

NEW YORK STATE DEPARTMENT OF HEALTH

A Request for Proposal for

Division of Long Term Care Resources
Office of Long Term Care

RFP No.0907070849

Long Term Care Assessment Center

Schedule of Key Events

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| RFP Release Date | July 27, 2009 |
| Letter of Intent Due (<u>Strongly Recommended</u>) | August 5, 2009 |
| Bidders Conference | August 12, 2009 |
| Written Questions Due | August 26, 2009 |
| Response to Questions | September 14, 2009 |
| Proposal Due Date | October 8, 2009 |

Contacts Pursuant to State Finance Law § 139-j and 139-k

DESIGNATED CONTACTS:

Pursuant to State Finance Law §§ 139-j and 139-k, the Department of Health identifies the following designated contacts to whom all communications attempting to influence this procurement must be made:

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Permissible Subject Matter Contacts:

Pursuant to State Finance Law § 139-j(3)(a), the Department of Health also identifies the following allowable contacts for communications related to the following subjects:

RFP Release Date:

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Submission of written proposals or bids:

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For further information regarding these statutory provisions, see the Lobbying Statute summary in Section E. 12 of this solicitation.

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Schedule of Events

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| Proposals Due | October 8, 2009 |
| Anticipated Contractor Selection | November 1, 2009 |
| Anticipated Contract Start Date – Start Up | January 1, 2010 |
| Anticipated Contract Start Date – Assessment Center Services | March 1, 2010 |

A. INTRODUCTION

The New York State Department of Health (DOH) has been authorized by Section 29 of Part D of Chapter 58 of the Laws of 2009 to establish a demonstration program under which it will designate two long term care assessment centers. The requirements for the centers can be found in New York State Social Services Law (SSL) Section 367-w. The demonstration program will include one or more contracts. The center(s) will assume responsibilities for assessment, authorization and related activities for a range of Medicaid long term care services. The goals of this demonstration are to:

- Improve the administration of services;
- Achieve improved accuracy and standardization of assessments and authorizations;
- Identify changes, including recommendations for regulatory or legislative action, to further improve management of such programs; and
- Ensure that consumers are entitled to the same medical assistance benefits and standards as if authorizations and assessments were made by a governmental entity.

This Request for Proposals (RFP) seeks proposals from qualified entities which can contract with DOH to be the regional long term care assessment center(s).

The demonstration project will serve the following Medicaid consumers in two areas, the first of which shall be established in the geographic area served by CASA VII serving Community Planning Districts 10-13 in Kings County within the City of New York, and the second of which shall be established for the area of Orange and Ulster Counties.:

- Individuals not receiving any long term care (LTC) services immediately prior to January 1, 2010, or the contract start date, whichever is later, for the services listed below.
- Consumers requiring a reassessment for a LTC service listed below that was received prior to the contract start date, when such reassessment occurs on any date during the six months following January 1, 2010, or the contract start date, whichever is later, whether such reassessment is the result of a regularly scheduled reassessment date or the result of a substantive change in consumer's medical or social condition/situation
- Consumers receiving one or more of the LTC services listed below on January 1, 2010 or the contract date, whichever is later, and who seek an additional LTC service.

Assessment services for the following are the Medicaid programs to be included in the demonstration:

- Personal Care Services Program (PCSP);
- Personal Emergency Response Systems (PERS);
- Consumer Directed Personal Assistance Program (CDPAP) services;
- Assisted Living Program (ALP);
- Long Term Home Health Care Program (LTHHCP);
- AIDS Home Care Program (AHCP);
- Managed Long Term Care (MLTC);
- Certain services provided by Certified Home Health Care Agencies (CHHA)

Payment under the contract resulting from this RFP is contingent on the availability of state funds and the availability of Medicaid federal financial participation (FFP) to New York State (NYS) for the affected services.

B. BACKGROUND

Assessments under the following programs will be included in this demonstration project. Details about the statutory and regulatory requirements of the programs are also listed below.

Additional information about the assessment process is included in Attachments 19-21 to this RFP. Attachment 21 contains the collection of the assessment tools for each of the included programs and services. The contractor will be responsible for assuming the assessment and service authorization functions currently performed by the Human Resources Administration (HRA) in New York City or by the Orange County and Ulster County Departments of Social Services (hereafter referred to as local districts) which are described in Attachment 19. As these functions and responsibilities will vary by program and service type, a summary of such functions and responsibilities is presented in Part C of this RFP.

B.1. Personal Care Services Program (PCSP)

Personal care services provide assistance with activities of daily living (ADL) and instrumental activities of daily living (IADL).

- Federal Social Security Act (SSA) section 1902(a)(24);
- Title 42 of the Code of Federal Regulation (CFR) section 440.167;
- SSL section 365-a (2)(e); and
- Title 18 of the Official Compilation of New York Codes, Rules and Regulations (NYCRR) section 505.14.

B.2. Personal Emergency Response Services (PERS) Program

PERS is an electronic communication system used in the home of a client which allows the client to signal for help in an emergency situation. PERS is a supportive service available to Medicaid recipients who are also receiving Medicaid funded personal care aide or home health aide services.

- SSL section 367-g; and 1
- 8 NYCRR section 505.33.

B.3. Consumer Directed Personal Assistance Program (CDPAP)

The CDPAP is a service delivery vehicle that provides self-directed personal care services. This program provides services to chronically ill or physically disabled individuals who have a medical need for help with activities of daily living (ADLs) or skilled nursing services. The consumer, or the person acting on the consumer's behalf, assumes full responsibility for hiring, training, supervising, and terminating the employment of persons providing the services. Services can include any of the services provided by a personal care aide (home attendant) or home health aide, as well as skilled nursing tasks.

- SSL section 365-f;
- New York State Education Law (SEL) Article 139: Nursing, Section 6908.

B.4. Assisted Living Program (ALP)

The ALP is available to those individuals determined to be nursing home eligible. An ALP is operated in a DOH licensed Adult Care Facility (ACF). ALPs must possess either a valid license as a Licensed Home Care Services Agency (LHCSA), a valid certificate of authority as a Certified Home Health Care Agency (CHHA) or valid authorization as a Long Term Home Health Care Program (LTHHCP). In the event an ALP does not operate a CHHA, it must contract with an existing CHHA. Services provided through the ALP must include room, board, housekeeping, supervision, personal care, case management activities, and home health services. Services also include PERS, nursing, physical therapy, occupational therapy, speech, medical supplies not requiring prior approval and adult day health care in approved programs.

- Federal Title 42 USC Section 1396a;
- SSL section 461-I;
- 18 NYCRR section 505.35;
- 18 NYCRR Part 494; and
- 18 NYCRR section 485.2.

B.5. Long Term Home Health Care Program (LTHHCP)

The LTHHCP is a home and community based waiver program under section 1915c of the federal Social Security Act (Medicaid). The LTHHCP offers a comprehensive, coordinated plan of services for Medicaid eligible individuals whose needs can appropriately and cost effectively be met outside of an institutional setting. The program coordinates the medical, social, rehabilitative, and other supportive needs of the individual so that he/she can be safely maintained at home in the community. Such services may include nursing, home health aide, medical supplies and equipment, physical therapy, occupational therapy, respiratory therapy, speech-language pathology, audiology, medical social services, nutritional counseling, personal care aide, homemaker / housekeeper, personal emergency response system, home maintenance and environmental modifications, assistive technology, social day care and transportation to social day care, respite services, moving assistance and home delivered or congregate meals.

Participants of the LTHHCP are subject to an individual expenditure cap established for each county based on the average cost of nursing home care in the county. All Medicaid expenditures for participants are factored into an individual's monthly budget and, under certain circumstances, an annualized budget where: the cost of their care does not exceed the 75% expenditure cap; or 50% expenditure cap if a resident of an adult care facility; or, the 100% expenditure cap if determined to have special needs.

- New York State Public Health Law (PHL) Article 36;
- 10 NYCRR Parts 761, 762 and 763;
- SSL sections 367-c and 367-e; and
- 18 NYCRR section 505.21.

B.6. AIDS Home Care Program (AHCP)

The AHCP is a subset of the LTHHCP and operates under federal waiver authority following the same processes and procedures. AHCP are authorized as LTHHCPs and designated as an AHCP. AHCPs provide long term care services to individuals who need nursing facility levels of care and have been diagnosed with AIDS or have been determined to have the etiological agent and an illness associated with such infection. AHCP include the same services as listed above for the LTHHCP.

- New York State Public Health Law (PHL) Article 36;
- 10 NYCRR Parts 761, 762 and 763;
- SSL sections 367-c and 367-e; and
- 18 NYCRR section 505.21.

B.7. Managed Long Term Care Plans (MLTCPs)

Enrollment in MLTCPs is limited to consumers determined to be nursing home eligible who reside in the plan's service area and who can be safely served in the community with the services of the plan. Case management requirements dictate the development of a written care plan that assures access to needed covered services as well as referral to and coordination of services that may not be included in the plan's benefit package. MLTCPs offer comprehensive long term care services including home and community based and institutionally based long term care and ancillary services necessary to meet the needs of the covered person. There are several models of MLTCPs.

- 42 CFR section 438;
- PHL Article 44; and
- 10 NYCRR Parts 98-1 and 98-2.

B.8. Certified Home Health Agency Services (CHHA)

These entities provide home health services to consumers who are residing in the community. CHHAs provide services which are of a preventive, therapeutic, rehabilitative, health guidance and/or supportive nature to individuals at home. These services are nursing, home health aide, medical supplies, equipment and appliances suitable for use in the home, physical therapy, occupational therapy, speech/language pathology, nutritional counseling and social work services. The contractor will be responsible for review of assessments conducted by a CHHA and for the authorization of home health services provided by a CHHA to a consumer for more than 60 days.

- PHL Article 36;
- 10 NYCRR Parts 761, 762 and 763;
- SSL section 366-e; and
- 18 NYCRR section 505.23.

C. DETAILED SPECIFICATIONS

C.1. Overview

The contract resulting from this RFP will be for a three year period, with an anticipated contract start date of January 1, 2010, and an assessment center start date within 60 days following the contract start date. The contractor will be allowed an initial period of up to 60 days under the contract to establish its systems and ramp up prior to conducting its first assessments.

The contractor's responsibilities will vary by program or service. Generally, the contractor will perform the core functions necessary to comply with federal and State Medicaid requirements for the included assessments and service authorizations. The contractor will institute, with DOH approval, modified management tools and business processes to test and evaluate ways of improving management and efficiency of the activities covered under the contract. However, consumers applying to participate in the programs and services covered under this RFP shall be entitled to the same medical assistance benefits and standards and to the same notice and procedural due process rights and standards as if the assessment and authorization was made by a governmental entity. Once the contract has begun, implementation of any new changes must be made with DOH approval. Additionally, the contractor will be responsible for preparation of biannual reports.

Payment under the contract resulting from this RFP is contingent on availability of Federal Financial Participation (FFP) to New York State (NYS). The contractor must work with DOH to provide any information requested by the Centers for Medicare and Medicaid Services (CMS) to assure continued receipt of FFP. Should CMS request changes to the procedures and protocols employed by the contractor, the contractor must amend its procedures/protocols to be consistent with CMS' requirements. Such changes must be consistent with approved policies and procedures of, and approved by, DOH. If federal audit(s) find the contractor's performance has resulted in inappropriate claims for services or expenditures, the contractor shall be financially responsible for any recoupment the federal government imposes on NYS.

C.2. Assessment, Reassessment and Case Management.

The contractor will provide comprehensive assessments and reassessments, service authorizations, and ongoing case management for Medicaid eligible consumers requesting and/or accessing services. The bidder agrees to design and implement an administrative structure to meet the requirements as stated below. See Part D.

The contractor will be expected to receive referrals and required documentation from a variety of sources, including, but not limited to hospitals, programs, provider organizations, NYConnects (if applicable), health plans, physicians, etc. Initial referrals may also be received from HRA and/or the local district(s). To help assure that referrals are received in a timely manner, the contractor will be expected to notify and provide training if necessary to referral sources regarding the contractor's roles and responsibilities with respect to assessment and authorization services. Additionally, in responding to this RFP, the bidder should propose and describe a system for tracking outcomes of individuals who, based upon assessment findings, had services denied, terminated or approved for lesser amounts than requested.

The Department requires that services be made available in a culturally sensitive manner and that interpretation assistance is available so that consumers are comfortable and understanding of the assessment and services being authorized. Assessment of consumer needs and authorization of services will occur following confirmation that the consumer has been determined to be Medicaid eligible. It is expected that as part of the assessment and reassessment processes, the contractor will support involvement of caregivers and a consumer's representative or advocate as a part of those processes. The contractor will have a direct link to DOH systems for purposes of verifying Medicaid eligibility. Additionally, the contractor will report its consumer-specific service authorizations directly to eMedNY where such information will be used in claims processing.

C.2.a. PCSP

- Review physician orders;
- Conduct home based nursing and social assessment;
- Conduct home based reassessment every six months or upon unexpected change in social circumstance, mental status or medical condition;
- Conduct home based reassessment every twelve months for specified populations; and
- Initial service authorization and reauthorization with such authorizations specifying number of service hours to be provided

C.2.b. PERS

- Validate that consumer is in receipt of personal care aide or home health aide services;
- Review PERS request and supporting documentation;
- Issue service authorization; and
- Conduct reassessment every six months or when an unexpected change in the consumer's circumstances, mental status or medical condition occurs that affects consumer's use or understanding of PERS.
- PERS assessment and authorization is conducted as part of the PCSP assessment and authorization process, and is not a stand-alone assessment

C.2.c. CDPAP

- Facilitate and review physician orders;
- Conduct home based nursing and social assessment;
- Conduct home based reassessment every six months or upon unexpected change in social circumstance, mental status or medical condition;
- Conduct home based reassessment every twelve months for specified populations; and
- Issue initial service authorization and reauthorization with such authorizations specifying number of service hours to be provided

C.2.d. ALP

- Review of physician orders;
- Review home based assessment conducted by the ALP's affiliated CHHA;
- Review assignment of nursing home RUGS category for consistency with assessments and proposed plan of care;
- Review the reassessment conducted by the ALP's affiliated CHHA every subsequent six month period or upon change in client health status; and
- Authorize and reauthorize the consumer's participation in the program

C.2.e. LTHHCP

- Obtain physician order for a nursing and social assessment;
- Conduct nursing facility level of care determination;
- Conduct home based nursing and social assessment jointly with LTHHCP;
- Determine Medicaid service costs are within the approved expenditure cap;
- Conduct home based reassessment every 120 days or sooner if the consumer's needs require it; and
- Authorize and reauthorize the consumer's participation in the program with such authorizations specifying number and type of service hours to be provided

C.2.f. AHCP

- Obtain physician order for a nursing and social assessment;
- Conduct nursing facility level of care determination;
- Conduct home based nursing and social assessment jointly with AHCP;
- Determine Medicaid service costs are within the approved expenditure cap;
- Conduct home based reassessment every 120 days or sooner if the consumer's needs require it; and
- Authorize and reauthorize the consumer's participation in the program with such authorizations specifying number and type of service hours to be provided

C.2.g. MLTCP

- Review home based assessments conducted by MLTCPs in order to determine nursing home level of care;
- Confirm enrollment in the MLTCP is voluntary; and
- Authorize enrollment in a MLTCP.

C.2.h. CHHA Services

- Review physician orders;
- Review client documentation submitted by the CHHA; and

- Determine continuing need for services beyond a sixty day period.

C.3. Medical Director Review

In some circumstances, including but not limited to those described in the "Staffing" section below, the Medical Director will be required to review the findings and / or authorizations of the assessment team.

C.4. Fair Hearings and Court Appearances

Authorization decisions made by the Contractor are considered the decisions of the Department. Beneficiaries have the right to appeal the Department's decision to deny or modify (approve other than as requested) requests for provision of the affected long term care services. Contractor must make qualified personnel available at the time of a Fair Hearing to testify on behalf of the Department related to denial or modification of such services. Contractor must prepare in advance for the Fair Hearings and must provide any materials it intends to introduce at the Fair Hearing to the beneficiary and or their representative, and OTDA for review upon oral or written request but no less than five business days prior to the Fair Hearing. The beneficiary and or their representative are entitled to a pre-hearing conference so as to eliminate the need to hold a Fair Hearing. Contractor is required to act promptly (or in a timely manner) with any definitive and final administrative decisions.

C.5. Administration

In addition to the professional services required to conduct and review assessments administrative tasks, including the work of the Project Director, will need to be performed. Some of these tasks may be performed by professional staff and others by dedicated clerical and other support staff. Typical administrative activities include:

- Receiving, processing and closing a case (typically performed by contractor support staff);
- Receiving information/forms re an assessment;
- Sending an acknowledgement letter;
- Assigning a due date to an assessment, reassessment or other;
- Assigning and scheduling an assessment, reassessment, or other;
- Creating a new consumer file;
- Sending a letter with assessment results to appropriate parties;
- Issuing service authorizations and reauthorizations;
- Review Medicaid service costs to determine if costs are within the approved expenditure cap;
- Creating a claim or voucher under the contract;
- Preparing required reports for submission to DOH;
- Attending meetings with the Department related to the contract;
- Travel expenses related to the contract or any Unit under the contract;
- Telephone calls, photocopies, postage or any other expenses related to the contract.

C.6. Start Up Activities

It is anticipated that the contract awarded under this RFP will commence on or about January 1, 2010, with an assessment center start date occurring within 60 days following the contract start date. There are a variety of start up activities that the contractor may have to perform during the start up that will not be performed at other times during the contract period. It is the intention of DOH that the contractor will be paid a lump sum for start up activities. See Sections D.3.b.X. and D.4.

C.7. Training

The contractor will be responsible for providing initial training to all contractor staff in the program areas for which the contractor will be responsible under the terms of the contract. The contractor will need to provide subsequent training to meet the effects of staff turnover or changes in program requirements. All material developed by the contractor must be reviewed and approved by DOH and all curricula and materials will become the property of DOH.

Training for contractor staff will include at a minimum:

- all program regulations and policies;
- all documents used in the administration of the programs;
- the principles and requirements of the Americans with Disabilities Act;
- cultural sensitivity to the populations served;
- confidentiality under Medicaid and health care programs, including requirements of the Health Insurance Portability and Accountability Act (HIPAA); and
- the procedures of HRA and/or the local district(s) with respect to those LTC services that are the subject of this demonstration

HRA and/or local district staff must be trained in the contractor's procedures so they can appropriately interact with contractor's staff. Additionally, the contractor must train staff from hospitals, NYConnects, and agencies in the community that are anticipated to make referrals to the Assessment Center.

C.8. Staffing

The contractor will be expected to maintain adequate staff to perform the activities described above. At a minimum the contractor must provide a project manager, medical director, case managers, nurse assessors and sufficient supervisory and support staff to manage and maintain the demonstration project. The required minimum qualifications for a position are listed in the description of the position.

Contractor's staff should have the skills and background to be able to meet the needs of the individuals to be served effectively. The contractor shall submit for review to the Department, their staffing plan and resumes of staff for those positions listed above. Such submission shall occur prior to initiation of assessments and service authorizations.

C.8.a. Project Manager

The bidder will need to identify a project manager to interact with DOH. This project manager must be employed by the contractor and must be approved by the DOH. The project manager should have experience at overseeing large and complex programs, staff supervision and experience in community-based long term care programs. This manager will be the primary person with whom the DOH conducts all business-related tasks to be performed under this contract and must have the signatory authority for the contractor.

C.8.b. Medical Director

A physician licensed to practice in New York State with experience in delivering care to consumers of all ages and disabilities requiring and receiving long term care services. The Medical Director will have a range of responsibilities including reviewing cases where other clinicians disagree on needs of consumers as well as any request for twenty-four hour continuous care. He or she will make recommendation for provision of services through resolution of any differences in opinion, and/or the need for twenty-four hour care. The medical director will represent the contractor, as necessary at case conferences, Fair Hearings or in litigation.

C.8.c. Supervisory Positions

A registered nurse with a baccalaureate degree from an accredited college and two years of full-time casework experience. The individual(s) must have demonstrated ability and experience in independent action and decision making; supervising and in assisting in the effectuation, monitoring or evaluation of service delivery programs or of operations auxiliary to such programs.

C.8.d. Case Manager

A baccalaureate degree from an accredited college in a pertinent field such as nursing, social work or related health or human services field. Responsibilities will include conducting assessment and reassessment of consumers, determining eligibility for services, developing and/or approving plans of care; performing counseling and investigative activities; making necessary referrals for additional services as required and performing related work.

C.8.e. Registered Nurse Assessor

A license and current registration to practice as a registered professional nurse in New York State and at least two years of satisfactory experience in home health care. These individuals will have a range of responsibilities including conducting assessments and reassessments of consumers, determining eligibility for such services based upon a review and interpretation of a physician's order and a functional assessment of the consumer, developing a plan of care and providing case management and/or social assessment functions.

C.8.f. Support Staff

Support staff includes all non-professional staff utilized to fulfill the mission of the assessment centers. These may include, secretaries, clerks, administrative assistants, bookkeepers, accountants and similar staff. Support staff also includes IT staff, and anyone not providing direct services to consumers.

C.9. Information Technology

The contractor should possess sufficient information technology (IT) capabilities to be able meet documentation, electronic communication and data/report submission requirements. This includes necessary equipment and staff. Staff can be configured by the contractor to fit the design of the business processes it develops to implement the requirements of the RFP. The cost of specialized IT staff is considered administration and must not be charged to service units.

C.10. Travel

As part of the contract resulting from this RFP, the Contractor will be reimbursed for travel by employees to perform assessment, reassessment, case management or to attend fair hearings, court appearances, or training. The contractor must pay its employees state approved rates for mileage and travel per diem. The information about these rates can be obtained from <http://www.osc.state.ny.us/agencies/travel/reimbrate.htm>

D. PROPOSAL REQUIREMENTS

D.1. Who May Apply

Governmental entities, not-for-profit, or for-profit organizations may apply to become a Long Term Care Assessment Center. Bidders may submit a proposal for one or both of the assessment centers designated in this RFP. If the bidder wishes to submit a proposal for both centers the bidder must submit a complete and separate proposal for each center.

D.1.a. Minimum Eligibility Requirements

Bidders must have experience in conducting assessments and reassessments for the provision of home and community based services or similar health care determinations, and management of services to Medicaid consumers. All bidders are required to complete the Bidder's Assurances (Attachment 10). Health care providers meeting the capability and experience requirements may submit bids to become assessment centers. Bidders must describe their experience in detail, including the time frames over which such experience was gained. See Section D.3.b.IV. below for details of how to respond.

D.1.b. Preferred Eligibility

Bidders will be assessed on the extent of their experience in preferred categories. Bidders must then explain this experience in detail in a separate statement and by completing chart. See Sections D.3.b.IV(A) and D.3.b.IV(D) below.

D.2. Proposal Content -- Overview

Bidders may submit a proposal for one or both of the assessment centers designated in this RFP. If the bidder wishes to submit a proposal for both centers the bidder must submit a complete and separate proposal for each center. If a single bidder is the successful bidder for both assessment centers a single contract will be awarded to that bidder.

The contractors will be selected based on a submitted proposal demonstrating their ability to fully implement the Long Term Care Assessment Center Demonstration project. Proposals are divided into three parts: The Technical Component, The Cost Component and Supporting Documentation.

The documents required of each Component of the proposal are listed in Sections D.3., D.4. and D.5. below. Bidders must place the documents required for each Component in binders with tabs identifying each by number and name. The Supporting Documentation may be included in the same binder with the Technical Component, following the documents required for the Technical Component.

Bidders must not include any materials required by the Technical Component or the Supporting Documentation in the Cost Component. Bidders must not include any materials required by the Cost Component in the Technical Component or the Supporting Documentation. Including cost information in the Technical Component will result in a disqualification of the proposal.

- D.2.a. The Technical Component contains the bidder's background, capability and experience and all of the information and plans of how the bidder will implement the project.
- D.2.b. The Cost Component contains the bid documents and other financial documents related to the price and cost of the proposal.
- D.2.c. The Supporting Documentation includes all other documents required by the Department and any additional information or documentation the bidder wishes to supply as part of its proposal.

D.3. Technical Component

D.3.a. Document List and General Instructions

A completed Technical Component consists of the following sections. Each section must be placed in a tabbed binder with both the name of section and the section number on the tab. Each document must include the information requested in Part D.3.b. The Technical Component will contain 13 primary tabs as show below. Part D.3.b.IV. will contain 6 additional tabs which are described in that section below.

- I. Transmittal Letter
- II. Table of Contents
- III. Executive Summary
- IV. Project Narrative -- General Section
- V. Project Narrative -- Service Units
- VI. Data Security
- VII. Bidder's Assurances
- VIII. Conflict of Interest Statement
- IX. Medicaid Confidentiality
- X. Start Up Activities
- XI. Administration
- XII. Training
- XIII. Travel

The documents included in the Technical Component sections D.3.b.II, III, IV, V and VI must be completed on plain white paper, with the pages numbered consecutively and must not contain any identifying information about the bidder.

D.3.b. Document Specific Requirements

D.3.b.I. Transmittal Letter

A form is provided (Attachment 2) that will serve as the Transmittal Letter. This form or a reasonable facsimile may be used. The Transmittal Letter must include the name of a person who should be contacted by DOH with questions about your proposal or a proposed contract. The transmittal letter must contain all of the listed information and must be submitted with each proposal. Failure to submit this form properly completed with a proposal will result in the proposal being disqualified from consideration.

D.3.b.II. Table of Contents

The Table of Contents must identify by name and page number the location of all sections of your application including attachments. Each main table of contents entry must correspond with a tabbed section of your proposal. If you include additional attachments to any section, please add a tab to identify the location of the attachments.

D.3.b.III. Executive Summary

Please provide a summary your proposal. This summary should be no more than five (5) pages in length and should include a brief discussion of all the key elements of the proposal. **Do not include any cost information in the Executive Summary. Inclusion of cost information in the Executive Summary will result in a disqualification of your proposal.**

D.3.b.IV. Project Narrative – General Section

The project narrative has six parts, each of which must be identified by a separate tab in the binder with the number and name of the section. The detailed specifications for this RFP are in Part C and must be taken into consideration in developing the narratives. The General Section will be scored for relevance to DOH needs, experience and the quality of the response. The narrative for Sections D.3.b.IV(A) through (F) must not exceed 30 pages in length, single spaced in a font no smaller than Times New Roman, 12.

D.3.b.IV(A) Preferred Eligibility

While a bidder's general eligibility to bid on and receive a contract under this RFP will be determined by the bidder's combined answers to the narrative, preferred eligibility, should be addressed by completing the chart in Attachment 9, and verifying the information provided in the chart in responding to the questions in Part D.3.b.IV(D).

Bidders will be scored on their preferred eligibility experience. For each of the items listed below, describe the extent of the bidder's experience as "Substantial," "Some," or "Minimal."

- Substantial Experience is direct experience in the qualifying area of more than 3 years.
- Substantial Recent Experience is direct experience in the qualifying are of more than 3 years, the 3 most recent years of this experience gained in the period between January 1, 2006 and the date of the proposal.
- Some Experience is direct experience in the qualifying area of at least 1 year but less than 3 years.
- Some Recent Experience is direct experience in the qualifying are of at least 1 year but less than 3 years, all of this experience gained in the period between January 1, 2007 and the date of the proposal.
- Minimal Experience is direct experience in the qualify area of less than one year.

D.3.b.IV(B) Organization Mission:

- (1) Describe your organization, its mission, services and capacity.
- (2) Explain, using examples, how this demonstration project fits into your organization's overall mission.

D.3.b.IV(C) Applicant Capability

- (1) Describe the organizational structure of your proposed Long Term Care Assessment Center, including essential staff and functions.
- (2) Demonstrate how your proposed staffing will be integrated into your current organizational structure and include one or more Organizational Charts covering personnel names/titles, to whom the Project Manager will report to and lines of communication and decision making with your organization.
- (3) Demonstrate your organization's ability to hire/train/retain sufficient qualified staff to meet the objectives of the demonstration project effectively.
- (4) Describe your organization's staffing plan for this project. Indicate the staff types and qualifications for each of the staff you plan on hiring to carry out these objectives.
- (5) Describe how your organization will maintain adequate staff to perform the activities as enumerated in Section D.3.b.V.

D.3.b.IV(D) Experience

- (1) Describe your organization's experience with government contracts, either state, federal or local, for health care and health care related services. Please list all such contracts to which your organization has been a party during the period beginning July 1, 2004, and ending June 30, 2009.
- (2) Demonstrate your organization's experience in conducting assessments and reassessments for provision of home and community based services or similar health care determinations, and management of services to Medicaid consumers. Please use specific examples.
- (3) Demonstrate your organization's experience in coordinating long term care services and programs including, but not limited to those services covered by this RFP. Please use examples and include dates.
- (4) Explain your organization's knowledge of the principles and requirements of Title II of the Americans with Disabilities Act (ADA) and the independent living concepts of personal choice, control and the dignity of risk. Please provide one or more examples.
- (5) Describe the steps your organization's uses to build effective collaborative relationships with long term care community based entities including, but not limited to, home and community based waiver programs, nursing facilities,

hospitals, physicians, managed care organizations, long term care service providers and other pertinent community resources.

