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status _____/_____/_____ Month Day Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	
	Full Maiden Name (person's birth name before they were married)	<input type="checkbox"/> Male <input type="checkbox"/> Female								
	City of Birth State of Birth Country of Birth	/ /								
	This Person's Mother's Full Maiden Name									
05	_____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status _____/_____/_____ Month Day Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	
	Full Maiden Name (person's birth name before they were married)	<input type="checkbox"/> Male <input type="checkbox"/> Female								
	City of Birth State of Birth Country of Birth	/ /								
	This Person's Mother's Full Maiden Name									
06	_____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status _____/_____/_____ Month Day Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	
	Full Maiden Name (person's birth name before they were married)	<input type="checkbox"/> Male <input type="checkbox"/> Female								
	City of Birth State of Birth Country of Birth	/ /								
	This Person's Mother's Full Maiden Name									
07	_____	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Child Health Plus <input type="checkbox"/> Medicaid <input type="checkbox"/> Family Health Plus ID Number from Benefit Card/Plan Card, if known:		<input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Immigrant/non-citizen Enter the date you received your immigration status _____/_____/_____ Month Day Year <input type="checkbox"/> Non-immigrant (Visa holder) <input type="checkbox"/> None of the above	
	Full Maiden Name (person's birth name before they were married)	<input type="checkbox"/> Male <input type="checkbox"/> Female								
	City of Birth State of Birth Country of Birth	/ /								
	This Person's Mother's Full Maiden Name									

Is anyone in your household a veteran? Yes No If yes, name: _____

Effective 7/1/10, citizen children who provide a SSN are not required to provide identity or citizenship documentation if eligible for Child Health Plus.
SEND PROOF Refer to the "Documents Needed When You Apply for Health Insurance" in the instructions on pages 1-3, "Documentation Checklist for Health Insurance", for a list of documents that prove Identity, Citizenship or Immigration Status.
 *Race/Ethnic Group Codes (optional): **A**-Asian, **B**-Black or African-American, **I**- Native American or Alaskan Native, **P**- Native Hawaiian or other Pacific Islander, **W**-White, **U**-Unknown. Please also tell us if you are Hispanic or Latino-**H**
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Section C Household Income

Write the types of money and the amount received by everyone listed in Section B and **SEND PROOF**

Earnings from Work: Includes wages, salaries, commissions, tips, overtime, self-employment. If you are self-employed check here: Check here if no earnings from work:

Name of Person	Type of Income/Employer Name	How Much? (before taxes)	How Often? (weekly, monthly)

Unearned Income: Includes Social Security Benefits, disability payments, unemployment payments, interest and dividends, veterans' benefits, Workers' Compensation, child support payments/alimony, rental income, pension, annuities and trust income. Check here if no unearned income:

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

Contributions: Money from relatives or friends, roomers or boarders (include money that anyone gives you each month to help meet living expenses). Check here if no contributions:

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

Other: Temporary (cash) Assistance, Supplemental Security Income (SSI) payments, student grants, or loans. Check here if none:

Name of Person	Type of Income/Source	How Much? (before taxes)	How Often? (weekly, monthly)

1. Do you or any applying adult in Section B have no income? No Yes Who? _____

2. If there is no income listed above, please explain how you are living:
(For example: living with friend or relative)

3. Have you or anyone who is applying changed jobs or stopped working in the last 3 months? No Yes

If yes: Your last job was: Date ____/____/____ Name of Employer: _____

4. Are you or anyone who is applying a student in a vocational, undergraduate, or graduate program? No Yes

If yes: Full Time Part Time Undergraduate Graduate Student's Name: _____

5. Do you have to pay for childcare (or for care of a disabled adult) in order to work or go to school? No Yes

Child's/adult's name:	How much? \$	How Often? (weekly, every two weeks, monthly)
Child's/adult's name:	How much? \$	How Often? (weekly, every two weeks, monthly)
Child's/adult's name:	How much? \$	How Often? (weekly, every two weeks, monthly)

6. If you are not eligible for Medicaid or Family Health Plus coverage, you may still be eligible for the Family Planning Benefit Program. Are you interested in receiving coverage for Family Planning Services only? No Yes

Section D Health Insurance

You and your family may still be eligible even if you have other health insurance.

1. Does anyone who is applying have Medicare? No Yes **If yes, include a copy of your card (red, white and blue card), for each Medicare beneficiary. SEND PROOF**
Complete the rest of this application and complete Supplement A.

2. Does anyone who is applying already have other commercial health insurance, including long term care insurance? No Yes **If yes, you must send a copy of the front and back of the insurance card with this application. SEND PROOF**

Name of Insured (primary) _____ Persons Covered _____ Cost of Policy _____ End date of coverage, if ending soon _____/_____/_____
Month Day Year

Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do NOT need to complete Supplement A.

3. Is the parent/step-parent of any child applying a public employee who can get family coverage through a state health benefits plan? (see instructions) No Yes
If yes, does the public agency where that person works pay all or part of the cost of the health plan? No Yes

4. In the past 6 months, has anyone lost or cancelled any type of health insurance that was provided through an employer? No Yes (If no, skip to question 5) If yes, what date did you lose coverage? _____/_____/_____
Month Day Year

Your answer to this question will help us understand why people change their health insurance.

Why do the person(s) no longer have the health insurance? (Check only one)

- | | |
|--|---|
| <input type="checkbox"/> 1. The person who had the insurance no longer works for the employer that provided the insurance. | <input type="checkbox"/> 4. The cost of health insurance went up and it was no longer affordable. |
| <input type="checkbox"/> 2. The employer stopped offering health insurance. | <input type="checkbox"/> 5. Child Health Plus or Family Health Plus costs less than the insurance the person(s) used to have. |
| <input type="checkbox"/> 3. The employer stopped offering health insurance for the child(ren) or stopped paying for health insurance for the child(ren) but continued to cover the working parent. | <input type="checkbox"/> 6. Child Health Plus or Family Health Plus offers better benefits than the insurance the person(s) used to have. |

5. Does your current job offer health insurance? **We may be able to help pay for it.** No Yes If yes, a "Request for Information Employer Sponsored Health Insurance" form will be sent to you.

Section E Housing Expenses

1. Monthly housing payment such as rent or mortgage, including property taxes (just your share). \$ _____
2. If you pay for water separately how much do you pay? \$ _____ **SEND PROOF** How often do you pay? every month 2 times a year quarterly (4 times a year) once a year
3. Do you receive free housing as part of your pay? No Yes

Section F Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for the applicants.

If no one applying is Blind, Disabled, Chronically Ill or in a Nursing Home **STOP** please go to Section G.

1. Are you, or anyone who lives with you, and is applying, in a residential treatment facility or receiving nursing home care in a hospital, nursing home or other medical institution? No Yes
If yes, finish completing this application **AND** complete Supplement A.

2. Are you or anyone who lives with you blind, disabled or chronically ill? No Yes If yes, finish completing this application **AND** complete Supplement A.

Note: If you are applying for the Medicare Savings Program only (MSP), go to Section G. You do not need to complete Supplement A.

Section G Additional Health Questions

1. Does anyone applying have paid or unpaid medical or prescription bills for this month or the three months before this month? Medicaid may be able to pay these bills or reimburse you.

No Yes If yes: Name: _____ In which month(s) of the previous three months do you have medical bills? _____

SEND PROOF of income for any month in the three-month period for which you have bills. If you have paid medical bills for which you are seeking reimbursement, you must send copies and proof of payment.

2. Do you, or anyone applying, have any unpaid medical or prescription bills older than the previous three months? No Yes

3. Have you, or anyone who lives with you and is applying, moved into this county from another state or New York State county within the past three months? No Yes

If yes, who? _____ Which state? _____ Which county? _____

4. Does anyone who is applying have a pending lawsuit due to an injury? No Yes If yes, who: _____

5. Does anyone applying have a Workers' Compensation case or an injury, illness, or disability that was caused by someone else (that could be covered by insurance)? No Yes

If yes, who? _____

Section H

Parent or Spouse Not Living in the Household or Deceased Families who are applying for their children and pregnant women are **NOT** required to fill out this section. All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside the home to be eligible for health insurance, unless there is good cause. Children may still be eligible even if a parent is not willing to provide this information. If you fear physical or emotional harm as a result of providing information about a parent or spouse not living in the home, you may be excused from providing this information. This is called **Good Cause**. You may be asked to show that you have a good reason for your fears.

1. Is the spouse or parent of anyone applying deceased? No Yes

If yes, name of applicant with deceased parent or spouse : _____ (If spouse or parent is deceased go to question 3.)

2. Does a parent of any applying child live outside the home? (If no, skip to question 3) No Yes

If you fear physical or emotional harm if you provide information about a parent who does not live in the home, check this box

Child's Name: _____	Name of parent living outside the home _____ Date of Birth (if known): ____/____/____	Current or last known address: Street: _____ City/State: _____ SSN (if known): _____
Child's Name: _____	Name of parent living outside the home _____ Date of Birth (if known): ____/____/____	Current or last known address: Street: _____ City/State: _____ SSN (if known): _____

3. Is anyone applying still married to someone who lives outside the home? No Yes If yes, name of person applying who is still married: _____

If you fear physical or emotional harm if you provide information about a spouse who does not live in the home, check this box

Legal name of spouse living outside of the home: _____	Date of Birth (if known): _____	Current or last known address: Street: _____ City/State: _____ SSN (if known): _____
--	---	---

Section I Health Plan Selection

If you are in receipt of Medicare, **STOP** skip this section.

IMPORTANT: People with Family Health Plus and Child Health Plus **must** choose a health plan to get their health services. Most people with Medicaid **must** choose a health plan; if you don't choose a health plan you may be automatically enrolled in one unless it is determined you are exempt. **For Medicaid and Family Health Plus:** If you need information about what plans are available in your county, what plans your doctor is in and if you have to join, please call **New York Medicaid CHOICE** at 1-800-505-5678. You can also call or visit your local Department of Social Services. For information about Child Health Plus plans, call 1-800-698-4543. If you already know what plan you want, use this section for your plan choice.

NOTE: If you or family members are found eligible for Medicaid, you will be enrolled in the health plan you choose if it provides Medicaid. If you live in a county that does not require people on Medicaid to join a health plan, you can tell us you do not want to be in a health plan by calling or writing to your local Department of Social Services or by checking this box

Legal Last Name	Legal First Name	Date of Birth	Social Security #	Name of Health Plan You are Enrolling in	Preferred Doctor or Health Center (optional) Check Box if Your Current Provider	OB/GYN (optional)
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	
					<input type="checkbox"/>	

Section J Signature

I agree to have the information on this application and on the annual renewal shared only among Medicaid, Family Health Plus, Child Health Plus, the health plans indicated in Section I, the local social services district, and the facilitated enrollment organization providing the application assistance. I also consent to sharing this information with any school-based health center that provides services to the applicant(s). I understand this information is being shared for the purpose of determining the eligibility of those individuals applying for Medicaid, Family Health Plus, Child Health Plus, or to evaluate the success of these programs. Each applying adult must sign this application in the space below. By signing this application, I understand that each person applying for Medicaid, Family Health Plus, Child Health Plus, will be enrolled in the appropriate program, if eligible. **I have also read and understand the Terms, Rights and Responsibilities included in this application booklet on the next page.** I certify under penalty of perjury that everything on this application is the truth as best I know.

Date

Signature of adult applicant or authorized representative for the applicant

Date

Signature of adult applicant or authorized representative for the applicant

TERMS, RIGHTS AND RESPONSIBILITIES

By completing and signing this application, I am applying for Medicaid, Family Health Plus, and Child Health Plus. I understand that this application, notices and other supporting information will be sent to the program(s) for which I want to apply. I agree to the release of personal and financial information from this application and any other information needed to determine eligibility for these programs. I understand that I may be asked for more information. I agree to immediately report any changes to the information on this application.

- I understand that I must provide the information needed to prove my eligibility for each program. If I have been unable to get the information for Medicaid or Family Health Plus, I will tell the social services district. The social services district may be able to help in getting the information.
- If I am applying at a place other than a local department of social services, and my children are not found eligible for Medicaid using this application, I can contact the local department of social services to see if my children are eligible for Medicaid on some other basis.
- I understand that workers from the programs for which family members or I have applied may check the information given by me for this application. The agencies that run these programs will keep this information confidential according to 42 U.S.C. 1396a (a) (7) and 42 CFR 431.300-431.307, and any federal and state laws and regulations.
- By applying for Child Health Plus, I agree to pay the applicable premium contribution not paid by New York State.
- I understand that Medicaid, Family Health Plus, and Child Health Plus will not pay medical expenses that insurance or another person is supposed to pay, and that if I am applying for Medicaid or Family Health Plus,

I am giving to the agency all of my rights to pursue and receive medical support from a spouse or parents of persons under 21 years old and my right to pursue and receive third party payments for the entire time I am in receipt of benefits.

- I will file any claims for health or accident insurance benefits or any other resources to which I am entitled. I understand that I have the right to claim good cause not to cooperate in using health insurance if its use could cause harm to my health or safety or to the health and safety of someone I am legally responsible for.
- I understand that my eligibility for these programs will not be affected by my race, color, or national origin. I also understand that depending on the requirements of these individual programs, my age, sex, disability or citizenship status may be a factor in whether or not I am eligible.
- I understand that if my child is on Medicaid or Family Health Plus, he or she can get comprehensive primary and preventive care, including all necessary treatment through the Child/Teen Health Program. I can get more information on this program from the local department of social services.
- I understand that anyone who knowingly lies or hides the truth in order to receive services under these programs is committing a crime and subject to federal and state penalties and may have to repay the amount of benefits received and pay civil penalties. The New York State Department of Tax and Finance has the right to review income information on this form.

SOCIAL SECURITY NUMBER

Child Health Plus: SSNs are not required to enroll in Child Health Plus. If available, I will include it for children applying for Child Health Plus.

Medicaid, or Family Health Plus: SSNs are required for all applicants, unless the person is pregnant or a non-qualified alien. SSNs are not required for members of my household who are not applying for benefits. I understand that this is required by Federal Law at 42 U.S.C. 1320b-7 (a) and by Medicaid regulations at 42 CFR 435.910. SSNs are used in many ways, both within department of social services (DSS) and between the DSS and federal, state, and local agencies, both in New York and other jurisdictions. Some uses of SSNs are: to check identity, to identify and verify earned and unearned income, to see if non-custodial parents can get health insurance coverage for applicants, to see if applicants can get medical support, and to see if applicants can get money or other help. SSNs may also be used for identification of the recipient within and between central governmental Medicaid agencies to insure proper services are made available to the recipient. Also, if I apply for other programs in this joint application, those programs will have access to my SSN and could use it in the administration of the program.