- (6) Demonstrate your organization's knowledge of all reimbursement streams, especially the interaction between the Medicaid and Medicare programs. Explain how your organization currently uses these systems. Include whether your organization currently has access to WMS and / or EmedNY and for what purpose(s).
- (7) Demonstrate your organization's experience in managing services to a Medicaid population and individuals of all ages with a range of medical needs and levels of disability. Please use examples and include dates.
- (8) Demonstrate your organization's experience in managing culturally sensitive and competent services for consumers of all backgrounds. Please use examples and include dates.
- (9) Demonstrate your organization's experience in providing for linguistically competent services. Please use examples and include dates.
- (10) Demonstrate your organization's experience in assessing if a consumer requires nursing home level care. Describe any contracts your organization has had within the five year period ending June 30, 2009, to perform these services.
- (11) Demonstrate your organization's experience in assessing consumer needs based on evaluation of medical, nursing, environmental and/or social factors and applying findings to service planning, authorization and management. Describe any contracts your organization has had within the five year period ending June 30, 2009, to perform these services.
- (12) Demonstrate your organization's experience in meeting due process requirements designed to protect consumer rights. Please use examples and include dates.
- (13) Describe your organization's knowledge of and experience with the Fair Hearings process. Please include examples.
- (14) Describe your organization's experience with assessing consumer satisfaction levels and modifying operational practices based on the findings resulting from conducting and evaluating consumer survey results. If available, please provide copies of materials used for this purpose in the past or proposed to be used under the contract that will result from this RFP.
- (15) Demonstrate your organization's experience in providing timely reports and the ability to work within established timeframes. Describe any contracts your organization has had within the five year period ending June 30, 2009, involving these activities.
- (16) Describe your organization's experience with the data technology resources necessary to support the proposal. Demonstrate your organization's experience

with and capacity of interfacing with State reporting systems such as eMedNY and the Welfare Management System (WMS).

D.3.b.IV(E) Staffing

The bidder's narrative must include a plan for how the bidder will hire and maintain staff levels, and how staff quality will be maintained. The contractor should submit copies of licenses, vitae and resumes of those staff that are currently employed as part of the Supporting Documentation. See Attachments 7 and 8 (Direct and Indirect Staffing Summaries), which must be completed, and will assist in determining the total staffing requirements. In addition the bidder must complete Consultant Services Form A (Attachment 14) and include that form in the Cost Component. The bidder should take care not to mix up these forms. Including the incorrect form in the Technical or Cost Component could result in a disqualification of the proposal.

Please provide proposed total numbers of staff to be utilized for each of the services described in section C.2. and their qualifications, such as degrees, licensure, certification, relevant experience, etc.).

If the bidder already has staff proposed for any of the required staffing positions, please provide their names and the position(s) they are proposed to fill. Include copies of licenses, certificates or other documentation of their qualifications in the Supporting Documentation. See Section D.5. for details on how to submit Supporting Documentation.

D.3.b.IV(F) Workplan

Bidders should submit a section describing, both in narrative and tabular form, how each of the required program activities will be accomplished and the timeframes for program implementation and operation. This submission should separately delineate key activities by (1) initial program implementation, and (2) operations following performance of initial assessments and service authorizations. Bidders should include a description of a plan through which it will track outcomes of individuals who, through the assessment/reassessment process, are determined not appropriate to receive services that are the subject of this RFP, or who have had previously authorized amounts of service reduced or terminated as a result of reassessment. Additionally, such workplan description should reference planned collaboration with NYConnects.

This section should describe the goal-related objectives, activities and timeframes for the development and operation of the project based on the activities identified in the bidder's proposed workplan.

The narrative workplan and timeline should, include, at the minimum, discuss

- Establishment of internal systems;
- Performance of core functions necessary to comply with federal and State Medicaid requirements;
- Facilitation and participation in meeting of stakeholders to discuss implementation of this demonstration;
- Participation with DOH in preparation of biannual reports.

D.3.b.V. Project Narrative – Service Units

The assessment center(s) will be expected to provide assessment, reassessment, case management and authorization of services for each program as described in Section C.2. As part of its proposal, the contractor must develop an implementation plan meeting all of the standards in Part C.2 of this RFP for the assessment activities listed there. The bidder must use the summaries in Section C.2., in addition to more detailed information contained in the attachments to this RFP to develop its plan. The plan for service delivery for each of the activities listed in Section C.2. will be assessed by the Department in determining whether a contract will be awarded.

The implementation plan must include not only the assessment, reassessment and case management services listed in Section C.2., but also plans for medical director review and administrative review in a fair hearing or before the courts. Please describe how medical director reviews of assessments will be handled.

Please define a model/plan for assessment and authorization for each of the services described in Section C.2. that will meet the standards provided in this RFP and will be used to provide the services described in section C.2 of the RFP. In the model/plan, please address how you will perform each of the following 17 activities for each of 8 program areas described in Section C.2. Information about the screening and assessment process is included in Attachment 19 to this RFP, which depicts the workflow for the various programs. Minimum performance standards with respect to assessment and authorization response and completion timeframes is presented in Attachment 20.

You may use Attachment 6 to this RFP to assist in developing your plan and response to the requirements of this section of the RFP. Use of Attachment 6 is optional, however, if you choose not to use Attachment 6, your response must be numbered to correspond to the 17 items listed below.

- (1) Verify Medicaid eligibility to ensure that only consumers determined financially eligible for Medicaid by HRA and/or the local district(s) are assessed;
- (2) Conduct initial intake and screenings to determine the need for services and assessed for program participation;
- (3) Accept and process referrals from multiple sources, including initial referrals from HRA and/or the local district(s) and referrals received from sources other than HRA and/or the local district(s);
- (4) Obtain physician's orders and work with home care program representatives in order to obtain the physician's orders; and establish an internal process for triaging and assigning completed physician's orders to staff responsible for completing assessments;
- (5) Conduct initial nursing and social assessment to determine appropriateness of participating programs included in this demonstration for the consumer. Assessment tools utilized will be the existing HRA,

and/or local district tools, the State's model tools or alternate tools proposed by the contractor and approved for use by DOH. All assessments/reassessments must, at a minimum:

- Be face-to-face with the consumer in his/her home;
 - Be strength-based;
 - Be task-based;
 - Identify and document the link between functional ability and need for each task;
 - Consider the age appropriateness of services as well as developmental level;
 - Consider, identify and utilize efficiencies;
 - Encourage and identify participation of informal supports;
 - Consider and identify contribution of any formal supports; and
 - Comply with all applicable state and federal laws and regulations;
- (6) Develop a plan of care and services that recognizes variations in specific program requirements and required interaction with service vendors;
- (7) Authorize the specific hours of service resulting from the completed assessments and identify and assign the service vendor which will provide the authorized services. If it is determined services are not appropriate, give timely notice and referrals to HRA and/or the local district(s), or other appropriate agencies;
- (8) Transmit referrals, including care plans, to service vendors for service provision;
- (9) Transmit the service authorization, including vendor identification, to eMedNY;
- (10) Reassess to determine the continued appropriateness for participation in the authorized program(s) and services every six months or more frequently if required by a change in the consumer's medical or social circumstances, or in the case of LTHHCPs, every 120 days. The process must apply assessment tools utilized by HRA and/or the local district(s), the State models or alternate tools approved by DOH.

Such process must continue to comply with all applicable local, state and federal law(s) and regulation(s). In the event that DOH approves the use of a new or revised assessment tool(s), DOH shall provide prior notice to the contractor and shall allow sufficient time for staff to be trained in the use of such tool(s);

- (11) Obtain physician orders and care plans for consumers receiving home health services on the 40th day of service for review and determination of continuing service beyond 60 days. Such determination must be made by the 50th day and communicated to the consumer, the CHHA and the HRA/LDSS;

- (12) Interfacing with New York City HRA and/or other local district(s) to coordinate activities and services, such as adult protective services or children's services or NY Connects, as necessary.
- (13) Conducting case conferences to resolve any differences before going to a Fair Hearing;
- (14) Providing the appropriate Notice(s) of Decision (NOD), using forms approved by DOH, that provides consumers with specific information regarding their application for services in accordance with Medicaid due process requirements. The notices contain information related to the opportunity to participate in a conference with the authorizing agency. The contractor will, using information obtained through the nursing and social assessment process, support their decision at the conference and/or Fair Hearing, if a conference or Fair Hearing is requested by the consumer. The Notices of Decision issued by the contractor shall include its address and other contact information to assure the consumer's ability to access documents and obtain copies of such documents concerning the consumer's case and for preparation for the Fair Hearing. If Court appearance(s) is necessary as a result of the outcome of a Fair Hearing, the contractor will cooperate with the Department, HRA or the LDSS, and provide staff as necessary to support the assessment;
- (15) Providing a toll free telephone access number for handling consumer and provider inquiries;
- (16) In addition to maintaining an effective working relationship with HRA and other participating local districts, the contractor must also maintain such relationships with all others charged with assessment, authorization and/or case management responsibilities for other needed services/programs. This includes the Regional Resource Development Centers under contract to DOH for regional administration of the Traumatic Brain Injury and Nursing Home Transition and Diversion Medicaid waivers, HRA/LDSS and/or OMR/DD staff responsible for the Care at Home Medicaid waivers and DOH staff responsible for prior approval of private duty nursing.
- (17) Providing a description of a plan through which the contractor will track outcomes of individuals who, through the assessment/reassessment processes, are determined not appropriate to receive services that are the subject of this RFP, or who have had previously authorized amounts of service reduced or terminated as a result of reassessment. Additionally, such description should include collaboration with NYConnects.

D.3.b.VI. Data Security

- (1) Demonstrate how your organization has established and utilized Information Technology (IT) capacity to securely maintain and track data.

- (2) If your organization does not currently have such technology in place, please describe how you will implement secure data maintenance and tracking. See Section E.14. and Medicaid Confidentiality below at D.3.b.IX.

D.3.b.VII Bidder's Assurances

Every bidder must complete and submit with its proposal Attachment 10, (Bidder's Assurances). The bidder must include appropriate documentation to support assurances numbers 5 and 6 on this form.

D.3.b.VIII. Conflict of Interest

All bidders must address the issue of conflict of interest as part of the narrative. Those bidders which do not believe their organization would have any conflict of interest in serving as an Assessment Center must provide a narrative explanation for such belief. Those applicants for which a potential conflict of interest exists, or may be perceived to exist, must provide narrative detail regarding conflict or perceived conflict and policies to be employed and steps to be taken to negate such a conflict. This narrative requirement is in addition to the bidder's need to complete Attachment 11 (Conflict of Interest)..

Include copies of existing policies and procedures that your organization uses to prevent conflicts of interest and assure against influence in regard to referrals.

D.3.b.IX. Medicaid Confidentiality

Describe procedures, including but not limited to HIPAA procedures, the Bidder will use to ensure the confidentiality of all information collected by the Bidder's or any sub-Contractors' staff, and the confidentiality of information to which these staff have access. See Attachments 26: HIPAA Business Associate Agreement and Attachment 27: Medicaid Confidential Data/Protected Health Information Privacy and the Medicaid Data Use Agreement, which will be incorporated into the successful Bidder's contract under this RFP. The Data Use Agreement must be approved by CMS before data may be accessed under its terms.

D.3.b.X. Start Up Activities

The bidder must submit a plan for how it will perform start up activities. This plan should include the bidder's current capacity of staffing and resources. The plan should indicate what additional staffing and resources are needed and how the bidder will obtain such resources. The timeline for completing the activities described should be included in the bidder's workplan.

D.3.b.XI. Administrative Activities

D.3.b.XI(A) General Administration

The bidder shall submit an implementation plan explaining how administrative tasks will be handled. In developing this plan the bidder should refer to the cost requirements as well as the technical requirements of this RFP, but should use caution not to include any cost information in the implementation plan.

D.3.b.XI(B) Administrative Case Management

The bidder shall submit an implementation plan explaining how administrative case management will be delivered. The plan should take into account all the following activities as well as any other activities that the bidder believes to constitute case management. The bidder should demonstrate how the plan will avoid duplicate billing for direct assessment services and administrative case management services.

Case management activities include, but may not be limited to:

- monitoring long term care services to ensure such services are provided according to the authorization and that the consumer's needs are appropriately met;
- obtaining and reviewing a copy of the orientation visit report and the nursing supervisory visit report;
- obtaining and reviewing a copy of the physician signed plan of care as applicable;
- providing access to the consumer of his or her written records, including physicians' orders and nursing assessments;
- receiving, reviewing and acting upon recommendations from the agency or program providing nursing supervision of the consumer;
- initiating and complying with the procedures specified in 18 NYCRR 505.21 and 505.23; when the consumer's social circumstances, mental status or medical condition unexpectedly change during the authorization period;
- assuring that capability exists for the following activities:
 - arranging for continued delivery of long term care services to the consumer when the agency or program providing such services is unable to maintain case coverage;
 - making temporary changes in the level, amount or frequency of long term care services provided or arranging for another type of service or program when there is an unexpected change in the consumer's social circumstances, mental status or medical condition;
 - arranging for reductions in the amount of long term care services or the termination of long term care services when indicated and, when necessary, making referrals to other types of services or levels of care that the consumer may require.

D.3.b.XII. Training

The bidder must submit a plan for how it will manage training activities. This plan should identify training that will be needed by contractor staff and HRA or LDSS staff that will need to interface with the contractor. Additionally, the contractor must train staff from

hospitals, NYConnects, and agencies in the community that are anticipated to make referrals to the Assessment Center. The plan should describe how curricula will be developed and a time frame for when training will be delivered. The plan should indicate what additional staffing and resources are needed to deliver required training and how the bidder will obtain such resources.

D.3.b.XIII. Travel

The Bidder must provide a good faith estimate in its narrative of the average monthly travel costs it expects to incur. Travel for administrative activities or reasons and commuting cost will be not reimbursed, and the costs must be included in the bid for Administration. The Bidder must explain in its narrative how it will assure that it will not bill the Department for inappropriate travel costs. Bidders are cautioned not to include any cost or price numbers in the travel narrative.

D.4. Cost Component

D.4.a. Overview

The cost component is the bid for the contract. The DOH will use a best value method of contracting for the assessment center services. Under best value procurement while price is an important consideration in the selection of a contractor for each assessment center, the award(s) will not necessarily be made to the Bidder with the lowest price. In a best value procurement the basis for awarding the contract is the bidder that optimizes quality, cost and efficiency among responsive and responsible bidders.

Contract pricing will be based on the first year of the contract. Any price increases for subsequent years of the contract will be subject to the National Consumer Price Index for all Urban Consumers (CPI-U) as published by the U.S. Department of Labor Statistics for the 12 month period prior to the end of the then current year of the contract.

The Cost Component for each assessment center shall include three (3) separate sections, presented in the order below.

D.4.b. Bid Form – Attachment 3

This form must accompany the Cost Component for each assessment center bid. It presents the bidder's commitment to a contract and includes questions on prior non-responsibility, procurement terminations or withholds of the Bidder and certifies that all information is complete and accurate.

D.4.c. Line Item Bid Form – Attachment 5

This form must be submitted for each assessment center. The information provided in this form will be used to score the Cost Component of each bidder and the contents will be compared to that submitted by other bidders. The Department recommends that bidders complete the Technical Component and the Supporting Documentation before attempting to complete the Line Item Bid Form. This form is in four parts, and every part must be completed. If a bidder fails to complete the Line Item Bid Form, the proposal will be disqualified.

In completing the Line Item Bid Form, each section of the Cost Component must include at a minimum, the items listed below. Proposals should be direct, clear and concise. Proposals will be reviewed for the mathematical accuracy of the submitted Cost Component forms. The Department reserves the right to reject any Proposal with discrepancies in the Cost Component.

D.4.c.I Part I – Service Units

This part of the cost Component must be bid as a unit price inclusive of all the activities described in Section C.2. for each Unit listed. Most units require separate bids for the initial assessment and any reassessment services related to that unit. The assessment tools included in Attachment 21 can assist in calculating this cost.

Assessment for Personal Emergency Response Systems (PERS) cannot be billed separately. Using the data provided, the bidder should make an allowance for the cost of PERS assessment in as part of assessments performed relative to applicable programs and services that are the subject of this RFP.

D.4.c.II Part II – Hourly Activities

Certain activities, while directly related to the assessment process may not apply to each and every assessment. The three activities listed on Part II will be reimbursed to the contractor on an agreed hourly rate.

The cost of the Medical Director may be reimbursed on an hourly rate for assessment reviews and fair hearing and court activities that can be tied to a particular consumer. With the consent of the Department, the contractor may be reimbursed for other professional activities of the Medical Director. The other activities of the Medical Director must be included in the cost of administration.

The cost of other staff involved in fair hearings and court actions may also be reimbursed on an hourly basis. Any staff type for which an hourly price is not provided in this Part will not be separately reimbursed for any services provided under the contract resulting from this RFP.

D.4.c.III Part III – Fixed Price Services

D.4.c.III(A) Start Up Costs

The bidder shall submit a single price to support all of the start up costs described in the Technical Component.

D.4.c.III(B) Training Costs

The bidder shall submit a single price to support all of the Training costs described in the Technical Component. This price should reflect costs associated with the first year of the contract.

D.4.c.III(C) Administrative Case Management

The bidder shall submit a proposal for the costs of administrative case management, not as a dollar amount but as a fixed percentage of the costs of each service unit billed. The bidder may submit a single percentage to be applied to all Service Unit billings, or may submit a proposal of separate percentages for each Service Unit. The bidder must guarantee the percentage(s) for the life of the contract. The bidder may include an allowance for profit in the administrative case management percentage.

D.4.c.III(D) Administration

The bidder shall submit a proposal for the costs of administration, not as a dollar amount but as a fixed percentage of all other costs billed. Costs associated with the bidder's plan for tracking outcomes of individuals who, based upon assessment findings, had services denied, terminated or approved for lesser amounts than requested are considered an expense under this section. The bidder must guarantee this percentage for the life of the contract. The bidder may include an allowance for profit in the administrative percentage.

D.4.c.III(E) Part IV – Unanticipated Hourly Services

There may be unforeseen circumstances associated with the assessment centers either during ramp up or implementation. The bidder is required to quote a firm hourly price for any staff who may be called upon to perform functions not clearly outlined in the RFP. Prior approval must be received in writing from DOH before the contractor engages in services that would be billed under this Part.

D.4.d. Other Required Cost Component Forms

D.4.d.I Minority / Women's Business Enterprises Forms

The M/WBE Forms included in Attachment 12 must be completed, and a plan for how the bidder intends to include minority and women's business enterprises into the contract must be explained in a narrative. If the bidder does not intend to use these services, the narrative must include a justification that explains the bidder's rationale. Failure to include the M/WBE forms and narratives in the proposal will result in the proposal being disqualified.

D.4.d.II. Consultant Services Form A

All bidders must complete consultant services form A and return it with their bid. This form must be included in the Cost Component and nowhere else in the proposal.

D.5. Supporting Documentation

Supporting documentation should be separated from the Technical and Cost Components. Please use continuous Roman numbering, starting with "XIV." If the bidder includes additional documentation, it must be identified in the narrative by name and tab number.

- XIV. Curricula Vitae, Resumes, Licenses and Certifications
- XV. Independently Audited Financial Statements
- XVI. References
- XVII. Vendor Responsibility Attestation
- XVIII. Certificate of Incorporation
- XIX. Certificate of Authority
- XX. Sales Tax Forms
- XXI. Any Additional Documentation

D.5.a. Curricula Vitae, Resumes, Licenses and Certifications

Include resumes / curricula for key project staff and the medical director. Include copies of current New York State licenses and registration documents for all nurses and social workers who will be responsible for performing the assessment and supervisory functions. Include similar information for any other licensed professionals who will be used to perform any activities of any contract awarded under this RFP. You may also include any additional documentation related to staff qualifications which will assist the Department in assessing the Bidder's capability of performing the requirements of the RFP.

D.5.b. Independently Audited Financial Statements

The Department requires audited financial statements in order to conduct its review of the Bidder's financial stability and ability to perform a contract under this RFP. These financial statements must be included in the Supporting Documentation. Do not include this information in the Technical or Cost Components. Include a complete copy of the Bidder's independently audited financial statements or Dunn and Bradstreet Business Information Reports for the last three years (calendar years 2006, 2007 and 2008, or fiscal years ending during those years, as applicable).

If not included as part of the independently audited annual financial statements, the Bidder must also include in this section full disclosure of all significant litigation affecting the Bidder, whether as defendant or plaintiff, the status of any pending litigation, and the outcome of any litigation concluded within the same three-year period.

If the Bidder proposes to subcontract any portion of the work required under the contract, and the proposed sub-Contractor will be paid more than 25% of the bid price, include the same financial information for each such proposed Sub-contractor as is required in this section for the Bidder. Include the **percentage**, not the dollar value, of the total contract which will be performed by each proposed sub-Contractor. Do not include any other bid information with the proposed Sub-contractors' financial information. Inclusion of bid information other than the percentage of effort to be performed by a proposed sub-Contractor may result in disqualification of the Proposal.

D.5.c. References

Include contact information for three organizations with which the Bidder has contracted in the three year period ending December 31, 2008, for services similar to those required by this RFP. "Contact information" is the name and title of the person most familiar with the Bidder's performance who is still employed by the organization, his or her telephone number at the organization, and the organization's name, address and general

telephone number, if different. Each reference should describe the work performed by the Bidder for the organization, including start and end dates.

If the bidder has contracted with HRA and/or any local district, or the DOH for any purpose during this time period, in addition to the three references required above, include reference information for all such public contracts.

D.5.d. Vendor Responsibility Attestation

Each bidder must complete the appropriate vendor responsibility questionnaire (see Part E) and complete and submit with its proposal the Vendor Responsibility Attestation, Attachment 13. For this RFP, any sub-contractors must be approved by DOH and comply with M/WBE requirements. If the subcontractor is paid over \$100,000, they must submit a Vendor Responsibility questionnaire.

D.5.e. Certificate of Incorporation, Partnership Agreement, or Doing Business Certificate

If incorporated in New York, please provide a copy of your Certificate of Incorporation and proof of filing with the Department of State.

If incorporated outside New York, please provide a copy of your authority to do business in New York and proof of filing with the Department of State.

If a partnership, provide a copy of your partnership agreement. If doing business under an assumed name, please provide a copy of the DBA certificate with proof of filing. If a sole proprietorship, please so state in this section. If doing business under an assumed, please provide a copy of the DBA certificate with proof of filing.

D.5.f. Certificate of Authority

If you are a health care provider, an ALP, an adult care facility or an assisted living residence, please provide a copy of your license, certification or certificate of authority from DOH. If your license or authority is not issued by DOH, provide a copy of the license issued by another authority.

D.5.g. Sales Tax Forms

The sales tax forms required to be submitted by Part E.15 of this RFP, are to be included in the Supporting Documents section of the proposal.

D.5.h. Additional Documentation

Additional documentation is neither encouraged nor discouraged if it is relevant to the proposal or the bidder. If additional documentation is provided it should be labeled and included under Tab XXII. If additional documentation is provided, the bidder should include all documents in the Proposal Table of Contents.

D.6. METHOD OF AWARD

At the discretion of the Department of Health, all bids may be rejected. Applications meeting the guidelines set forth above will be reviewed and evaluated competitively by the Department of Health. Important considerations in the review process will be:

- A clear and appropriate cost narrative that supports the prices bid for each of the services included in the proposal;
- The extent to which the requirements of the RFP have been fully addressed;
- The bidder's ability to improve administration of services;
- The bidder's capability to achieve improved accuracy and standardization of assessments and authorizations;
- The bidder's capability to identify changes, including recommendations for regulatory or legislative action to further improve management of long term care programs;
- The bidder's demonstrated experience in conducting assessments for provision of long term care services; and
- The bidder's demonstrated experience in managing services to a Medicaid population and individuals of all ages with a range of medical needs and levels of disability.

After consideration of the following specific standards, the Technical and Cost Components will be weighted according to one or more formulae.

D.6.a. Overview

The following paragraphs of the RFP set forth the criteria to be used by the Department for evaluation of the Technical and Cost Components submitted in response to this RFP. All bids must contain two separate Components, as well as the Supporting Documentation.

- Technical Component (70 percent of total score);
- Cost Component (30 percent of total score).

D.6.b. Preliminary Review (Pass/Fail Criteria)

The proposal must meet and pass various criteria. If any of the following apply, the Proposal is considered incomplete and will not be scored.

- Proposal(s) not submitted by the time and date required by the RFP;
- Proposal does not contain separate Technical Component and Cost Components;
- Proposals for more than one Assessment Center are included in the same package;

- Signed Bidder's Assurances (Attachment 10), including the narrative support for assurances 5 and 6, are not included;
- Completed and signed Transmittal Letter for each proposal are not included;
- Completed and signed Bid Form not submitted;
- Completed Line Item Bid Form not submitted;
- Executive Summary as required by RFP not included;
- Completed Direct and Indirect Staffing Summary not included;
- Conflict of Interest Statement not included;

D.6.c. Proposal Formatting Requirements

Bidders formatting and submission requirements for each Assessment Center bid of the Proposal are as follows:

Two (2) original bound signed proposals,
One (1) unbound copy
Four (4) bound copies and
One (1) set of CDs with files in .pdf format

Submit separate Proposals clearly marked on the outside cover with the name of the Bidder, the title and number of the procurement as stated on the first page of this RFP, the name of the Assessment Center, as stated in Part A: Introduction, of the RFP and notation whether the package contains the "Technical Component" or the "Cost Component;"

Prepare Proposals on letter size (8.5 x 11) white paper, text on one side only.

- For each proposal, submit Technical Component in a three ring binder;
- For each proposal, organize the Technical Component with tab dividers identifying each section;
- Clearly number pages of the Technical Component, with each section separately numbered and identified in the Table of Contents; a separate Table of Contents may be used for the Supporting Documents; a separate Table of Contents must be used for the Cost Component;
- Prepare and format the Technical Component with the tabbed sections following the list in Part D.3.a. Include both the name and number of the section on the tab.
- Prepare and format the Supporting Documents with the tabbed sections following the list in Part D.5. These may be submitted in the same binder as the Technical Component or in a separate binder;
- Submit the Cost Component either in a binder or stapled or otherwise fastened together;
- Prepare and format the Cost Component with the following sections: Bid Form (Attachment 3) or No Bid Form (Attachment 4), Line Item Bid Form

(Attachment 5), Minority / Women's Business Enterprises Forms (Attachment 13) and Consultant Services Form A, (Attachment 14). Do not include any of these forms in the Technical Component.

D.6.d. Understanding of Assessment Programs

Bidders will be evaluated on how well they demonstrate scope of knowledge and ability to translate the goals and requirements contained in the RFP into an effective and efficient Assessment Center pursuant to Federal/State statutes, regulations, policies and practices.

D.6.e. Technical Approach

The Bidder's work plan will be evaluated on the quality of task definition including a statement of expected problems and proposed solutions with respect to conducting all required activities set forth in Part C and in Part D of the RFP, meeting the data security requirements, and the overall project management plan. Specific attention will be given to the Bidder's understanding and demonstrated ability to develop, implement, and manage an effective assessment program.

The bidder will also be evaluated on its ability to coordinate and develop linkages with referral organizations including NYConnects' information and assistance program, physicians, hospitals, clinics, home-based service agencies, community coalitions, nursing facilities, adult care facilities, and other community resources in New York State.

The Technical Component will be evaluated on the completion and timeliness of its deliverable schedule as well as its management and implementation plan.

The Bidder's policies and procedures for monitoring internal effectiveness (including sub-Contractors, if applicable) will be evaluated.

The appropriateness of the staffing levels and qualifications for each task will be evaluated with respect to their feasibility/adequacy to complete the required work in a successful manner and fully support the Bidder's work plan. The Bidder needs to provide rationale/justification i.e. workload estimates to demonstrate the feasibility of their staffing model. If the Bidder is submitting a bid for both Assessment Centers, it will be evaluated on its plan for providing sufficient Contractor or sub-contractor staff to meet all deliverables for both Centers, even though the award of a contract for one Center will not guarantee the award of the second Center to the same Contractor.

D.6.f. Personnel

The credentials and expertise of the personnel involved (including sub- Contractors and consultants, if applicable) in the Service Units included in the bid will be carefully evaluated. The Bidder's Proposal will be judged on the skills, type, and length of experience of the individuals proposed as well as the extent to which the appropriate disciplines are adequately represented. Evidence of staff experience should include résumés, publications and work references, etc.

D.6.g. Organization, Experience, and Capability

D.6.g.I. Evidence of the organization's experience and ability to implement the assessment center within the specified time frame will be reviewed and evaluated. Experience over the three year period ending December 31, 2008, will be considered as most relevant. Evidence which demonstrates this experience and ability may include published reports; programmatic data; and documentation of past experience. Evidence of experience working with large state and federal data files will be reviewed and evaluated.

D.6.g.II. The Bidder will also be judged on the extent to which their Proposal reflects experience in the subject area of each Unit within the Assessment Center and can reasonably be expected to successfully complete the tasks required by the Proposal.

D.6.g.III. The successful Bidder will be required to maintain experienced staff as included in the schedule of deliverables to be attached to the contract and will be penalized if such standards are not met during the term of the contract. See Part F.8. for additional information about penalties. Bidders must provide the names, address, telephone numbers and contact persons for contracts within the past two years which the Bidder feels are relevant to the activity of each Assessment Center of this RFP bid. These references will be contacted by the Department as a means of confirming representation made in the Proposal for each Assessment Center. The references listed should be recent, i.e. someone the Bidder has engaged in business with within the most recent two-year period. This information will be used by the Department as part of an overall evaluation of the Bidder's capabilities and experience.

D.6.h. Cost Component

The Bidder is expected to submit a bid for each of the Service Units described in this RFP. The Department will use these Service Unit price bids to compile a comprehensive cost Component which will be used as a foundation for evaluating competing Proposals for each Assessment Center. The Cost Component of each Bidder will be evaluated separately from the Technical Component. The pricing information must be correlated to the schedule of deliverables and projected workload described in the RFP and outlined in the Bidder's work plan. Price will be a consideration in the selection of a Contractor from qualifying Proposals, but the award will not necessarily be made to the Bidder with the lowest bid.