FOR MEDICAID APPLICANTS ONLY

- **Release of Educational Records**
I give permission to the local department of social services and New York State to obtain any information regarding the educational records of my child(ren), herein named, necessary for claiming Medicaid reimbursements for health-related educational services, and to provide the appropriate federal government agency access to this information for the sole purpose of audit.
- **Early Intervention Program**
If my child is evaluated for or participates in the New York State Early Intervention Program, I give permission to the local department of social services and New York State to share my child's Medicaid eligibility information with my county Early Intervention Program for the purpose of billing Medicaid.

- **Reimbursement of Medical Expenses**

I understand that I have a right as part of my Medicaid application, or later, to request reimbursement of expenses I paid for covered medical care, services and supplies received during the three month period prior to the month of my application. After the date of my application, reimbursement of covered medical care, services and supplies will only be available if obtained from Medicaid enrolled providers.

FAMILY HEALTH PLUS AND MEDICAID MANAGED CARE

I understand that in order to receive Family Health Plus benefits, I must join a managed care health plan. I also know that in some counties, joining a health plan may be required to receive Medicaid. I have read how to find out whether my county requires Medicaid enrollees to join a health plan, and how to find out what health plans are available to me in Family Health Plus and in Medicaid managed care. I understand that if I am found eligible for Family Health Plus, I will be enrolled in the Family Health Plus plan I have chosen. I/we also understand that if I/we are found eligible for Medicaid instead of Family Health Plus and I/we are in a county that requires Medicaid enrollees to be in a managed care health plan, I/we will be enrolled in the health plan I/we chose unless that health plan does not participate in Medicaid managed care. If I/we are in a county that does not require enrollees to be in a Medicaid managed care health plan, I/we will still be enrolled in the health plan I/we chose unless I/we notify my local social services department in writing, or I/we check the box in Section I, that I/we do not want to be in that plan.

I have read how to find out the rights and benefits that I will have as a member of a managed care health plan and the benefit limitations of managed care membership. I understand that in both Family Health Plus and Medicaid managed care, I must choose a Primary Care Provider (PCP) and that I will have a choice from at least three PCPs in my health plan. I understand that once I enroll in a health plan, I will have to use my PCP and other providers in my health plan except in a few special circumstances. I understand that if a child is born to me while I am a member of a Medicaid managed care health plan, my child will be enrolled in the same health plan that I am in. I understand that if a child is born to me while I am a member of a Family Health Plus plan that also participates in Medicaid managed care, my child will be enrolled in the same health plan that I am in.

- **Release of Medical Information**

I consent to the release of any medical information about me and any members of my family for whom I can give consent:

- By my PCP, any other health care provider or the New York State Department of Health (NYSDOH) to my health plan and any health care providers involved in caring for me or my family, as reasonably necessary for my health plan or my providers to carry out treatment, payment, or health care operations. This may include pharmacy and other medical claims information needed to help manage my care;
- By my health plan and any health care providers to NYSDOH and other authorized federal, state, and local agencies for purposes of administration of the Medicaid, Child Health Plus, and Family Health Plus programs; and

- By my health plan to other persons or organizations, as reasonably necessary for my health plan to carry out treatment, payment, or health care operations.

I also agree that the information released for treatment, payment and health care operations may include HIV, mental health or alcohol and substance abuse information about me and members of my family to the extent permitted by law, until I revoke this consent.

If more than one adult in the family is joining a Family Health Plus or Medicaid health plan, the signature of each adult applying is necessary for consent to release information.

- **Reimbursement of Medical Expenses**

I understand that if I am determined eligible for Family Health Plus my enrollment will be effective no later than 90 days from the date of submission of a completed application. In the event of an error or delay in my enrollment, Medicaid may be able to reimburse me for reasonable medical expenses I pay as a result of the error or delay. Medicaid may pay my provider for any unpaid expenses only if that provider is a Medicaid enrolled provider.

FOR OFFICE USE ONLY

To be completed by the person assisting with the application

Signature of Person Who Obtained Eligibility Information: X _____	Employed By: (check one) <input type="checkbox"/> Community-Based Facilitated Enrollment Agency <input type="checkbox"/> Health Plan <input type="checkbox"/> Social Services District <input type="checkbox"/> Provider Agency <input type="checkbox"/> Qualified Entities Employer Name: _____
--	--

To be completed by Facilitated Enrollers

Facilitated Enroller:		Lead Agency/Plan Name:		Lead Org/Plan ID:
Language Used for Application Assistance:	Application Start Date:	Application Sequence Number:	Application Completion Date:	Enter Code of Applying Child: Medicaid _____ CHPlus _____

To be used by the local Social Services District

Eligibility Determined By:	Date:	Eligibility Approved By:	Date:
Center Office:	Application Date:	Unit ID:	Worker ID:
Case Name:	District:	Case Type:	Case #:
Effective Date:	MA Disposition Reason Code: <input type="checkbox"/> Denial Code <input type="checkbox"/> Withdrawal	Proxy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Registry #: Ver:

To be used by Child Health Plus Plans

CHPlus Disposition: <input type="checkbox"/> Approved <input type="checkbox"/> Denied	Denial Code:	Effective Date:	# Children Enrolled (CHPlus):
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PUBLIC CHARGE INFORMATION

The United States Citizenship and Immigration Services (USCIS) has stated that enrollment in Medicaid, Family Health Plus, Child Health Plus or the Family Planning Benefit Program CANNOT affect a person's ability to get a green card, become a citizen, sponsor a family member, or travel in and out of the country. This is not true if Medicaid pays for long-term care in a place such as a nursing home or psychiatric hospital.

The State will not report any information on this application to the USCIS.

- **Race/Ethnic Group.** This information is optional and it will help us make sure that all people have access to the programs. If you fill out this information, use the code shown on the application that best describes each person's race or ethnic background. You may pick more than one.

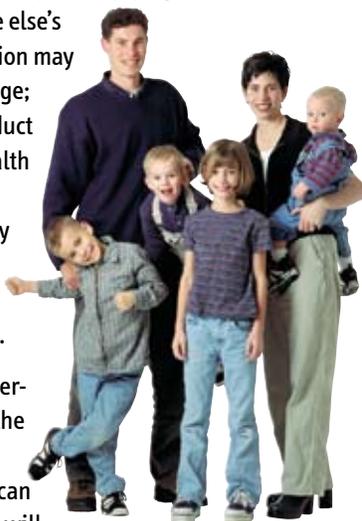
SECTION C Household Income (Money Received)

- In this section, list all types of income (money received) and the amounts received by the people you listed in Section B.
- Please tell us how much you make before taxes are taken out.
- If there is no money coming into your home, explain how you are paying for your living expenses, such as food and housing.
- We need to know if you have changed jobs or if you are a student.
- We also need to know if you pay another person or place, such as a day care center, to take care of your children or disabled spouse or parent while you are working or going to school. If you do, we need to know how much you pay. We may be able to deduct some of the amount that you pay for these costs from the amount we count as your income.

SECTION D Health Insurance

It is important to tell us whether anyone applying is covered or could be covered by someone else's health insurance. This information may affect their eligibility for coverage; for some applicants, we can deduct the amount that you pay for health insurance from the amount we count as your income; or we may be able to pay the cost of your health insurance premium if we determine it is cost effective.

Some children who had employer-based health insurance within the past six months may be subject to a waiting period before they can enroll in Child Health Plus. This will



depend on your household income and the reason your children lost employer-based coverage.

NOTE: State Health Benefits Plans provide health insurance coverage through the New York State Health Insurance Program (NYSHIP). Coverage is offered to employees/retirees of NYS government, the State Legislature and the Unified Court System. Some local government agencies and school districts also elect to participate in NYSHIP. If you are not sure, check with your employer. If your child has access to State Health Insurance Benefits through NYSHIP, he/she will be ineligible for Child Health Plus coverage.

We may be able to help pay for health insurance premiums if you have or can get insurance through your job. We will need to gather more information about the insurance and will mail an insurance questionnaire to you.



SECTION E Housing Expenses

Write in your monthly cost of housing. This includes your rent, monthly mortgage payment or other housing payment. If you have a mortgage payment, include property taxes in the amount you tell us. If you share your housing expenses or your rent is subsidized, please only tell us how much YOU pay toward your rent or mortgage. If you pay for your water, tell us how much you pay and how often.

SECTION F Blind, Disabled, Chronically Ill or Nursing Home Care

These questions help us determine which program is best for each applicant, and what services may be needed. A person with a disability, serious illness or high medical bills may be able to get more health services. You may have a disability if your daily activities are limited because of an illness or condition that has lasted or is expected to last for at least 12 months. If you are blind, disabled, chronically ill or need nursing home care, you will need to complete Supplement A. If neither you nor anyone applying is blind, disabled, chronically ill or in a nursing home, go to Section G.

SECTION G Additional Health Questions

If you have paid or unpaid medical bills from the past three months, Medicaid may be able to pay for these costs. Let us know who these bills are for and in which months. Include copies of the medical bills with this application. Note: This three-month period begins when the local department of social services receives your application or when you meet with a Facilitated Enroller. You will need to tell us what your income was for any past months in which you have medical bills so that we can see if you are eligible during that time. We also ask about where you lived in the past three months, because this may affect our ability to pay for past bills. We ask about any pending lawsuits or health issues caused by someone else so we know if someone else should pay for any portion of your medical care costs.

MORE INSTRUCTIONS ON BACK ▶

SECTION H Parent or Spouse Not Living in the Household or Deceased

- If any applicants have an absent spouse or parent, you must complete this section so we can see if medical support is available to you or your child.
- Pregnant women do not have to answer these questions until 60 days after the birth of their child. All other people who are applying and are age 21 or over must be willing to provide information about a parent of an applying minor or a spouse living outside the home to be eligible for health insurance, unless there is good cause. An example of “good cause” is fear of physical or emotional harm to you or a family member. Question 2 refers to the **PARENT** of any applying child under age 21. Question 3 refers to the **SPOUSE** of anyone applying.
- If the parents are not willing to provide this information, the applying child may still be eligible for Medicaid or Child Health Plus.

SECTION I Health Plan Selection

What is a Health Plan? Applying for programs through Access NY Health Care may mean you get your health care coverage through a Managed Care plan. When you join a plan, you choose one doctor (Primary Care Provider or PCP) from that plan to take care of your regular needs. If you want to keep the doctor you have, you need to pick the plan that works with your doctor. Managed Care health plans focus on preventive care so small problems do not become big ones. If you need a specialist, your PCP will refer you to one.

Who Must Choose a Health Plan? People who are eligible for Family Health Plus and Child Health Plus **MUST** choose a health plan to get medical care. **MOST** people who are eligible for Medicaid **MUST** choose a health plan to get most of their Medicaid benefits. Keep reading to find out how to get more information on this.



How Do I Know What Health Plan to Choose and If I Can Enroll?

For Medicaid and Family Health Plus, if you want to find out more about how managed care plans work, if you have to join, and how to choose a plan, call **Medicaid CHOICE** at **1-800-505-5678**, or call or visit your local department of social services. Ask for a Managed Care Education Packet. Information about health plans is also on the NYSDOH website at www.nyhealth.gov. You can also enroll by phone, by calling **1-800-505-5678**.

NOTE: If you or a family member are found eligible for Medicaid, and are in a county that does not require people on Medicaid to join a health plan, you will still be enrolled in the health plan you choose if it provides Medicaid, unless you check the box on the application that says you don't want to be enrolled, or tell us you do not want to be enrolled by calling or writing to your local department of social services.

For Child Health Plus:

For information about Child Health Plus plans, call **1-800-698-4543**.

Child Health Plus Premium

There are no premiums for Medicaid, or Family Health Plus. There may be a monthly premium for Child Health Plus. Use the enclosed chart to determine if you need to pay a premium based on your monthly income. You must include the first month's premium with the completed application or your child will not be enrolled.

SECTION J Signature

Please read the paragraph in this section carefully and read the **Terms, Rights and Responsibilities** section. You must then sign and date the application.

ATTACHMENT 3 HEALTH INSURANCE SCREENING WORKSHEET

Family Name: _____ Worksheet _____ of _____

1. Applicants for Health Insurance on this Worksheet (From Section B of the Application)					
Adult _____ Line #	Pregnant Woman _____ Line #	19-20 Year Old _____ Line #	Child _____ Line #	Child _____ Line #	
Adult _____ Line #	Pregnant Woman _____ Line #	19-20 Year Old _____ Line #	Child _____ Line #	Child _____ Line #	
Child _____ Line #	Child _____ Line #	Child _____ Line #	Child _____ Line #	Child _____ Line #	
2. Family Size * (From Section B of the Application)					
a. # of applying adults			_____		
b. # of applying/non-applying children under age 21			_____		
c. # of non-applying legally responsible relatives (spouse for applying spouse; parent for applying children)			_____		
* Count Pregnant Woman as 2					
			TOTAL _____		
3. Monthly Income (From Section C of the Application)					
Family's total countable gross monthly income			\$ _____		
(weekly gross x 4.333333; biweekly gross x 2.166666)					
4. Citizenship/Immigration Status (From Section B of the Application)					
a. For pregnant women, skip this part, GO TO #5.					
b. For persons who checked they are Citizens or Immigrants, GO TO #5.					
c. For children under 1 who are <u>not</u> Citizens and who checked Non-Immigrant (Visa holder) or "None of the Above" in Section B, GO TO #7.					
d. For persons who are not Citizens and who checked Non-Immigrant (Visa holder) or "None of the Above" in Section B, GO TO #9 (appear ineligible unless require emergency medical treatment).					
5. Medicaid Net Monthly Income					
a. DEDUCTIONS					
_____ # of working family members X \$90/month.....			= \$ _____		
Childcare costs for child under 2 years* (actual or \$200 per child, whichever is less):					
Child Line # _____ \$ _____ + Child Line # _____ \$ _____ + Child Line # _____ \$ _____			= \$ _____		
Childcare costs for child 2 years and over* (actual or \$175 per child, whichever is less)					
Child Line # _____ \$ _____ + Child Line # _____ \$ _____ + Child Line # _____ \$ _____			= \$ _____		
Adult Dependent Care costs* (Actual or \$175, whichever is less).....			= \$ _____		
Health Insurance premium*.....			= \$ _____		
\$100 from total child support received.....			= \$ _____		
\$5.00 per day per child for informal daycare.....			= \$ _____		
Appropriate expenses from roomer/boarder income.....			= \$ _____		
TOTAL DEDUCTIONS					
.....			= (\$ _____)		
* not a deductible item for non-disabled single adults and childless couples, age 21 or over.					
b. MEDICAID MONTHLY INCOME: Subtract Total Deductions (#5.a.) from Monthly Income (#3)			\$ _____		

ATTACHMENT 4

Model Protocols for Submission and Processing of Facilitated Enrollment Applications between _____ County Department of Social Services and _____

These protocols are based upon New York State Department of Health (SDOH) guidelines for Facilitated Enrollment (FE) as outlined in all related OMM and CHP ADMs and the NYS Health Insurance Program FE Manual and are in agreement between _____ (herein referred to as the FE Agency) and _____ County Department of Social Services (herein referred to as the Department). These protocols specifically address the manner in which FE activities will take place between the two parties.