D.6.i. Scoring Methodology

In addition to proposals disqualified for failing to meet the minimum standards of Part D.6.b., proposals will be disqualified during the review process if any of the following circumstances are found:

- Information about the costs of services, other than the good faith estimate of reimbursable travel expense, is included in the binder containing the Technical Component;
- Any required Cost Component documents are included in the Technical Component;
- Any required Technical Component documents are included in the Cost Component;

- Any cost information is included in the Executive Summary;
- Consultant Services Form A included in the Technical Component or Supporting Documentation;
- Bidder's Assurances does not include adequate supporting documentation for assurances 5 and 6;
- Cost of staffing is included in the staffing narrative or the Direct and Indirect Staffing Summary; and

D.6.i.1. Technical Component Score (70 percent)

DOH will evaluate and score Technical Components based on each bidder's ability to perform the Scope of Work and Detailed Specifications described in this RFP for each Assessment Center for which the bidder has submitted a proposal. Each proposal for each Assessment Center will be scored separately from the proposals for the other Assessment Center.

The bidder receiving the highest technical score will receive seventy (70) points and the remaining bids will then be normalized against the highest scored proposal received based on a formula weighing the relative ranking of the technical score.

D.6.i.2 Cost Component Score (30 percent)

DOH will evaluate and score each bidder's Cost Component as submitted for the Assessment Center for which the bidder has applied. Each proposal for each Assessment Center will be scored separately. The bid price will be reviewed for completeness and consistency with instructions provided in the RFP.

The bidder receiving the lowest cost score will receive thirty (30) points and the remaining bids will then be normalized against the lowest scored proposal received based on a formula weighing the relative ranking of the cost score.

D.6.i.3 Total Combined Score

There is a maximum achievable total score of 100 (Technical Component score 70 plus Cost Component score 30). The scores will be ranked in order of highest Total Combined Scores, and a selection of the responsible bidders will be made based on the highest Total Combined Scores for each Assessment Center.

If the State is unsuccessful in negotiating a contract with a selected bidder within an acceptable time frame, the State may begin contract negotiations with the next qualified bidder(s) in order to serve and realize the best interests of the State.

Prior to final selection, this RFP and all responses thereto are subject to various State reviews. The DOH, Attorney General, and the Office of the State Comptroller must approve the final contract.

D.6.j. Financial and Reference Reviews

The Bidder with the highest scoring Proposal for an Assessment Center will then proceed to the Financial Viability and Stability Review. The members of the Selection

Committee will conduct the review of the highest scoring Bidder for each Assessment Center.

D.6.j.I. Financial Viability and Stability Review

The highest Bidder for each Assessment Center will be reviewed for financial viability and stability first. The purpose of this phase of the review is to determine whether the Bidder has sufficient current and sustained financial capacity, with minimal negative indicators, to perform the terms of the contract for the Assessment Center successfully. Reviewers will use the information from the independently audited financial statements and any other information deemed appropriate and relevant to this review to determine this criterion. If the Bidder fails this review it is not eligible to be awarded the contract and its Proposal will be eliminated from further review.

The Proposal must include proof of incorporation (or partnership or other organizational model) and financial viability. This information should include a minimum of three (3) years of audited financial statements or other appropriate documentation including credit report, Dunn & Bradstreet Reports, etc. If the Bidder has been in business for less than three years, the Bidder should provide audited financial statements for its entire business history. The Bidder is required to demonstrate financial viability to the satisfaction of the State.

As part of this review, the Bidder will be responsible for demonstrating the ability to cover 20% of the annual value of the bid to ensure its capacity to provide or the activities needed for the assessments required by the Service Units described in this RFP.

D.6.j.II. Responsibility Review (VRR)

If the highest Bidder for an Assessment Center is successful in the Financial Viability and Stability Review, it will also be reviewed for responsibility. Reviewers will use the Vendor Responsibility Questionnaire (VRQ) and any other information submitted in the Cost Component, the Supporting Documentation or otherwise available to or obtained by the DOH to complete this process. Reviewers will consider whether the Bidder meets such criteria as

- Satisfactory record of prior performance,
- Necessary licenses,
- Satisfactory record of business integrity, and
- Compliance with public policy.

An unfavorable determination in one or more of these areas may result in a non-responsibility determination by the Department. Such determination means that the Bidder is not eligible to be awarded the contract for either Assessment Center and will be eliminated from further review. The Committee will then submit the next highest Bidder in each Assessment Center to financial review. This process will continue until a Bidder for each Assessment Center passes the financial review or all Bidders for an Assessment Center are eliminated.

D.6.k. Reference Review

The highest scoring Bidder to pass Vendor Responsibility Review for each Assessment Center will proceed to reference check. If the Reference Review confirms the bidder's capability to perform its contractual obligations, the Bidder will be awarded the contract for that Assessment Center.

If the same bidder is the highest scoring bidder for both Assessment Centers and passes all the required reviews, a single contract for both Assessment Centers will be awarded to that bidder.

E. ADMINISTRATIVE PROVISIONS

E.1. Issuing Agency

This Request for Proposal (RFP) is a solicitation issued by the NYS Department of Health. The Department is responsible for the requirements specified herein and for the evaluation of all proposals.

E.2. Inquiries – Questions and Answers.

All substantive pre-bidders conference questions must be submitted by August 5, 2009, and final written questions must be submitted by August 26, 2009 by email to AssessmentCenter@health.state.ny.us, or by regular mail to:

David Spaulding
NYS Department of Health
Office of Long Term Care
Division of LTC Resources
1 Commerce Plaza, 8th Floor
Albany, New York 12237

Questions received at the above address or email by close of business on August 5, 2009, will be addressed at the bidder's conference. Responses to all written questions will be posted on the DOH website no later than September 14, 2009.

To the degree possible, each inquiry should cite the RFP section and paragraph to which it refers. Written questions will be accepted until the date posted on the cover of this RFP.

Questions of a technical nature can be addressed by email or via telephone by calling Patricia Keelan at (518) 408-3744. **Questions are of a technical nature if they are limited to how to prepare your proposal (e.g., formatting) rather than relating to the substance of the proposal.**

Prospective bidders should note that all clarification and exceptions, including those relating to the terms and conditions of the contract, are to be raised prior to the submission of a proposal.

Questions and answers, as well as any RFP updates and/or modifications, will be posted on the Department of Health's website at <http://www.nyhealth.gov/funding/> by the date listed in the Schedule of Events at the beginning of this RFP. Bidders wishing to receive a paper copy of these documents must send a request, in writing, to the Department at the address above.

If prospective bidders would like to receive notification when updates/modifications are posted (including responses to written questions), please complete and submit a letter of intent. Prospective bidders may also use the letter of intent to request actual (hard copy) documents containing update information.

E.3. Letter of Intent

Prospective bidders are strongly encouraged to submit a letter of intent to apply. This letter of intent should be received by DOH by August 5, 2009. Letters of intent should be directed to:

David Spaulding
NYS Department of Health
Office of Long Term Care
Division of LTC Resources
1 Commerce Plaza, 8th Floor
Albany, New York 12210

E.4. Submission of Proposals

Proposals must be **received** at the following address by the date and time posted on the cover sheet of this RFP. Late proposals will not be accepted.

David Spaulding
NYS Department of Health
Office of Long Term Care
Division of LTC Resources
1 Commerce Plaza, 8th Floor
Albany, New York 12210

Bidders shall submit for each Assessment Center on which a proposal is submitted:

Two (2) original bound signed proposals,
One (1) unbound copy
Four (4) bound copies and
One (1) set of CDs with files in .pdf format.

Responses to this solicitation should be clearly marked with the name and number of the RFP as appears on the front page, and whether the proposal is for the geographic area served by CASA VII in Kings County within the City of New York or for the Orange and Ulster County region, and directed to the above address.

It is the bidders' responsibility to see that bids are delivered to the address listed above prior to the date and time of the bid due date. Late bids due to delay by the carrier or not received in the Department's mail room in time for transmission to the address listed above will not be considered.

- The Bid Form must be filled out in its entirety.
- The responsible corporate officer for contract negotiation must be listed. This document must be signed by the responsible corporate officer.
- All evidence and documentation requested under Section D, Proposal Requirements must be provided at the time the proposal is submitted.

By signing the "Bid Form" each person attests to its express authority to sign on behalf of the Bidder.

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.

Submission of a proposal indicates the bidder's acceptance of all conditions and terms contained in this RFP, including the terms and conditions of the contract. Any exceptions allowed by the Department during the Question and Answer Phase must be clearly noted in a cover letter attached to the proposal.

A bidder may be disqualified from receiving a contract if such bidder 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.

E.5. THE DEPARTMENT OF HEALTH RESERVES THE RIGHT TO

- a. Reject any or all proposals received in response to this RFP.
- b. Award more than one contract resulting from this RFP.
- c. Waive or modify minor irregularities in proposals received after prior notification to the bidder.
- d. Adjust or correct cost or cost figures with the concurrence of bidder if errors exist and can be documented to the satisfaction of DOH and the State Comptroller.
- e. Negotiate with vendors responding to this RFP within the requirements to serve the best interests of the State.
- f. Eliminate mandatory requirements unmet by all bidders.
- g. If the Department of Health is unsuccessful in negotiating a contract with the selected vendor within an acceptable time frame, the Department of Health may begin contract negotiations with the next qualified vendor(s) in order to serve and realize the best interests of the State.
- h. To award the contract(s) based on geographic or regional considerations to serve the best interests of the state.

E.6. Payment

E.6.a. Invoices and vouchers

If awarded a contract, the contractor shall submit quarterly invoices to the payment office designated below or any other person or location to which DOH may direct the contractor to submit claims for payment:

NYS Department of Health
Office of Long Term Care
Division of LTC Resources
Claims and Payment Unit
1 Commerce Plaza, 8th Floor
Albany, New York 12210

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

Payment will be made quarterly upon receipt of acceptable invoices. In order to be viewed as acceptable, invoices must accompany required report(s) and must document completion of billed work.

In addition payment is contingent upon all required reports being submitted on time as required by this RFP.

Penalties will be imposed for the contractor's failure of any performance standard included in the contract awarded pursuant to this RFP.

E.6.b. Provisions Upon Default

E.6.b.i. The services to be performed by the bidder shall be at all times subject to the direction and control of the Department as to all matters arising in connection with or relating to the contract resulting from this RFP.

E.6.b.ii. In the event that the bidder, through any cause, fails to perform any of the terms, covenants or promises of any contract resulting from this RFP, 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 contractor.

E.6.b.iii. If, in the judgment of the Department of Health, the contractor 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 RFP 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.

E.7. Periodic Reporting Requirements

The contractor will be required to submit the following periodic reports that will include, but not be limited to, an assessment of the project, an analysis of the level and costs of services managed under the contract, recipient satisfaction and other matters as may be pertinent, including submission of data requested by DOH. Examples of such data and information are shown below. The contractor will also facilitate and participate in meetings of stakeholders to discuss implementation and operation of this demonstration program. Such meetings must be held at least twice a year.

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

E.7.a. During the development and implementation phase, the contractor shall submit monthly reports, including, but not limited to:

Discussion of milestones achieved and evaluation of project status;
Discussion of any delays or other issues encountered;
Plan of action for addressing any delays or other issues encountered;
Objectives for the next reporting period;
Objectives for the time remaining in the start up period.

E.7.b. Following initial delivery of Assessment Center services, on a quarterly basis, a narrative report which at the minimum, shall include:

Discussion of milestones achieved and evaluation of project status;
Discussion of any delays or other issues encountered;
Plan of action for addressing any delays or other issues encountered;
Discussion of activities that have met and not met timelines set forth in the Workplan;
Objectives for the next reporting period;
Objectives for the remaining demonstration period;
Financial report of project expenses.

E.7.c. Quarterly statistical reports including at a minimum the following data:

- Number of assessments completed;
- Number of reassessments completed;
- Number of assessments completed that did not result in authorization of any of the listed services, delineated by category of reason for services not being authorized;
- Number of nursing home level of care determinations completed;
- Number of consumers authorized to receive services delineated by program/service;
- The percentage of occurrences when reassessments resulted in one of the following, delineated by program/service:
 - Additional hours of the service(s) previously being received;
 - Reduction in hours of service(s) previously being received;
 - Termination of all services;
 - A new service replacing the service(s) previously being received;
 - An new service provided in addition to the service(s) previously being received;
- Number of Fair Hearing requests received, number that occurred and the percentage of Fair Hearings in which the consumer's position prevailed;
- Number and type of inquiries and complaints received from consumers;
- Number and type of inquiries and complaints received from providers;
- Ratio of non-administrative and non-supervisory FTEs to number of assessments and reassessments conducted as delineated by type of staff (e.g. nurse, social worker);
- Results of consumer satisfaction surveys developed by the contractor and approved by DOH;
- Other data and information as may be requested by DOH.

E.7.d. Semi-annual reports including at a minimum the following:

- Key implementation issues or challenges, and the manner in which they were resolved;
- Key operational issues or challenges, and the manner in which they were resolved;
- Best practices;

- Principal lessons learned that would have applicability to an expansion of Assessment Centers in New York State.

E.7.e. An Annual Report will be required.

E.8. Term of Contract

This agreement shall be effective upon approval of the NYS Office of the State Comptroller.

The contract shall last for a period of three (3) years from the date of contract execution.

It is expected that contracts resulting from this RFP will have the following time period: January 1, 2010 – December 31, 2012, although the State reserves the right to change these dates.

This agreement may be canceled at any time by the Department of Health giving to 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 canceled.

E.9. Debriefing

Once an award has been made, bidders may request a debriefing of their proposal. Please note the debriefing will be limited only to the strengths and weaknesses of the bidder's proposal, and will not include any discussion of other proposals. Requests must be received no later than three months from date of award announcement.

E.10. Vendor Responsibility Questionnaire

New York State Procurement Law requires that state agencies award contracts only to responsible vendors. Vendors are invited to file the required Vendor Responsibility Questionnaire online via the New York State VendRep System or may choose to complete and submit a paper questionnaire. To enroll in and use the New York State VendRep System, see the VendRep System Instructions available at www.osc.state.ny.us/vendrep or go directly to the VendRep system online at <https://portal.osc.state.ny.us>. For direct VendRep System user assistance, the OSC Help Desk may be reached at 866-370-4672 or 518-408-4672 or by email at helpdesk@osc.state.ny.us. Vendors opting to file a paper questionnaire can obtain the appropriate questionnaire from the VendRep website www.osc.state.ny.us/vendrep or may contact the Department of Health or the Office of the State Comptroller for a copy of the paper form. Bidders must also complete and submit the Vendor Responsibility Attestation (Attachment 13).

E.11. State Consultant Services Reporting

Chapter 10 of the Laws of 2006 amended certain sections of State Finance Law and Civil Service Law to require disclosure of information regarding contracts for consulting services in New York State.

The winning bidders for procurements involving consultant services must complete a "State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term" (Attachment 14) in order to be eligible for a contract.

Winning bidders must also agree to complete a "State Consultant Services Form B, Contractor's Annual Employment Report" (Attachment 15) for each state fiscal year included in the resulting contract. This report must be submitted annually to the Department of Health, the Office of the State Comptroller, and Department of Civil Service.

Both of these forms are included as attachments to this document.

E.12. Lobbying Statute

Chapter 1 of the Laws of 2005, as amended by Chapter 596 of the Laws of 2005, provides, among other things, the following as pertains to development of procurement contracts with governmental entities:

- a. makes the lobbying law applicable to attempts to influence procurement contracts once the procurement process has been commenced by a state agency, unified court system, state legislature, public authority, certain industrial development agencies and local benefit corporations;
- b. requires the above mentioned governmental entities to record all contacts made by lobbyists and contractors about a governmental procurement so that the public knows who is contacting governmental entities about procurements;
- c. requires governmental entities to designate persons who generally may be the only staff contacted relative to the governmental procurement by that entity in a restricted period;
- d. authorizes the New York State Commission on Public Integrity to impose fines and penalties against persons/organizations engaging in impermissible contacts about a governmental procurement and provides for the debarment of repeat violators;
- e. directs the Office of General Services to disclose and maintain a list of non-responsible bidders pursuant to this new law and those who have been debarred and publish such list on its website;
- f. requires the timely disclosure of accurate and complete information from offerers with respect to determinations of non-responsibility and debarment;
- g. expands the definition of lobbying to include attempts to influence gubernatorial or local Executive Orders, Tribal–State Agreements, and procurement contracts;
- h. modifies the governance of the New York State Commission on Public Integrity
- i. provides that opinions of the Commission shall be binding only on the person to whom such opinion is rendered;
- j. increases the monetary threshold which triggers a lobbyist's obligations under the Lobbying Act from \$2,000 to \$5,000; and
- k. establishes the Advisory Council on Procurement Lobbying.

Generally speaking, two related aspects of procurements were amended: (i) activities by the business and lobbying community seeking procurement contracts (through amendments to the Legislative Law) and (ii) activities involving governmental agencies establishing procurement contracts (through amendments to the State Finance Law).

Additionally, a new section 1-t was added to the Legislative Law establishing an Advisory Council on Procurement Lobbying (Advisory Council). This Advisory Council is authorized to establish the following model guidelines regarding the restrictions on contacts during the procurement process for use by governmental entities (see Legislative Law §1-t (e) and State Finance Law §139-j). In an effort to facilitate compliance by governmental entities, the Advisory Council has prepared model forms and language that can be used to meet the obligations imposed by State Finance Law §139-k, Disclosure of Contacts and Responsibility of Offerers. Sections 139-j and 139-k are collectively referred to as “new State Finance Law.”

It should be noted that while this Advisory Council is charged with the responsibility of providing advice to the New York State Commission on Public Integrity regarding procurement lobbying, the Commission retains full responsibility for the interpretation, administration and enforcement of the Lobbying Act established by Article 1-A of the Legislative Law (see Legislative Law §1-t (c) and §1-d). Accordingly, questions regarding the registration and operation of the Lobbying Act should be directed to the New York State Commission on Public Integrity.

E.13. Accessibility of State Agency Web-based Intranet and Internet Information and Applications

Any web-based intranet and internet information and applications development, or programming delivered pursuant to the contract or procurement will comply with New York State Enterprise IT Policy NYS-P08-005, “Accessibility of Web-based Information and Applications” as such policy may be amended, modified or superseded, which requires that state agency web-based intranet and internet information and applications are accessible to persons with disabilities. Web content must conform to New York State Enterprise IT Policy NYS-P08-005 Appendix A, as determined by quality assurance testing. Such quality assurance testing will be conducted by NYS Department of Health and the results of such testing must be satisfactory to NYS Department of Health before web content will be considered a qualified deliverable under contract or procurement.

E.14. Information Security Breach and Notification Act

Section 208 of the State Technology Law (STL) and Section 899-aa of the General Business Law (GBL) require that State entities and persons or businesses conducting business in New York who own or license computerized data which includes private information including an individual’s unencrypted personal information plus one or more of the following: social security number, driver’s license number or non-driver ID, account number, credit or debit card number plus security code, access code or password which permits access to an individual’s financial account, must disclose to a New York resident when their private information was, or is reasonably believed to have been, acquired by a person without valid authorization. Notification of breach of that private information to all individuals affected or potentially affected must occur in the most expedient time possible without unreasonable delay, after measures are taken to determine the scope of the breach and to restore integrity; provided, however, that notification may be delayed if law enforcement determines that expedient notification would impede a criminal investigation.

When notification is necessary, the State entity or person or business conducting business in New York must also notify the following New York State agencies: the Attorney General, the Office of Cyber Security & Critical Infrastructure Coordination (CSCIC) and the Consumer Protection Board (CPB). Information relative to the law and the notification process is available at: <http://www.cscic.state.ny.us/security/securitybreach/>.

E.15. New York State Tax Law Section 5-a

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded state contracts for commodities, services and technology valued at more than \$100,000 to certify to the Department of Tax and Finance (DTF) that they are registered to collect New York State and local sales and compensating use taxes. The law applies to contracts where the total amount of such contractors' sales delivered into New York State are in excess of \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made, and with respect to any affiliates and subcontractors whose sales delivered into New York State exceeded \$300,000 for the four quarterly periods immediately preceding the quarterly period in which the certification is made.

This law imposes upon certain contractors the obligation to certify whether or not the contractor, its affiliates, and its subcontractors are required to register to collect state sales and compensating use tax and contractors must certify to DTF that each affiliate and subcontractor exceeding such sales threshold is registered with DTF to collect New York State and local sales and compensating use taxes. The law prohibits the State Comptroller, or other approving agencies, from approving a contract awarded to an offerer meeting the registration requirements but who is not so registered in accordance with the law.

Contractor must complete and submit directly to the New York State Taxation and Finance, Contractor Certification Form ST-220-TD attached hereto (Attachment 16). Unless the information upon which the ST-220-TD is based changes, this form only needs to be filed once with DTF. If the information changes for the contractor, its affiliate(s), or its subcontractor(s), a new form (ST-220-TD) must be filed with DTF.

Contractor must complete and submit to the Department of Health the form ST-220-CA attached hereto (Attachment 17), certifying that the contractor filed the ST-220-TD with DTF. Failure to make either of these filings may render an offerer non-responsive and non-responsible. Offerers shall take the necessary steps to provide properly certified forms within a timely manner to ensure compliance with the law.

E.16. Piggybacking

New York State Finance Law section 163(10)(e) (see also <http://www.ogs.state.ny.us/procurecounc/pgbguidelines.asp>) allows the Commissioner of the NYS Office of General Services to consent to the use of this contract by other New York State Agencies, and other authorized purchasers, subject to conditions and the Contractor's consent.

E.17. M/WBE Utilization Plan for Subcontracting and Purchasing

The Department of Health (DOH) encourages the use of Minority and/or Women Owned Business Enterprises (M/WBE's) for any subcontracting or purchasing related to this contract. Bidders who are not currently a New York State certified M/WBE must define the portion of all consumable products and personnel required for this proposal that will be sourced from a M/WBE. The amount must be stated in total dollars and as a percent of the total cost necessary to fulfill the RFP requirement. Supportive documentation must include a detail description of work that is required including products and services.

The goal for usage of M/WBE's is at least 10% of monies used for contract activities (Minority-owned – 5%; Women-owned – 5%). In order to assure a good-faith effort to attain this goal, the DOH requires that bidders complete the M/WBE Utilization Plan (Attachment 12) and submit this Plan with their bid documents.

Bidders that are New York State certified MBE's or WBE's are not required to complete this form. Instead, such bidders must simply provide evidence of their certified status.

Failure to submit the above referenced Plan (or evidence of certified M/WBE status) may result in disqualification of the vendor from consideration for award.

F. APPENDICES

The following will be incorporated as appendices into any contract resulting from this Request for Proposal. This Request for Proposal will, itself, be referenced as an appendix of the contract.

- APPENDIX A - Standard Clauses for All New York State Contracts
- APPENDIX B - Request for Proposal
- APPENDIX C - Proposal
The bidder's proposal (if selected for award), including any Bid Forms and all proposal requirements.
- APPENDIX D - General Specifications
- 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**, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, 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**, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
 - **DB-120.1** – Certificate of Disability Benefits Insurance
 - **DB-155** – Certificate of Disability Benefits Self-Insurance
- APPENDIX F – Payment and Reporting Requirements

- ❑ APPENDIX H - Health Insurance Portability and Accountability Act (HIPAA) (if applicable)
- ❑ APPENDIX I – Medicaid Confidentiality and Data Use Agreements
- ❑ APPENDIX X – Modification Agreement Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods)

G. ATTACHMENTS

- 1 Letter of Intent
- 2 Transmittal Letter
- 3 Bid Form
- 4 No Bid Form
- 5 Line Item Bid Form
- 6 Service Units Technical Form
- 7 Direct Staffing Summary Form
- 8 Indirect Staffing Summary Form
- 9 Preferred Eligibility Summary
- 10 Bidders Assurances
- 11 Conflict of Interest Statement
- 12 Minority/Women's Business Enterprise Procurement Forms
- 13 Vendor Responsibility Attestation
- 14 State Consultant Services Form A
- 15 State Consultant Services Form B, Contractor's Annual Employment Report
- 16 NYSDTF Contractor Certification Form ST-220-TD
- 17 NYSDTF Contractor Certification Form ST-220-CA
- 18 Service Unit Volume Projections Chart
- 19 Long Term Care Assessment Process
- 20 Long Term Care Assessment Performance Standards
- 21 Long Term Care Assessment Tools
- 22 Miscellaneous Consulting Services Contract Boilerplate
- 23 Appendix A – Standard Clauses for All New York State Contracts
- 24 Appendix D – General Specifications
- 25 Appendix F – Payment and Reporting Terms
- 26 Appendix H – HIPAA Business Associate Agreement
- 27 Appendix I – Medicaid Confidentiality and Data Use Agreements
- 28 Sample Vendor Responsibility Questionnaire
- 29 Bidder's Checklist

Attachment 1

Letter of Intent to Develop a Proposal in Response to RFP

Attachment 1

Letter of Intent to Develop a Proposal in Response to RFP

This is to notify the New York State Department of Health of this Bidder's intention to develop a Proposal in response to this RFP. It is understood that this Letter of Intent is strongly recommended if the bidder wishes to submit a proposal or to receive further correspondence related to this RFP.

This Notice should be returned via mail or fax to:

David Spaulding
Division of LTC Resources, Office of Long Term Care
NYS Department of Health
1 Commerce Plaza, 8th Floor
Albany, NY, 12210
Fax # 518-473-0601
AssessmentCenter@health.state.ny.us

1. Name of Potential Proposing Organization:

2. Organization Address:

Street: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ FAX: (____) _____

E-mail: _____

Authorized Signature

Date

Attachment 2

FORM FOR TRANSMITTAL LETTER
(Please use your organization's official letterhead)

Attachment 2

FORM FOR TRANSMITTAL LETTER
(Please use your organization's official letterhead)

[Date]

NYS Department of Health
Division of LTC Resources, Office of Long Term Care
1 Commerce Plaza, 8th Floor
Albany, NY, 12210

ATTN: David Spaulding

RFP # _____

This proposal is submitted for CASA VII or Orange & Ulster

Name of bidder:

Address of bidder:

Official Contact Person:

Telephone number of contact person:

Email address of contact person:

Signature of authorized person

Date

Attachment 3

**NEW YORK STATE
DEPARTMENT OF HEALTH**

BID FORM

Attachment 3

**NEW YORK STATE
DEPARTMENT OF HEALTH**

BID FORM

PROCUREMENT TITLE: _____ FAU # _____

Bidder Name:
Bidder Address:

Bidder Fed ID No:

A. _____ bids a total price of \$ _____
(Name of Offerer/Bidder)

B. Affirmations & Disclosures related to State Finance Law §§ 139-j & 139-k:

Offerer/Bidder affirms that it understands and agrees to comply with the procedures of the Department of Health relative to permissible contacts (provided below) as required by State Finance Law §139-j (3) and §139-j (6) (b).

Pursuant to State Finance Law §§139-j and 139-k, this *Invitation for Bid or Request for Proposal* includes and imposes certain restrictions on communications between the Department of Health (DOH) and an Offerer during the procurement process. An Offerer/bidder is restricted from making contacts from the earliest notice of intent to solicit *bids/proposals* through final award and approval of the Procurement Contract by the DOH and, if applicable, Office of the State Comptroller (“restricted period”) to other than designated staff unless it is a contact that is included among certain statutory exceptions set forth in State Finance Law §139-j(3)(a). Designated staff, as of the date hereof, is/are identified on the first page of this *Invitation for Bid, Request for Proposal, or other solicitation document*. DOH employees are also required to obtain certain information when contacted during the restricted period and make a determination of the responsibility of the Offerer/bidder pursuant to these two statutes. Certain findings of non-responsibility can result in rejection for contract award and in the event of two findings within a 4 year period, the Offerer/bidder is debarred from obtaining governmental Procurement Contracts. Further information about these requirements can be found on the Office of General Services Website at: <http://www.ogs.state.ny.us/aboutOgs/regulations/defaultAdvisoryCouncil.html>

1. Has any Governmental Entity made a finding of non-responsibility regarding the individual or entity seeking to enter into the Procurement Contract in the previous four years? (Please circle):

No Yes

If yes, please answer the next questions:

1a. Was the basis for the finding of non-responsibility due to a violation of State Finance Law §139-j (Please circle):

No Yes

1b. Was the basis for the finding of non-responsibility due to the intentional provision of false or incomplete information to a Governmental Entity? (Please circle):

No

Yes

1c. If you answered yes to any of the above questions, please provide details regarding the finding of non-responsibility below.

Governmental Entity: _____

Date of Finding of Non-responsibility: _____

Basis of Finding of Non-Responsibility:

(Add additional pages as necessary)

2a. Has any Governmental Entity or other governmental agency terminated or withheld a Procurement Contract with the above-named individual or entity due to the intentional provision of false or incomplete information? (Please circle):

No

Yes

2b. If yes, please provide details below.

Governmental Entity: _____

Date of Termination or Withholding of Contract: _____

Basis of Termination or Withholding:

(Add additional pages as necessary)

C. Offerer/Bidder certifies that all information provided to the Department of Health with respect to State Finance Law §139-k is complete, true and accurate.