Both parties shall adhere to the rules and regulations set forth by the SDOH. Every effort shall be made by each party to address processing issues and comply with the signed protocols. Failure of either party to comply with these protocols should be brought to the attention of the designated contact persons named herein. In the event the contact persons are unable to come to resolution, either party may bring the matter to the attention of the SDOH. SDOH retains the sole authority to suspend or terminate the FE Agency's FE activities.

Both parties will identify a primary and alternate contact person. The names and telephone numbers of contact persons will be exchanged between both parties. The contact person at the Department will be _____ (FE Unit Supervisor). The designated contact persons for the FE Agency will be _____.

Meetings between the Department and the FE Agency will be held on a schedule agreed upon by both parties, to ensure communication and for case conferences, creating corrective action plans and training, if needed. Additional meetings requested by either party to address particular application processing issues should be held as needed.

The Department will receive the following from the SDOH prior to initiating work with the FE Agency: 1) notification of approval to do FE, and 2) notification of successful completion of SDOH FE Program Training and 3) the names and telephone numbers of contacts.

Modifications to these protocols must be in writing and agreed upon by both parties. These protocols will remain in effect until SDOH requires that new protocols be developed and adopted or SDOH agrees that termination by either party is appropriate.

The FE Agency agrees to:

1. Follow the guidelines established by the SDOH for each FE application. Assist individuals in completing the *Access NY Health Care* application (DOH 4220). Applications for adults age 65 and older are not appropriate for submission and

these individuals should be directed to the Department to complete the application process.

2. Managed Care Plan Selection Process: Details to be provided by the Department and FE Agency.
3. Ensure that the facilitator obtains all required documentation prior to delivery to the Department and that all documentation is date stamped and signed upon receipt by the facilitated enroller.
4. Ensure, unless otherwise agreed to by the Department, that all applying family members are included in one application and that, for adult only applications or situations where children are not being enrolled temporarily or presumptively, the applicant does not sign the application until the application is complete including obtaining all documentation.
5. Ensure, that whenever possible, completed applications are submitted to the Department within 15 days of the application signature date. This will not always be possible, except in rare circumstances, if an applying child is enrolled temporarily or presumptively in CHPlus.
6. Develop internal tracking systems and quality assurance guidelines to guarantee timeliness and accuracy of all applications. Develop corrective action plans if greater than 3% of applications have missing documentation or are determined ineligible for other reasons.
7. The FE Agency will maintain copies of the applications and supporting documentation in a secured location for at least one year, unless otherwise specified.
8. Provide each applicant with education and mandated material regarding client rights and responsibilities.
9. Ensure that the facilitated enroller will follow up with families to complete the application process and assist families in selecting a health plan. As part of this function educate each applicant regarding required managed care information including inquiring about existing provider relationships, identifying the health plans in which such providers participate, describing the complete choice of health plans available to the family and acting as a neutral party in the health plan selection process. The facilitated enroller will distribute informational materials developed by the SDOH and have the families sign the required forms to be submitted with the application.
10. Review all applications for accuracy and completeness. The FE Agency must submit applications in a timely manner to Department. An agreed upon schedule to drop off applications will be determined by both parties, but shall be at least weekly. The SDOH developed transmittal form or comparable tool agreed to by both parties will accompany each bundle of applications.

11. **Application Tracking:** The FE Agency and the Department must agree on procedures for submitting applications, the location to which applications will be submitted, mechanism for following up on applications returned by the Department and how decisions will be conveyed to the FE Agency.
12. The FE Agency will refer clients to the Department only if they have not received the determination notice 45/60 days after they submitted the application to the Department, 45 days for children and pregnant woman and 60 days for adults. The Department will then be responsible for responding to inquires from applicants.

The Department agrees to:

1. Accept the completed *Access NY Health Care* (DOH 4220) application submitted by the FE Agency for children under age 19 and/or adults age 19-64.
2. At its discretion and consistent with the FE Manual, return to the FE Agency any incomplete applications. The Department must use the SDOH status need for correction form or comparable tool agreed to by both parties to notify the FE Agency of corrections needed, within 5 business days of receipt by the Department.
3. Confirm receipt of each application submitted by the FE Agency within 3 business days.
4. Complete the determination of eligibility in a timely manner. If there has been no decision within the timeframe specified in item 12 above, the Department will then be responsible for responding to inquiries from applicants and the FE Agency. If the determination is ineligible, the Department must include a reason for the ineligibility. In the case of excess income denials, the amount of the excess must be provided.
5. **Application Tracking:** The Department is to provide a description of procedures for receiving and tracking applications including location where the applications will be received, control mechanisms, and communications with the FE Agency on incomplete applications and eligibility determinations.
6. Formally reject as duplicate coverage any applications for clients found to have active MA cases or closed cases with active Transitional MA (MA) coverage or other extended MA coverage beyond two future months.
7. The Department may develop appropriate quality assurance screening tools to monitor application completeness and eligibility standards. The Department will obtain approval of any screening tools from the SDOH and will share such screening tools with the FE Agency. The Department will provide the FE Agency with the results of quality assurance reviews and, if necessary, assist with the development of corrective action plans.
8. The Department may use the approved screening tool to monitor the FE Agency's error rate. If greater than 3% of the FE Agency's applications have missing

documentation or are found to be ineligible for other reasons, the FE Agency may be asked to develop a corrective action plan by SDOH. The Department will not include the following situations when calculating FE Agency's error rate: cases already in receipt of assistance where the FE Agency was not informed of such coverage, cases due to close and cases received more than 15 days after the applicant's signature date when the children were enrolled temporarily or presumptively in CHPlus.

Agreed to by:

Signature

Date

Print Name and Title

Name of County Department of Social Services

Signature

Date

Print Name and Title

Name of FE Agency

ATTACHMENT 6

CERTIFICATION REGARDING STATE and FEDERAL CONFIDENTIALITY REQUIREMENTS FOR FACILITATED ENROLLMENT AGENCY

The facilitated enrollment (FE) agency is required to maintain the confidentiality of information obtained on the Access New York Health Care application and information concerning the determination of eligibility for MA/FHP/CHPlus.

Such information may be shared by a FE agency, its subcontractors conducting facilitated enrollment, and the programs and agencies identified in the Access New York Health Care applications, provided that the applicant has given appropriate written authorization on the application and provided that the release is for the purposes of determining eligibility or evaluating the success of the program by the New York State Department of Health or its authorized representative. Such information shall not be disclosed by a FE agency or its subcontractors for any other purpose.

The FE agency agrees to maintain confidentiality of such information in accordance with New York State and federal laws and regulations including, Social Security Act § 1902(a)(7) and 42 U.S.C. § 1396a(a)(7), 42 C.F.R. § 431.300 et seq., 42 C.F.R. § 457.1110, 42 C.F.R. Part 2, N.Y. Social Services Law § 367-b(4) and § 369(4), the Health Insurance Portability and Accountability Act (HIPAA) at 45 C.F.R. Parts 160 and 164, N.Y. Public Health Law Article 27-f and Public Officers Law Article 6-a. In addition, the FE agency agrees that there will be no further disclosure of MA Confidential Data (MCD) without prior, written approval of the New York State Department of Health, MA Confidentiality Data Review Committee (MCDRC). The FE agency agrees to require and ensure that any approved agreement, contract, or document contains a statement that the subcontractor or other party may not further disclose the MCD without the prior written approval of the New York State Department of Health, MCDRC.

By signing below, an authorized person of the FE agency certifies that he/she has read and understands the terms and requirements above.

Name of FE Agency: _____

Name of Authorized Person:

(Print Clearly)

Signature of Authorized Person:

Date: _____

**CERTIFICATION REGARDING STATE and FEDERAL CONFIDENTIALITY
REQUIREMENTS FOR FACILITATED ENROLLMENT SUBCONTRACTORS**

A facilitated enrollment (FE) subcontractor (“facilitator”) is required to maintain the confidentiality of information obtained on the Access New York Health Care application and information concerning the determination of eligibility for MA/FHP/CHPlus.

Such information may be shared by a subcontractor facilitator, FE agency and the programs and agencies identified in the Access New York Health Care applications, provided that the applicant has given appropriate written authorization on the application and provided that the release is for the purposes of determining eligibility or evaluating the success of the program by the New York State Department of Health or its authorized representative. Such information shall not be disclosed by a facilitator for any other purpose.

The FE agency agrees to maintain confidentiality of such information in accordance with New York State and federal laws and regulations including, Social Security Act § 1902(a)(7) and 42 U.S.C. § 1396a(a)(7), 42 C.F.R. § 431.300 et seq., 42 C.F.R. § 457.1110, 42 C.F.R. Part 2, N.Y. Social Services Law § 367-b(4) and § 369(4), the Health Insurance Portability and Accountability Act (HIPAA) at 45 C.F.R. Parts 160 and 164, N.Y. Public Health Law Article 27-f and Public Officers Law Article 6-a.

By signing below, the facilitator certifies that he/she has read and understands the terms and requirements above.

Name of Subcontractor: _____

Name of Facilitator: _____
(Print Clearly)

Signature of Facilitator: _____

Date: _____

**ATTACHMENT 7
GRANT CONTRACT (STANDARD) (2/10)**

STATE AGENCY (Name and Address): . NYS COMPTROLLER'S NUMBER:
 .
 . ORIGINATING AGENCY CODE:

CONTRACTOR (Name and Address): . TYPE OF PROGRAM(S)
 .
 .

FEDERAL TAX IDENTIFICATION NUMBER: . INITIAL CONTRACT PERIOD
 .
 . FROM:
 MUNICIPALITY NO. (if applicable): . TO:
 .
 .
 CHARITIES REGISTRATION NUMBER: . FUNDING AMOUNT FOR INITIAL PERIOD:
 ____ - ____ - ____ or () EXEMPT: .
 (If EXEMPT, indicate basis for exemption): . _____
 . MULTI-YEAR TERM (if applicable):
 . FROM:

 . TO:

CONTRACTOR HAS() HAS NOT() TIMELY
 FILED WITH THE ATTORNEY GENERAL'S
 CHARITIES BUREAU ALL REQUIRED PERIODIC
 OR ANNUAL WRITTEN REPORTS.

CONTRACTOR IS() IS NOT() A
 SECTARIAN ENTITY
 CONTRACTOR IS() IS NOT() A
 NOT-FOR-PROFIT ORGANIZATION

APPENDICES ATTACHED AND PART OF THIS AGREEMENT

_____	APPENDIX A	Standard clauses as required by the Attorney General for all State contracts.
_____	APPENDIX A-1	Agency-Specific Clauses
_____	APPENDIX B	Budget
_____	APPENDIX C	Payment and Reporting Schedule
_____	APPENDIX D	Program Workplan
_____	APPENDIX G	Notices
_____	APPENDIX X	Modification Agreement Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods)

OTHER APPENDICES

_____	APPENDIX A-2	Program-Specific Clauses
_____	APPENDIX E-1	Proof of Workers' Compensation Coverage
_____	APPENDIX E-2	Proof of Disability Insurance Coverage
_____	APPENDIX H	Federal Health Insurance Portability and Accountability Act Business Associate Agreement
_____	APPENDIX _____	_____
_____	APPENDIX _____	_____

IN WITNESS THEREOF, the parties hereto have executed or approved this AGREEMENT on the dates below their signatures.

Contract No. _____

CONTRACTOR . STATE AGENCY

By: _____ By: _____
(Print Name) (Print Name)

Title: _____ Title: _____

Date: _____ Date: _____

State Agency Certification:

“In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract.”

STATE OF NEW YORK)
County of _____) SS:

On the ___ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(Signature and office of the individual taking acknowledgement)

ATTORNEY GENERAL’S SIGNATURE . STATE COMPTROLLER’S SIGNATURE

Title: _____ Title: _____

Date: _____ Date: _____

STATE OF NEW YORK

AGREEMENT

This AGREEMENT is hereby made by and between the State of New York agency (STATE) and the public or private agency (CONTRACTOR) identified on the face page hereof.

WITNESSETH:

WHEREAS, the STATE has the authority to regulate and provide funding for the establishment and operation of program services and desires to contract with skilled parties possessing the necessary resources to provide such services; and

WHEREAS, the CONTRACTOR is ready, willing and able to provide such program services and possesses or can make available all necessary qualified personnel, licenses, facilities and expertise to perform or have performed the services required pursuant to the terms of this AGREEMENT;

NOW THEREFORE, in consideration of the promises, responsibilities and covenants herein, the STATE and the CONTRACTOR agree as follows:

I. Conditions of Agreement

- A. This AGREEMENT may consist of successive periods (PERIOD), as specified within the AGREEMENT or within a subsequent Modification Agreement(s) (Appendix X). Each additional or superseding PERIOD shall be on the forms specified by the particular State agency, and shall be incorporated into this AGREEMENT.
- B. Funding for the first PERIOD shall not exceed the funding amount specified on the face page hereof. Funding for each subsequent PERIOD, if any, shall not exceed the amount specified in the appropriate appendix for that PERIOD.
- C. This AGREEMENT incorporates the face pages attached and all of the marked appendices identified on the face page hereof.
- D. For each succeeding PERIOD of this AGREEMENT, the parties shall prepare new appendices, to the extent that any require modification, and a Modification Agreement (The attached Appendix X is the blank form to be used). Any terms of this AGREEMENT not modified shall remain in effect for each PERIOD of the AGREEMENT.

To modify the AGREEMENT within an existing PERIOD, the parties shall revise or complete the appropriate appendix form(s). Any change in the amount of consideration to be paid, change in scope or change in the term, is subject to the approval of the Office of the State Comptroller.

Any other modifications shall be processed in accordance with agency guidelines as stated in Appendix A1.

- E. The CONTRACTOR shall perform all services to the satisfaction of the STATE. The CONTRACTOR shall provide services and meet the program objectives summarized in the Program Workplan (Appendix D) in accordance with: provisions of the AGREEMENT; relevant laws, rules and regulations, administrative and fiscal guidelines; and where applicable, operating certificates for facilities or licenses for an activity or program.
- F. If the CONTRACTOR enters into subcontracts for the performance of work pursuant to this AGREEMENT, the CONTRACTOR shall take full responsibility for the acts and omissions of its subcontractors. Nothing in the subcontract shall impair the rights of the STATE under this AGREEMENT. No contractual relationship shall be deemed to exist between the subcontractor and the STATE.
- G. Appendix A (Standard Clauses as required by the Attorney General for all State contracts) takes precedence over all other parts of the AGREEMENT.

II. Payment and Reporting

- A. The CONTRACTOR, to be eligible for payment, shall submit to the STATE's designated payment office (identified in Appendix C) any appropriate documentation as required by the Payment and Reporting Schedule (Appendix C) and by agency fiscal guidelines, in a manner acceptable to the STATE.
- B. The STATE shall make payments and any reconciliations in accordance with the Payment and Reporting Schedule (Appendix C). The STATE shall pay the CONTRACTOR, in consideration of contract services for a given PERIOD, a sum not to exceed the amount noted on the face page hereof or in the respective Appendix designating the payment amount for that given PERIOD. This sum shall not duplicate reimbursement from other sources for CONTRACTOR costs and services provided pursuant to this AGREEMENT.
- C. The CONTRACTOR shall meet the audit requirements specified by the STATE.
- D. The CONTRACTOR shall provide complete and accurate billing vouchers to the Agency's designated payment office in order to receive payment. Billing vouchers submitted to the Agency must contain all information and supporting documentation required by the Contract, the Agency and the State Comptroller. Payment for vouchers submitted by the CONTRACTOR shall be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epunit@osc.state.ny.us or by telephone at 518-

474-6019. CONTRACTOR acknowledges that it will not receive payment on any vouchers submitted under this contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9, must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at <http://www.osc.state.ny.us/epay>.

Completed W-9 forms should be submitted to the following address:

NYS Office of the State Comptroller
Bureau of Accounting Operations
Warrant & Payment Control Unit
110 State Street, 9th Floor
Albany, NY 12236

III. Terminations

- A. This AGREEMENT may be terminated at any time upon mutual written consent of the STATE and the CONTRACTOR.
- B. The STATE may terminate the AGREEMENT immediately, upon written notice of termination to the CONTRACTOR, if the CONTRACTOR fails to comply with the terms and conditions of this AGREEMENT and/or with any laws, rules and regulations, policies or procedures affecting this AGREEMENT.
- C. The STATE may also terminate this AGREEMENT for any reason in accordance with provisions set forth in Appendix A-1.
- D. Written notice of termination, where required, shall be sent by personal messenger service or by certified mail, return receipt requested. The termination shall be effective in accordance with the terms of the notice.
- E. Upon receipt of notice of termination, the CONTRACTOR agrees to cancel, prior to the effective date of any prospective termination, as many outstanding obligations as possible, and agrees not to incur any new obligations after receipt of the notice without approval by the STATE.
- F. The STATE shall be responsible for payment on claims pursuant to services provided and costs incurred pursuant to terms of the AGREEMENT. In no event shall the STATE be liable for expenses and obligations arising from the program(s) in this AGREEMENT after the termination date.

IV. Indemnification

- A. The CONTRACTOR 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 CONTRACTOR or its subcontractors pursuant to this AGREEMENT. The CONTRACTOR shall indemnify and hold harmless the STATE 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.
- B. The CONTRACTOR is an independent contractor and may neither hold itself out nor claim to be an officer, employee or subdivision of the STATE nor make any claims, demand or application to or for any right based upon any different status.

V. Property

Any equipment, furniture, supplies or other property purchased pursuant to this AGREEMENT is deemed to be the property of the STATE except as may otherwise be governed by Federal or State laws, rules and regulations, or as stated in Appendix A-2.

VI. Safeguards for Services and Confidentiality

- A. Services performed pursuant to this AGREEMENT are secular in nature and shall be performed in a manner that does not discriminate on the basis of religious belief, or promote or discourage adherence to religion in general or particular religious beliefs.
- B. Funds provided pursuant to this AGREEMENT shall not be used for any partisan political activity, or for activities that may influence legislation or the election or defeat of any candidate for public office.
- C. Information relating to individuals who may receive services pursuant to this AGREEMENT shall be maintained and used only for the purposes intended under the contract and in conformity with applicable provisions of laws and regulations, or specified in Appendix A-1.

APPENDIX A

STANDARD CLAUSES FOR NEW YORK STATE CONTRACTS

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STANDARD CLAUSES FOR NYS CONTRACTS

The parties to the attached contract, license, lease, amendment or other agreement of any kind (hereinafter, "the contract" or "this contract") agree to be bound by the following clauses which are hereby made a part of the contract (the word "Contractor" herein refers to any party other than the State, whether a contractor, licensor, licensee, lessor, lessee or any other party):

1. EXECUTORY CLAUSE. In accordance with Section 41 of the State Finance Law, the State shall have no liability under this contract to the Contractor or to anyone else beyond funds appropriated and available for this contract.

2. NON-ASSIGNMENT CLAUSE. In accordance with Section 138 of the State Finance Law, this contract may not be assigned by the Contractor or its right, title or interest therein assigned, transferred, conveyed, sublet or otherwise disposed of without the State's previous written consent, and attempts to do so are null and void. Notwithstanding the foregoing, such prior written consent of an assignment of a contract let pursuant to Article XI of the State Finance Law may be waived at the discretion of the contracting agency and with the concurrence of the State Comptroller where the original contract was subject to the State Comptroller's approval, where the assignment is due to a reorganization, merger or consolidation of the Contractor's business entity or enterprise. The State retains its right to approve an assignment and to require that any Contractor demonstrate its responsibility to do business with the State. The Contractor may, however, assign its right to receive payments without the State's prior written consent unless this contract concerns Certificates of Participation pursuant to Article 5-A of the State Finance Law.

3. COMPTROLLER'S APPROVAL. In accordance with Section 112 of the State Finance Law (or, if this contract is with the State University or City University of New York, Section 355 or Section 6218 of the Education Law), if this contract exceeds \$50,000 (or the minimum thresholds agreed to by the Office of the State Comptroller for certain S.U.N.Y. and C.U.N.Y. contracts), or if this is an amendment for any amount to a contract which, as so amended, exceeds said statutory amount, or if, by this contract, the State agrees to give something other than money when the value or

reasonably estimated value of such consideration exceeds \$10,000, it shall not be valid, effective or binding upon the State until it has been approved by the State Comptroller and filed in his office. Comptroller's approval of contracts let by the Office of General Services is required when such contracts exceed \$85,000 (State Finance Law Section 163.6.a).

4. WORKERS' COMPENSATION BENEFITS. In accordance with Section 142 of the State Finance Law, this contract shall be void and of no force and effect unless the Contractor shall provide and maintain coverage during the life of this contract for the benefit of such employees as are required to be covered by the provisions of the Workers' Compensation Law.

5. NON-DISCRIMINATION REQUIREMENTS. To the extent required by Article 15 of the Executive Law (also known as the Human Rights Law) and all other State and Federal statutory and constitutional non-discrimination provisions, the Contractor will not discriminate against any employee or applicant for employment because of race, creed, color, sex, national origin, sexual orientation, age, disability, genetic predisposition or carrier status, or marital status. Furthermore, in accordance with Section 220-e of the Labor Law, if this is a contract for the construction, alteration or repair of any public building or public work or for the manufacture, sale or distribution of materials, equipment or supplies, and to the extent that this contract shall be performed within the State of New York, Contractor agrees that neither it nor its subcontractors shall, by reason of race, creed, color, disability, sex, or national origin: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. If this is a building service contract as defined in Section 230 of the Labor Law, then, in accordance with Section 239 thereof, Contractor agrees that neither it nor its subcontractors shall by reason of race, creed, color, national origin, age, sex or disability: (a) discriminate in hiring against any New York State citizen who is qualified and available to perform the work; or (b) discriminate against or intimidate any employee hired for the performance of work under this contract. Contractor is subject to fines of \$50.00 per person per day for any violation of Section 220-e or Section 239 as well as possible termination of

this contract and forfeiture of all moneys due hereunder for a second or subsequent violation.

6. WAGE AND HOURS PROVISIONS. If this is a public work contract covered by Article 8 of the Labor Law or a building service contract covered by Article 9 thereof, neither Contractor's employees nor the employees of its subcontractors may be required or permitted to work more than the number of hours or days stated in said statutes, except as otherwise provided in the Labor Law and as set forth in prevailing wage and supplement schedules issued by the State Labor Department. Furthermore, Contractor and its subcontractors must pay at least the prevailing wage rate and pay or provide the prevailing supplements, including the premium rates for overtime pay, as determined by the State Labor Department in accordance with the Labor Law. Additionally, effective April 28, 2008, if this is a public work contract covered by Article 8 of the Labor Law, the Contractor understands and agrees that the filing of payrolls in a manner consistent with Subdivision 3-a of Section 220 of the Labor Law shall be a condition precedent to payment by the State of any State approved sums due and owing for work done upon the project.

7. NON-COLLUSIVE BIDDING CERTIFICATION. In accordance with Section 139-d of the State Finance Law, if this contract was awarded based upon the submission of bids, Contractor affirms, under penalty of perjury, that its bid was arrived at independently and without collusion aimed at restricting competition. Contractor further affirms that, at the time Contractor submitted its bid, an authorized and responsible person executed and delivered to the State a non-collusive bidding certification on Contractor's behalf.

8. INTERNATIONAL BOYCOTT PROHIBITION. In accordance with Section 220-f of the Labor Law and Section 139-h of the State Finance Law, if this contract exceeds \$5,000, the Contractor agrees, as a material condition of the contract, that neither the Contractor nor any substantially owned or affiliated person, firm, partnership or corporation has participated, is participating, or shall participate in an international boycott in violation of the federal Export Administration Act of 1979 (50 USC App. Sections 2401 et seq.) or regulations thereunder. If such Contractor, or any of the aforesaid affiliates of Contractor, is convicted or is otherwise found to have violated said laws or regulations upon the final determination of the United States Commerce

Department or any other appropriate agency of the United States subsequent to the contract's execution, such contract, amendment or modification thereto shall be rendered forfeit and void. The Contractor shall so notify the State Comptroller within five (5) business days of such conviction, determination or disposition of appeal (2NYCRR 105.4).

9. SET-OFF RIGHTS. The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any moneys due to the Contractor under this contract up to any amounts due and owing to the State with regard to this contract, any other contract with any State department or agency, including any contract for a term commencing prior to the term of this contract, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Comptroller.

10. RECORDS. The Contractor shall establish and maintain complete and accurate books, records, documents, accounts and other evidence directly pertinent to performance under this contract (hereinafter, collectively, "the Records"). The Records must be kept for the balance of the calendar year in which they were made and for six (6) additional years thereafter. The State Comptroller, the Attorney General and any other person or entity authorized to conduct an examination, as well as the agency or agencies involved in this contract, shall have access to the Records during normal business hours at an office of the Contractor within the State of New York or, if no such office is available, at a mutually agreeable and reasonable venue within the State, for the term specified above for the purposes of inspection, auditing and copying. The State shall take reasonable steps to protect from public disclosure any of the Records which are exempt from disclosure under Section 87 of the Public Officers Law (the "Statute") provided that: (i) the Contractor shall timely inform an appropriate State official, in writing, that said records should not be disclosed; and (ii) said records shall be sufficiently identified; and (iii) designation of said records as exempt under the Statute is reasonable. Nothing contained herein shall diminish, or in any way adversely

affect, the State's right to discovery in any pending or future litigation.

11. IDENTIFYING INFORMATION AND PRIVACY NOTIFICATION.

(a) FEDERAL EMPLOYER IDENTIFICATION NUMBER and/or FEDERAL SOCIAL SECURITY NUMBER. All invoices or New York State standard vouchers submitted for payment for the sale of goods or services or the lease of real or personal property to a New York State agency must include the payee's identification number, i.e., the seller's or lessor's identification number. The number is either the payee's Federal employer identification number or Federal social security number, or both such numbers when the payee has both such numbers. Failure to include this number or numbers may delay payment. Where the payee does not have such number or numbers, the payee, on its invoice or New York State standard voucher, must give the reason or reasons why the payee does not have such number or numbers.

(b) PRIVACY NOTIFICATION. (1) The authority to request the above personal information from a seller of goods or services or a lessor of real or personal property, and the authority to maintain such information, is found in Section 5 of the State Tax Law. Disclosure of this information by the seller or lessor to the State is mandatory. The principal purpose for which the information is collected is to enable the State to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by law. (2) The personal information is requested by the purchasing unit of the agency contracting to purchase the goods or services or lease the real or personal property covered by this contract or lease. The information is maintained in New York State's Central Accounting System by the Director of Accounting Operations, Office of the State Comptroller, 110 State Street, Albany, New York 12236.