D. Offerer/Bidder agrees to provide the following documentation either *with their submitted bid/proposal or upon award* as indicated below:

With Bid

Upon Award

1. A completed N.Y.S Taxation and Finance Contractor Certification Form ST-220-CA (for procurements greater than or equal to \$100,000)

2. A completed N.Y.S. Office of the State Comptroller Vendor Responsibility Questionnaire (for procurements greater than or equal to \$100,000)

3. A completed State Consultant Services Form A, Contractor's Planned Employment From Contract Start Date through End of Contract Term

(Officer Signature)

(Date)

(Officer Title)

(Telephone)

(e-mail Address)

Attachment 4

**NEW YORK STATE
DEPARTMENT OF HEALTH**

NO-BID FORM

Attachment 5

Line Item Bid Form

Attachment 5

Line Item Bid Form

| PART I | | |
|---|--------------------|------------|
| SERVICE UNITS | | |
| Service Unit | Description | 2010 Price |
| Personal Care Services Program (PSCP) | | |
| 1 | Initial Assessment | \$ |
| 2 | Reassessment | \$ |
| Consumer Directed Personal Assistance Program (CDPAP) | | |
| 3 | Initial Assessment | \$ |
| 4 | Reassessment | \$ |
| Assisted Living Program (ALP) | | |
| 5 | Initial Assessment | \$ |
| 6 | Reassessment | \$ |
| Long Term Home Health Care Program (LTHHCP) | | |
| 7 | Initial Assessment | \$ |
| 8 | Reassessment | \$ |
| AIDS Home Care Program (AHCP) | | |
| 9 | Initial Assessment | \$ |
| 10 | Reassessment | \$ |
| Managed Long Term Care (MLTC) | | |
| 11 | Initial Assessment | \$ |
| 12 | Reassessment | \$ |
| Certified Home Health Agency (CHHA) Services | | |
| 13 | Initial Assessment | \$ |
| 14 | Reassessment | \$ |

| PART II | | | | |
|---|-------|--------------------------|----------------------|-----------|
| HOURLY ACTIVITIES | | | | |
| For each hourly activity, please provide a price per hour for each person along with their title, who may participate in the activity. Please be inclusive, as the contractor will not be reimbursed for hourly staff not included in this table. | | | | |
| Activity | Title | Year 2010 Price Per hour | Estimated # of Hours | Total Bid |
| Medical Director | | \$ | | \$ |
| 15. Assessment review | | \$ | | \$ |
| 16. Other professional activities | | \$ | | \$ |
| Testimony at Fair Hearings | | \$ | | \$ |
| 17. Medical Director | | \$ | | \$ |
| 18. Professional staff | | \$ | | \$ |
| 19. Other staff | | \$ | | \$ |
| Testimony in Court | | \$ | | \$ |
| 20. Medical Director | | \$ | | \$ |
| 21. Professional staff | | \$ | | |
| 22. Other staff | | \$ | | \$ |

*Insert your estimated number of hours

| PART III | |
|---|-------|
| FIXED PRICE SERVICES | |
| Activity | Price |
| 23. Start Up Costs | \$ |
| 24. Training Costs for Year One | \$ |
| 25. Case Management (as a fixed percentage of the Service Unit Price) | % |
| 26. Administration (as a fixed percentage of the Service Unit Price) | % |

| PART IV | | |
|---|----------------|------------------------------------|
| ADDITIONAL HOURLY RATES | | |
| Staff Titles | Price per Hour | Describe Responsibilities / Duties |
| Project Manager | \$ | |
| Physicians (List specialties on separate lines below, and list responsibilities, duties for each) | | |
| Medical Director | \$ | |
| | \$ | |
| RN Assessor | \$ | |
| RN Supervisor | \$ | |
| MSW Assessor | \$ | |
| MSW Supervisor | \$ | |
| Case Manager (list by specialization, e.g., RN, MSW, other, list responsibilities for each) | | |
| | \$ | |
| | \$ | |
| Non-professional staff (list by title and include responsibilities, duties for each) | | |
| | \$ | |
| | \$ | |
| | \$ | |
| If there are additional titles that the Bidder proposes to use in its contract, please list those titles below and describe their duties / responsibilities and the price per hour that would be charged. Please use additional pages if necessary. | | |
| | \$ | |
| | \$ | |
| | \$ | |

Attachment 6

Service Units Technical Reporting Form

Attachment 6

**Service Units Technical Reporting Form
(Optional)**

Information Required: If you choose to use this form, please complete it form FOR EACH SERVICE UNIT LISTED IN PART I OF THE LINE ITEM BID FORM. The Instructions are in Part D.3.b.V. and C.2. Use a separate form for each Service Unit. Use as many pages as necessary or include required information on attached pages. If using attached pages, identify clearly what information is being provided by numbering each section to correspond with the numbers on this form. Please do not leave any blanks. If a particular requirement is not applicable to a particular Service Unit please so indicate. Do not use terms such as “see above” or other cross references in your response. Do not include any financial or cost information in this form.

INSERT THE NAME AND NUMBER OF THE SERVICE UNIT IN THE TOP BOX BELOW:

| | |
|------------------------|--|
| Unit # and Name | |
|------------------------|--|

| Unit # | Description: | Response: |
|--------|--|-----------|
| 1 | Verify Medicaid eligibility to ensure that only consumers determined financially eligible for Medicaid by HRA and/or the local district(s) are assessed | |
| 2 | Conduct initial intake and screenings to determine the need for services and assessed for program participation | |
| 3 | Accept and process referrals from multiple sources, including initial referrals from HRA and/or the local district(s) and referrals received from sources other than HRA and/or the local district(s) | |
| 4 | Obtain physician’s orders and work with home care program representatives in order to obtain the physician’s orders; and establish an internal process for triaging and assigning completed physician’s orders to staff responsible for completing assessments | |
| 5 | Conduct initial nursing and social assessment to determine appropriateness of participating programs included in this demonstration for the consumer. Assessment tools utilized will be the existing HRA, and/or local district tools, the State’s model tools or alternate tools proposed by the contractor and approved for use by DOH. All assessments/reassessments must, at | |

| Unit # | Description: | Response: |
|-------------|--|-----------|
| | a minimum: | |
| 5 (cont) | <ul style="list-style-type: none"> • Be face-to-face with the consumer in his/her home; • Be strength-based; • Be task-based; • Identify and document the link between functional ability and need for each task; • Consider the age appropriateness of services as well as developmental level; • Consider, identify and utilize efficiencies; • Encourage and identify participation of informal supports; • Consider and identify contribution of any formal supports; and • Comply with all applicable state and federal laws and regulations | |
| 6 | Develop a plan of care and services that recognizes variations in specific program requirements and required interaction with service vendors | |
| 7 | Authorize the specific hours of service resulting from the completed assessments and identify and assign the service vendor which will provide the authorized services. If it is determined services are not appropriate, give timely notice and referrals to HRA and/or the local district(s), or other appropriate agencies | |
| 8 | Transmit referrals, including care plans, to service vendors for service provision | |
| 9 | Transmit the service authorization, including vendor identification, to eMedNY | |
| 10 | Reassess to determine the continued appropriateness for participation in the authorized program(s) and services every six months or more frequently if required by a change in the consumer's medical or social circumstances, or in the case of LTHHCPs, every 120 days. The process must apply assessment tools utilized by HRA and/or the local district(s), the State models or alternate tools approved by DOH. | |

| Unit # | Description: | Response: |
|--------|---|-----------|
| | Such process must continue to comply with all applicable local, state and federal law(s) and regulation(s). In the event that DOH approves the use of a new or revised assessment tool(s), DOH shall provide prior notice to the contractor and shall allow sufficient time for staff to be trained in the use of such tool(s) | |
| 11 | Obtain physician orders and care plans for consumers receiving home health services on the 40th day of service for review and determination of continuing service beyond 60 days. Such determination must be made by the 50th day and communicated to the consumer, the CHHA and the HRA/LDSS | |
| 12 | Interfacing with New York City HRA and/or other local district(s) to coordinate activities and services, such as adult protective services or children's services or NY Connects, as necessary | |
| 13 | Conducting case conferences to resolve any differences before going to a Fair Hearing | |
| 14 | Providing the appropriate Notice(s) of Decision (NOD), using forms approved by DOH, that provides consumers with specific information regarding their application for services in accordance with Medicaid due process requirements. The notices contain information related to the opportunity to participate in a conference with the authorizing agency. The contractor will, using information obtained through the nursing and social assessment process, support their decision at the conference and/or Fair Hearing, if a conference or Fair Hearing is requested by the consumer. The Notices of Decision issued by the contractor shall include its address and other contact information to assure the consumer's ability to access documents and obtain copies of such documents concerning the consumer's case and for preparation for the Fair Hearing. If Court appearance(s) is necessary as a result of the outcome of a Fair Hearing, the | |

| Unit # | Description: | Response: |
|--------|--|-----------|
| | contractor will cooperate with the Department, HRA or the LDSS, and provide staff as necessary to support the assessment | |
| 15 | Providing a toll free telephone access number for handling consumer and provider inquiries | |
| 16 | In addition to maintaining an effective working relationship with HRA and other participating local districts, the contractor must also maintain such relationships with all others charged with assessment, authorization and/or case management responsibilities for other needed services/programs. This includes the Regional Resource Development Centers under contract to DOH for regional administration of the Traumatic Brain Injury and Nursing Home Transition and Diversion Medicaid waivers, HRA/LDSS and/or OMR/DD staff responsible for the Care at Home Medicaid waivers and DOH staff responsible for prior approval of private duty nursing | |
| 17 | Providing a description of a plan through which the contractor will track outcomes of individuals who, through the assessment/reassessment processes, are determined not appropriate to receive services that are the subject of this RFP, or who have had previously authorized amounts of service reduced or terminated as a result of reassessment. Additionally, such description should include collaboration with NYConnects | |

Attachment 7

DIRECT STAFFING SUMMARY

Attachment 7

DIRECT STAFFING SUMMARY

For each activity, list all position titles that will be utilized for that activity including, minimum qualifications for each title, the estimated percent of full time equivalent of each title for the service unit, and responsibilities and duties of each title. The Department reserves the right to review and approve the titles and qualifications of Contractor staff performing administrative functions. You may use this Word document as a form or use additional pages containing the information requested in a similar format, so long as complete information is provided and that staff titles, qualifications, FTEs and responsibilities are associated with each of the service units listed.

PLEASE LIST ONE TITLE PER LINE IN YOUR RESPONSE. You must complete the form for each activity. Do NOT use terms such as “see above” or “see response to unit x.” At the end of the form please include a chart listing the total number of staff in each category that you expect to employ to fulfill the contract.

| ACTIVITY | UNIT # | TITLE | MINIMUM QUALIFICATIONS | %FTE | RESPONSIBILITIES and DUTIES |
|--|---------------|--------------|-------------------------------|-------------|------------------------------------|
| Personal Care Services Program (PCSP) | | | | | |
| Initial Assessment | | | | | |
| Reassessment | | | | | |
| Case Management | n/a | | | | |
| Personal Emergency Response Systems (PERS) | | | | | |
| Initial Assessment | | | | | |
| Reassessment | | | | | |
| Case Management | n/a | | | | |
| Consumer Directed Personal Assistance Program (CDPAP) | | | | | |
| Initial Assessment | | | | | |
| Reassessment | | | | | |
| Case Management | n/a | | | | |

| ACTIVITY | UNIT # | TITLE | MINIMUM QUALIFICATIONS | %FTE | RESPONSIBILITIES and DUTIES |
|---|---------------|--------------|-------------------------------|-------------|------------------------------------|
| Assisted Living Program (ALP) | | | | | |
| Initial Assessment | | | | | |
| Reassessment | | | | | |
| Case Management | n/a | | | | |
| Long Term Home Health Care Program (LTHHCP) | | | | | |
| Initial Assessment | | | | | |
| Reassessment | | | | | |
| Case Management | n/a | | | | |
| AIDS Home Care Program (AHCP) | | | | | |
| Initial Assessment | | | | | |
| Reassessment | | | | | |
| Case Management | n/a | | | | |
| Managed Long Term Care (MLTC) | | | | | |
| Initial Assessment | | | | | |
| Reassessment | | | | | |
| Case Management | n/a | | | | |
| Certified Home Health Agency (CHHA) Services | | | | | |
| Initial Assessment | | | | | |
| Reassessment | | | | | |
| Case Management | n/a | | | | |
| Medical Director | | | | | |
| Medical Director | | | | | |

Attachment 8

INDIRECT STAFFING SUMMARY

Attachment 8

INDIRECT STAFFING SUMMARY

For the contract as a whole, list all individual titles and the percent of full time equivalent of each tile(s) that will be utilized for administrative activities. The Department reserves the right to review and approve the titles and qualifications of Contractor staff performing administrative functions. You may use this Word document as a form or use additional pages containing the information requested in a similar format, so long as complete information is provided. If certain staff will only be used during the “Start Up” period, please so indicate under “Responsibilities and Duties.”

PLEASE LIST ONE TITLE PER LINE IN YOUR RESPONSE. Please do NOT use terms such as “see above” or “see response to unit x.” If direct staff listed above will also be performing administrative activities, please list such staff in both charts. Total FTEs for a single item may not exceed 100%. At the end of the form please include a chart listing the total number of staff in each category that you expect to employ to fulfill the contract.

| ACTIVITY | TITLE | MINIMUM QUALIFICATIONS | %FTE | RESPONSIBILITIES and DUTIES |
|---------------------------|--------------|-------------------------------|-------------|------------------------------------|
| Project Manager | | | | |
| Project Management | | | | |
| Medical Director | | | | |
| Administration | | | | |
| Administrative | | | | |
| General | | | | |
| Training | | | | |

Attachment 9

Preferred Qualifications

Attachment 9

Preferred Qualifications

Indicate the level of experience in each of the areas listed. Substantial Experience is direct experience in the qualifying area of more than 3 years. Some Experience is direct experience in the qualifying area of at least 1 year but less than 3 years. Minimal Experience is direct experience in the qualify area of less than one year.

Indicate in the check boxes to the right of Substantial and Some Experience whether the experience is recent. Substantial Recent Experience is direct experience gained in the period between January 1, 2006 and the date of the proposal. Some Recent Experience is direct experience gained in the period between January 1, 2007 and the date of the proposal.

See Part D.3.b.IV(A) for more information.

| Qualification | Level of Experience | | | |
|---|----------------------------|-------------|----------------|--|
| | Substantial | Some | Minimal | |
| Providing and/or coordinating long term care services and programs including, but not limited to those programs covered by the contract | | | | |
| Knowledge of the principles and requirements of Title II of the Americans with Disabilities Act (ADA) and the independent living concepts of personal choice, control and the dignity of risk | | | | |
| Knowledge of the steps necessary to build effective collaborative relationships with long term care community based entities including, but not limited to, home and community based waiver programs, nursing facilities, hospitals, physicians, managed care organizations, long term care service providers and other pertinent community resources | | | | |
| Knowledge of government programs, especially the interaction between the Medicaid and Medicare programs | | | | |
| Managing services to a Medicaid population and individuals of all ages with a range of medical needs and levels of disability | | | | |
| Providing for linguistically competent services | | | | |
| Managing culturally sensitive and competent services for consumers of all backgrounds | | | | |
| Assessing if a consumer requires nursing home level care | | | | |
| Assessing consumer needs based on evaluation of medical, nursing, environmental and/or social factors and applying findings to service planning, authorization and management | | | | |
| Meeting due process requirements designed to protect consumer rights | | | | |
| Managing services and communication to consumers over a multi-year period | | | | |
| Providing timely reports and the ability to work within established timeframes | | | | |
| Providing case management services | | | | |
| Providing necessary services to consumers 24 hours per day | | | | |
| Technology resources necessary to support the demonstration | | | | |

Attachment 10

Bidder's Assurances

Attachment 10

Bidder's Assurances

The Bidder's Assurances form **MUST** be signed in ink by an official authorized to bind the organization to the provisions of the RFP and Proposal for the Component bid. **Proposals which do not include this signed form will be considered non-responsive, resulting in rejection of the Proposal for that Component.**

1. The Bidder accepts the terms and conditions of this RFP as relates to the part or parts on which the bidder has submitted a proposal.
2. The bid is valid for a period of two hundred forty (240) calendar days from the date of submission of the Proposal.
3. The Bidder agrees to be responsible to the Department for performance of all work specified in this Component of the RFP, including work assigned to subContractors.
4. The Bidder assures that the detailed work plan and schedule of deliverables set forth by the organization as its Technical Proposal for this Component will fulfill all statewide requirements as described in the RFP and will provide for the dedicated qualified staff, space, expertise and capacity to fulfill contract deliverables for this Component.
5. The Bidder assures the organization and its employees, subContractors, consultants and volunteers will implement and maintain policies and procedures to assure the confidentiality of personally identifiable data and information or records pertaining to patient care including compliance with all pertinent Health Insurance Portability and Accountability Act (HIPAA) requirements, Article 27F of the Public Health Law, and the privacy and confidentiality requirements of the Medicaid program. Please attach a copy of current policies from your organization.
6. The Bidder assures its ability to secure an indemnity (for at least \$5,000,000) to protect the organization and, in turn, the State against any loss of claim incurred as a result of carrying out the duties and responsibilities of this program. Please provide documentary proof to support this assurance, either by providing a certificate of insurance for existing general liability coverage or an insurance binder showing the availability of general liability coverage in at least this amount. Upon award of a contract, the State of New York must be listed on this policy.
7. The Bidder assures that no funds were paid or will be paid, by or on behalf of the Bidder, to any person for the purpose of influencing or attempting to influence any officer or employee of the federal or state government with regard to obtaining a contract for this Component.
8. The Bidder assures that it conforms to vendor responsibility requirements of State Finance Law. The Bidder has completed the Vendor Responsibility Questionnaire and Attestation.

Signature of Authorized Official

Date

Printed Name of Authorized Official

Attachment 11

Bidder Attestation – Conflict of Interest

Attachment 11

Bidder Attestation – Conflict of Interest

(Must be attached to application packet)

I certify that the information provided is correct. I understand and agree that, at any time, the State may review all employer records and documentation necessary to ensure compliance with the requirements of the RFP and that any monies found to have been expended which are not in compliance with the terms and conditions of the grant may be recouped by the State. The bidder further agrees to comply with the requirements of the RFP including all appendices.

I certify that, if awarded a regional long term care assessment center contract, my organization including our employees and/or subcontractors will or will not provide long term care services that are the subject of this RFP.

I certify that, if my organization currently or in the future directly or indirectly through one or more affiliates provides long term care services that are the subject of this RFP, my organization, has or will have sufficient organizational mechanisms and policies in place to ensure the independence and autonomy of the regional long term care assessment center and to preserve the consumers' right to freedom of choice in selection of service providers.

[Note: At least one copy of the submitted proposals must contain original signatures.]

Signature of official from lead organization: _____

Print/type Name: _____

Title and Organization: _____

Correspondence Address: _____

E-mail Address: _____

Telephone: _____

Fax Number: _____

Date Signed: _____

Attachment 12

**New York State Department of Health
M/WBE Procurement Forms**

Attachment 12

**New York State Department of Health
M/WBE Procurement Forms**

The following forms are required to maintain maximum participation in M/WBE procurement and contracting:

1. Bidders Proposed M/WBE Utilization Form
2. Minority Owned Business Enterprise Information
3. Women Owned Business Enterprise Information
4. Subcontracting Utilization Form
5. M/WBE Letter of Intent to Participate
6. M/WBE Staffing Plan

New York State Department of Health

BIDDERS PROPOSED M/WBE UTILIZATION PLAN

| | |
|---------------------|-------------------|
| Bidder Name: | |
| RFP Title: | RFP Number |

Description of Plan to Meet M/WBE Goals

PROJECTED M/WBE USAGE

| | % | Amount |
|--|------------|---------------|
| 1. Total Dollar Value of Proposal Bid | 100 | \$ |
| 2. MBE Goal Applied to the Contract | | \$ |
| 3. WBE Goal Applied to the Contract | | \$ |
| 4. M/WBE Combined Totals | | \$ |

New York State Department of Health

**MINORITY OWNED BUSINESS ENTERPRISE (MBE)
INFORMATION**

In order to achieve the MBE Goals, bidder expects to subcontract with New York State certified MINORITY-OWNED entities as follows:

| MBE Firm (Exactly as Registered) | Description of Work (Products/Services) [MBE] | Projected MBE Dollar Amount |
|---|--|--|
| Name Address City, State, ZIP Employer I.D. Telephone Number () - | | \$ _____ |
| Name Address City, State, ZIP Employer I.D. Telephone Number () - | | \$ _____ |
| Name Address City, State, ZIP Employer I.D. Telephone Number () - | | \$ _____ |

New York State Department of Health

Value: _____
 Date Bid: _____ Date Let: _____ Completion
 Date: _____

Contract Awardee/Recipient: _____
 Name

 Address

 Telephone

Description of Contract/Project
 Location: _____

Subcontractors Purchase with Majority Vendors:

Participation Goals Anticipated: _____ % MBE _____ %
 WBE
 Participation Goals Achieved: _____ % MBE _____ %
 WBE

Subcontractors/Suppliers:

| Firm Name and City | Description of Work | Dollar Value | Date of Subcontract | Identify if MBE or WBE or NYS Certified |
|--------------------|---------------------|--------------|---------------------|---|
| | | | | |
| | | | | |
| | | | | |

| | | | |
|---|--------------------------|--------------|-------|
| Contractor's Agreement: My firm proposes to use the MBEs listed on this form | | | |
| Prepared By: (Signature of Contractor) | Print Contractor's Name: | Telephone #: | Date: |
| Grant Recipient Affirmative Action Officer Signature (If applicable): | | | |

| FOR OFFICE USE ONLY | |
|--|-------|
| Reviewed: By: | Date: |
| M/WBE Firms Certified: _____ Not Certified: _____ | |

CBO: _____

MCBO: _____

New York State Department of Health

MWBE ONLY

**MWBE SUBCONTRACTORS AND SUPPLIERS
LETTER OF INTENT TO PARTICIPATE**

To: _____ Federal ID Number: _____
(Name of Contractor)

Proposal/ Contract Number: _____

Contract Scope of Work:

The undersigned intends to perform services or provide material, supplies or equipment
as: _____

Name of MWBE:

Address:

Federal ID Number:

Telephone Number:

Designation:

MBE - Subcontractor

WBE - Subcontractor

MBE - Supplier

WBE - Supplier

Joint venture with:

Name:

Address:

Fed ID Number:

MBE

WBE

Are you New York State Certified MWBE? _____Yes _____No

The undersigned is prepared to perform the following work or services or supply the following materials, supplies or equipment in connection with the above proposal/contract. (Specify in detail the particular items of work or services to be performed or the materials to be supplied):

at the following price: \$ _____

The contractor proposes, and the undersigned agrees to, the following beginning and completion dates for such work.

Date Proposal/ Contract to be started:

Date Proposal/ Contract to be Completed:

Date Supplies ordered: _____ Delivery Date: _____

The above work will not further subcontracted without the express written permission of the contractor and notification of the Office. The undersigned will enter into a formal agreement for the above work with the contractor ONLY upon the Contractor's execution of a contract with the Office.

Date

Signature of M/WBE Contractor

Printed/Typed Name of M/WBE Contractor

INSTRUCTIONS FOR M/WBE SUBCONTRACTORS AND SUPPLIERS LETTER OF INTENT TO PARTICIPATE

This form is to be submitted with bid attached to the Subcontractor's Information Form in a sealed envelope for each certified Minority or Women-Owned Business enterprise the Bidder/Awardee/Contractor proposes to utilize as subcontractors, service providers or suppliers.

If the MBE or WBE proposed for portion of this proposal/contract is part of a joint or other temporarily-formed business entity of independent business entities, the name and address of the joint venture or temporarily-formed business should be indicated.

New York State Department of Health M/WBE STAFFING PLAN

Check applicable categories: Project Staff

Consultants Subcontractors

Contractor
Name _____

Address _____

| | Total | Male | Female | Black | Hispani c | Asian/ Pacific Islande r | Other |
|---------------------------------|-------|------|--------|-------|--------------|-----------------------------------|-------|
| STAFF | | | | | | | |
| Administrators | | | | | | | |
| Managers/Supervisors | | | | | | | |
| Professionals | | | | | | | |
| Technicians | | | | | | | |
| Clerical | | | | | | | |
| Craft/Maintenance | | | | | | | |
| Operatives | | | | | | | |
| Laborers | | | | | | | |
| Public Assistance Recipients | | | | | | | |
| TOTAL | | | | | | | |

(Name and Title)

Date

Attachment 13

Vendor Responsibility Attestation

Attachment 13

Vendor Responsibility Attestation

To comply with the Vendor Responsibility Requirements outlined in Section E, Administrative, 8. Vendor Responsibility Questionnaire, I hereby certify:

Choose one:

- An on-line Vendor Responsibility Questionnaire has been updated or created at OSC's website: <https://portal.osc.state.ny.us> within the last six months.

- A hard copy Vendor Responsibility Questionnaire is included with this proposal/bid and is dated within the last six months.

- A Vendor Responsibility Questionnaire is not required due to an exempt status. Exemptions include governmental entities, public authorities, public colleges and universities, public benefit corporations, and Indian Nations.

Signature of Organization Official: _____

Print/type Name: _____

Title: _____

Organization: _____

Date Signed: _____

Attachment 14

**State Consultant Services
Form A**

Attachment 14

State Consultant Services
FORM A

OSC Use Only
Reporting Code:
Category Code:
Date Contract Approved:

Contractor's Planned Employment
From Contract Start Date through End of Contract Term

| | |
|---|---------------------------------------|
| New York State Department of Health Contractor Name: | Agency Code 12000 Contract Number: |
| Contract Start Date: / / | Contract End Date: / / |

| Employment Category | Number of Employees | Number of Hours to be Worked | Amount Payable Under the Contract |
|---------------------|---------------------|------------------------------|-----------------------------------|
| | | | |
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| | | | |
| | | | |
| | | | |
| Totals this page: | 0 | 0 | \$ 0.00 |
| Grand Total: | 0 | 0 | \$ 0.00 |

Name of person who prepared this report:

Title:

Phone #:

Preparer's signature:

Date Prepared: / /

Page of
(use additional pages if necessary)

Instructions

State Consultant Services

Form A: Contractor's Planned Employment

And

Form B: Contractor's Annual Employment Report

Form A: This report must be completed before work begins on a contract. Typically it is completed as a part of the original bid proposal. The report is submitted only to the soliciting agency who will in turn submit the report to the NYS Office of the State Comptroller.

Form B: This report must be completed annually for the period April 1 through March 31. The report must be submitted by May 15th of each year to the following three addresses:

1. the designated payment office (DPO) outlined in the consulting contract.
2. NYS Office of the State Comptroller
Bureau of Contracts
110 State Street, 11th Floor
Albany, NY 12236
Attn: Consultant Reporting
or via fax to –
(518) 474-8030 or (518) 473-8808
3. NYS Department of Civil Service
Alfred E. Smith Office Building
Albany, NY 12239
Attn: Consultant Reporting

Completing the Reports:

Scope of Contract (Form B only): a general classification of the single category that best fits the predominate nature of the services provided under the contract.

Employment Category: the specific occupation(s), as listed in the O*NET occupational classification system, which best describe the employees providing services under the contract. Access the O*NET database, which is available through the US Department of Labor's Employment and Training Administration, on-line at online.onetcenter.org to find a list of occupations.)

Number of Employees: the total number of employees in the employment category employed to provide services under the contract during the Report Period, including part time employees and employees of subcontractors.

Number of hours (to be) worked: for Form A, the total number of hours to be worked, and for Form B, the total number of hours worked during the Report Period by the employees in the employment category.

Amount Payable under the Contract: the total amount paid or payable by the State to the State contractor under the contract, for work by the employees in the employment category, for services provided during the Report Period.

Attachment 15

**State Consultant Services
Form B**

Attachment 15

(Sample Letter to Vendors Regarding Submission of Form B)

Dear Contractor:

Chapter 10 of the Laws of 2006 mandates that State contractors report annually by employment category, the number of persons employed to provide services under a contract for consulting services; the number of hours worked; and the amount paid to the contractor by the State as compensation for work performed. This report is to include work performed by subcontractors.

This letter serves as a reminder that Form B – State Consultant Services Contractor’s Annual Employment Report is due to the following state entities on or before May 15, 2007.

New York State Department of Health
Designated Payment Office Address indicated in State of New York Agreement

NYS Office of the State Comptroller
Bureau of Contracts
110 State Street, 11th floor
Albany, NY 12236
Attention: Consulting Reporting or via fax at
(518) 474-8030 or (518) 473-8808

NYS Department of Civil Service
Alfred E. Smith Office Building
Albany, NY 12239
Attention: Consultant Reporting

Form B – State Consultant Services Contractor’s Annual Employment Report and instructions on completing the form are enclosed. If you have questions, please contact your contract manager.

Instructions

State Consultant Services Form B: Contractor's Annual Employment Report

Form B: This report must be completed annually for the period April 1 through March 31. The report must be submitted by May 15th of each year to the following three addresses:

1. New York State Department of Health
<Insert Designated Payment Office (from contract)>
2. NYS Office of the State Comptroller
Bureau of Contracts
110 State Street, 11th Floor
Albany, NY 12236
Attn: Consultant Reporting
or via fax to –
(518) 474-8030 or (518) 473-8808
3. NYS Department of Civil Service
Alfred E. Smith Office Building
Albany, NY 12239
Attn: Consultant Reporting

Completing the Reports:

Scope of Contract: a general classification of the single category that best fits the predominate nature of the services provided under the contract.

Employment Category: the specific occupation(s), as listed in the O*NET occupational classification system, which best describe the employees providing services under the contract. Access the O*NET database, which is available through the US Department of Labor's Employment and Training Administration, on-line at online.onetcenter.org to find a list of occupations.)

Number of Employees: the total number of employees in the employment category employed to provide services under the contract during the Report Period, including part time employees and employees of subcontractors.

Number of hours (to be) worked: the total number of hours worked during the Report Period by the employees in the employment category.

Amount Payable under the Contract: the total amount paid or payable by the State to the State contractor under the contract, for work by the employees in the employment category, for services provided during the Report Period.