12. EQUAL EMPLOYMENT OPPORTUNITIES FOR MINORITIES AND WOMEN.

In accordance with Section 312 of the Executive Law and 5 NYCRR 143, if this contract is: (i) a written agreement or purchase order instrument, providing for a total expenditure in excess of \$25,000.00, whereby a

contracting agency is committed to expend or does expend funds in return for labor, services, supplies, equipment, materials or any combination of the foregoing, to be performed for, or rendered or furnished to the contracting agency; or (ii) a written agreement in excess of \$100,000.00 whereby a contracting agency is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon; or (iii) a written agreement in excess of \$100,000.00 whereby the owner of a State assisted housing project is committed to expend or does expend funds for the acquisition, construction, demolition, replacement, major repair or renovation of real property and improvements thereon for such project, then the following shall apply and by signing this agreement the Contractor certifies and affirms that it is Contractor's equal employment opportunity policy that:

(a) The Contractor will not discriminate against employees or applicants for employment because of race, creed, color, national origin, sex, age, disability or marital status, shall make and document its conscientious and active efforts to employ and utilize minority group members and women in its work force on State contracts and will undertake or continue existing programs of affirmative action to ensure that minority group members and women are afforded equal employment opportunities without discrimination. Affirmative action shall mean recruitment, employment, job assignment, promotion, upgradings, demotion, transfer, layoff, or termination and rates of pay or other forms of compensation;

(b) at the request of the contracting agency, the Contractor shall request each employment agency, labor union, or authorized representative of workers with which it has a collective bargaining or other agreement or understanding, to furnish a written statement that such employment agency, labor union or representative will not discriminate on the basis of race, creed, color, national origin, sex, age, disability or marital status and that such union or representative will affirmatively cooperate in the implementation of the Contractor's obligations herein; and

(c) the Contractor shall state, in all solicitations or advertisements for employees, that, in the performance of the State contract, all qualified applicants will be afforded equal employment opportunities without

discrimination because of race, creed, color, national origin, sex, age, disability or marital status.

Contractor will include the provisions of "a", "b", and "c" above, in every subcontract over \$25,000.00 for the construction, demolition, replacement, major repair, renovation, planning or design of real property and improvements thereon (the "Work") except where the Work is for the beneficial use of the Contractor. Section 312 does not apply to: (i) work, goods or services unrelated to this contract; or (ii) employment outside New York State. The State shall consider compliance by a contractor or subcontractor with the requirements of any federal law concerning equal employment opportunity which effectuates the purpose of this section. The contracting agency shall determine whether the imposition of the requirements of the provisions hereof duplicate or conflict with any such federal law and if such duplication or conflict exists, the contracting agency shall waive the applicability of Section 312 to the extent of such duplication or conflict. Contractor will comply with all duly promulgated and lawful rules and regulations of the Department of Economic Development's Division of Minority and Women's Business Development pertaining hereto.

13. CONFLICTING TERMS. In the event of a conflict between the terms of the contract (including any and all attachments thereto and amendments thereof) and the terms of this Appendix A, the terms of this Appendix A shall control.

14. GOVERNING LAW. This contract shall be governed by the laws of the State of New York except where the Federal supremacy clause requires otherwise.

15. LATE PAYMENT. Timeliness of payment and any interest to be paid to Contractor for late payment shall be governed by Article 11-A of the State Finance Law to the extent required by law.

16. NO ARBITRATION. Disputes involving this contract, including the breach or alleged breach thereof, may not be submitted to binding arbitration (except where statutorily authorized), but must, instead, be heard in a court of competent jurisdiction of the State of New York.

17. SERVICE OF PROCESS. In addition to the methods of service allowed by the State Civil Practice Law & Rules ("CPLR"), Contractor hereby consents to

service of process upon it by registered or certified mail, return receipt requested. Service hereunder shall be complete upon Contractor's actual receipt of process or upon the State's receipt of the return thereof by the United States Postal Service as refused or undeliverable. Contractor must promptly notify the State, in writing, of each and every change of address to which service of process can be made. Service by the State to the last known address shall be sufficient. Contractor will have thirty (30) calendar days after service hereunder is complete in which to respond.

18. PROHIBITION ON PURCHASE OF TROPICAL HARDWOODS. The Contractor certifies and warrants that all wood products to be used under this contract award will be in accordance with, but not limited to, the specifications and provisions of Section 165 of the State Finance Law, (Use of Tropical Hardwoods) which prohibits purchase and use of tropical hardwoods, unless specifically exempted, by the State or any governmental agency or political subdivision or public benefit corporation. Qualification for an exemption under this law will be the responsibility of the contractor to establish to meet with the approval of the State.

In addition, when any portion of this contract involving the use of woods, whether supply or installation, is to be performed by any subcontractor, the prime Contractor will indicate and certify in the submitted bid proposal that the subcontractor has been informed and is in compliance with specifications and provisions regarding use of tropical hardwoods as detailed in §165 State Finance Law. Any such use must meet with the approval of the State; otherwise, the bid may not be considered responsive. Under bidder certifications, proof of qualification for exemption will be the responsibility of the Contractor to meet with the approval of the State.

19. MACBRIDE FAIR EMPLOYMENT PRINCIPLES. In accordance with the MacBride Fair Employment Principles (Chapter 807 of the Laws of 1992), the Contractor hereby stipulates that the Contractor either (a) has no business operations in Northern Ireland, or (b) shall take lawful steps in good faith to conduct any business operations in Northern Ireland in accordance with the MacBride Fair Employment Principles (as described in Section 165 of the New York State Finance Law), and shall permit independent monitoring of compliance with such principles.

20. OMNIBUS PROCUREMENT ACT OF 1992. It is the policy of New York State to maximize opportunities for the participation of New York State business enterprises, including minority and women-owned business enterprises as bidders, subcontractors and suppliers on its procurement contracts.

Information on the availability of New York State subcontractors and suppliers is available from:

NYS Department of Economic Development
Division for Small Business
30 South Pearl St -- 7th Floor
Albany, New York 12245
Telephone: 518-292-5220
Fax: 518-292-5884
<http://www.empire.state.ny.us>

A directory of certified minority and women-owned business enterprises is available from:

NYS Department of Economic Development
Division of Minority and Women's Business Development
30 South Pearl St -- 2nd Floor
Albany, New York 12245
Telephone: 518-292-5250
Fax: 518-292-5803
<http://www.empire.state.ny.us>

The Omnibus Procurement Act of 1992 requires that by signing this bid proposal or contract, as applicable, Contractors certify that whenever the total bid amount is greater than \$1 million:

- (a) The Contractor has made reasonable efforts to encourage the participation of New York State Business Enterprises as suppliers and subcontractors, including certified minority and women-owned business enterprises, on this project, and has retained the documentation of these efforts to be provided upon request to the State;
- (b) The Contractor has complied with the Federal Equal Opportunity Act of 1972 (P.L. 92-261), as amended;
- (c) The Contractor agrees to make reasonable efforts to provide notification to New York State residents of employment opportunities on this project through listing any such positions with the Job Service Division of the New York State Department of Labor, or providing such

notification in such manner as is consistent with existing collective bargaining contracts or agreements. The Contractor agrees to document these efforts and to provide said documentation to the State upon request; and

- (d) The Contractor acknowledges notice that the State may seek to obtain offset credits from foreign countries as a result of this contract and agrees to cooperate with the State in these efforts.

21. RECIPROCITY AND SANCTIONS PROVISIONS. Bidders are hereby notified that if their principal place of business is located in a country, nation, province, state or political subdivision that penalizes New York State vendors, and if the goods or services they offer will be substantially produced or performed outside New York State, the Omnibus Procurement Act 1994 and 2000 amendments (Chapter 684 and Chapter 383, respectively) require that they be denied contracts which they would otherwise obtain. NOTE: As of May 15, 2002, the list of discriminatory jurisdictions subject to this provision includes the states of South Carolina, Alaska, West Virginia, Wyoming, Louisiana and Hawaii. Contact NYS Department of Economic Development for a current list of jurisdictions subject to this provision.

22. COMPLIANCE WITH NEW YORK STATE INFORMATION SECURITY BREACH AND NOTIFICATION ACT. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208).

23. COMPLIANCE WITH CONSULTANT DISCLOSURE LAW. If this is a contract for consulting services, defined for purposes of this requirement to include analysis, evaluation, research, training, data processing, computer programming, engineering, environmental, health, and mental health services, accounting, auditing, paralegal, legal or similar services, then, in accordance with Section 163 (4-g) of the State Finance Law (as amended by Chapter 10 of the Laws of 2006), the Contractor shall timely, accurately and properly comply with the requirement to submit an annual employment report for the contract to the agency that awarded the contract, the Department of Civil Service and the State Comptroller.

24. PROCUREMENT LOBBYING. To the extent this agreement is a "procurement contract" as defined by State Finance Law Sections 139-j and 139-k, by signing this agreement the contractor certifies and affirms that all disclosures made in accordance with State Finance Law Sections 139-j and 139-k are complete, true and accurate. In the event such certification is found to be intentionally false or intentionally incomplete, the State may terminate the agreement by providing written notification to the Contractor in accordance with the terms of the agreement.

25. CERTIFICATION OF REGISTRATION TO COLLECT SALES AND COMPENSATING USE TAX BY CERTAIN STATE CONTRACTORS, AFFILIATES AND SUBCONTRACTORS.

To the extent this agreement is a contract as defined by Tax Law Section 5-a, if the contractor fails to make the certification required by Tax Law Section 5-a or if during the term of the contract, the Department of Taxation and Finance or the covered agency, as defined by Tax Law 5-a, discovers that the certification, made under penalty of perjury, is false, then such failure to file or false certification shall be a material breach of this contract and this contract may be terminated, by providing written notification to the Contractor in accordance with the terms of the agreement, if the covered agency determines that such action is in the best interest of the State.

APPENDIX A-1
(REV 10/08)

AGENCY SPECIFIC CLAUSES FOR ALL
DEPARTMENT OF HEALTH CONTRACTS

1. If the CONTRACTOR is a charitable organization required to be registered with the New York State Attorney General pursuant to Article 7-A of the New York State Executive Law, the CONTRACTOR shall furnish to the STATE such proof of registration (a copy of Receipt form) at the time of the execution of this AGREEMENT. The annual report form 497 is not required. If the CONTRACTOR is a business corporation or not-for-profit corporation, the CONTRACTOR shall also furnish a copy of its Certificate of Incorporation, as filed with the New York Department of State, to the Department of Health at the time of the execution of this AGREEMENT.
2. The CONTRACTOR certifies that all revenue earned during the budget period as a result of services and related activities performed pursuant to this contract shall be used either to expand those program services funded by this AGREEMENT or to offset expenditures submitted to the STATE for reimbursement.
3. Administrative Rules and Audits:
 - a. If this contract is funded in whole or in part from federal funds, the CONTRACTOR shall comply with the following federal grant requirements regarding administration and allowable costs.
 - i. For a local or Indian tribal government, use the principles in the common rule, "Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments," and Office of Management and Budget (OMB) Circular A-87, "Cost Principles for State, Local and Indian Tribal Governments".
 - ii. For a nonprofit organization other than
 - ◆ an institution of higher education,
 - ◆ a hospital, or
 - ◆ an organization named in OMB Circular A-122, "Cost Principles for Non-profit Organizations", as not subject to that circular,use the principles in OMB Circular A-110, "Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals and Other Non-profit Organizations," and OMB Circular A-122.
 - iii. For an Educational Institution, use the principles in OMB Circular A-110 and OMB Circular A-21, "Cost Principles for Educational Institutions".
 - iv. For a hospital, use the principles in OMB Circular A-110, Department of Health and Human Services, 45 CFR 74, Appendix E, "Principles for Determining Costs Applicable to Research and Development Under Grants and Contracts with Hospitals" and, if not covered for audit purposes by OMB Circular A-133, "Audits of States Local Governments

and Non-profit Organizations”, then subject to program specific audit requirements following Government Auditing Standards for financial audits.

- b. If this contract is funded entirely from STATE funds, and if there are no specific administration and allowable costs requirements applicable, CONTRACTOR shall adhere to the applicable principles in “a” above.
 - c. The CONTRACTOR shall comply with the following grant requirements regarding audits.
 - i. If the contract is funded from federal funds, and the CONTRACTOR spends more than \$500,000 in federal funds in their fiscal year, an audit report must be submitted in accordance with OMB Circular A-133.
 - ii. If this contract is funded from other than federal funds or if the contract is funded from a combination of STATE and federal funds but federal funds are less than \$500,000, and if the CONTRACTOR receives \$300,000 or more in total annual payments from the STATE, the CONTRACTOR shall submit to the STATE after the end of the CONTRACTOR's fiscal year an audit report. The audit report shall be submitted to the STATE within thirty days after its completion but no later than nine months after the end of the audit period. The audit report shall summarize the business and financial transactions of the CONTRACTOR. The report shall be prepared and certified by an independent accounting firm or other accounting entity, which is demonstrably independent of the administration of the program being audited. Audits performed of the CONTRACTOR's records shall be conducted in accordance with Government Auditing Standards issued by the Comptroller General of the United States covering financial audits. This audit requirement may be met through entity-wide audits, coincident with the CONTRACTOR's fiscal year, as described in OMB Circular A-133. Reports, disclosures, comments and opinions required under these publications should be so noted in the audit report.
 - d. For audit reports due on or after April 1, 2003, that are not received by the dates due, the following steps shall be taken:
 - i. If the audit report is one or more days late, voucher payments shall be held until a compliant audit report is received.
 - ii. If the audit report is 91 or more days late, the STATE shall recover payments for all STATE funded contracts for periods for which compliant audit reports are not received.
 - iii. If the audit report is 180 days or more late, the STATE shall terminate all active contracts, prohibit renewal of those contracts and prohibit the execution of future contracts until all outstanding compliant audit reports have been submitted.
4. The CONTRACTOR shall accept responsibility for compensating the STATE for any exceptions which are revealed on an audit and sustained after completion of the normal audit procedure.

5. FEDERAL CERTIFICATIONS: This section shall be applicable to this AGREEMENT only if any of the funds made available to the CONTRACTOR under this AGREEMENT are federal funds.

a. LOBBYING CERTIFICATION

- 1) If the CONTRACTOR is a tax-exempt organization under Section 501 (c)(4) of the Internal Revenue Code, the CONTRACTOR certifies that it will not engage in lobbying activities of any kind regardless of how funded.
- 2) The CONTRACTOR acknowledges that as a recipient of federal appropriated funds, it is subject to the limitations on the use of such funds to influence certain Federal contracting and financial transactions, as specified in Public Law 101-121, section 319, and codified in section 1352 of Title 31 of the United States Code. In accordance with P.L. 101-121, section 319, 31 U.S.C. 1352 and implementing regulations, the CONTRACTOR affirmatively acknowledges and represents that it is prohibited and shall refrain from using Federal funds received under this AGREEMENT for the purposes of lobbying; provided, however, that such prohibition does not apply in the case of a payment of reasonable compensation made to an officer or employee of the CONTRACTOR to the extent that the payment is for agency and legislative liaison activities not directly related to the awarding of any Federal contract, the making of any Federal grant or 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. Nor does such prohibition prohibit any reasonable payment to a person in connection with, or any payment of reasonable compensation to an officer or employee of the CONTRACTOR if the payment is for professional or technical services rendered directly in the preparation, submission or negotiation of any bid, proposal, or application for a Federal contract, grant, loan, or cooperative agreement, or an extension, continuation, renewal, amendment, or modification thereof, or for meeting requirements imposed by or pursuant to law as a condition for receiving that Federal contract, grant, loan or cooperative agreement.
- 3) This section shall be applicable to this AGREEMENT only if federal funds allotted exceed \$100,000.
 - a) The CONTRACTOR certifies, to the best of his or her knowledge and belief, that:
 - ◆ No federal appropriated funds have been paid or will be paid, by or on behalf of the CONTRACTOR, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal amendment or modification of any federal contract, grant, loan, or cooperative agreement.

- ◆ If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the CONTRACTOR shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.
 - b) The CONTRACTOR shall require that the language of this certification be included in the award documents for all sub-awards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans, and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.
 - c) The CONTRACTOR shall disclose specified information on any agreement with lobbyists whom the CONTRACTOR will pay with other Federal appropriated funds by completion and submission to the STATE of the Federal Standard Form-LLL, "Disclosure Form to Report Lobbying", in accordance with its instructions. This form may be obtained by contacting either the Office of Management and Budget Fax Information Line at (202) 395-9068 or the Bureau of Accounts Management at (518) 474-1208. Completed forms should be submitted to the New York State Department of Health, Bureau of Accounts Management, Empire State Plaza, Corning Tower Building, Room 1315, Albany, 12237-0016.
 - d) The CONTRACTOR shall file quarterly updates on the use of lobbyists if material changes occur, using the same standard disclosure form identified in (c) above to report such updated information.
- 4) The reporting requirements enumerated in subsection (3) of this paragraph shall not apply to the CONTRACTOR with respect to:
- a) Payments of reasonable compensation made to its regularly employed officers or employees;
 - b) A request for or receipt of a contract (other than a contract referred to in clause (c) below), grant, cooperative agreement, subcontract (other than a subcontract referred to in clause (c) below), or subgrant that does not exceed \$100,000; and
 - c) A request for or receipt of a loan, or a commitment providing for the United States to insure or guarantee a loan, that does not exceed

\$150,000, including a contract or subcontract to carry out any purpose for which such a loan is made.

b. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE:

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this AGREEMENT, the CONTRACTOR certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The CONTRACTOR agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

c. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

Regulations of the Department of Health and Human Services, located at Part 76 of Title 45 of the Code of Federal Regulations (CFR), implement Executive Orders 12549 and 12689 concerning debarment and suspension of participants in federal programs and activities. Executive Order 12549 provides that, to the extent permitted by law, Executive departments and agencies shall participate in a government-wide system for non-procurement debarment and suspension. Executive Order 12689 extends the debarment and suspension policy to procurement activities of the federal government. A person who is debarred or suspended by a federal agency is excluded from federal financial and non-financial assistance and benefits under federal programs and activities, both directly (primary covered transaction) and indirectly (lower tier covered transactions). Debarment or suspension by one federal agency has government-wide effect.

Pursuant to the above-cited regulations, the New York State Department of Health (as a participant in a primary covered transaction) may not knowingly do business with a person who is debarred, suspended, proposed for debarment, or subject to other government-wide exclusion (including any exclusion from Medicare and State health care program participation on or after August 25, 1995), and the Department of Health must require its prospective contractors, as prospective lower tier participants, to provide the certification in Appendix B to Part 76 of Title 45 CFR, as set forth below:

1) APPENDIX B TO 45 CFR PART 76-CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION-LOWER TIER COVERED TRANSACTIONS

Instructions for Certification

- a) By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
- b) The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
- c) The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
- d) The terms *covered transaction*, *debarred*, *suspended*, *ineligible*, *lower tier covered transaction*, *participant*, *person*, *primary covered transaction*, *principal*, *proposal*, and *voluntarily excluded*, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
- e) The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
- f) The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions.
- g) A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its

principals. Each participant may, but is not required to, check the List of Parties Excluded From Federal Procurement and Non-procurement Programs.

- h) Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
- i) Except for transactions authorized under paragraph "e" of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

2) Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower Tier Covered Transactions

- a) The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department agency.
- b) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

- 6. The STATE, its employees, representatives and designees, shall have the right at any time during normal business hours to inspect the sites where services are performed and observe the services being performed by the CONTRACTOR. The CONTRACTOR shall render all assistance and cooperation to the STATE in making such inspections. The surveyors shall have the responsibility for determining contract compliance as well as the quality of service being rendered.
- 7. The CONTRACTOR will not discriminate in the terms, conditions and privileges of employment, against any employee, or against any applicant for employment because of race, creed, color, sex, national origin, age, disability, sexual orientation or marital status. The CONTRACTOR has an affirmative duty to take prompt, effective, investigative and remedial action where it has actual or constructive notice of discrimination in the terms, conditions or privileges of employment against (including harassment of) any of its employees by any of its other employees, including managerial personnel, based on any of the factors listed above.
- 8. The CONTRACTOR shall not discriminate on the basis of race, creed, color, sex, national origin, age, disability, sexual orientation or marital status against any person seeking services for which the CONTRACTOR may receive reimbursement or payment under this AGREEMENT.

9. The CONTRACTOR shall comply with all applicable federal, State and local civil rights and human rights laws with reference to equal employment opportunities and the provision of services.
10. The STATE may cancel this AGREEMENT at any time by giving the CONTRACTOR not less than thirty (30) days written notice that on or after a date therein specified, this AGREEMENT shall be deemed terminated and cancelled.
11. Where the STATE does not provide notice to the NOT-FOR-PROFIT CONTRACTOR of its intent to not renew this contract by the date by which such notice is required by Section 179-t(1) of the State Finance Law, then this contract shall be deemed continued until the date that the agency provides the notice required by Section 179-t, and the expenses incurred during such extension shall be reimbursable under the terms of this contract.

12. Other Modifications

- a. Modifications of this AGREEMENT as specified below may be made within an existing PERIOD by mutual written agreement of both parties:
 - ◆ Appendix B - Budget line interchanges; Any proposed modification to the contract which results in a change of greater than 10 percent to any budget category, must be submitted to OSC for approval;
 - ◆ Appendix C - Section 11, Progress and Final Reports;
 - ◆ Appendix D - Program Workplan will require OSC approval.
 - b. To make any other modification of this AGREEMENT within an existing PERIOD, the parties shall revise or complete the appropriate appendix form(s), and a Modification Agreement (Appendix X is the blank form to be used), which shall be effective only upon approval by the Office of the State Comptroller.
13. Unless the CONTRACTOR is a political sub-division of New York State, the CONTRACTOR shall provide proof, completed by the CONTRACTOR's insurance carrier and/or the Workers' Compensation Board, of coverage for

Workers' Compensation, for which one of the following is incorporated into this contract as **Appendix E-1**:

- **CE-200** - Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage is Not Required; OR
- **C-105.2** -- Certificate of Workers' Compensation Insurance. PLEASE NOTE: The State Insurance Fund provides its own version of this form, the **U-26.3**; OR
- **SI-12** -- Certificate of Workers' Compensation Self-Insurance, OR **GSI-105.2** -- Certificate of Participation in Workers' Compensation Group Self-Insurance

Disability Benefits coverage, for which one of the following is incorporated into this contract as **Appendix E-2**:

- **CE-200** - Certificate of Attestation For New York Entities With No Employees And Certain Out Of State Entities, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage is Not Required; OR
- **DB-120.1** -- Certificate of Disability Benefits Insurance OR
- **DB-155** -- Certificate of Disability Benefits Self-Insurance

14. Contractor shall comply with the provisions of the New York State Information Security Breach and Notification Act (General Business Law Section 899-aa; State Technology Law Section 208). Contractor shall be liable for the costs associated with such breach if caused by Contractor's negligent or willful acts or omissions, or the negligent or willful acts or omissions of Contractor's agents, officers, employees or subcontractors.
15. All products supplied pursuant to this agreement shall meet local, state and federal regulations, guidelines and action levels for lead as they exist at the time of the State's acceptance of this contract.
16. Additional clauses as may be required under this AGREEMENT are annexed hereto as appendices and are made a part hereof if so indicated on the face page of this AGREEMENT.

APPENDIX C

PAYMENT AND REPORTING SCHEDULE

1. Payment and Reporting Terms and Conditions

A. The STATE may, at its discretion, make an advance payment to the CONTRACTOR, during the initial or any subsequent PERIOD, in an amount to be determined by the STATE but not to exceed 25 percent of the maximum amount indicated in the budget as set forth in the most recently approved Appendix B. If this payment is to be made, it will be due thirty calendar days, excluding legal holidays, after the later of either:

- ❶ the first day of the contract term specified in the Initial Contract Period identified on the face page of the AGREEMENT or if renewed, in the PERIOD identified in the Appendix X, OR
- ❶ if this contract is wholly or partially supported by Federal funds, availability of the federal funds;

provided, however, that a STATE has not determined otherwise in a written notification to the CONTRACTOR suspending a Written Directive associated with this AGREEMENT, and that a proper voucher for such advance has been received in the STATE's designated payment office. If no advance payment is to be made, the initial payment under this AGREEMENT shall be due thirty calendar days, excluding legal holidays, after the later of either:

- ❶ the end of the first quarterly period of this AGREEMENT; or
- ❶ if this contract is wholly or partially supported by federal funds, availability of the federal funds:

provided, however, that the proper voucher for this payment has been received in the STATE's designated payment office.

B. No payment under this AGREEMENT, other than advances as authorized herein, will be made by the STATE to the CONTRACTOR unless proof of performance of required services or accomplishments is provided. If the CONTRACTOR fails to perform the services required under this AGREEMENT the STATE shall, in addition to any remedies available by law or equity, recoup payments made but not earned, by set-off against any other public funds owed to CONTRACTOR.

- C. Any optional advance payment(s) shall be applied by the STATE to future payments due to the CONTRACTOR for services provided during initial or subsequent PERIODS. Should funds for subsequent PERIODS not be appropriated or budgeted by the STATE for the purpose herein specified, the STATE shall, in accordance with Section 41 of the State Finance Law, have no liability under this AGREEMENT to the CONTRACTOR, and this AGREEMENT shall be considered terminated and cancelled.
- D. The CONTRACTOR will be entitled to receive payments for work, projects, and services rendered as detailed and described in the program workplan, Appendix D. All payments shall be in conformance with the rules and regulations of the Office of the State Comptroller. The CONTRACTOR shall provide complete and accurate billing vouchers to the Agency's designated payment office in order to receive payment. Billing vouchers submitted to the Agency must contain all information and supporting documentation required by the Contract, the Agency and the State Comptroller. Payment for vouchers submitted by the CONTRACTOR shall be rendered electronically unless payment by paper check is expressly authorized by the Commissioner, in the Commissioner's sole discretion, due to extenuating circumstances. Such electronic payment shall be made in accordance with ordinary State procedures and practices. The CONTRACTOR shall comply with the State Comptroller's procedures to authorize electronic payments. Authorization forms are available at the State Comptroller's website at www.osc.state.ny.us/epay/index.htm, by email at epunit@osc.state.ny.us or by telephone at 518-474-6019. The CONTRACTOR acknowledges that it will not receive payment on any vouchers submitted under this contract if it does not comply with the State Comptroller's electronic payment procedures, except where the Commissioner has expressly authorized payment by paper check as set forth above.

In addition to the Electronic Payment Authorization Form, a Substitute Form W-9, must be on file with the Office of the State Comptroller, Bureau of Accounting Operations. Additional information and procedures for enrollment can be found at <http://www.osc.state.ny.us/epay>.

Completed W-9 forms should be submitted to the following address:

NYS Office of the State Comptroller
Bureau of Accounting Operations
Warrant & Payment Control Unit
110 State Street, 9th Floor
Albany, NY 12236

- E. The CONTRACTOR will provide the STATE with the reports of progress or other specific work products pursuant to this AGREEMENT as described in this Appendix below. In addition, a final report must be submitted by the CONTRACTOR no later than 45 days after the end of this AGREEMENT. All required reports or other work products developed under this AGREEMENT must be completed as provided by the agreed upon work schedule in a manner

satisfactory and acceptable to the STATE in order for the CONTRACTOR to be eligible for payment.

- F. The CONTRACTOR shall submit to the STATE monthly voucher claims and reports of expenditures on such forms and in such detail as the STATE shall require. The CONTRACTOR shall submit vouchers to their designated Contract Manager.

All vouchers submitted by the CONTRACTOR pursuant to this AGREEMENT shall be submitted to the STATE no later than 30 days after the end date of the period for which reimbursement is being claimed. In no event shall the amount received by the CONTRACTOR exceed the budget amount approved by the STATE, and, if actual expenditures by the CONTRACTOR are less than such sum, the amount payable by the STATE to the CONTRACTOR shall not exceed the amount of actual expenditures. All contract advances in excess of actual expenditures will be recouped by the STATE prior to the end of the applicable budget period.

- G. If the CONTRACTOR is eligible for an annual cost of living adjustment (COLA), enacted in New York State Law, that is associated with this grant AGREEMENT, payment of such COLA, or a portion thereof, may be applied toward payment of amounts payable under Appendix B of this AGREEMENT or may be made separate from payments under this AGREEMENT, at the discretion of the STATE.

Before payment of a COLA can be made, the STATE shall notify the CONTRACTOR, in writing, of eligibility for any COLA. If payment is to be made separate from payments under this AGREEMENT, the CONTRACTOR shall be required to submit a written certification attesting that all COLA funding will be used to promote the recruitment and retention of staff or respond to other critical non-personal service costs during the State fiscal year for which the cost of living adjustment was allocated, or provide any other such certification as may be required in the enacted legislation authorizing the COLA.

II. Progress and Final Reports

Report Type:

- A. Narrative/Qualitative Report
The CONTRACTOR will submit, on a monthly basis, not later than 30 days from the end of the month, a report summarizing the services rendered during the month/quarter. This report will detail how the CONTRACTOR has progressed toward attaining the qualitative goals enumerated in the Program Workplan (Appendix D).