FORM B

| |
|--|
| <p>OSC Use Only: Reporting Code: Category Code:</p> |
|--|

| |
|---|
| <p>State Consultant Services Contractor's Annual Employment Report Report Period: April 1, to March 31,</p> |
|---|

| |
|---|
| Contracting State Agency Name: _____ Agency Code: _____ Contract Number: _____ Contract Term: / / to / / Contractor Name: _____ Contractor Address: _____ Description of Services Being Provided: _____ |
|---|

| |
|---|
| <p>Scope of Contract (Choose one that best fits): Analysis <input type="checkbox"/> Evaluation <input type="checkbox"/> Research <input type="checkbox"/> Training <input type="checkbox"/> Data Processing <input type="checkbox"/> Computer Programming <input type="checkbox"/> Other IT consulting <input type="checkbox"/> Engineering <input type="checkbox"/> Architect Services <input type="checkbox"/> Surveying <input type="checkbox"/> Environmental Services <input type="checkbox"/> Health Services <input type="checkbox"/> Mental Health Services <input type="checkbox"/> Accounting <input type="checkbox"/> Auditing <input type="checkbox"/> Paralegal <input type="checkbox"/> Legal <input type="checkbox"/> Other Consulting <input type="checkbox"/></p> |
|---|

| Employment Category | Number of Employees | Number of Hours Worked | Amount Payable Under the Contract |
|------------------------|---------------------|------------------------|-----------------------------------|
| | | | |
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| | | | |
| | | | |
| Total this page | 0 | 0 | \$ 0.00 |
| Grand Total | | | |

| |
|--|
| Name of person who prepared this report: Preparer's Signature: _____ Title: _____ Phone #: _____ Date Prepared: / / |
|--|

Use additional pages if necessary) Page of

Attachment 16

**DTF Form St-220-TD
Contractor Certification**

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)



Contractor Certification

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

ST-220-TD

(5/07)

For information, consult Publication 223, *Questions and Answers Concerning Tax Law Section 5-a (see Need help? below)*.

| | | | | |
|---|--------------------------------|---|---|--------------------------------------|
| Contractor name | | | | |
| Contractor's principal place of business | | City | State | ZIP code |
| Contractor's mailing address (if different than above) | | | | |
| Contractor's federal employer identification number (EIN) | | Contractor's sales tax ID number (if different from contractor's EIN) | | Contractor's telephone number () |
| Covered agency or state agency | Contract number or description | | Estimated contract value over the full term of contract (but not including renewals) \$ | |
| Covered agency address | | | Covered agency telephone number | |

General information

Section 5-a of the Tax Law, as amended, effective April 26, 2006, requires certain contractors awarded certain state contracts valued at more than \$100,000 to certify to the Tax Department that they are registered to collect New York State and local sales and compensating use taxes, if they made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000, measured over a specified period. In addition, contractors must certify to the Tax Department that each affiliate and subcontractor exceeding such sales threshold during a specified period is registered to collect New York State and local sales and compensating use taxes. Contractors must also file a Form ST-220-CA, certifying to the procuring state entity that they filed Form ST-220-TD with the Tax Department and that the information contained on Form ST-220-TD is correct and complete as of the date they file Form ST-220-CA.

All sections must be completed including all fields on the top of this page, all sections on page 2, Schedule A on page 3, if applicable, and Individual, Corporation, Partnership, or LLC Acknowledgement on page 4. If you do not complete these areas, the form will be returned to you for completion.

For more detailed information regarding this form and section 5-a of the Tax Law, see Publication 223, *Questions and Answers Concerning Tax Law Section 5-a, (as amended, effective April 26, 2006)*, available at www.nystax.gov. Information is also available by calling the Tax Department's Contractor Information Center at 1 800 698-2931.

Note: Form ST-220-TD must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 4 of this form must be completed before a notary public.

Mail completed form to:

**NYS TAX DEPARTMENT
DATA ENTRY SECTION
W A HARRIMAN CAMPUS
ALBANY NY 12227**

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).

This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.

Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.

Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.

This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227.

Need help?



Internet access: www.nystax.gov
(for information, forms, and publications)



Fax-on-demand forms: 1 800 748-3676



Telephone assistance is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday.

To order forms and publications: 1 800 462-8100

Sales Tax Information Center: 1 800 698-2909

From areas outside the U.S. and outside Canada: (518) 485-6800

Hearing and speech impaired (telecommunications device for the deaf (TDD) callers only): 1 800 634-2110



Persons with disabilities: In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, please call 1 800 972-1233.

I, _____, hereby affirm, under penalty of perjury, that I am _____
(name) (title)
of the above-named contractor, and that I am authorized to make this certification on behalf of such contractor.

Complete Sections 1, 2, and 3 below. Make only one entry in each section.

Section 1 — Contractor registration status

- The contractor has made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made. The contractor is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law, and is listed on Schedule A of this certification.
- The contractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Section 2 — Affiliate registration status

- The contractor does not have any affiliates.
- To the best of the contractor's knowledge, the contractor has one or more affiliates having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made, and each affiliate exceeding the \$300,000 cumulative sales threshold during such quarters is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed each affiliate exceeding the \$300,000 cumulative sales threshold during such quarters on Schedule A of this certification.
- To the best of the contractor's knowledge, the contractor has one or more affiliates, and each affiliate has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Section 3 — Subcontractor registration status

- The contractor does not have any subcontractors.
- To the best of the contractor's knowledge, the contractor has one or more subcontractors having made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made, and each subcontractor exceeding the \$300,000 cumulative sales threshold during such quarters is registered to collect New York State and local sales and compensating use taxes with the Commissioner of Taxation and Finance pursuant to sections 1134 and 1253 of the Tax Law. The contractor has listed each subcontractor exceeding the \$300,000 cumulative sales threshold during such quarters on Schedule A of this certification.
- To the best of the contractor's knowledge, the contractor has one or more subcontractors, and each subcontractor has not made sales delivered by any means to locations within New York State of tangible personal property or taxable services having a cumulative value in excess of \$300,000 during the four sales tax quarters which immediately precede the sales tax quarter in which this certification is made.

Sworn to this ____ day of _____, 20 ____

(sign before a notary public)

(title)

Attachment 17

DTF Form St-220-CA
Contractor Certification to Covered Agency
(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)



Contractor Certification to Covered Agency

(Pursuant to Section 5-a of the Tax Law, as amended, effective April 26, 2006)

ST-220-CA

(6/06)

For information, consult Publication 223, *Questions and Answers Concerning Tax Law Section 5-a* (see *Need Help? on back*).

| | | | |
|---|---|--|----------|
| Contractor name | | For covered agency use only Contract number or description | |
| Contractor's principal place of business | City | State | ZIP code |
| Contractor's mailing address (if different than above) | | Estimated contract value over the full term of contract (but not including renewals) | |
| Contractor's federal employer identification number (EIN) | Contractor's sales tax ID number (if different from contractor's EIN) | | \$ |
| Contractor's telephone number | Covered agency name | | |
| Covered agency address | | Covered agency telephone number | |

I, _____, hereby affirm, under penalty of perjury, that I am _____

(name)

(title)

of the above-named contractor, that I am authorized to make this certification on behalf of such contractor, and I further certify that:

(Mark an X in only one box)

The contractor has filed Form ST-220-TD with the Department of Taxation and Finance in connection with this contract and, to the best of contractor's knowledge, the information provided on the Form ST-220-TD, is correct and complete.

The contractor has previously filed Form ST-220-TD with the Tax Department in connection with _____
(insert contract number or description)

and, to the best of the contractor's knowledge, the information provided on that previously filed Form ST-220-TD, is correct and complete as of the current date, and thus the contractor is not required to file a new Form ST-220-TD at this time.

Sworn to this ____ day of _____, 20 ____

(sign before a notary public)

(title)

Instructions

General information

Tax Law section 5-a was amended, effective April 26, 2006. On or after that date, in all cases where a contract is subject to Tax Law section 5-a, a contractor must file (1) Form ST-220-CA, *Contractor Certification to Covered Agency*, with a covered agency, and (2) Form ST-220-TD with the Tax Department before a contract may take effect. The circumstances when a contract is subject to section 5-a are listed in Publication 223, Q&A 3. This publication is available on our Web site, by fax, or by mail. (See *Need help?* for more information on how to obtain this publication.) In addition, a contractor must file a new Form ST-220-CA with a covered agency before an existing contract with such agency may be renewed.

If you have questions, please call our information center at 1 800 698-2931.

Note: Form ST-220-CA must be signed by a person authorized to make the certification on behalf of the contractor, and the acknowledgement on page 2 of this form must be completed before a notary public.

When to complete this form

As set forth in Publication 223, a contract is subject to section 5-a, and you must make the required certification(s), if:

- i. The procuring entity is a *covered agency* within the meaning of the statute (see Publication 223, Q&A 5);
- ii. The contractor is a *contractor* within the meaning of the statute (see Publication 223, Q&A 6); and
- iii. The contract is a *contract* within the meaning of the statute. This is the case when it (a) has a value in excess of \$100,000 and (b) is a contract for *commodities* or *services*, as such terms are defined for purposes of the statute (see Publication 223, Q&A 8 and 9).

Furthermore, the procuring entity must have begun the solicitation to purchase on or after January 1, 2005, and the resulting contract must have been awarded, amended, extended, renewed, or assigned *on or after April 26, 2006* (the effective date of the section 5-a amendments).

Individual, Corporation, Partnership, or LLC Acknowledgment

STATE OF }
: SS.:
COUNTY OF }

On the ___ day of _____ in the year 20___, before me personally appeared _____,
known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that
_he resides at _____,
Town of _____,
County of _____,
State of _____; and further that:

[Mark an X in the appropriate box and complete the accompanying statement.]

- (If an individual): _he executed the foregoing instrument in his/her name and on his/her own behalf.
(If a corporation): _he is the _____ of _____, the corporation described in said instrument; that, by authority of the Board of Directors of said corporation, _he is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.
(If a partnership): _he is a _____ of _____, the partnership described in said instrument; that, by the terms of said partnership, _he is authorized to execute the foregoing instrument on behalf of the partnership for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said partnership as the act and deed of said partnership.
(If a limited liability company): _he is a duly authorized member of _____, LLC, the limited liability company described in said instrument; that _he is authorized to execute the foregoing instrument on behalf of the limited liability company for purposes set forth therein; and that, pursuant to that authority, _he executed the foregoing instrument in the name of and on behalf of said limited liability company as the act and deed of said limited liability company.

Notary Public

Registration No.

Privacy notification

The Commissioner of Taxation and Finance may collect and maintain personal information pursuant to the New York State Tax Law, including but not limited to, sections 5-a, 171, 171-a, 287, 308, 429, 475, 505, 697, 1096, 1142, and 1415 of that Law; and may require disclosure of social security numbers pursuant to 42 USC 405(c)(2)(C)(i).
This information will be used to determine and administer tax liabilities and, when authorized by law, for certain tax offset and exchange of tax information programs as well as for any other lawful purpose.
Information concerning quarterly wages paid to employees is provided to certain state agencies for purposes of fraud prevention, support enforcement, evaluation of the effectiveness of certain employment and training programs and other purposes authorized by law.
Failure to provide the required information may subject you to civil or criminal penalties, or both, under the Tax Law.
This information is maintained by the Director of Records Management and Data Entry, NYS Tax Department, W A Harriman Campus, Albany NY 12227; telephone 1 800 225-5829. From areas outside the United States and outside Canada, call (518) 485-6800.

Need help?
Internet access: www.nystax.gov (for information, forms, and publications)
Fax-on-demand forms: 1 800 748-3676
Telephone assistance is available from 8:00 A.M. to 5:00 P.M. (eastern time), Monday through Friday. 1 800 698-2931
To order forms and publications: 1 800 462-8100
From areas outside the U.S. and outside Canada: (518) 485-6800
Hearing and speech impaired (telecommunications device for the deaf (TDD) callers only): 1 800 634-2110
Persons with disabilities: In compliance with the Americans with Disabilities Act, we will ensure that our lobbies, offices, meeting rooms, and other facilities are accessible to persons with disabilities. If you have questions about special accommodations for persons with disabilities, please call 1 800 972-1233.

Attachment 18

Service Unit Volume Projections Charts

Service Unit Volume Projections Charts

| | 2008 | |
|-------------------------------------|--------------|---------------|
| | New | Existing |
| Orange County | | |
| LTHHCP/AHCP Total | 94 | 384 |
| PCSP Total | 153 | 673 |
| ALP Total | 17 | 64 |
| MLTC Total | 76 | 319 |
| CHHA (60 Day+) Total | 208 | 289 |
| Orange County Total | 548 | 1,729 |
| Ulster County | | |
| LTHHCP/AHCP Total | 57 | 233 |
| PCSP Total | 152 | 629 |
| ALP Total | 13 | 67 |
| MLTC Total | 0 | 0 |
| CHHA (60 Day+) Total | 138 | 506 |
| Ulster County Total | 360 | 1,435 |
| Ulster & Orange Combined | | |
| CASA VII in Kings County | | |
| LTHHCP/AHCP Total | 140 | 1,166 |
| PCSP Total | 605 | 6,290 |
| ALP Total | 16 | 73 |
| MLTC Total | 340 | 2,285 |
| CHHA (60 Day+) Total | 952 | 4,002 |
| CASA VII Total | 2,052 | 13,814 |

Assessment Centers Total

| Annual Assessment Estimate | | | | | | | | | | | | | | | | |
|-----------------------------------|---------|---------|---------|---------|---------|-------------------|---------------------|---------|---------|----------|----------|----------|-------------------|--------------|--------------|--------|
| 1st 6 Months: New Recipients Only | | | | | | | Next 6 months: Full | | | | | | | Year 1 Total | Year 2 Total | |
| Month 1 | Month 2 | Month 3 | Month 4 | Month 5 | Month 6 | 1st 6 month Total | Month 7 | Month 8 | Month 9 | Month 10 | Month 11 | Month 12 | 2nd 6 month Total | | | |
| | | | | | | | | | | | | | | | | |
| | 8 | 8 | 8 | 8 | 16 | 16 | 63 | 96 | 96 | 96 | 96 | 96 | 96 | 576 | 639 | 1,152 |
| | 13 | 13 | 13 | 13 | 13 | 13 | 77 | 75 | 75 | 75 | 75 | 75 | 75 | 449 | 525 | 897 |
| | 1 | 1 | 1 | 1 | 1 | 1 | 9 | 11 | 11 | 11 | 11 | 11 | 11 | 64 | 73 | 128 |
| | 6 | 6 | 6 | 6 | 6 | 6 | 38 | 53 | 53 | 53 | 53 | 53 | 53 | 319 | 357 | 638 |
| | 17 | 17 | 35 | 35 | 52 | 52 | 208 | 145 | 145 | 145 | 145 | 145 | 145 | 867 | 1,075 | 1,734 |
| | 46 | 46 | 63 | 63 | 88 | 88 | 394 | 379 | 379 | 379 | 379 | 379 | 379 | 2275 | 2,668 | 4,549 |
| | | | | | | | | | | | | | | | | - |
| | | | | | | | | | | | | | | | | - |
| | 5 | 5 | 5 | 5 | 10 | 10 | 38 | 58 | 58 | 58 | 58 | 58 | 58 | 350 | 388 | 699 |
| | 13 | 13 | 13 | 13 | 13 | 13 | 76 | 70 | 70 | 70 | 70 | 70 | 70 | 419 | 495 | 839 |
| | 1 | 1 | 1 | 1 | 1 | 1 | 7 | 11 | 11 | 11 | 11 | 11 | 11 | 67 | 74 | 134 |
| | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | - | - |
| | 12 | 12 | 23 | 23 | 35 | 35 | 138 | 253 | 253 | 253 | 253 | 253 | 253 | 1518 | 1,656 | 3,036 |
| | 30 | 30 | 42 | 42 | 58 | 58 | 259 | 392 | 392 | 392 | 392 | 392 | 392 | 2354 | 2,612 | 4,708 |
| | | | | | | | | | | | | | | | | - |
| | 76 | 76 | 105 | 105 | 146 | 146 | 652 | 771 | 771 | 771 | 771 | 771 | 771 | 4629 | 5,281 | 9,257 |
| | | | | | | | | | | | | | | | | - |
| | | | | | | | | | | | | | | | | - |
| | 12 | 12 | 12 | 12 | 23 | 23 | 93 | 291 | 291 | 291 | 291 | 291 | 291 | 1748 | 1,841 | 3,497 |
| | 50 | 50 | 50 | 50 | 50 | 50 | 302 | 699 | 699 | 699 | 699 | 699 | 699 | 4193 | 4,495 | 8,386 |
| | 1 | 1 | 1 | 1 | 1 | 1 | 8 | 12 | 12 | 12 | 12 | 12 | 12 | 73 | 81 | 146 |
| | 28 | 28 | 28 | 28 | 28 | 28 | 170 | 381 | 381 | 381 | 381 | 381 | 381 | 2285 | 2,454 | 4,569 |
| | 79 | 79 | 159 | 159 | 238 | 238 | 952 | 667 | 667 | 667 | 667 | 667 | 667 | 4002 | 4,954 | 8,004 |
| | 171 | 171 | 250 | 250 | 341 | 341 | 1525 | 6,907 | 6,907 | 6,907 | 6,907 | 6,907 | 6,907 | 41443 | 42,968 | 82,886 |
| | | | | | | | | | | | | | | | | - |
| | 247 | 247 | 355 | 355 | 487 | 487 | 2177 | 7,679 | 7,679 | 7,679 | 7,679 | 7,679 | 7,679 | 46071 | 48,248 | 92,143 |

Frequency of Assessment
 LTHHCP/AHCP: 120 Days
 PCSP: 270 Days (Avg of 12 month and 6 month)
 ALP: 180 Days
 MLTC: 180 Days
 CHHA: 60 Days

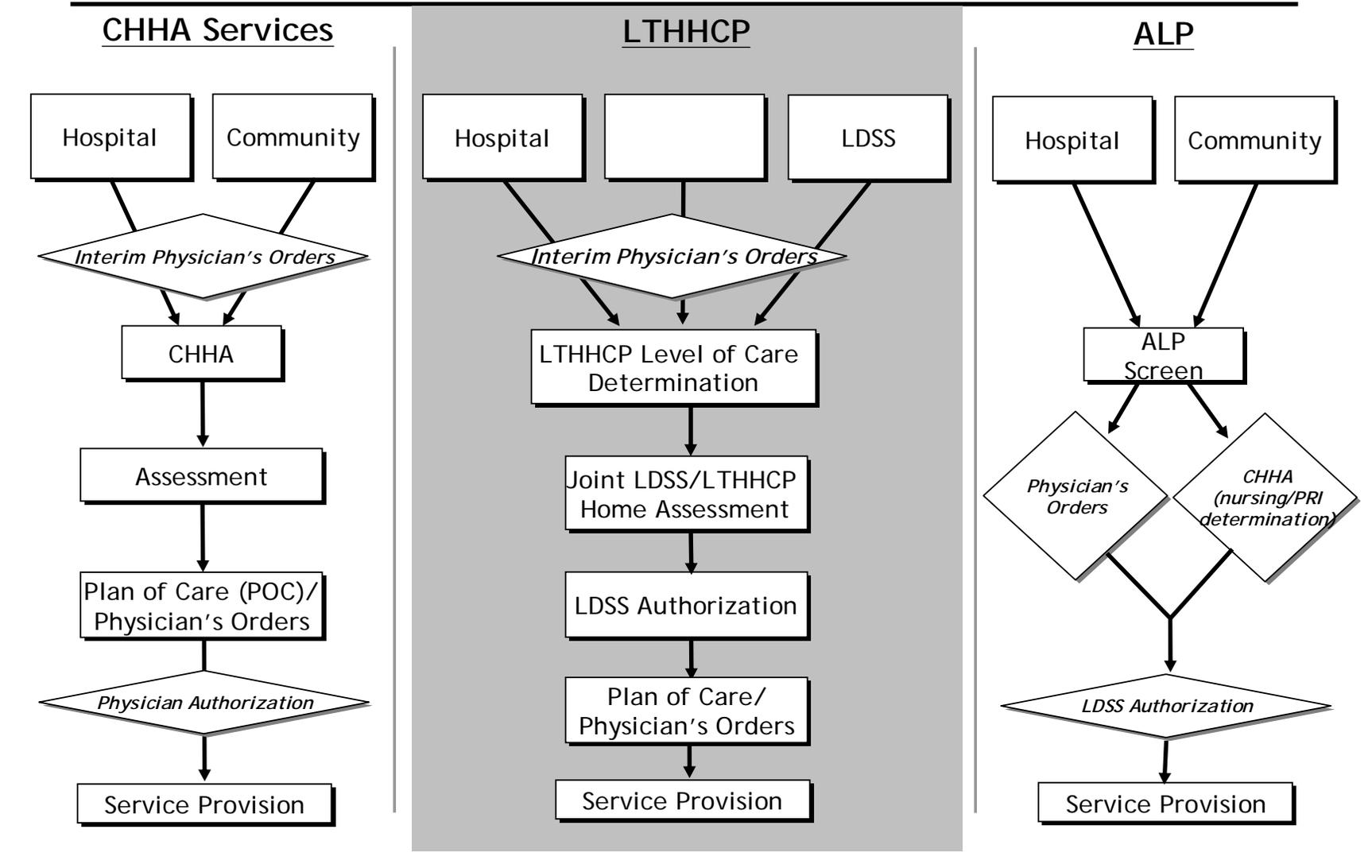
Source: 2008 Data Warehouse

Notes:
 Estimates do not include reassessments that occur as a result of a significant change in a consumer's medical / social circumstances prior to their scheduled reassessment.
 Estimates do not include instances in which a consumer is assessed or reassessed and it is determined the consumer is not appropriate for admission / continuation in one or more of the long term care program or services for which the Assessment Center has assessment and authorization responsibilities.

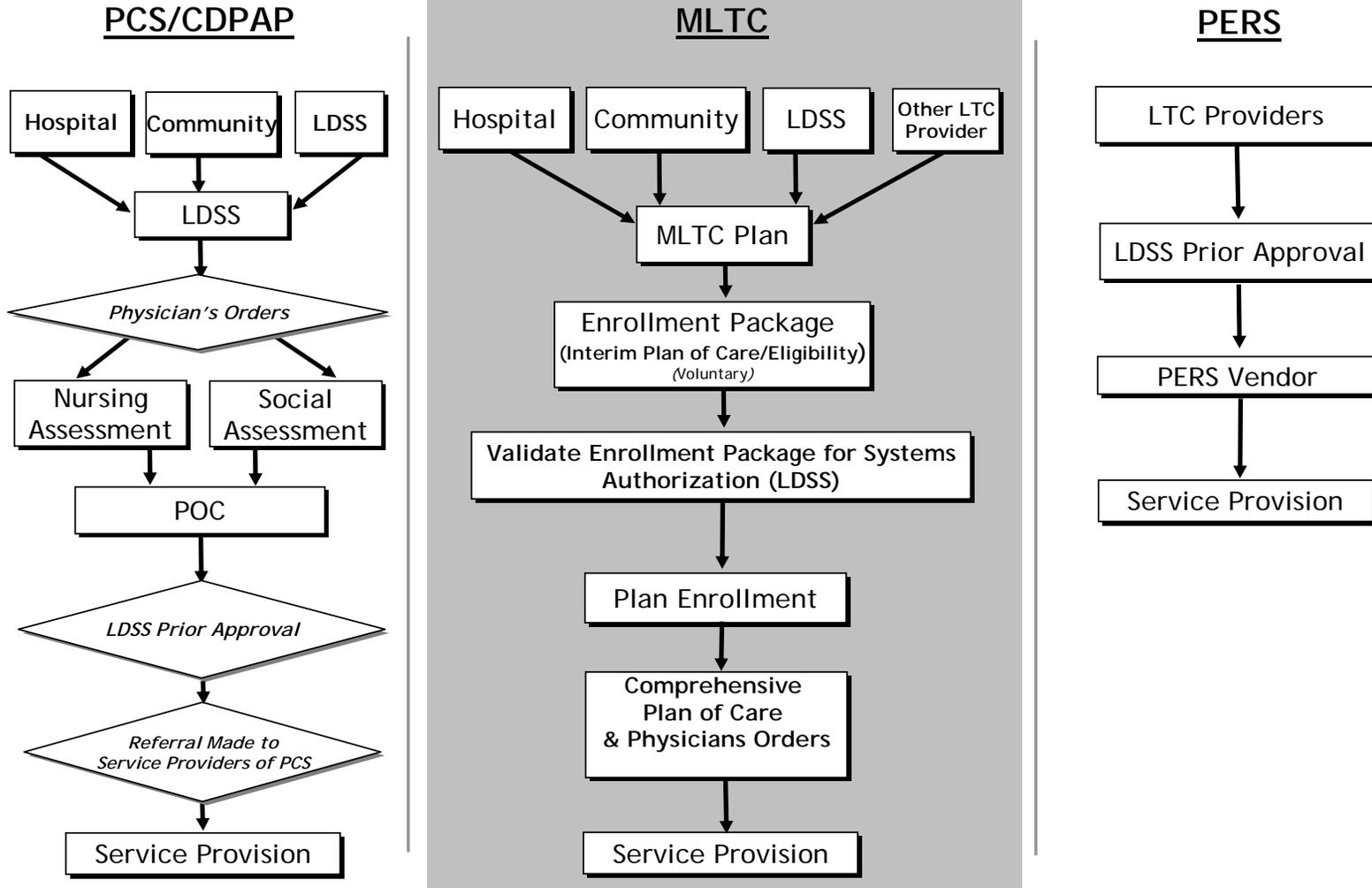
Attachment 19

LONG TERM CARE ASSESSMENT PROCESS

CURRENT LONG TERM CARE ASSESSMENT PROCESS



CURRENT LONG TERM CARE ASSESSMENT PROCESS



Attachment 20

Select Minimum Performance Standards

Attachment 20

Select Minimum Performance Standards

Provided below are key regulatory references and citations relating to requirements of HRA and local districts with respect to responding to the needs of consumers for each of the listed programs and services. The contractor is expected to at least meet these minimum requirements. Links to access these references are provided below:

<http://www.nyhealth.gov/nysdoh/phforum/nycrr10.htm>

<http://www.nyhealth.gov/nysdoh/phforum/nycrr18.htm>

http://www.health.state.ny.us/health_care/medicaid/reference/lthhcp/index.htm

<http://onlineresources.wnyc.net/pb/default.asp>

PCSP

- 18 NYCRR 505.14 a
- 80 ADM-9

PERS

- 18 NYCRR 505.33
- 91 ADM-42
- GIS 04 MA/029

CDPAP

- 18 NYCRR 505.14 a
- 80 ADM-9

ALP

- 94 ADM-9
- 01 OMM/LCM-1

LTHHCP

- 83 ADM 74
- 18 NYCRR 505.21
- 10 NYCRR 763
- LTHHCP Reference Manual

AHCP

- 83 ADM 74
- 18 NYCRR 505.21
- 10 NYCRR 763
- LTHHCP Reference Manual

CHHA

- 10 NYCRR 763.5(a)

Attachment 21

Long Term Care Assessment Tools

| |
|---|
| RUG II Group (print name) RHCF Level of Care: <input type="checkbox"/> HRF <input type="checkbox"/> SNF |
|---|

Use with separate Hospital and Community PRI Instructions

I. ADMINISTRATIVE DATA

- | | |
|--|---|
| 1. OPERATING CERTIFICATE NUMBER (1-8) | 2. SOCIAL SECURITY NUMBER (9-17) |
| 3. OFFICIAL NAME OF HOSPITAL OR OTHER AGENCY/FACILITY COMPLETING THIS REVIEW | |
| 4A. PATIENT NAME (AND COMMUNITY ADDRESS IF REVIEWED IN COMMUNITY) | 11A. DATE OF HOSPITAL ADMISSION OR INITIAL AGENCY VISIT (49-56) - - - MO DAY YEAR |
| 4B. COUNTY OF RESIDENCE | 11B. DATE OF ALTERNATE LEVEL OF CARE STATUS IN HOSPITAL (IF APPLICABLE) (57-64) - - - MO DAY YEAR |
| 5. DATE OF PRI COMPLETION (18-25) - - - MO DAY YEAR | 12. MEDICAID NUMBER (65-75) |
| 6. MEDICAL RECORD NUMBER/CASE NUMBER (26-34) | 13. MEDICARE NUMBER (76-85) |
| 7. HOSPITAL ROOM NUMBER (35-39) | 14. PRIMARY PAYOR (86) 1=Medicaid 2=Medicare 3= Other |
| 8. NAME OF HOSPITAL UNIT/DIVISION/BUILDING | 15. REASON FOR PRI COMPLETION (87) 1. RHCF Application from Hospital 2. RHCF Application from Community 3. Other (Specify:) |
| 9. DATE OF BIRTH (40-47) - - - MO DAY YEAR | |
| 10. SEX (48) 1=Male 2=Female | |

II. MEDICAL EVENTS

- | | |
|---|--|
| 16. DECUBITUS LEVEL: ENTER THE MOST SEVERE LEVEL (0-5) AS DEFINED IN THE INSTRUCTIONS. | 18. MEDICAL TREATMENTS: READ THE INSTRUCTIONS FOR THE QUALIFIERS. 1=YES 2=NO |
| 17. MEDICAL CONDITIONS: DURING THE PAST WEEK. READ THE INSTRUCTIONS FOR SPECIFIC DEFINITIONS 1=YES 2=NO | A. Tracheostomy Care/Suctioning (Daily—Exclude self-care) _____ |
| A. Comatose _____ | B. Suctioning-General (Daily) _____ |
| B. Dehydration _____ | C. Oxygen (Daily) _____ |
| C. Internal Bleeding _____ | D. Respiratory Care (Daily) _____ |
| D. Stasis Ulcer _____ | E. Nasal Gastric Feeding _____ |
| E. Terminally Ill _____ | F. Parenteral Feeding _____ |
| F. Contractures _____ | G. Wound Care _____ |
| G. Diabetes Mellitus _____ | H. Chemotherapy _____ |
| H. Urinary Tract Infection _____ | I. Transfusion _____ |
| I. HIV Infection Symptomatic _____ | J. Dialysis _____ |
| J. Accident _____ | K. Bowel and Bladder Rehabilitation (SEE INSTRUCTIONS) _____ |
| K. Ventilator Dependent _____ | L. Catheter (Indwelling or External) _____ |
| | M. Physical Restraints (Daytime Only) _____ |

III. ACTIVITIES OF DAILY LIVING (ADLs)

Measure the capability of the patient to perform each ADL 60% or more of the time it is performed during the past week (7 days). Read the Instructions for the Changed Condition Rule and the definitions of the ADL terms.