(Note: This report should address all goals and objectives of the project and include a discussion of problems encountered and steps taken to solve them.)

B. Statistical/Quantitative Report

The CONTRACTOR will submit, on a monthly basis, not later than 30 days from the end of the month, a detailed report analyzing the quantitative aspects of the program plan, as appropriate (e.g., staff changes, site directory changes, number of applications processed, outreach events, training sessions conducted, etc.)

C. Expenditure Report

The CONTRACTOR will submit, on a monthly basis, not later than 30 days after the end date for which reimbursement is being claimed, a detailed expenditure report, by object of expense. This report will accompany the voucher submitted for such period.

D. Final Report

The CONTRACTOR will submit a final report, as required by the contract, reporting on all aspects of the program, detailing how the use of grant funds were utilized in achieving the goals set forth in the program Workplan (Appendix D).

APPENDIX D

Facilitated Enrollment Workplan: Contract Deliverables

<i>Start-Up Activities</i>	<i>Outcomes/Deliverables</i>
Develop detailed final FE workplan and budget	Approved workplan and budget by SDOH
Identify and submit to SDOH for approval facilitated enrollment site schedule (locations w/address, days and times, and languages spoken)	Appropriate sites with day, evening, and weekend hours to reach target population
Develop and submit to SDOH for approval protocols with local department(s) of social services/HRA and FE agency internal operating protocols	Protocols with LDSS(s)/HRA and internal operating protocols outlining quality assurance process, and receipt and processing of applications
Complete State and Federal Confidentiality Requirements Statement for FE Agency and send to SDOH	Understanding of confidentiality requirements documented
Develop contract with SDOH	Signed grant contract sent to SDOH within 30 days of contract receipt
Develop subcontracts, if applicable, and send copy of all signed subcontracts to SDOH	Documentation of executed facilitated enrollment agreements
Hire staff per SDOH approved budget; train staff and adhere to official SDOH FE Program training curriculum, and HIPAA; staff complete State and Federal Confidentiality Requirement Statement for FE Agency and/or Subcontractors	Appropriate number of FE agency staff and facilitators hired and trained to implement program; understanding of confidentiality requirements documented
Ensure data system is operational to transmit electronically application and enrollment data to SDOH through an Internet-based system, Health Commerce System (HCS).	Technical capacity to report through HCS
Complete HCS User Permission forms and train staff to enter, retrieve and edit HCS data	Permission granted and staffing capacity to use HCS data system
<i>Ongoing Activities</i>	<i>Outcomes/Deliverables</i>
Assist individuals to complete applications for new and renewal for health insurance	Completed and signed applications
Conduct quality assurance on Access NY Health Care applications and process them following SDOH approved internal operating protocols.	Submitted to LDSS/health plan accurate and complete applications
Communicate regularly with LDSS and health plans to address issues and follow program requirements, and ensure LDSS/HRA protocols are implemented and revised as needed	Adhere to program requirements and protocols
Coordinate, monitor/evaluate and communicate regularly with subcontractors and facilitators to address issues, ensure program requirements and protocols are implemented and correct deficiencies	Facilitators and subcontractor performance monitored to ensure accurate and complete applications submitted to FE agency; correction plan submitted to SDOH for any program deficiencies or issues with facilitators
Provide on going training to facilitators	Facilitators updated on SDOH FE Program
Enter application and determination data on the Health Commerce System (HCS) as directed by SDOH at least weekly and by 5 th business day following end of month	Current data on HCS
Submit timely required expenditure and progress reports and vouchers to SDOH 30 days after the end of the reporting period	On time reports and vouchers
Submit data on the length of time required for a person to get an appointment with a facilitator in the progress report or upon request by SDOH	Timely screening and application assistance appointments
Submit all proposed program and outreach materials for SDOH approval prior to use	Accurate and up to date FE Program information to public
Report promptly to SDOH changes in the number of full time equivalent facilitators within the currently approved budget	Up to date facilitator numbers
Submit budget modifications for SDOH approval prior to the effective date of the proposed modification	Prospective budget modifications
Attend mandatory SDOH meetings	Updated about program issues, successes and policies

APPENDIX G
NOTICES

All notices permitted or required hereunder shall be in writing and shall be transmitted either:

- (a) via certified or registered United States mail, return receipt requested;
- (b) by facsimile transmission;
- (c) by personal delivery;
- (d) by expedited delivery service; or
- (e) by e-mail.

Such notices shall be addressed as follows or to such different addresses as the parties may from time to time designate:

State of New York Department of Health

Name:

Title:

Address:

Telephone Number:

Facsimile Number:

E-Mail Address:

[Insert Contractor Name]

Name:

Title:

Address:

Telephone Number:

Facsimile Number:

E-Mail Address:

Any such notice shall be deemed to have been given either at the time of personal delivery or, in the case of expedited delivery service or certified or registered United States mail, as of the date of first attempted delivery at the address and in the manner provided herein, or in the case of facsimile transmission or email, upon receipt.

The parties may, from time to time, specify any new or different address in the United States as their address for purpose of receiving notice under this AGREEMENT by giving fifteen (15) days written notice to the other party sent in accordance herewith. The parties agree to mutually designate individuals as their respective representative for the purposes of receiving notices under this AGREEMENT. Additional individuals may be designated in writing by the parties for purposes of implementation and administration/billing, resolving issues and problems, and/or for dispute resolution.

**APPENDIX X
Agency Code 12000**

Contract Number: _____

Contractor: _____

Amendment Number X-_____

This is an AGREEMENT between THE STATE OF NEW YORK, acting by and through NYS Department of Health, having its principal office at Albany, New York, (hereinafter referred to as the STATE), and _____ (hereinafter referred to as the CONTRACTOR), for amendment of this contract.

This amendment makes the following changes to the contract (check all that apply):

- _____ Modifies the contract period at no additional cost
- _____ Modifies the contract period at additional cost
- _____ Modifies the budget or payment terms
- _____ Modifies the work plan or deliverables
- _____ Replaces appendix(es) _____ with the attached appendix(es) _____
- _____ Adds the attached appendix(es) _____
- _____ Other: (describe) _____

This amendment *is* / *is not* a contract renewal as allowed for in the existing contract.

All other provisions of said AGREEMENT shall remain in full force and effect.

Prior to this amendment, the contract value and period were:

\$ _____
(Value before amendment)

From ____ / ____ / ____ to ____ / ____ / ____.
(Initial start date)

This amendment provides the following addition (complete only items being modified):

\$ _____

From ____ / ____ / ____ to ____ / ____ / ____.

This will result in new contract terms of:

\$ _____
(All years thus far combined)

From ____ / ____ / ____ to ____ / ____ / ____.
(Initial start date) (Amendment end date)

Signature Page for:

Contract Number: _____

Contractor: _____

Amendment Number: X-_____

-
IN WITNESS WHEREOF, the parties hereto have executed this AGREEMENT as of the dates appearing under their signatures.

CONTRACTOR SIGNATURE:

By: _____ Date: _____

(signature)

Printed Name: _____

Title: _____

STATE OF NEW YORK)
) SS:
County of _____)

On the ____ day of _____ in the year _____ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is(are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their/ capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

(Signature and office of the individual taking acknowledgement)

STATE AGENCY SIGNATURE

"In addition to the acceptance of this contract, I also certify that original copies of this signature page will be attached to all other exact copies of this contract."

By: _____ Date: _____

(signature)

Printed Name: _____

Title: _____

ATTORNEY GENERAL'S SIGNATURE

By: _____ Date: _____

STATE COMPTROLLER'S SIGNATURE

By: _____ Date: _____

Appendix H

for CONTRACTOR that uses or discloses individually identifiable health information on behalf of a New York State Department of Health HIPAA-Covered Program

- I. Definitions. For purposes of this Appendix H of this AGREEMENT:
 - A. “Business Associate” shall mean CONTRACTOR.
 - B. “Covered Program” shall mean the STATE.
 - C. Other terms used, but not otherwise defined, in this AGREEMENT shall have the same meaning as those terms in the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act (“HITECH”) and implementing regulations, including those at 45 CFR Parts 160 and 164.
- II. Obligations and Activities of Business Associate:
 - A. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this AGREEMENT or as Required By Law.
 - B. Business Associate agrees to use the appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this AGREEMENT.
 - C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this AGREEMENT.
 - D. Business Associate agrees to report to Covered Program as soon as reasonably practicable any use or disclosure of the Protected Health Information not provided for by this AGREEMENT of which it becomes aware. Business Associate also agrees to report to Covered Program any Breach of Unsecured Protected Health Information of which it becomes aware. Such report shall include, to the extent possible:
 1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
 2. A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
 3. Any steps individuals should take to protect themselves from potential harm resulting from the breach;
 4. A description of what Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches; and
 5. Contact procedures for Covered Program to ask questions or learn additional information.
 - E. Business Associate agrees to ensure that any agent, including a subcontractor, to

whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Program agrees to the same restrictions and conditions that apply through this AGREEMENT to Business Associate with respect to such information.

- F. Business Associate agrees to provide access, at the request of Covered Program, and in the time and manner designated by Covered Program, to Protected Health Information in a Designated Record Set, to Covered Program in order for Covered Program to comply with 45 CFR § 164.524.
 - G. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Covered Program directs in order for Covered Program to comply with 45 CFR § 164.526.
 - H. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Program available to Covered Program, or to the Secretary of the federal Department of Health and Human Services, in a time and manner designated by Covered Program or the Secretary, for purposes of the Secretary determining Covered Program's compliance with HIPAA, HITECH and 45 CFR Parts 160 and 164.
 - I. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
 - J. Business Associate agrees to provide to Covered Program, in time and manner designated by Covered Program, information collected in accordance with this AGREEMENT, to permit Covered Program to comply with 45 CFR § 164.528.
 - K. Business Associate agrees to comply with the security standards for the protection of electronic protected health information in 45 CFR § 164.308, 45 CFR § 164.310, 45 CFR § 164.312 and 45 CFR § 164.316.
- III. Permitted Uses and Disclosures by Business Associate
- A. Except as otherwise limited in this AGREEMENT, Business Associate may only use or disclose Protected Health Information as necessary to perform functions, activities, or services for, or on behalf of, Covered Program as specified in this AGREEMENT.
 - B. Business Associate may use Protected Health Information for the proper management and administration of Business Associate.
 - C. Business Associate may disclose Protected Health Information as Required By Law.
- IV. Term and Termination
- A. This AGREEMENT shall be effective for the term as specified on the cover page of this AGREEMENT, after which time all of the Protected Health Information provided by Covered Program to Business Associate, or created or received by

Business Associate on behalf of Covered Program, shall be destroyed or returned to Covered Program; provided that, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Appendix H of this AGREEMENT.

- B. Termination for Cause. Upon Covered Program's knowledge of a material breach by Business Associate, Covered Program may provide an opportunity for Business Associate to cure the breach and end the violation or may terminate this AGREEMENT if Business Associate does not cure the breach and end the violation within the time specified by Covered Program, or Covered Program may immediately terminate this AGREEMENT if Business Associate has breached a material term of this AGREEMENT and cure is not possible.
- C. Effect of Termination.
 - 1. Except as provided in paragraph (c)(2) below, upon termination of this AGREEMENT, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Program, or created or received by Business Associate on behalf of Covered Program. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
 - 2. In the event that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Program notification of the conditions that make return or destruction infeasible. Upon mutual agreement of Business Associate and Covered Program that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this AGREEMENT to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

V. Violations

- A. Any violation of this AGREEMENT may cause irreparable harm to the STATE. Therefore, the STATE may seek any legal remedy, including an injunction or specific performance for such harm, without bond, security or necessity of demonstrating actual damages.
- B. Business Associate shall indemnify and hold the STATE harmless against all claims and costs resulting from acts/omissions of Business Associate in connection with Business Associate's obligations under this AGREEMENT. Business Associate shall be fully liable for the actions of its agents, employees, partners or subcontractors and shall fully indemnify and save harmless the STATE from suits, actions, damages and costs, of every name and description relating to breach notification required by 45 CFR Part 164 Subpart D, or State Technology Law § 208, caused by any intentional act or negligence of Business Associate, its agents, employees, partners or subcontractors, without limitation; provided,

however, that Business Associate shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the STATE.

VI. Miscellaneous

- A. Regulatory References. A reference in this AGREEMENT to a section in the Code of Federal Regulations means the section as in effect or as amended, and for which compliance is required.
- B. Amendment. Business Associate and Covered Program agree to take such action as is necessary to amend this AGREEMENT from time to time as is necessary for Covered Program to comply with the requirements of HIPAA, HITECH and 45 CFR Parts 160 and 164.
- C. Survival. The respective rights and obligations of Business Associate under (IV)(C) of this Appendix H of this AGREEMENT shall survive the termination of this AGREEMENT.
- D. Interpretation. Any ambiguity in this AGREEMENT shall be resolved in favor of a meaning that permits Covered Program to comply with HIPAA, HITECH and 45 CFR Parts 160 and 164.
- E. HIV/AIDS. If HIV/AIDS information is to be disclosed under this AGREEMENT, Business Associate acknowledges that it has been informed of the confidentiality requirements of Public Health Law Article 27-F.

Appendix H

for CONTRACTOR that uses or discloses individually identifiable health information on behalf of a New York State Department of Health HIPAA-Covered Program

- I. Definitions. For purposes of this Appendix H of this AGREEMENT:
 - A. “Business Associate” shall mean CONTRACTOR.
 - B. “Covered Program” shall mean the STATE.
 - C. Other terms used, but not otherwise defined, in this AGREEMENT shall have the same meaning as those terms in the federal Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act (“HITECH”) and implementing regulations, including those at 45 CFR Parts 160 and 164.
- II. Obligations and Activities of Business Associate:
 - A. Business Associate agrees to not use or disclose Protected Health Information other than as permitted or required by this AGREEMENT or as Required By Law.
 - B. Business Associate agrees to use the appropriate administrative, physical and technical safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this AGREEMENT.
 - C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this AGREEMENT.
 - D. Business Associate agrees to report to Covered Program as soon as reasonably practicable any use or disclosure of the Protected Health Information not provided for by this AGREEMENT of which it becomes aware. Business Associate also agrees to report to Covered Program any Breach of Unsecured Protected Health Information of which it becomes aware. Such report shall include, to the extent possible:
 - 1. A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
 - 2. A description of the types of Unsecured Protected Health Information that were involved in the Breach (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);
 - 3. Any steps individuals should take to protect themselves from potential harm resulting from the breach;
 - 4. A description of what Business Associate is doing to investigate the Breach, to mitigate harm to individuals, and to protect against any further Breaches; and
 - 5. Contact procedures for Covered Program to ask questions or learn additional information.
 - E. Business Associate agrees to ensure that any agent, including a subcontractor, to

whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Program agrees to the same restrictions and conditions that apply through this AGREEMENT to Business Associate with respect to such information.