19. EATING: PROCESS OF GETTING FOOD BY ANY MEANS FROM THE RECEPTACLE INTO THE BODY (FOR EXAMPLE: PLATE, CUP, TUBE) 19. (113)

1=Feeds self without supervision or physical assistance. May use adaptive equipment.

2=Requires *intermittent* supervision (that is, verbal encouragement/guidance) and/or minimal physical assistance with minor parts of eating, such as cutting food, buttering bread or opening milk carton.

3= Requires continual help (encouragement/teaching/physical assistance) with eating or meal will not be completed.

4=Totally fed by hand, patient does not manually participate

5=Tube or parenteral feeding for primary intake of food. (Not just for supplemental nourishments)

20. MOBILITY: HOW THE PATIENT MOVES ABOUT 20. (114)

1=Walks with no supervision or human assistance. May require mechanical device (for example, a walker), but not a wheelchair.

2=Walks with intermittent supervision (that is, verbal cueing and observation). May require human assistance for difficult parts of walking (for example, stairs, ramps).

3= Walks with *constant* one-to-one supervision and/or constant physical assistance.

4= Wheels with no supervision or assistance, except for difficult maneuvers (for example, elevators, ramps). May actually be able to walk, but generally does not move.

5= Is wheeled, chairfast or bedfast. Relies on someone else to move about, if at all.

21. TRANSFER: PROCESS OF MOVING BETWEEN POSITIONS, TO/FROM BED, CHAIR, STANDING, (EXCLUDE TRANSFERS TO/FROM BATH AND TOILET). 21. (115)

1=Requires no supervision or physical assistance to complete necessary transfers. May use equipment, such as railings, trapeze.

2=Requires *intermittent* supervision (that is, verbal cueing, guidance) and/or physical assistance for difficult maneuvers only.

3=Requires one person to provide constant guidance, steadiness and/or physical assistance. Patient may participate in transfer.

4=Requires two people to provide constant supervision and/or physically lift. May need lifting equipment.

5=Cannot and is not gotten out of bed.

22. TOILETING: PROCESS OF GETTING TO AND FROM A TOILET (OR USE OF OTHER TOILETING EQUIPMENT, SUCH AS BEDPAN). TRANSFERRING ON AND OFF TOILET, CLEANSING SELF AFTER ELIMINATION AND ADJUSTING CLOTHES. 22. (116)

1=Requires no supervision or physical assistance. May require special equipment, such as a raised toilet or grab bars.

2=Requires *intermittent* supervision for safety or encouragement, or *minor* physical assistance (for example, clothes adjustment or washing hands).

3=Continent of bowel *and* bladder. Requires constant supervision and/or physical assistance with *major/all* parts of the task, *including* appliances (i.e., colostomy, ileostomy, urinary catheter).

4=Incontinent of bowel *and/or* bladder and is not taken to a bathroom.

5=Incontinent of bowel *and/or* bladder, but is taken to a bathroom every two to four hours during the day and as needed at night.

IV. BEHAVIORS

23. VERBAL DISRUPTION: BY YELLING, BAITING, THREATENING, ETC. 23. (117)

1=No known history

2=Known history or occurrences, but not during the past week (7 days)

3=Short-lived or predictable disruption regardless of frequency (for example, during specific care routines, such as bathing.)

4=Unpredictable, recurring verbal disruption at least once during the past week (7 days) for no foretold reason

5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions)

24. PHYSICAL AGGRESSION: ASSAULTIVE OR COMBATIVE TO SELF OR OTHERS WITH INTENT FOR INJURY. (FOR EXAMPLE, HITS SELF, THROWS OBJECTS, PUNCHES, DANGEROUS MANEUVERS WITH WHEELCHAIR) 24. (118)

1=No known history.

2=Known history or occurrences, but not during the past week (7 days).

3=Predictable aggression during specific care routines or as a reaction to normal stimuli (for example, bumped into), regardless of frequency. May strike or fight.

4=Unpredictable, recurring aggression at least once during the past week (7 days) for no apparent or foretold reason (that is, not just during specific care routines or as a reaction to normal stimuli).

5=Patient is at level #4 above, but does not fulfill the active treatment and assessment qualifiers (in the instructions).

25. DISRUPTIVE, INFANTILE OR SOCIALLY INAPPROPRIATE BEHAVIOR: CHILDISH, REPETITIVE OR ANTISOCIAL PHYSICAL BEHAVIOR WHICH CREATES *DISRUPTION WITH OTHERS*. (FOR EXAMPLE, CONSTANTLY UNDRESSING SELF, STEALING, SMEARING FECES, SEXUALLY DISPLAYING ONESELF TO OTHERS). EXCLUDE VERBAL ACTIONS. READ THE INSTRUCTIONS FOR OTHER EXCLUSIONS. **25.**
(119)

- | | |
|---|--|
| <p>1=No known history</p> <p>2=Displays this behavior, but is not disruptive to others (for example, rocking in place).</p> <p>3=Known history or occurrences, but not during the past week (7 days).</p> | <p>4=Occurrences of this disruptive behavior at least once during the past week (7 days)</p> <p>5=Patient is at level #4 above, but does not fulfill the active treatment and psychiatric assessment qualifiers (in instructions).</p> |
|---|--|

26. HALLUCINATIONS: EXPERIENCED AT LEAST ONCE DURING THE PAST WEEK. VISUAL, AUDITORY OR TACTILE PERCEPTIONS THAT HAVE NO BASIS IN EXTERNAL REALITY. **26.**
(120)

- | | | |
|--------------|-------------|---|
| <p>1=Yes</p> | <p>2=No</p> | <p>3=Yes, but does not fulfill the active treatment and psychiatric assessment qualifiers (in the instructions)</p> |
|--------------|-------------|---|

V. SPECIALIZED SERVICES

27. PHYSICAL AND OCCUPATIONAL THERAPIES: READ INSTRUCTIONS AND QUALIFIERS. EXCLUDE REHABILITATIVE NURSES AND OTHER SPECIALIZED THERAPISTS (FOR EXAMPLE, SPEECH THERAPIST). ENTER THE LEVEL, DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS).

A. Physical Therapy (P.T.)

P.T. Level
(121)

P.T. Days
(122)

P.T. Time
(123-126) HOURS MINWEEK

B. Occupational Therapy (O.T.)

O.T. Level
(127)

O.T. Days
(128)

O.T. Time
(129-132) HOURS MINWEEK

LEVEL

- 1=Does not receive.
- 2= Maintenance program-Requires and is currently receiving physical and/or occupational therapy to help stabilize or slow functional deterioration.

3=Restorative Therapy-Requires and is currently receiving physical and/or occupational therapy for the past week.

4=Receives therapy, but does not fulfill the qualifiers stated in the instructions. (For example, therapy provided for only two days).

DAYS AND TIME PER WEEK: ENTER THE CURRENT NUMBER OF DAYS AND TIME (HOURS AND MINUTES) DURING THE PAST WEEK (7 DAYS) THAT EACH THERAPY WAS PROVIDED. ENTER ZERO IF AT #1 LEVEL ABOVE. READ INSTRUCTIONS AS TO QUALIFIERS IN COUNTING DAYS AND TIME.

28. NUMBER OF PHYSICIAN VISITS: DO NOT ANSWER THIS QUESTION FOR HOSPITALIZED PATIENTS, (ENTER ZERO), UNLESS ON ALTERNATE LEVEL OF CARE STATUS. ENTER ONLY THE NUMBER OF VISITS DURING THE PAST WEEK THAT ADHERED TO THE PATIENT NEED AND DOCUMENTATION QUALIFIERS IN THE INSTRUCTIONS. THE PATIENT MUST BE MEDICALLY UNSTABLE TO ENTER ANY PHYSICIAN VISITS, OTHERWISE ENTER A ZERO. **28.**
(133-134)

VI. DIAGNOSIS

29. PRIMARY PROBLEM: THE MEDICAL CONDITION REQUIRING THE LARGEST AMOUNT OF NURSING TIME IN THE HOSPITAL OR CARE TIME IF IN THE COMMUNITY. (FOR HOSPITALIZED PATIENTS THIS MAY OR MAY NOT BE THE ADMISSION DIAGNOSIS).

ICD-9 Code of medical problem

29.
(135-139)

If code cannot be located, print medical name here:

VII. PLAN OF CARE SUMMARY

This section is to communicate to providers any additional clinical information, which may be needed for their preadmission review of the patient. It does not have to be completed if the information below is already provided by your own form, which is attached to this H/C-PRI.

30. DIAGNOSES AND PROGNOSIS: FOR EACH DIAGNOSIS, DESCRIBE THE PROGNOSIS AND CARE PLAN IMPLICATIONS.

Primary Prognosis

1.

Secondary (Include Sensory Impairments)

1.

2.

3.

4.

31. REHABILITATION POTENTIAL (INFORMATION FROM THERAPISTS)

A. POTENTIAL DEGREE OF IMPROVEMENT WITH ADLs WITHIN SIX MONTHS (DESCRIBE IN TERMS OF ADL LEVELS ON THE HC-PRI):

B. CURRENT THERAPY CARE PLAN: DESCRIBE THE TREATMENTS (INCLUDING WHY) AND ANY SPECIAL EQUIPMENT REQUIRED.

32. MEDICATIONS

| NAME | DOSE | FREQUENCY | ROUTE | DIAGNOSIS REQUIRING EACH MEDICATION |
|------|------|-----------|-------|-------------------------------------|
|------|------|-----------|-------|-------------------------------------|

33. TREATMENTS: INCLUDE ALL DRESSINGS, IRRIGATIONS, WOUND CARE, OXYGEN.

| A. TREATMENTS | DESCRIBE WHY NEEDED | FREQUENCY |
|---------------|---------------------|-----------|
|---------------|---------------------|-----------|

B. NARRATIVE: DESCRIBE SPECIAL DIET, ALLERGIES, ABNORMAL LAB VALUES, PACEMAKER.

34. RACE/ETHNIC GROUP: ENTER THE CODE WHICH BEST DESCRIBES THE PATIENT'S RACE OR ETHNIC GROUP 34.

- 1=White 4=Black/Hispanic 7=American Indian or Alaskan Native
- 2=White/Hispanic 5=Asian or Pacific Islander 8=American Indian or Alaskan Native/Hispanic
- 3=Black 6=Asian or Pacific Islander/Hispanic 9=Other

35. QUALIFIED ASSESSOR: I HAVE PERSONALLY OBSERVED/INTERVIEWED THIS PATIENT AND COMPLETED THIS H/C PRI.

YES NO

I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

SIGNATURE OF QUALIFIED ASSESSOR

IDENTIFICATION NO.

Review completed Patient Review Instrument (PRI) or Hospital and Community PRI (H/C PRI) before beginning the SCREEN. Use with separate PRI or H/C PRI and SCREEN instructions.

IDENTIFICATION

| | |
|---|---|
| <p>1. Facility Operating Certificate Number:</p> <p>2. Patient/Resident/Person Social Security Number:</p> <p>3. Name of person(s) completing SCREEN:</p> | <p>4. Patient/Resident/Person Name:</p> <p>5. Date of H/C-PRI or PRI completion: MONTH DAY YEAR</p> <p>6a. Date of SCREEN Initiation: MONTH DAY YEAR</p> <p>6b. Date of SCREEN completion: MONTH DAY YEAR</p> |
|---|---|

DIRECT REFERRAL FACTOR FOR RHCF

- YES NO
7. Person has a home in the community (owns or rents a home, lives in an Adult Care Facility or with family or friends) and that place is still available OR appropriate community based living can be arranged OR the person is eligible for an Adult Care Facility.
 If NO, explain on a separate sheet of paper and attach to this form.

Guideline: If item 7 is marked NO, explain as indicated above and refer to RHCF. Proceed to REFERRAL DECISION (Item 21).
 If item 7 is marked YES, proceed to DIRECT REFERRAL FACTORS FOR HOME ASSESSMENT.

DIRECT REFERRAL FACTORS FOR HOME ASSESSMENT

- YES NO
8. Person understands information given and strongly opposes placement/continued stay in a Residential Health Care Facility.
9. Person is aware of the cost of necessary community services and desires to use private resources (e.g., insurance, income, savings) to purchase care at home or in an Adult Care Facility.
10. Person has a good informal support system - willing and capable (physically and mentally) of caring for most of the specific needs of the person.
11. All ADL responses = 1 or 2 (see PRI PART III, 19-22).
12. Person was independent in ADL prior to most recent acute episode and shows good rate of return of physical and mental functioning.

Guideline: If any direct referral factor (8-12) is marked YES, refer to Home Assessment or Assessment for Adult Care Facility. Proceed to REFERRAL DECISION: Item 21. If all direct referral factors (8-12) are marked NO, proceed to HOME AND CAREGIVING ARRANGEMENTS

HOME AND CAREGIVING ARRANGEMENTS

Check YES and NO boxes to document each response. For questions on the far right, enter the number of the answer that best applies.

13. a. Estimate the total number of hours per day that Informal supports are willing and able to provide supervision or assistance to the person.

b. Estimate the total number of hours per day that that the person can be alone.

+

c. Add a and b (a+b=c):

d. Is the number of hours in line c 12 or more?

YES NO

14. Within six months can the number of hours per day that the person is attended by self or Informal supports be increased to 12 or more?

YES NO

15. If NO, enter principal reason (1, 2 or 3):

1. Person understands options and has decided to enter/remain home.
2. Person has no informal supports.
3. Informal supports are unable or unwilling to provide additional assistance or person does not want care from informal supports.

16. Is there a need for restorative services which is documented by a physician or rehabilitation specialist?

NO YES

17. Can the person receive restorative services at home, at adult day care or as an outpatient?

YES NO

18. If NO, enter principal reason (1, 2 or 3):

1. Restorative services are not availab. in person's community.
2. Restorative services are too costly or not covered.
3. Person cannot access restorative services.

19. Can the person be placed in the community without causing undue risk to self or others? (only consider reason listed in Item 20)

YES NO

20. If question 19 is NO, enter principal reason (1, 2, 3 or 4):

1. Person has history of unpredictable behaviors and may injure self or others.
2. Comatose or all ADL responses = 4 or 5 (PRI PART III, 19-22).
3. Requires constant monitoring due to health threatening medical problems.
4. Skilled services are needed at least one time per day and cannot be delegated to nonprofessionals or Informal supports.

Go to 21

REFERRAL DECISION

21. Enter principal reason (1, 2, 3, 4 or 5):

1. RHCF: Item 7 is marked NO OR an entry appears in item 15 or 20, OR a home assessment was done by an authorized home care agency and it was determined that the person cannot be cared for in the community. This home assessment represents the person's current status.
2. RHCF for Restorative Services: There is an entry in item 18.
3. Home Assessment or Assessment for Adult Care Facility: One or more of items 8-12 are marked YES or no entries appear in items 15, 18, or 20.
4. Community based and RHCF care are both being investigated.
5. Referral Decision indicates Home Assessment or Assessment for Adult Care Facility but RHCF care is recommended.

If response 4 or 5 is chosen, explain:

DEMENTIA QUALIFIER

YES NO

22. Does the person have a diagnosis of dementia, (including Alzheimer's disease), without a diagnosis of MR/DD?

Guideline: If item 22 is marked YES, proceed to PATIENT/RESIDENT/PERSON DISPOSITION (item 36).
If item 22 is marked NO, proceed to LEVEL I REVIEW FOR POSSIBLE MENTAL ILLNESS (item 23).

LEVEL I REVIEW FOR POSSIBLE MENTAL ILLNESS (MI)

YES NO

23. Does the person have a serious mental illness?

Guideline: Proceed to Level I Review for Possible Mental Retardation/Developmental Disability.

LEVEL I REVIEW FOR POSSIBLE MENTAL RETARDATION/DEVELOPMENTAL DISABILITY (MR/DD)

Answer Items 24-27 in order, as soon as an item is marked YES, proceed to Categorical Determinations (Items 28-31).

YES NO

24. Does the person have a current diagnosis of mental retardation or a developmental disability (cerebral palsy, autism or epilepsy) and did the mental retardation or developmental disability manifest itself prior to age 22 and it is likely to continue indefinitely and result in substantial functional limitations in three or more areas of major life activity?
25. Was this person referred by an agency that serves persons with MR/DD or has this person ever been deemed eligible AND received MR/DD services current or past?
26. Is there a documented history of mental retardation or developmental disability in the person's past?
27. Does the person present evidence (cognitive or behavioral functions) that may indicate the presence of mental retardation or developmental disability?

Guideline: If items 23-27 are marked NO, proceed to Patient/Resident/Person Disposition (item 36).
If any of items 23-27 are marked YES, proceed to Categorical Determinations (items 28-31).

CATEGORICAL DETERMINATIONS

Guideline: All items must be answered.

YES NO

28. Does the person qualify for convalescent care?
29. Is the person seriously ill?
30. Is the person terminally ill?
31. Is the person admitted for a very brief and finite stay or a provisional emergency admission?

Guideline: If any of the items 28-31 are marked YES, proceed to DANGER TO SELF OR OTHER QUALIFIERS (item 32). If all are marked NO, proceed to LEVEL II REFERRALS (item 34).

DANGER TO SELF OR OTHERS QUALIFIERS

YES NO

32. Based on your interview of the person (and/or available informants), and/or a review of the person's medical record, is there any evidence to suggest that the person has or may have had homicidal or suicidal thinking or behavior during the past two years?

Guideline: If item 32 is marked YES, proceed to item 33. If NO, proceed to Patient/Resident/Person Disposition (item 36).

33. Based on a current mental health consultation, has the person been deemed homicidal or suicidal by a qualified mental health specialist?

Guideline: If item 33 is marked YES, proceed to LEVEL II REFERRALS (item 34). If NO, proceed to Patient/Resident/Person Disposition (item 36).

LEVEL II REFERRALS

34. Enter the Level II Referral decision (1, 2, or 3)

1. Level II mental illness assessment.
2. Level II assessment and determination by the Office of Mental Retardation and Developmental Disabilities.
3. Both 1 and 2.

Complete Item 35 only after obtaining the Level II determination(s) from the appropriate Office of Mental Health (OMH) and/or Office of Mental Retardation and Developmental Disabilities (OMR/DD) designee.

LEVEL II DETERMINATIONS

YES NO

35. Based upon the Level II determination(s), specialized services are required.

Guideline: If item 35 is marked YES, complete item 38. If item 35 is marked NO, proceed to Patient/Resident/Person Disposition (Item 36).

PATIENT/RESIDENT/PERSON DISPOSITION

36. Enter one response (1, 2, 3, 4, 5, 6, 7 or 8):

- | | |
|--|----------------------------------|
| 1. Home | 5. RHCF for restorative services |
| 2. Home with home care services | 6. RHCF for other services |
| 3. Adult Care Facility | 7. Person died |
| 4. Adult Care Facility with home care services | 8. Other (specify) _____ |

PATIENT/RESIDENT/PERSON OR REPRESENTATIVE ACKNOWLEDGEMENT

Guideline: Check the appropriate box(es)

37. a. I have had the opportunity to participate in decisions regarding arrangements for my continuing care and I have received verbal and written information regarding the range of services in my community.
- b. I have been informed in writing that the Office of Mental Health, Office of Mental Retardation and Developmental Disabilities (please circle the appropriate office(s)) will now be involved in determining my appropriate service/placement.

Patient/Resident/Person or Representatives signature

QUALIFIED SCREENER

38. I have personally observed/interviewed this person and completed this SCREEN: I certify that I am a trained and qualified screener and the information contained herein is a true abstract of the person's condition and circumstances.

YES NO

Signature of Qualified Screener

SCREENER IDENTIFICATION NUMBER
(Assigned by NYS DOH)

UPDATE

39. The information contained herein has not changed and is a true abstract of the person's condition and circumstances.

| | | | | |
|--|----------------|---------|----------------|---|
| SIGNATURE OF TRAINED AND QUALIFIED SCREENER _____ REVIEW DATE H/C-PRI OR PRI: | MONTH DAY YEAR | SCREEN: | MONTH DAY YEAR | _____ SCREENER IDENTIFICATION NUMBER |
| SIGNATURE OF TRAINED AND QUALIFIED SCREENER _____ REVIEW DATE H/C-PRI OR PRI: | MONTH DAY YEAR | SCREEN: | MONTH DAY YEAR | _____ SCREENER IDENTIFICATION NUMBER |
| SIGNATURE OF TRAINED AND QUALIFIED SCREENER _____ REVIEW DATE H/C-PRI OR PRI: | MONTH DAY YEAR | SCREEN: | MONTH DAY YEAR | _____ SCREENER IDENTIFICATION NUMBER |
| SIGNATURE OF TRAINED AND QUALIFIED SCREENER _____ REVIEW DATE H/C-PRI OR PRI: | MONTH DAY YEAR | SCREEN: | MONTH DAY YEAR | _____ SCREENER IDENTIFICATION NUMBER |

ASSISTED LIVING PROGRAM INTERIM ASSESSMENT

Name of ALP: _____

CHECK ONE: ___ 45 Days ___ Interim six (6) months

Name: _____ SSA#: _____ CIN#: _____

PRI Score: _____ PRI Date: _____ DOB: _____

New Certification from: _____ to _____

Describe change(s) in resident's health or functional status since last medical evaluation:

(Consider: diagnosis, health, mental health, diet, allergies, functional or behavioral status, need for assistance and related information)

Current Medications: (or see initialed and dated attachment) (Consider changes to medication regimen)

Skilled Professional Services:

Physician:

I have examined the above resident and this evaluation describes the resident's medical condition, needs, and regimens. The resident's condition is stable and the individual is medically appropriate to be cared for in an ALP.

Date of examination: _____

Signature (required): _____ Date: _____

Nurses:

We have reviewed the last full assessment that was completed on _____, as well as all subsequent assessment documentation. We have conducted a reassessment of the resident and agree that the previous assessment reflects the resident's current condition and needs, with the above changes (**if any**). The resident's health/safety needs require more care and services to meet health or functioning needs than can be provided in an AH or EHP but can safely be provided in an ALP. If no, specify the reason and indicate appropriate level of care.

Signature: _____
(CHHA/LTHHCP RN)

Date: _____

Signature: _____
(ALP RN)

Date: _____

MEDICAL EVALUATION (page 2)

Name: _____

Is the individual:

Free of communicable disease? ___ Yes ___ No. If no, describe: _____

Able to transfer without assistance? ___ Yes ___ No. If no, describe: _____

Ambulatory without assistance? ___ Yes ___ No. If no, describe: _____

Describe Activity Restrictions/Assistance Needed with ADLs (e.g., eating, transferring, toileting):

Describe Current Treatment Plan (e.g., nursing, therapies, etc.):

Is the individual's condition stable? ___ Yes ___ No. If no, describe: _____

Does the individual have a history, current condition or recent hospitalization for mental disability?
___ Yes ___ No. If yes, describe: _____

Is a Mental Health Evaluation recommended? ___ Yes ___ No

Date of Today's Examination _____ Recommended frequency of Medical Exams _____

I certify that I have accurately described the individual's medical condition, needs, and regimens, including any medication regimens, and that the individual is medically appropriate to be cared for in an Adult Home, Enriched Housing Program or an ALP.

Signature: _____
Nurse Practitioner, Physician or Specialist's Assistant

Date: _____

Signature: _____
Physician (required)

Date: _____

**ASSISTED LIVING PROGRAM
NURSING/FUNCTIONAL/SOCIAL ASSESSMENT**

An Assisted Living Program (ALP) provides long-term residential care, room, board, housekeeping, personal care, supervision, and provides or arranges for home health services to eligible residents in an adult care facility (ACF).

Individual's Name: _____ Date of Birth: _____ SSA #: _____

Indicate whether the individual requires assistance with any of the following. Complete all sections:

| | YES | NO | DESCRIPTION/LEVEL | FREQUENCY | DURATION |
|--------------------------------|-----|----|-------------------|-----------|----------|
| Nursing | | | | | |
| Diet Counseling-Specify Diet | | | | | |
| Dressings | | | | | |
| Vital Sign Monitoring | | | | | |
| Medication Administration | | | | | |
| Tube Feeding* | | | | | |
| Tube Irrigation* | | | | | |
| Suctioning* | | | | | |
| Laboratory Services | | | | | |
| Physical Therapy | | | | | |
| Occupational Therapy | | | | | |
| Speech pathology | | | | | |
| Inhalation Therapy | | | | | |
| Oxygen Therapy | | | | | |
| Medical Social Service | | | | | |
| Counseling | | | | | |
| Transportation Arrangements | | | | | |
| Personal/Financial Errands | | | | | |
| Legal/Protective Services | | | | | |
| Bathing | | | | | |
| Grooming | | | | | |
| Dressing | | | | | |
| Toileting | | | | | |
| Eating | | | | | |
| Exercise/Activity/Walking | | | | | |
| Bedbound Care | | | | | |
| Housekeeping Services | | | | | |
| Laundry Services | | | | | |
| Meal Preparation | | | | | |
| Shopping (food, supplies) | | | | | |
| Transportation Attendant | | | | | |
| Ramps Outside/Inside | | | | | |
| Commode/Special Bed/Wheelchair | | | | | |
| Structural Modifications | | | | | |
| Bed Protector/Diapers | | | | | |
| Cane/Walker/Crutches/Other | | | | | |
| Catheter/Colostomy Supplies | | | | | |
| Eyeglasses/Hearing Aide | | | | | |
| Self-help Devices (specify) | | | | | |
| Other: 1) | | | | | |
| 2) | | | | | |

***Please note:** A yes response in any of these categories may indicate that the individual may be inappropriate for placement or continued stay in the ALP.

**ASSISTED LIVING PROGRAM
NURSING/FUNCTIONAL/SOCIAL ASSESSMENT**

Community Support: Indicate organization serving individual at present or who has provided a service in the past six months (e.g. Home Care Services, Adult Day Health Care, Day Treatment Programs).

| ORGANIZATION | TYPE OF SERVICE | PRESENTLY | RECEIVING | CONTACT PERSON | TELEPHONE nO |
|--------------|-----------------|-----------|-----------|----------------|--------------|
| | | HRS/DAY | HRS/WK | | |
| | | | | | |
| | | | | | |
| | | | | | |

PRI RUG CATEGORY _____ PRI Attached? ___ Yes ___ No

Can the individual's health/safety needs be met through an ALP? ___ Yes ___ No

If yes, specify the reason and indicate appropriate level of care: _____

If yes, can the individual's needs be met in a lower level of care? ___ Yes ___ No

If yes, explain _____

Narrative: Use this space to describe aspects of the individual's care/needs not adequately covered above.

Signature (CHHA/LTHHP RN): _____ Date: _____

CHHA/LTHHCP Name: _____ Telephone No: _____

Signature (ALP RN): _____ Date: _____

Member ID Number: _____

**MANAGED LONG-TERM CARE (MLTC)
SEMI-ANNUAL ASSESSMENT OF MEMBERS (SAAM)
Version 2.5**

(Adapted from the Outcome and Assessment Information Set [OASIS-B1])

CLINICAL RECORD ITEMS

(M0090) Date Assessment Completed:

___/___/___
month day year

(L0091) Assessor Name:

_____(First) _____(MI) _____(Last) _____(Suffix)

(L0092) Assessor License Number:

(ML0100) This Assessment is Currently Being Completed for the Following Reason:

- 1 – Start of enrollment
- 2 – Reassessment due to:
 - 1 – Scheduled semiannual reassessment
 - 2 – Deferred semiannual reassessment
 - 3 – Significant condition change or other optional reassessment
- 3 – Disenrollment [**Go to L0904**]

(L0110) Member's Location at the Time of This Assessment:

- 1 – Community
- 2 – Nursing Home
- 3 – Hospital [**Assessment at this location must be for pre-enrollment purposes only**]

(L0120a) Member's Most Current SAAM Index at the Time of this Assessment. (Item is calculated by DELTA):

DIAGNOSIS/PROGNOSIS/SURGERIES

(ML0230/ML0240/L0245) Diagnoses, Severity Index and Surgeries: List the member's primary diagnosis and other secondary diagnoses or problems and ICD-9-CM code(s) at the level of highest specificity for which the member is receiving long-term care. ICD-9-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses. Rate each condition using the following severity index.

Severity Rating

- 0 - Asymptomatic, no treatment needed at this time
- 1 - Symptoms well controlled with current therapy
- 2 - Symptoms controlled with difficulty, affecting daily functioning; member needs ongoing monitoring
- 3 - Symptoms poorly controlled, member needs frequent adjustment in treatment and dose monitoring
- 4 - Symptoms poorly controlled, history of rehospitalizations

| <u>(ML0230) Primary Diagnosis</u> <i>(V-codes may be used)</i> | <u>ICD-9-CM</u> <i>(Three digits required; Five digits optional)</i> | <u>Severity Rating</u> <i>(Choose one value that represents the most severe rating appropriate for each diagnosis)</i> |
|---|---|---|
| a. _____ | (____ . ____) | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 |

| <u>(ML0240) Other Diagnoses</u> <i>(E-codes or V-codes may be used)</i> | <u>ICD-9-CM</u> <i>(Three digits required; Five digits optional)</i> | <u>Severity Rating</u> <i>(Choose one value that represents the most severe rating appropriate for each diagnosis)</i> |
|--|---|---|
| b. _____ | (█ ____ . ____) | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 |
| c. _____ | (█ ____ . ____) | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 |
| d. _____ | (█ ____ . ____) | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 |
| e. _____ | (█ ____ . ____) | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 |
| f. _____ | (█ ____ . ____) | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 |

Using ICD-9 procedure codes, list surgeries the member has had that impact the member's functional status.

| <u>(L0245) Surgeries</u> | <u>ICD-9-CM</u> <i>(Three digits required; Four digits optional)</i> |
|--------------------------|---|
| g. _____ | (█ ____ . ____) |
| h. _____ | (█ ____ . ____) |
| i. _____ | (█ ____ . ____) |

Member ID Number: _____

(ML0250a) Nursing Therapies the member receives from the managed long-term care plan (all settings): **(Mark all that apply.)**

- 1 - Intravenous or infusion therapy (excludes TPN)
- 2 - Parenteral nutrition (TPN or lipids)
- 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- 4 - Suctioning
- 5 - Bowel rehabilitation
- 6 - Bladder rehabilitation
- 7 - Inhalation therapy
- 8 - None of the above

(ML0260) Overall Prognosis: BEST description of member's overall prognosis:

- 0 - Poor: imminent decline likely
- 1 - Fair: maintenance likely
- 2 - Good: some improvement expected

(L0265) Rehabilitation Therapies: Therapies provided by a therapist **at the time of this assessment** for skilled rehabilitation on a **short-term or long-term** basis or to improve functioning or to establish a maintenance therapy program. **(Mark all that apply.)**

- 1 Physical therapy
- 2 - Occupational therapy
- 3 - Speech therapy
- 4 - None of the above

(ML0270) Rehabilitative Prognosis: BEST description of member's prognosis for functional status:

- 0 - Poor: minimal improvement in functional status is expected; decline is possible
- 1 - Good: marked improvement in functional status is expected
- UK - Unknown

Member ID Number: _____

(ML0290a) High Risk Factors characterizing this member: **Body Mass Indices (BMI) are provided as a reference and are NOT required prior to assigning a member to either of the weight risk factors. Assessors may mark these risk factors based on observation.**

- 1 - Smoking
- 2 - Underweight (BMI < 18.5)
- 3 - Overweight (BMI 25-29.9)
- 4 - Obese (BMI >=30)
- 5 - Alcohol dependency
- 6 - Drug dependency
- 7 - None of the above
- UK - Unknown

(L0300) Flu Immunization Status: Has the member received an influenza vaccination in the past year?

[Do not answer if this is the member's SOE assessment.]

- 1 - Yes
- 2 - No - Contraindicated
- 3 - No - Refuses immunization
- 4 - No - Other

LIVING ARRANGEMENTS

(ML0340) Member lives:

[Do not answer if the member is in a nursing home at the time of reassessment.]

- 1 - Alone
- 2 - With family member or friend
- 3 - With other than above

SUPPORTIVE ASSISTANCE

(ML0350) Assisting Person(s) Other than Services Covered by Plan: (Mark all that apply.)

[Do not answer if the member is in a nursing home at the time of reassessment.]

- 1 - Relatives, friends, or neighbors living outside the home
- 2 - Person residing in the home (EXCLUDING paid help)
- 3 - Paid help
- 4 - None of the above **[If None of the above, go to ML0390]**
- UK - Unknown **[If Unknown, go to ML0390]**

Member ID Number: _____

(ML0370) How often does the member receive assistance from the caregiver(s)?
[Do not answer if the member is in a nursing home at the time of reassessment.]

- 1 - Several times during day and night
- 2 - Several times during day
- 3 - Once daily
- 4 - Three or more times per week
- 5 - One to two times per week
- 6 - Less often than weekly
- UK - Unknown

(ML0380) Type of Caregiver Assistance: (Mark all that apply.) [Do not answer if the member is in a nursing home at the time of reassessment.]

- 1 - ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
- 2 - IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances)
- 3 - Clinical assistance (e.g., wound care, colostomy care, etc.)
- 4 - Environmental support (housing, home maintenance)
- 5 - Psychosocial support (socialization, companionship, recreation)
- 6 - Advocates or facilitates member's participation in appropriate medical care
- 7 - Financial agent, power of attorney, or conservator of finance
- 8 - Health care agent, conservator of person, or medical power of attorney
- UK - Unknown

SENSORY STATUS

(ML0390) Vision with corrective lenses if the member usually wears them:

- 0 - Normal vision: sees adequately in most situations; can see medication labels, newspaper.
- 1 - Partially impaired: cannot see medication labels or newspaper, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
- 2 - Severely impaired: cannot locate objects without hearing or touching them or member nonresponsive.

Member ID Number: _____

(ML0400) Hearing and Ability to Understand Spoken Language in member's own language (with hearing aids if the member usually uses them):

- 0 - No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation.
- 1 - With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice.
- 2 - Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance.
- 3 - Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, additional time.
- 4 - Unable to hear and understand familiar words or common expressions consistently, or member nonresponsive.

(ML0410) Speech and Oral (Verbal) Expression of Language (in member's own language):

- 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- 2 - Expresses simple ideas or needs with moderate difficulty (needs minimal prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
- 5 - Member nonresponsive or unable to speak.

(ML0420) Frequency of Pain interfering with member's activity or movement:

- 0 - Member has no pain or pain does not interfere with activity or movement
- 1 - Less often than daily
- 2 - Daily, but not constantly
- 3 - All of the time

(ML0430) Intractable Pain: Is the member experiencing pain that is not easily relieved, occurs at least daily, and affects the member's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?

- 0 - No
- 1 - Yes

INTEGUMENTARY STATUS

(ML0440) Does this member have a **Skin Lesion** or an **Open Wound**? This excludes "OSTOMIES."

- 0 - No [If No, go to *ML0490*]
- 1 - Yes

(ML0445) Does this member have a **Pressure Ulcer**?

- 0 - No [If No, go to *ML0468*]
- 1 - Yes

(M0450) **Current Number of Pressure Ulcers at Each Stage:** (Mark one response for each stage.)

| <u>Pressure Ulcer Stages</u> | <u>Number of Pressure Ulcers</u> |
|---|---|
| a) Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators. | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 or more |
| b) Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 or more |
| c) Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 or more |
| d) Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.) | <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 or more |
| e) In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? | |
| <ul style="list-style-type: none"> <input type="radio"/> 0 - No <input type="radio"/> 1 - Yes | |

(ML0468) Does this member have a **Stasis Ulcer**?

- 0 - No [If No, go to *ML0482*]
- 1 - Yes

(M0470) **Current Number of Observable Stasis Ulcer(s):**

- 0 - Zero
- 1 - One
- 2 - Two
- 3 - Three
- 4 - Four or more

Member ID Number: _____

(M0476) Status of Most Problematic (Observable) Stasis Ulcer:

- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable stasis ulcer

(ML0482) Does this member have a Surgical Wound?

- 0 - No [If No, go to *ML0490*]
- 1 - Yes

(M0484) Current Number of (Observable) Surgical Wounds: (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.)

- 0 - Zero
- 1 - One
- 2 - Two
- 3 - Three
- 4 - Four or more

(M0488) Status of Most Problematic (Observable) Surgical Wound:

- 1 - Fully granulating
- 2 - Early/partial granulation
- 3 - Not healing
- NA - No observable surgical wound

RESPIRATORY STATUS

(ML0490) When is the member dyspneic or noticeably Short of Breath?

- 0 - Never, member is not short of breath
- 1 - When walking more than 20 feet, climbing stairs
- 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- 4 - At rest (during day or night)

Member ID Number: _____

(ML0500) Respiratory Treatments utilized (all settings): **(Mark all that apply.)**

- 1 - Oxygen (intermittent or continuous)
- 2 - Ventilator (continually or at night)
- 3 - Continuous positive airway pressure
- 4 - None of the above

ELIMINATION STATUS

(L0510) Urinary Tract Infection: Please indicate if, and how often, the member has been treated for a urinary tract infection since the last assessment. ***[If the member has a urinary tract infection at the time of assessment, include it in the count. If this is the member's SOE assessment, mark "0 - None" if s/he does not have a urinary tract infection, mark "1 - One" if s/he has a urinary tract infection.]***

- 0 - None
- 1 - One
- 2 - Two
- 3 - Three
- 4 - Four or more
- NA - Member on prophylactic treatment
- UK - Unknown

(ML0520a) Urinary Incontinence or Urinary Catheter Presence:

- 0 - No incontinence or catheter
[If No, go to *ML0540b*]
- 1 - Member is incontinent
- 2 - Member has a urinary ostomy or requires urinary catheter (i.e., external, indwelling, intermittent, suprapubic)
[Go to *ML0540b*]

(ML0530) When does Urinary Incontinence occur?

- 0 - Timed-voiding defers incontinence
[Go to *ML0540b*]
- 1 - During the night only
- 2 - During the day and night

(L0535) How often does Urinary Incontinence occur?

- 0 - Once a week or less
- 1 - More than once a week

Member ID Number: _____

(ML0540b) Bowel Incontinence Frequency:

- 0 - Very rarely or never has bowel incontinence
- 1 - Less than once weekly
- 2 - One to three times weekly
- 3 - Four to six times weekly
- 4 - On a daily basis
- 5 - More often than once daily
- 6 - Member has an ostomy for bowel elimination with which member needs assistance from the **MLTC plan**
- 7 - Member has an ostomy for bowel elimination
- UK - Unknown

FALLS

(L0550) Indicate the **Number of Falls** experienced by the member during the past six months:

- 0 - None [**Go to ML0560**]
- 1 - One
- 2 - Two to five
- 3 - More than five

(L0555) Number of Falls Resulting in Medical Intervention: Indicate the number of falls requiring medical intervention (e.g., emergency department visit, clinic, physician's office, etc.)

- 0 - None
- 1 - One
- 2 - Two to five
- 3 - More than five

NEURO/EMOTIONAL/BEHAVIORAL STATUS

(ML0560) Cognitive Functioning: (Member's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)

- 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

(ML0570) When Confused (Reported or Observed):

- 0 - Never
- 1 - In new or complex situations only
- 2 - On awakening or at night only
- 3 - During the day and evening, but not constantly
- 4 - Constantly
- NA - Member nonresponsive

(ML0580) When Anxious (Reported or Observed):

- 0 - None of the time
- 1 - Less often than daily
- 2 - Daily, but not constantly
- 3 - All of the time
- NA - Member nonresponsive

(ML0590) Depressive Feelings Reported or Observed in Member: (Mark all that apply.)

- 1 - Depressed mood (e.g., feeling sad, tearful)
- 2 - Sense of failure or self reproach
- 3 - Hopelessness
- 4 - Recurrent thoughts of death
- 5 - Thoughts of suicide
- 6 - None of the above feelings observed or reported

Member ID Number: _____

| <u>(ML0610) Behaviors Demonstrated</u> (Reported or Observed) | <u>Frequency of Behaviors Demonstrated</u> Key: 0 Never 1 Less than once a month 2 Once a month 3 Several times each month 4 Several times a week 5 At least daily UK Unknown |
|---|--|
| a. Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions | ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ UK |
| b. Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc. | ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ UK |
| c. Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects) | ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ UK |
| d. Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions) | ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ UK |
| e. Delusional, hallucinatory, or paranoid behavior | ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ UK |
| f. Self abuse | ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ UK |

(L0615) Wandering: Has the member wandered over the past six months? (Wandering is defined as straying or becoming lost in the community due to impaired judgment. Example: A confused participant leaves home unattended and is not able to find his or her way back.)

- 0 - Never, with no special precautions. Has not wandered away from home, the Day Health Center, or other locations and no special precautions are in place or needed.
- 1 - Never, because special precautions are in place. Has not wandered away from home, Day Health Center, or other locations because special precautions have been instituted, such as continuous supervision and/or secured exits.
- 2 - Seldom (once/week or less). Has wandered away from home, the Day Health Center or other locations occasionally (once a week or less) over the past six months.
- 3 - Often (more than once/week). Has wandered away from home, the Day Health Center or other locations more than once a week over the past six months OR wanders once a week or more from some locations, but not others.
- UK - Unknown

Member ID Number: _____

(L0620) Memory Deficit: (Mark all that apply.)

- 1 - Failure to recognize familiar persons/places
- 2 - Inability to recall events of past 24 hours
- 3 - Significant memory loss so that supervision is required
- 4 - None of the above

ADL/IADLs

(ML0640) Grooming: Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

- 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- 2 - Someone must assist the member to groom self.
- 3 - Member depends entirely upon someone else for grooming needs.
- UK - Unknown

(ML0650) Ability to Dress Upper Body (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

- 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- 1 - Able to dress upper body without assistance if clothing is laid out or handed to the member.
- 2 - Someone must help the member put on upper body clothing.
- 3 - Member depends entirely upon another person to dress the upper body.
- UK - Unknown

(ML0660) Ability to Dress Lower Body (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

- 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the member.
- 2 - Someone must help the member put on undergarments, slacks, socks or nylons, and shoes.
- 3 - Member depends entirely upon another person to dress lower body.
- UK - Unknown

Member ID Number: _____

(ML0670) Bathing: Ability to wash entire body. Excludes grooming (washing face and hands only).

- 0 - Able to bathe self in shower or tub independently.
- 1 - With the use of devices, is able to bathe self in shower or tub independently.
- 2 - Able to bathe in shower or tub with the assistance of another person:
(a) for intermittent supervision or encouragement or reminders, OR
(b) to get in and out of the shower or tub, OR
(c) for washing difficult to reach areas.
- 3 - Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- 4 - Unable to use the shower or tub and is bathed in bed or bedside chair.
- 5 - Unable to effectively participate in bathing and is totally bathed by another person.
- UK - Unknown

(ML0680) Toileting: Ability to get to and from the toilet or bedside commode.

- 0 - Able to get to and from the toilet independently with or without a device.
- 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet.
- 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
- 4 - Is totally dependent in toileting.
- UK - Unknown

(ML0690a) Transferring: Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if member is bedfast.

- 0 - Able to independently transfer.
- 1 - Transfers with use of an assistive device.
- 2 - Transfers with minimal human assistance.
- 3 - Unable to transfer self but is able to bear weight and pivot during the transfer process.
- 4 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 5 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 6 - Bedfast, unable to transfer and is unable to turn and position self.
- UK - Unknown

Member ID Number: _____

(ML0700a) Ambulation/Locomotion: Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - Requires use of a device (e.g., cane, walker) to walk alone.
- 2 - Requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.
- UK - Unknown

(ML0710) Feeding or Eating: Ability to feed self meals and snacks. **Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.**

- 0 - Able to independently feed self.
- 1 - Able to feed self independently but requires:
 - (a) meal set-up; OR
 - (b) intermittent assistance or supervision from another person; OR
 - (c) a liquid, pureed or ground meat diet.
- 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- 5 - Unable to take in nutrients orally or by tube feeding.
- UK - Unknown

(ML0720) Planning and Preparing Light Meals (e.g., cereal, sandwich) or reheat delivered meals:
[Do not answer if the member is in a nursing home at the time of reassessment.]

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this long-term care admission).
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals.
- UK - Unknown

Member ID Number: _____

(ML0730) Transportation: Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway).

[Do not answer if the member is in a nursing home at the time of reassessment.]

- 0 - Able to independently drive a regular or adapted car; OR uses a regular or handicap-accessible public bus.
- 1 - Able to ride in a car only when driven by another person; OR able to use a bus or handicap van only when assisted or accompanied by another person.
- 2 - Unable to ride in a car, taxi, bus, or van, and requires transportation by ambulance.
- UK - Unknown

(ML0740) Laundry: Ability to do own laundry -- to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand.

[Do not answer if the member is in a nursing home at the time of reassessment.]

- 0 - (a) Able to independently take care of all laundry tasks; OR
(b) Physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this long-term care admission).
- 1 - Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry.
- 2 - Unable to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.
- UK - Unknown

(ML0750) Housekeeping: Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.

[Do not answer if the member is in a nursing home at the time of reassessment.]

- 0 - (a) Able to independently perform all housekeeping tasks; OR
(b) Physically, cognitively, and mentally able to perform all housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this long-term care admission).
- 1 - Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently.
- 2 - Able to perform housekeeping tasks with intermittent assistance or supervision from another person.
- 3 - Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process.
- 4 - Unable to effectively participate in any housekeeping tasks.
- UK - Unknown

Member ID Number: _____

(ML0760) Shopping: Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.

[Do not answer if the member is in a nursing home at the time of reassessment.]

- 0 - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; OR
(b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this long-term care admission).
- 1 - Able to go shopping, but needs some assistance:
(a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; OR
(b) Unable to go shopping alone, but can go with someone to assist.
- 2 - Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery.
- 3 - Needs someone to do all shopping and errands.
- UK - Unknown

(ML0770) Ability to Use Telephone: Ability to answer the phone, dial numbers, and effectively use the telephone to communicate.

- 0 - Able to dial numbers and answer calls appropriately and as desired.
- 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- 5 - Totally unable to use the telephone.
- NA - Member does not have a telephone.
- UK - Unknown

MEDICATIONS

(ML0780) Management of Oral Medications: Member's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

[Do not answer if the member is in a nursing home at the time of reassessment.]

- 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take medication(s) at the correct times if:
 - (a) individual dosages are prepared in advance by another person; OR
 - (b) given daily reminders; OR
 - (c) someone develops a drug diary or chart.
- 2 - Unable to take medication unless administered by someone else.
- NA - No oral medications prescribed.
- UK - Unknown

(ML0790) Management of Inhalant/Mist Medications: Member's ability to prepare and take all prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes all other forms of medication (oral tablets, injectable and IV medications).**

[Do not answer if the member is in a nursing home at the time of reassessment.]

- 0 - Able to independently take the correct medication and proper dosage at the correct times.
- 1 - Able to take medication at the correct times if:
 - (a) individual dosages are prepared in advance by another person, OR
 - (b) given daily reminders.
- 2 - Unable to take medication unless administered by someone else.
- NA - No inhalant/mist medications prescribed.
- UK - Unknown

(ML0800) Management of Injectable Medications: Member's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

[Do not answer if the member is in a nursing home at the time of reassessment.]

- 0 - Able to independently take the correct medication and proper dosage at the correct times.
- 1 - Able to take injectable medication at correct times if:
 - (a) individual syringes are prepared in advance by another person, OR
 - (b) given daily reminders.
- 2 - Unable to take injectable medications unless administered by someone else.
- NA - No injectable medications prescribed.
- UK - Unknown

Member ID Number: _____

(L0802) Adherence to Medications: Based on your knowledge, observation, and/or examination, how closely is the member's prescribed medication regimen adhered to (e.g., takes appropriate dosage, adheres to medication schedule, etc.)?

[Do not answer if the member is in a nursing home at the time of reassessment.]

- 0 - Poorly (medications taken appropriately less than 40% of the time)
- 1 - Fairly well (medications taken appropriately 40-80% of the time)
- 2 - Completely (medications taken appropriately over 80% of the time)
- NA - Participant does not have prescription medications
- UK- Unknown

(L0803) Adherence to Therapy/Medical Interventions: Based on your knowledge, observation, and/or examination, how closely is the member's therapy or medical intervention (other than medications) adhered to? (For example, prescribed diet, rehab therapy, etc.)

[Do not answer if the member is in a nursing home at the time of reassessment.]

- 0 - Poorly (adhered to as directed less than 40% of the time)
- 1 - Fairly well (adhered to as directed 40-80% of the time)
- 2 - Completely (adhered to as directed over 80% of the time)
- NA - No therapy or medical intervention (not including medications) prescribed
- UK- Unknown

EQUIPMENT MANAGEMENT

(ML0810) Member Management of Equipment (includes ONLY oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies): Member's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**

[Do not answer if the member is in a nursing home at the time of reassessment.]

- 0 - Member manages all tasks related to equipment completely independently.
- 1 - If someone else sets up equipment (i.e., fills portable oxygen tank, provides member with prepared solutions), member is able to manage all other aspects of equipment.
- 2 - Member requires considerable assistance from another person to manage equipment, but independently completes portions of the task.
- 3 - Member is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.
- 4 - Member is completely dependent on someone else to manage all equipment.
- NA - No equipment of this type used in care

Member ID Number: _____

EMERGENT CARE

(ML0830) Emergent Care: Since the last time SAAM data were collected, has the member utilized any of the following services for emergent care (other than home care services). **(Mark all that apply.)**

[Do not answer if this is the member's SOE assessment.]

- 0 - No emergent services [If no emergent care, go to ML0890]
- 1 - Hospital emergency room (includes 23-hour holding)g
- 2 - Doctor's office emergency visit/house call
- 3 - Outpatient Department/clinic emergency (includes urgicenter sites)
- UK - Unknown [If unknown, go to ML0890]

(ML0840) Emergent Care Reason: For what reason(s) did the member/family seek emergent care? **(Mark all that apply.)**

[Do not answer if this is the member's SOE assessment.]

- 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- 2 - Nausea, dehydration, malnutrition, constipation, impaction
- 3 - Injury caused by fall or accident at home
- 4 - Respiratory problems (e.g., shortness of breath, respiratory infection, tracheobronchial obstruction)
- 5 - Wound infection, deteriorating wound status, new lesion/ulcer
- 6 - Cardiac problems (e.g., fluid overload, exacerbation of CHF, chest pain)
- 7 - Hypo/Hyperglycemia, diabetes out of control
- 8 - GI bleeding, obstruction
- 9 - Other than above reasons
- UK - Reason unknown

HOSPITALIZATIONS

In the table below, please complete the following information concerning hospitalizations for this member since the last assessment.

[If there were no hospitalizations for this member, please skip to ML0900.]

[Do not answer if this is the member's SOE assessment.]

(ML0890) Hospitalization Admission Type:

- 1 - Emergent (unscheduled) care
- 2 - Urgent (scheduled within 24 hours of admission) care
- 3 - Elective (scheduled more than 24 hours before admission) care
- UK - Unknown

(ML0895) Clinical Reason(s) for Hospitalization:

- 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
- 2 - Injury caused by fall or accident at home
- 3 - Respiratory problems (SOB, infection, obstruction, COPD, pneumonia)
- 4 - Wound or tube site infection, deteriorating wound status, new lesion/ulcer
- 5 - Hypo/Hyperglycemia, diabetes out of control
- 6 - GI bleeding, obstruction
- 7 - Exacerbation of CHF, fluid overload, heart failure
- 8 - Myocardial infarction, stroke
- 9 - Chemotherapy or other cancer-related admission
- 10 - Scheduled surgical procedure
- 11 - Urinary tract infection
- 12 - IV catheter-related infection
- 13 - Deep vein thrombosis, pulmonary embolus
- 14 - Uncontrolled pain (including back pain)
- 15 - Psychotic episode or other change in mental status
- 16 - Other than above reasons

Member ID Number: _____

| (ML0890) Hospitalization Admission Type <i>(Mark one response for each hospitalization.)</i> | | | | | (ML0895) Clinical Reason(s) for Hospitalization <i>(Mark all that apply for each hospitalization.)</i> | | | | | | | | | | | | | | | |
|--|-------------------------|-------------------------|-------------------------|--------------------------|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| Hospitalization #1 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> UK | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 | <input type="checkbox"/> 11 | <input type="checkbox"/> 12 | <input type="checkbox"/> 13 | <input type="checkbox"/> 14 | <input type="checkbox"/> 15 | <input type="checkbox"/> 16 |
| Hospitalization #2 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> UK | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 | <input type="checkbox"/> 11 | <input type="checkbox"/> 12 | <input type="checkbox"/> 13 | <input type="checkbox"/> 14 | <input type="checkbox"/> 15 | <input type="checkbox"/> 16 |
| Hospitalization #3 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> UK | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 | <input type="checkbox"/> 11 | <input type="checkbox"/> 12 | <input type="checkbox"/> 13 | <input type="checkbox"/> 14 | <input type="checkbox"/> 15 | <input type="checkbox"/> 16 |
| Hospitalization #4 | <input type="radio"/> 1 | <input type="radio"/> 2 | <input type="radio"/> 3 | <input type="radio"/> UK | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 | <input type="checkbox"/> 11 | <input type="checkbox"/> 12 | <input type="checkbox"/> 13 | <input type="checkbox"/> 14 | <input type="checkbox"/> 15 | <input type="checkbox"/> 16 |

NURSING HOME ADMISSIONS

In the table below, please indicate the reason(s) for any nursing home admissions for this member since the last assessment.

[Do not answer if there were no nursing home admissions for this member]

[Do not answer if this is the member's SOE assessment.]

(ML0900) For what Reason(s) was the member Admitted to a Nursing Home?

- 1 - Therapy services
- 2 - Respite care
- 3 - End of life care
- 4 - Permanent placement
- 5 - Unsafe for care at home
- 6 - Other
- UK - Unknown

| (ML0900) Nursing Home Admission Reasons(s) <i>(Mark all that apply for each nursing home admission.)</i> | | | | | | | |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|
| Nursing Home Admission #1 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> UK |
| Nursing Home Admission #2 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> UK |
| Nursing Home Admission #3 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> UK |
| Nursing Home Admission #4 | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> UK |

Member ID Number: _____

(L0904) Date of Death: (If no death, go to L0905)

___/___/___

month day year

(L0905) Disenrollment Date:

___/___/___

month day year

(L0910) Disenrollment Status:

- 1 - Voluntary
- 2 - Involuntary

(L0920) Disenrollment Reason(s): (Mark all that apply.)

- 1 - Dissatisfied with quality of services
- 2 - Dissatisfied with quantity of services
- 3 - Did not like to be locked into provider network
- 4 - Admitted to out-of-network nursing home
- 5 - Did not like following approval process to obtain service
- 6 - Did not want to pay amount owed to plan
- 7 - No longer resides in service area
- 8 - Enrolled in another managed care program capitated by Medicaid, a hospice, a Home and Community Based Services (HCBS) Program, OMRDD Day Treatment or a Comprehensive Medicaid Case Management (CMCM) Program
- 9 - Absent from the plan's service area for more than 30 consecutive days (PACE w/o NYS DOH approval), 60 days (MLTC) or 90 days (MAPlus)
- 10 - Member/family/other informal care giver engaged in conduct or behavior which seriously impaired plan's ability to furnish services
- 11 - Physician refused to collaborate with the plan **(MLTC only)**
- 12 - Moved to new county, but denied continued enrollment by the new LDSS **(non-PACE)**
- 13 - Required nursing home care, but not institutionally eligible for Medicaid **(non-PACE)**

Member ID Number: _____

- 14 - Lost Medicaid Eligibility (**non-PACE**)
- 15 - Inpatient hospitalization for 45 days or longer (**MLTC Only**)
- 16 - Inpatient/resident of OMH/OMRDD/OASAS facility for 45 days or more (**MLTC Only**)
- 17 - No longer clinically eligible for nursing home level of care based on last clinical assessment of the calendar year
- 18 - Provided false information, deceived contractor or engaged in fraudulent conduct
- 19 - Knowingly failed to complete and submit necessary consent or release
- 20 - Other
- UK - Unknown

7. To be completed by S S W

OTHERS IN HOME/HOUSEHOLD: Indicate days/hours that these persons will provide care to patient.
If none will assist explain in narrative.

| | NAME | Age | Relationship | Days/Hours at Home | Days/Hours will Assist |
|----|------|-----|--------------|--------------------|------------------------|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |

8. To be completed by S S W

SIGNIFICANT OTHERS OUTSIDE OF HOME: Indicate days/hours when persons below will provide care to patient.

| | Name | Address | Age | Relationship | Days/Hours Assisting |
|----|------|---------|-----|--------------|----------------------|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |

9. To be completed by S S W

COMMUNITY SUPPORT: Indicate organization/persons serving patient at present or has provided a service in the past six (6) months.

| | Organization | Type of Service | Presently Receiving | Contact Person | Tel No. |
|----|--------------|-----------------|---------------------|----------------|---------|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |

10. To be completed by S S W and R.N.

PATIENT TRAITS:

| | Yes | No | ?N/A | If you check No. ?N/A, describe |
|--|-----|----|------|---------------------------------|
| Appears self directed and/or independent | | | | |
| Seems to make appropriate decisions | | | | |
| Can recall med routine/recent events | | | | |
| Participates in planning/treatment program | | | | |
| Seems to handle crises well | | | | |
| Accepts diagnosis | | | | |
| Motivated to remain at home | | | | |

11. To be completed by S S W and R.N. as appropriate
 FAMILY TRAITS:

| | Yes | No | ? | |
|--|-----|----|---|-------------------------------|
| a. Is motivated to keep patient home | | | | If no, because _____ |
| b. Is capable of providing care (physically & emotionally) | | | | If no, because _____ |
| c. Will keep patient home if not involved with care | | | | Because _____ |
| d. Will give care if support service given | | | | How much _____ |
| e. Requires instruction to provide care | | | | In what – who will give _____ |

12. To be completed by R.N.

| Home/Place where care will be provided: | Yes | No | ? | If problem, describe |
|--|-----|----|---|---|
| Neighborhood secure/safe | | | | |
| Housing adequate in terms of: Space | | | | |
| Convenient toilet facilities | | | | |
| Heating adequate and safe | | | | |
| Cooking facilities & refrigerator | | | | |
| Laundry facilities | | | | |
| Tub/shower/hot water | | | | |
| Elevator | | | | |
| Telephone accessible & usable | | | | |
| Is patient mobile in house | | | | |
| Any discernible hazards (please circle) | | | | Leaky gas, poor wiring, unsafe floors, steps, other (specify) |
| Construction adequate | | | | |
| Excess use of alcohol/drugs by patient/ caretaker; smokes carelessly. | | | | |
| Is patient's safety threatened if alone? | | | | |
| Pets | | | | |

ADDITIONAL ASSESSMENT FACTORS: _____

13. To be completed by R.N.
 RECOVERY POTENTIAL ANTICIPATED

| | | COMMENTS |
|---|--------------------------|----------|
| Full recovery | <input type="checkbox"/> | _____ |
| Recovery with patient management residual | <input type="checkbox"/> | _____ |
| Limited recovery managed by others | <input type="checkbox"/> | _____ |
| Deterioration | <input type="checkbox"/> | _____ |

**14. To be completed by R.N. – S S W to complete “D” as appropriate
FOR THE PATIENT TO REMAIN AT HOME – SERVICES REQUIRED**

WHO WILL PROVIDE

| SERVICES REQUIRED | YES | NO | TYPE/FREQ/DUR | AGENCY/FAMILY | AGENCY FREQUENCY |
|---|-----|----|---------------|---------------|------------------|
| A. Bathing | | | | | |
| Dressing | | | | | |
| Toileting | | | | | |
| Admin. Med. | | | | | |
| Grooming | | | | | |
| Spoon feeding | | | | | |
| Exercise/activity/walking | | | | | |
| Shopping (food/supplies) | | | | | |
| Meal preparation | | | | | |
| Diet Counseling | | | | | |
| Light housekeeping | | | | | |
| Personal laundry/household linens | | | | | |
| Personal/financial errands | | | | | |
| Other | | | | | |
| B. Nursing | | | | | |
| Physical Therapy | | | | | |
| Home Health Aide | | | | | |
| Speech Pathology | | | | | |
| Occupational Therapy | | | | | |
| Personal Care | | | | | |
| Homemaking | | | | | |
| Housekeeping | | | | | |
| Clinic/Physician | | | | | |
| Other 1. | | | | | |
| 2. | | | | | |
| C. Ramps outside/inside | | | | | |
| Grab bars/hallways/bathroom | | | | | |
| Commode/special bed/wheelchair | | | | | |
| Cane/walker/crutches | | | | | |
| Self-help device, specify | | | | | |
| Dressings/cath. equipment, etc. | | | | | |
| Bed protector/diapers | | | | | |
| Other | | | | | |
| D. Additional Services (Lab, O ² , medication) | | | | | |
| Telephone reassurance | | | | | |
| Diversion/friendly visitor | | | | | |
| Medical social service/counseling | | | | | |
| Legal/protective services | | | | | |
| Financial management/conservatorship | | | | | |
| Transportation arrangements | | | | | |
| Transportation attendant | | | | | |
| Home delivered meals | | | | | |
| Structural modification | | | | | |
| Other | | | | | |

15. To be completed by S S W and R.N

DMS Predictor Score _____ Override necessary Yes No

Can patient's health/safety needs be met through home care now? Yes No

If no, give specific reason why not _____

Institutional care required now? Yes No If yes, give specific reason why.