- F. Business Associate agrees to provide access, at the request of Covered Program, and in the time and manner designated by Covered Program, to Protected Health Information in a Designated Record Set, to Covered Program in order for Covered Program to comply with 45 CFR § 164.524.
 - G. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that Covered Program directs in order for Covered Program to comply with 45 CFR § 164.526.
 - H. Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Program available to Covered Program, or to the Secretary of the federal Department of Health and Human Services, in a time and manner designated by Covered Program or the Secretary, for purposes of the Secretary determining Covered Program's compliance with HIPAA, HITECH and 45 CFR Parts 160 and 164.
 - I. Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Program to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR § 164.528.
 - J. Business Associate agrees to provide to Covered Program, in time and manner designated by Covered Program, information collected in accordance with this AGREEMENT, to permit Covered Program to comply with 45 CFR § 164.528.
 - K. Business Associate agrees to comply with the security standards for the protection of electronic protected health information in 45 CFR § 164.308, 45 CFR § 164.310, 45 CFR § 164.312 and 45 CFR § 164.316.
- III. Permitted Uses and Disclosures by Business Associate
- A. Except as otherwise limited in this AGREEMENT, Business Associate may only use or disclose Protected Health Information as necessary to perform functions, activities, or services for, or on behalf of, Covered Program as specified in this AGREEMENT.
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however, that Business Associate shall not indemnify for that portion of any claim, loss or damage arising hereunder due to the negligent act or failure to act of the STATE.

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- A. Regulatory References. A reference in this AGREEMENT to a section in the Code of Federal Regulations means the section as in effect or as amended, and for which compliance is required.
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- D. Interpretation. Any ambiguity in this AGREEMENT shall be resolved in favor of a meaning that permits Covered Program to comply with HIPAA, HITECH and 45 CFR Parts 160 and 164.
- E. HIV/AIDS. If HIV/AIDS information is to be disclosed under this AGREEMENT, Business Associate acknowledges that it has been informed of the confidentiality requirements of Public Health Law Article 27-F.

ATTACHMENT 11

FACILITATED ENROLLMENT PROGRAM APPLICATION CHECKLIST

The following is a checklist for the applicant to review and ensure that all information is provided. The application must be received by Friday October 14, 2011, no later than 4:00 PM at the address listed in the RFA.

1. Transmittal Letter

- Letter is signed by an official authorized to bind the applicant to all requirements stated in the document
- Statement that the applicant's organization is a not-for-profit community based organization
- Statement attesting to the accuracy and truthfulness of all information contained in the application
- Statement that the applicant has read, understands, and is able and willing to comply with all the conditions and terms contained in the RFA
- If an applicant does not accept a certain condition or term, this needs to be clearly noted in the transmittal letter
- Statement that the application and all provisions of the budget will remain in effect for 180 days

2. Grant Application Cover Sheet

- Completion of the Grant Cover Sheet (Attachment 10)

3. Program Summary

- Provide a one-page summary of proposed FE Program including target area and population to be served, enrollment strategy, and how the application assistance process will be managed

4. Statement of Need

- Description of the target area (counties or boroughs and zip codes) and population, including the cultural and language characteristics of the area
- Explanation how the applicant's proposed FE Program will address an unmet need and why applicant is qualified to do FE

5. Applicant Organization

- Description of the organization's mission, organizational structure, the services it provides and the role it will play in the proposed FE Program

- Description of current and past experiences as SDOH contractor including funds received, services provided (last 5 years) and compliance with contractual requirements
- Commitment of board of directors, if applicable, and the organization to the program, community and the target population
- Staff retention rate for organization and each proposed subcontractor, if applicable; or average staff retention or the average amount of time similarly salaried staff have remained in a working relationship with the organization and each proposed subcontractor, if applicable
- Description of the dedicated program manager responsibilities and proportion of time person will devote to the FE Program

6. Proposed Facilitated Enrollment Strategy

- Approaches to be undertaken to reach children and adult populations in the proposed service area, including vulnerable and hard to reach populations including the availability of bilingual materials, if appropriate
- The proposed number of facilitated enrollers, including those to be employed by subcontractor(s), and discussion of their qualifications and prior experience working with target population and language capabilities
- Explanation as to why the applicant believes each subcontractor will be successful and/or the rationale for a proposed a new subcontractor to participate in the program.
- Number of quality review, support and other staff proposed for FE Program
- Identification of proposed subcontractor(s), if applicable and a letter of intent from each proposed subcontractor describing the proposed role it will play
- Estimated number of applications, monthly, to be submitted to the appropriate programs including an explanation of how the estimate was derived. Current FE agency should also include projected level of productivity in terms of applications submitted per facilitator per FTE week. New applicant, where possible, should based projection on prior experience assisting the target population in applying for benefits including health insurance and any other means tested program.
- Steps that will be taken to assist applicants with completing an application and obtaining necessary documentation, and following through to enrollment
- Commitment to provide original documentation certification services to individual applying for MA/FHP/CHPlus
- Description of the applicant's planned internal program procedures including the timeframes for handling applications, completing applications, performing quality review, and submitting the application to the appropriate entity for eligibility determination
- Description of applicant's experience working with health plans and/or LDSSs/HRA or proposed plan for developing such relationships
- Commitment that facilitator(s) present potential enrollees unbiased information and assistance for plan selection
- Commitment to comply with established procedures for transmitting MMC or FHPlus managed care plan choices to an enrollment broker or the LDSS

- Commitment to complete and comply with protocols with the applicable LDSS(s)/HRA

7. Identification of Proposed Locations and Schedules

- Detailed description of the potential locations where facilitated enrollment will occur and how these locations will enhance accessibility for facilitated enrollment
- Schedule of expected days and hours of operation including weekend and evening hours, and languages to be spoken
- Commitment to update sites in the SDOH FE site directory on a real time basis
- A completed form listing the proposed locations and schedules (Attachment 13)

8. Quality Assurance, Training, Outreach and Reporting

- Proposed schedule of frequent and regular communication between the applicant and its subcontractor(s), if applicable, and all Facilitated enroller
- Plan for monitoring the number of applications taken and appropriate processing of the applications of each facilitator hired directly by the applicant and hired by subcontractor(s), if applicable, including a plan of correction for non and under performance
- Commitment to not continue to fund at the same level non or under performing subcontractor(s)
- Description of how applicant will adjust arrangements with non or under performing subcontractor(s)
- Description of the quality assurance standards that will be implemented by the applicant to ensure complete, timely and highly accurate applications
- Commitment to establish written internal operating protocols for the FE Program
- Commitment to undergo training and adhere to the official SDOH FE Program training curriculum
- Plan to provide ongoing training and technical assistance to all Facilitated enroller hired by the applicant and its subcontractor(s)
- Demonstration that the applicant's current data collection and reporting systems will be accommodated to include the capacity to transmit data electronically to SDOH and include commitment that all required reports can be handled electronically, and that data entry will occur within the timeframe stated in the Appendix A-2 in the SDOH contract, Attachment 7
- Commitment, that if awarded funding, the applicant agrees confidential data must not be disclosed, except to an organization listed on the signed application, without prior written approval of the MA Confidential Data Review Committee

9. Readiness/ Workplan

- Proposed workplan, including timeframes and responsible parties (Attachment 14)
- Statement, that if awarded funding, the applicant will sign and submit the grant contract (included in Attachment 7 of the RFA) to SDOH within 30 days of contract receipt. If it is unlikely that the agency will be able to meet this

timeframe, the applicant should explain the circumstances creating this delay, and define the expected amount of time required for completion of the contract process

10. Budget and Justification

- Proposed FE Program budget and subcontractor(s) budget(s), if applicable (Attachments 15A and 15B), which includes allowable personnel and non-personnel costs and a line item justification(s) as defined in Sec.VIII.B, number 9 in the RFA
- Description of organizational governance which dictates personnel expenditures, if applicable
- Description how future COLAs and fringe benefit rate increases will be addressed in an environment of level funding

ADDITIONAL SUBMISSION ITEMS

Please note, that grantees must submit the following items to SDOH for review prior to final SDOH contract approval:

- Completed and signed Vendor Responsibility Questionnaire & Attestation and its subcontractor(s) depending on award amount for each
- Proposed final FE Program workplan and 12-month line item budget and justification
- Signed “Certification Regarding State & Federal Confidentiality Requirements for Facilitated Enrollment Agency”
- Protocols between grantee and LDSS(s)/HRA in the county(s) that the grantee will be serving
- Grantee FE Program internal operating protocols
- Specific facilitated enrollment site schedule (locations with addresses, days and times, languages spoken)
- Written assurance to comply with applicable American with Disabilities Act (ADA) standards to assure that FE sites, services, programs and activities are readily accessible to and usable by individuals with disabilities

ATTACHMENT 12

Allocation of NYS 2009 Uninsured Children and Adults to Counties

County	Age 0 to 18			Age 19 to 64		
	Uninsured	Population	% Unins	Uninsured	Population	% Unins
Albany	3,435	67,296	5.1%	22,146	190,148	11.6%
Allegany	846	12,015	7.0%	4,764	29,980	15.9%
Bronx	41,198	412,528	10.0%	233,935	837,272	27.9%
Broome	2,300	43,779	5.3%	19,324	118,351	16.3%
Cattaraugus	2,528	19,608	12.9%	9,731	47,562	20.5%
Cayuga	1,619	17,858	9.1%	7,234	49,791	14.5%
Chautauqua	2,019	31,408	6.4%	14,845	80,358	18.5%
Chemung	1,734	20,740	8.4%	7,444	53,847	13.8%
Chenango	952	12,025	7.9%	5,448	30,247	18.0%
Clinton	1,217	16,956	7.2%	7,873	53,576	14.7%
Columbia	1,384	13,378	10.3%	7,355	37,456	19.6%
Cortland	738	11,521	6.4%	4,790	30,201	15.9%
Delaware	842	9,818	8.6%	4,756	26,836	17.7%
Dutchess	3,090	71,625	4.3%	30,022	183,079	16.4%
Erie	12,838	209,531	6.1%	74,763	555,695	13.5%
Essex	834	7,425	11.2%	4,831	23,838	20.3%
Franklin	852	10,257	8.3%	5,001	33,116	15.1%
Fulton	796	12,532	6.3%	5,318	33,698	15.8%
Genesee	1,225	13,553	9.0%	6,132	34,871	17.6%
Greene	1,001	10,666	9.4%	5,157	30,496	16.9%
Hamilton	159	879	18.2%	922	2,979	31.0%
Herkimer	1,034	14,443	7.2%	6,051	37,529	16.1%
Jefferson	2,119	30,722	6.9%	12,970	74,052	17.5%
Kings	55,645	665,537	8.4%	387,324	1,601,447	24.2%
Lewis	581	6,342	9.2%	3,064	15,927	19.2%
Livingston	1,102	14,325	7.7%	6,291	40,311	15.6%
Madison	981	17,104	5.7%	7,023	43,265	16.2%
Monroe	11,208	178,488	6.3%	57,457	453,360	12.7%
Montgomery	763	11,938	6.4%	3,986	28,270	14.1%
Nassau	24,845	332,582	7.5%	128,223	818,120	15.7%
New York	23,778	277,247	8.6%	208,147	1,144,171	18.2%
Niagara	3,529	49,292	7.2%	20,097	131,975	15.2%
Oneida	2,401	53,129	4.5%	19,161	140,312	13.7%
Onondaga	7,039	111,917	6.3%	43,499	278,555	15.6%
Ontario	1,613	25,187	6.4%	9,855	64,394	15.3%
Orange	11,036	110,940	9.9%	43,981	232,618	18.9%
Orleans	826	9,972	8.3%	4,246	26,076	16.3%
Oswego	1,296	30,113	4.3%	12,243	76,345	16.0%
Otsego	1,209	13,486	9.0%	6,701	38,162	17.6%
Putnam	1,129	24,859	4.5%	7,821	62,571	12.5%
Queens	54,336	519,503	10.5%	430,701	1,486,288	29.0%
Rensselaer	516	35,970	1.4%	12,356	98,429	12.6%
Richmond	8,301	119,858	6.9%	39,523	310,479	12.7%
Rockland	5,157	87,555	5.9%	31,438	171,416	18.3%
Saratoga	2,402	51,324	4.7%	20,443	139,913	14.6%
Schenectady	2,499	37,057	6.7%	16,150	91,527	17.6%
Schoharie	540	7,204	7.5%	3,209	19,432	16.5%
Schuyler	358	4,094	8.7%	2,002	11,485	17.4%
Seneca	655	7,500	8.7%	3,441	21,365	16.1%
St Lawrence	2,122	25,893	8.2%	10,109	68,998	14.7%
Steuben	3,228	23,400	13.8%	10,364	58,118	17.8%
Suffolk	28,081	388,399	7.2%	164,587	925,960	17.8%
Sullivan	1,993	18,228	10.9%	9,811	46,563	21.1%
Tioga	884	12,248	7.2%	4,863	30,198	16.1%
Tompkins	268	21,764	1.2%	8,721	69,472	12.6%
Ulster	3,921	39,522	9.9%	24,404	115,727	21.1%
Warren	955	14,069	6.8%	8,363	40,358	20.7%
Washington	1,177	13,834	8.5%	6,696	39,271	17.1%
Wayne	2,562	23,031	11.1%	10,012	55,503	18.0%
Westchester	11,565	243,038	4.8%	120,052	577,570	20.8%
Wyoming	936	9,043	10.4%	4,625	26,826	17.2%
Yates	654	6,297	10.4%	2,628	14,120	18.6%
Statewide	366,853	4,711,838	7.8%	2,414,428	12,209,861	19.8%

The method allocates the NYC and Rest-of-State uninsured estimated by the Census Bureau's Current Population Survey (CPS) based on a county's share of the uninsured in the American Community Survey (ACS) or its share of the Census Bureau's SAHIE model for non-ACS counties.