Level of institutional care determined by your professional judgment: SNF HRF DCF

Can the patient be considered at a later time for home care? Yes No N/A

16. To be completed by S S W

SUMMARY OF SERVICE REQUIREMENTS

Indicate services required, schedule and charges (allowable charge in area)

| Services | Provided by | Hrs./Days/Wk. | Date Effective | Est. Dur. | Unit Cost | Payment by | | | |
|-----------------------------|-----------------|---------------|----------------|-----------|-----------|------------|----|------|-------|
| | | | | | | MC | MA | Self | Other |
| Physician | | | | | | | | | |
| Nursing | | | | | | | | | |
| Home Health Aide | | | | | | | | | |
| Physical Therapy | | | | | | | | | |
| Speech Pathology | | | | | | | | | |
| Resp. Therapy | | | | | | | | | |
| Med. Soc. Work | | | | | | | | | |
| Nutritional | | | | | | | | | |
| Personal Care | | | | | | | | | |
| Homemaking | | | | | | | | | |
| Housekeeping | | | | | | | | | |
| Other (Specify) | | | | | | | | | |
| Medical Supplies/Medication | | | | | | | | | |
| 1. | | | | | | | | | |
| 2. | | | | | | | | | |
| 3. | | | | | | | | | |
| Medical Equipment | | | | | | | | | |
| 1. | | | | | | | | | |
| 2. | | | | | | | | | |
| 3. | | | | | | | | | |
| Home Delivered Meals | | | | | | | | | |
| Transportation | | | | | | | | | |
| Additional Services | | | | | | | | | |
| 1. | | | | | | | | | |
| 2. | | | | | | | | | |
| | SUBTOTAL | | | | | | | | |
| Structural Modification | | | | | | | | | |
| Other (Specify) | | | | | | | | | |
| 1. | | | | | | | | | |
| 2. | | | | | | | | | |

SUBTOTAL _____

TOTAL COST _____

17. To be completed by S S W and R.N.

Person who will relieve in case of emergency

| Name | Address | Telephone | Relationship |
|------|---------|-----------|--------------|
|------|---------|-----------|--------------|

Narrative: Use this space to describe aspects of the patients care not adequately covered above.

| | | |
|--------------------------|-----------------|---------------|
| Assessment completed by: | _____ | _____ |
| | R.N. | Agency |
| | _____ | _____ |
| | Date Completed | Telephone No. |
| | _____ | _____ |
| | Local DSS Staff | District |
| | _____ | _____ |
| | Date Completed | Telephone No. |
| | _____ | _____ |
| | Supervisor DSS | District |
| | _____ | _____ |
| | Date | Telephone No. |

Authorization to provide services: _____
Local DSS Commissioner or Designee Date

NEW YORK STATE DEPARTMENT OF HEALTH
LONG TERM CARE PLACEMENT FORM
MEDICAL ASSESSMENT ABSTRACT

CURRENT PAT. LOCATION

- HOSP DCF
 SNF HOME CARE
 HRF OTHER
 SPECIFY _____

REASON FOR PREPARING FORM

- DISCHARGE/TRANSFER TO _____
 ADMISSION FROM _____
 REVIEW FOR PERIOD FROM _____ TO _____
 MEDICAID REVIEW DEATH
 OTHER. SPECIFY _____

PREDICTOR SCORE

PATIENT NAME LAST FIRST M.I. STREET CITY STATE ZIP SEX
 MALE
 FEMALE

| PATIENT NUMBERS | PATIENT DATES | PROVIDER INFO |
|--------------------------|---------------------------------|--|
| S.S. NO. _____ | DATE OF BIRTH _____ AGE _____ | NAME _____ |
| MEDICARE NO. _____ | DATE OF LATEST HOSP. STAY _____ | ADDRESS _____ |
| MEDICAID NO. _____ | FROM _____ | MEDICAID NO. _____ |
| SOC. SERVICE DIST. _____ | TO _____ | MEDICARE NO. _____ |
| MEDICAL RECORD NO. _____ | DATE THIS ADMISSION _____ | DOES PATIENT HAVE PRIVATE INSURANCE? NO <input type="checkbox"/> YES <input type="checkbox"/> |
| ROOM NO. _____ | RESPONSIBLE PHYSICIAN _____ | |

MEDICAL COVERAGE: PATIENT'S CONDITION AND TREATMENT REQUIRING SKILLED SUPERVISION (ALL ITEMS MUST BE COMPLETED)

1. A. DIAGNOSIS OCCASIONING CURRENT USE OF SERVICES:

PRIMARY _____
 OTHER _____
 OTHER _____
 OTHER _____

2. LIST SIGNIFICANT MEDS/INJECTIONS:
(FOR PARENTERAL MEDS ALSO CHECK ITEM 3A)

MED DOSE FREQUENCY ROUTE

B. NATURE OF SURGERY _____ DATE _____
 C. IF PATIENT HAD CVA/MI SPECIFY _____ DATE _____
 D. ALLERGIES OR SENSITIVITIES, SPECIFY _____

3. A. NURSING CARE & THERAPY

| (SPECIFY DETAILS IN 3D, 3E, OR ATTACHMENT) | FREQUENCY | | | SELF CARE | | CAN BE TRAINED | |
|--|-----------|-----------|-----------------|-------------|--------|----------------|--------|
| | NONE | DAY SHIFT | NIGHT/EVE SHIFT | Y E S | N O | YES | |
| | | | | | | Y E S | N O |
| PARENTERAL MEDS | | | | | | | |
| INHALATION TREATMENT | | | | | | | |
| OXYGEN | | | | | | | |
| SUCTIONING | | | | | | | |
| ASEPTIC DRESSING | | | | | | | |
| LESION IRRIGATION | | | | | | | |
| CATH/TUBE IRRIGATION | | | | | | | |
| OSTOMY CARE | | | | | | | |
| PARENTERAL FLUID | | | | | | | |
| TUBE FEEDINGS | | | | | | | |
| BOWEL/BLADDER REHAB | | | | | | | |
| BEDSORE TREATMENT | | | | | | | |
| OTHER (DESCRIBE) | | | | | | | |
| | | | | | | | |
| | | | | | | | |

3. D. IS THE PATIENT'S CONDITION UNSTABLE SO THAT AN R.N. MUST DETECT/EVALUATE NEED FOR MODIFICATIONS OF TREATMENT/CARE ON A DAILY BASIS?

NO YES

IF YES, DESCRIBE INSTABILITY AND SPECIFIC NEED FOR NURSING SUPERVISION, VITAL SIGNS RANGES, LAB VALUES, SYMPTOMS, ETC.

E. IS THERE HIGH PROBABILITY THAT COMPLICATIONS WOULD ARISE IN CARING FOR THE PATIENT WITHOUT SKILLED NURSING SUPERVISION OF THE TREATMENT PROGRAM ON A DAILY BASIS?

NO YES

IF YES, DESCRIBE (a) PATIENT'S CONDITION REQUIRING SKILLED NURSING SUPERVISION (b) THE AGGREGATE OF SERVICES TO BE PLANNED AND MANAGED IN THE TREATMENT PROGRAM. INDICATE SERVICES NEEDED AND POTENTIAL DANGERS OF COMPLICATING CLINICAL FACTORS.

B. INCONTINENT

URINE: OFTEN* SELDOM** NEVER FOLEY
 STOOL: OFTEN* SELDOM** NEVER

C. DOES PATIENT NEED SPECIAL DIET?

NO YES

IF YES, DESCRIBE _____

*MORE THAN ONCE A WEEK

**ONCE A WEEK OR LESS

F. CIRCLE THE MINIMUM NUMBER OF DAYS/WEEKS OF COMPLEX SKILLED NURSING SUPERVISION:

REQUIRES

RECEIVES

0 1 2 3 4 5 6 7

0 1 2 3 4 5 6 7

| 4. FUNCTION STATUS | SELF CARE | SOME HELP | TOTAL HELP | CAN NOT | REHAB* POTEN. |
|------------------------|-----------|-----------|------------|---------|---------------|
| WALKS WITH OR W/O AIDS | | | | | |
| TRANSFERRING | | | | | |
| WHEELING | | | | | |
| EATING/FEEDING | | | | | |
| TOILETING | | | | | |
| BATHING | | | | | |
| DRESSING | | | | | |

| 5. MENTAL STATUS | NEVER | SOME-TIMES | ALWAYS | | REHAB* POTEN. |
|-----------------------|-------|------------|--------|--|---------------|
| ALERT | | | | | |
| IMPAIRED JUDGEMENT | | | | | |
| AGITATED (NIGHTTIME) | | | | | |
| HALLUCINATES | | | | | |
| SEVERE DEPRESSION** | | | | | |
| ASSAULTIVE | | | | | |
| ABUSIVE | | | | | |
| RESTRAINT ORDER | | | | | |
| REGRESSIVE (BEHAVIOR) | | | | | |
| WANDERS | | | | | |
| OTHER (SPECIFY) | | | | | |

| 6. IMPAIRMENTS | NONE | PARTIAL | TOTAL | | REHAB* POTEN. |
|------------------------|------|---------|-------|--|---------------|
| SIGHT | | | | | |
| HEARING | | | | | |
| SPEECH | | | | | |
| COMMUNICATIONS | | | | | |
| OTHER(CONTACTURES,ETC) | | | | | |
| SPECIFY | | | | | |

7. SHORT TERM REHAB THERAPY PLAN
(TO BE COMPLETED BY THERAPIST)

| A. DESCRIPTION OF CONDITION (NOT DX) NEEDING INTERVENTION | SHORT TERM PLAN OF TREATMENT AND EVALUATION & PROGRESS IN LAST 2 WEEKS | ACHIEVEMENT DATE |
|---|--|------------------|
| | | |

B. CIRCLE MINIMUM NUMBER OF DAYS/WEEK OF SKILLED THERAPY FROM EACH OF THE FOLLOWING:

| REQUIRES | | RECEIVES |
|-----------------|--------|-------------|
| 0 1 2 3 4 5 6 7 | PT | 0 1 2 3 4 5 |
| 0 1 2 3 4 5 6 7 | OT | 0 1 2 3 4 5 |
| 0 1 2 3 4 5 6 7 | SPEECH | 0 1 2 3 4 5 |

8. DO THE WRITTEN ORDERS OF THE ATTENDING PHYSICIAN AND PLAN OF CARE DOCUMENT THAT THE ABOVE NURSING AND THERAPY ARE NECESSARY? NO YES
9. A. SHOULD THE PATIENT BE CONSIDERED FOR ANOTHER LEVEL OF CARE? NO YES IF YES: WHEN? _____ WHAT LEVEL? _____
- B. AS A PRACTICAL MATTER, COULD PATIENT BE CARED FOR AS AN OUTPATIENT? NO YES
- C. AS A PRACTICAL MATTER, COULD PATIENT BE CARED FOR UNDER HOME CARE? NO YES IF YES TO ANY OF ABOVE, ATTACH A DISCHARGE PLAN.
10. SHOULD THE PATIENT/RESIDENT BE MEDICALLY QUALIFIED FOR SNF CARE? COVERED QUESTIONABLE NON-COVERED **
11. ADDITIONAL COMMENTS ON PATIENT CARE PLAN/REHAB POTENTIAL: _____

12. I CERTIFY, TO THE BEST OF MY INFORMATION AND BELIEF, THAT THE INFORMATION ON THIS FORM IS A TRUE ABSTRACT OF THE PATIENT'S CONDITION AND MEDICAL RECORD.

(SIGNATURE OF DESIGNATED R.N. AND TITLE) DATE ASSESS. COMPLETED _____
TO BE COMPLETED BY U.R. AGENT OR REPRESENTATIVE UPON CONTINUED STAY REVIEW

13. ADDITIONAL INFORMATION BY U.R. REPRESENTATIVE _____ 15. U.R. REPRESENTATIVE: PLACEMENT _____
SIGNATURE _____ DATE _____

14. NEXT SCHEDULED REVIEW DATE _____ 16. U.R. PHYSICIAN: PLACEMENT _____
SIGNATURE _____ DATE _____

NEW YORK STATE DEPARTMENT OF HEALTH-OFFICE OF HEALTH SERVICES

TRANSFER FORM/PHYSICIAN ORDERS

| | | | |
|---|-----------------|---|-------------------------|
| Service Request to Name: Address: Phone: | | Date of Request: _____ | |
| | | <input type="checkbox"/> Long Term Home Health Program <input type="checkbox"/> Home Health Care Services | |
| | | Social Services District: Broome | |
| *PLEASE NOTE* IN ACCORDANCE WITH DEPARTMENT REGULATIONS, SECTION 504.14, PHYSICIANS' ORDERS SHALL BE BASED ON THE PATIENT'S CURRENT MEDICAL STATUS AS DETERMINED BY A MEDICAL EXAMINATION WITHIN 30 DAYS OF THE REQUEST FOR CARE | | | |
| Name of Patient: | | Date of Birth: | Sex: |
| | | | Social Security Number: |
| For Home Services Visit at (Address): | | Tel No. | |
| | | Medicare A Number: | |
| Care of (Name): | | Medicare B Number: | |
| Transfer From: | | Plan Relates To Condition For Which Patient Institutionalized | |
| Address: | | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A | |
| Contact Person of Referring Agency – Name and Title | | Tel. No. 778-2420 | |
| Name and Address of M.D. to Render Care | | License Number/State | |
| Diagnosis (include surgery and dates) Primary: | | Code: | |
| Secondary: | | Code: | |
| Physicians Certification of Need and Frequency | | Physicians Orders – Medications, Diet, Treatments, Equipment and Supplies, Activities, Instructions | |
| <input type="checkbox"/> Nursing | x/week or month | Prognosis _____ Therapeutic Goal(s) _____ Is Patient Essentially Homebound? <input type="checkbox"/> Yes <input type="checkbox"/> No Estimate of Patients Need for Home Health: Svs. _____ Wks. _____ Mos. _____ | |
| <input type="checkbox"/> Home Health Aide | x/week or month | | |
| <input type="checkbox"/> Physical Therapy | x/week or month | | |
| <input type="checkbox"/> Occupational Therapy | x/week or month | | |
| <input type="checkbox"/> Speech Pathology | x/week or month | | |
| <input type="checkbox"/> Medical Social Services | x/week or month | | |
| <input type="checkbox"/> Personal Care | x/week or month | | |
| <input type="checkbox"/> Other (Specify): | | | |
| M.D. Signature | Date | M.D. Name | License Number/State |
| Professional Assessment and Recommendations (Functional Limitations, Psycho-Social Status, Allergies) | | | |
| | | | |
| | | | |
| | | | |
| Signature: | | Title: | |



MEDICAL REQUEST FOR HOME CARE

GSS District Office _____ Attn: Case Load No. _____
 Address _____ Boro _____
 Zip Code _____ Tel. No. _____

Date Returned to/Received by GSS

FOR GSS USE ONLY

RETURN COMPLETED FORM TO:

1. CLIENT INFORMATION

| | | | | | |
|--|--------------------|-----------|------------------------|----------|------------------|
| PATIENT'S NAME (LAST NAME, FIRST NAME) | | BIRTHDATE | SOCIAL SECURITY NUMBER | | MEDICAID NO. |
| HOME ADDRESS (No. & Street) | | | BORO | ZIP CODE | TELEPHONE NO. |
| Hospital/Clinic Chart No. | II. MEDICAL STATUS | | Contact Person | | Contact Tel. No. |

PATIENT'S MEDICAL RELEASE: I hereby authorize all physicians and medical providers to release any information acquired in the course of my examination of treatment to the New York City HRA/ Dept. of Social Services in connection with my request for home care.

DATE: _____ SIGNATURE(X) _____

How long have you treated the patient? _____ Date of this examination: _____ Place of this Examination: _____ Date of next examination: _____

A. CURRENT CONDITION

DATE OF ONSET _____

Check(✓) prognosis of each

| | Anticipated Recovery 6 months (✓) | Chronic Condition (✓) | Deterioration of Present Function Level (✓) |
|--|-----------------------------------|-----------------------|---|
| 1. PRIMARY DIAGNOSIS/ ICD CODE _____ | | | |
| 2. SECONDARY DIAGNOSIS/ ICD CODE _____ | | | |
| 3. _____ | | | |
| 4. _____ | | | |
| 5. _____ | | | |

B. HOSPITAL INFORMATION

CURRENTLY IN: (Hospital Name) _____

ADMISSION DATE: _____

Reason for HOSPITALIZATION: _____

EXPECTED DATE OF DISCHARGE: _____

C. MEDICATION

| | DOSAGE | ORAL OR PARENTERAL | FREQUENCY |
|----|--------|--------------------|-----------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |

INDICATE PATIENT'S ABILITY TO TAKE MEDICATION: (*)

- 1. can self-administer
- 2. needs reminding
- 3. needs supervision
- 4. needs help with preparation
- 5. needs administration

(*) If patient CANNOT self-administer medication

(a) can he/she be trained to self-administer medication? Yes No If No, indicate why not: _____

(b) What arrangements have been made for the administration of medications? _____

D. IMPAIRMENT Does the patient have any of the following impairments? Yes No
If there is an impairment, indicate by check (✓) type and degree of impairment:

| SENSORY IMPAIRMENT | | MUSCULAR/MOTOR IMPAIRMENT | | CARDIOVASCULAR/RESPIRATORY IMPAIRMENT | |
|--------------------------|--------------------------|---------------------------|--------------------------|---------------------------------------|--------------------------|
| | PARTIAL | TOTAL | | PARTIAL | TOTAL |
| 1. Speech | <input type="checkbox"/> | <input type="checkbox"/> | 1. Dominant hand/arm | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Sight | <input type="checkbox"/> | <input type="checkbox"/> | 2. Other hand/arm | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Hearing | <input type="checkbox"/> | <input type="checkbox"/> | 3. Muscular Coordination | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Upper Extremities | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Lower Extremities | <input type="checkbox"/> | <input type="checkbox"/> |
| ELIMINATION (Check ✓) | | | | | |

| | Continent | Occasionally Incontinent | Incontinent |
|---------|-----------|--------------------------|-------------|
| Bladder | | | |
| Bowel | | | |

Indicate reason for incontinence and what is currently being done:

E. MENTAL STATUS – Does the patient exhibit any of the following? Yes No

If Yes, check appropriate boxes.

| | Some-times | Always | | Some-times | Always | | Some-times | Always | | Some-times | Always |
|------------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|
| 1. Disoriented to place/time | <input type="checkbox"/> | <input type="checkbox"/> | 4. Short-term memory impairment | <input type="checkbox"/> | <input type="checkbox"/> | 7. Impaired judgment | <input type="checkbox"/> | <input type="checkbox"/> | 10. Communication problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Anxiety | <input type="checkbox"/> | <input type="checkbox"/> | 5. Wandering | <input type="checkbox"/> | <input type="checkbox"/> | 8. Danger to others | <input type="checkbox"/> | <input type="checkbox"/> | 11. Sleep Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Agitation | <input type="checkbox"/> | <input type="checkbox"/> | 6. Depression | <input type="checkbox"/> | <input type="checkbox"/> | 9. Danger to Self | <input type="checkbox"/> | <input type="checkbox"/> | 12. Abusive | <input type="checkbox"/> | <input type="checkbox"/> |

Describe the nature, frequency and effect on client's functioning for any area checked.
Attach additional documentation if necessary.

Is patient alert? Always Sometimes Never

Can patient direct a home care worker? Yes No If No, explain below.

MEDICAL TREATMENT Does the patient need any of the following medical treatment? Yes No
Indicate medical treatment needed: (✓)

| | |
|--|--|
| 1. Decubitus Care | |
| 2. Dressings: Sterile Simple | |
| 3. Bed bound care (turning, exercising, positioning) | |
| 4. Ambulation exercise | |
| 5. ROM/Therapeutic exercise | |
| 6. Enema | |

| | |
|---------------------------|--|
| 7. Colostomy care | |
| 8. Ostomy care | |
| 9.. Oxygen administration | |
| 10. Catheter care | |
| 11. Tube irrigation | |
| 12. Monitor vital signs | |
| 13. Tube feedings | |
| 14. Inhalation therapy | |

| | |
|--|--|
| 15. Suctioning | |
| 16. Speech/hearing/ therapy | |
| 17. Occupational therapy | |
| 18. Rehabilitation therapy | |
| 19. Indicate any special dietary needs | |
| 20. Other | |

For each treatment checked, indicate frequency recommended, how the service is currently being provided and what plans have been made to provide the service in the future: (Attach additional documentation as necessary.)

G. EQUIPMENT/SUPPLIES

Please indicate which equipment/supplies the client has, needs or has been ordered.

| | Has | Needs | Ordered | | Has | Needs | Ordered | | Has | Needs | Ordered |
|--------------|-----|-------|---------|------------------|-----|-------|---------|-----------------|-----|-------|---------|
| Cane | | | | Bedpan/Urinal | | | | Bath Bar | | | |
| Crutches | | | | Commode | | | | Bath Seat | | | |
| Walker | | | | Diapers | | | | Grab Bar | | | |
| Wheelchair | | | | Hoyer Lift | | | | Shower Handle | | | |
| Hospital Bed | | | | Dressings | | | | Other (Specify) | | | |
| Side Rails | | | | Respiratory Aids | | | | | | | |

If any needed equipment was not ordered, what other plans have been made to meet this need?

III. IDENTIFICATION OF SERVICE NEEDS

A. Indicate ability to ambulate/transfer:

| | Can | Cannot | Can with assistance of: | | | | (Specify) |
|--------------------------------|-----|--------|-------------------------|--------|--------|--------|-----------|
| | | | Cane | Walker | Person | Other: | |
| 1. Ambulate inside | | | | | | | |
| 2. Ambulate outside | | | | | | | |
| 3. Get up from seated position | | | | | | | |
| 4. Get up from bed | | | | | | | |
| 5. Transfer to commode | | | | | | | |
| 6. Transfer to wheelchair | | | | | | | |

B. Indicate any services needed (✓)

A. CHORE SERVICES:

- Cleaning
 Laundry
 Reheat Meals
 Meal Prep
 Shopping

B. PERSONAL CARE SERVICES:

- | | Partial | Total | | Partial | Total |
|-------------|--------------------------|--------------------------|--------------------------------|--------------------------|--------------------------|
| 1. Grooming | <input type="checkbox"/> | <input type="checkbox"/> | 5. Feeding | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Dressing | <input type="checkbox"/> | <input type="checkbox"/> | 6. Toileting: Bedpan | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Washing | <input type="checkbox"/> | <input type="checkbox"/> | Commode | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Bathing | <input type="checkbox"/> | <input type="checkbox"/> | 7. Other special toilet needs: | | |

IV. REFERRALS

Has a referral been made to any of these agencies: Certified Home Health Agency, Hospital-Based Home Care Agency, a Health Related Facility (HRF), a Skilled Nursing Facility (SNF) or the Lombardi Program?

Yes * No

*Identify AGENCY

SERVICE

STATUS OF SERVICE

REFERRAL DATE

HOME CARE SOCIAL ASSESSMENT

| | | | | |
|-------------|-------------|---------|------------------|--|
| Office/CASA | Worker I.D. | Liaison | Telephone Number | Assessment Date(s) Telephone Home Visit |
|-------------|-------------|---------|------------------|--|

Reason For Preparation Initial Assessment Reauthorization Change

SOURCE OF REFERRAL:
(Name/Agency) _____ Telephone Number: _____

I. CLIENT INFORMATION

A. Primary Client

| | | | | | | | |
|--|------------|------------------------------|-----------|----------------------------------|--------------------------|------------------------------------|--------------------------|
| Client's Surname | First Name | M.I. | Age | Sex | Birthdate | Social Security No. | Client I.D. Number (CIN) |
| Medicare Number: _____ | | Third Party Insurance: _____ | | Primary <input type="checkbox"/> | | Secondary <input type="checkbox"/> | |
| Part B <input type="checkbox"/> Yes <input type="checkbox"/> No | | Insurance Company: _____ | | Certification Number: _____ | | | |
| Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Separated | | Subscriber's Name: _____ | | Group Number: _____ | | | |
| <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced | | | | | | | |
| Mutual Client(s) (if any) | Age | Sex | Birthdate | Social Security No. | Client I.D. Number (CIN) | | |
| B. Permanent Address (No. & Street) | | | Apt. | Borough | Zip Code | Telephone Number | |

C. Current Location (Assessment Site) IF DIFFERENT FROM ABOVE PERMANENT ADDRESS:

| | | | |
|----------------------------|---------------|----------|------------------|
| Hospital/Facility/Relative | Temp. Address | Zip Code | Telephone Number |
|----------------------------|---------------|----------|------------------|

If Health Facility, Date Admitted: ____/____/____ Date of Expected Discharge: ____/____/____

D. Languages Spoken/Understood: Primary: English Other: _____ Mutual: English Other: _____

E. OTHER INSTITUTIONS/PROFESSIONALS SERVING CLIENT(S) (Hospitals, Physicians, Clinics, etc.)

| | |
|--------------------------|------------------------------|
| Name/Health Care Source: | Contact Person: |
| Address: | Zip Code: Telephone No: |

F. Others Present At Interview:

| | |
|-------|---------------|
| Name: | Relationship: |
| Name: | Relationship: |

G. List Everyone In Home Not Requiring Service:

| | | |
|-------|------|---------------|
| Name: | Age: | Relationship: |
| Name: | Age: | Relationship: |

H. Person to Notify in an Emergency:

| | |
|-------------------------------|------------------------|
| Name: | Relationship: |
| Address: City: ZIP: | Home No. Work No. |

I. Protective Payee None

| | | |
|----------|------------------------|---------------|
| Name: | Relationship: | Home Tel. No. |
| Address: | Work Telephone Number: | |

II. LIVING ARRANGEMENTS

HOUSING TYPE: Cluster Care Site Yes No Consolidated Site Yes No
 Apt. House Hotel Other: _____ Can Sleep-In be Accommodated? Yes No
 1 Family House Furnished Room Walk-up _____
 2-4 Family House Sr. Citizen Housing (floor) _____
No. Of Rooms: _____

Wheelchair access inside? Yes No Outside to street? Yes No

Heavy-duty cleaning needed? Yes No Completed Yes No

| | | | |
|--|--|--|--|
| Landlord's Name | | Telephone No. | |
| Address | | | |
| SERVICES AVAILABLE: <input type="checkbox"/> Laundry <input type="checkbox"/> Linens <input type="checkbox"/> Cleaning Services <input type="checkbox"/> Meals <input type="checkbox"/> B <input type="checkbox"/> L <input type="checkbox"/> D <input type="checkbox"/> ALL | | FACILITIES: <input type="checkbox"/> Heat <input type="checkbox"/> Hot Water <input type="checkbox"/> Sink <input type="checkbox"/> Shower/Tub <input type="checkbox"/> Toilet <input type="checkbox"/> Own <input type="checkbox"/> Share Working Smoke Detector? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| <input type="checkbox"/> Refrigerator | | <input type="checkbox"/> Cooking Facil. | |
| <input type="checkbox"/> Washing Machine | | <input type="checkbox"/> Dryer | |
| <input type="checkbox"/> Air Conditioner | | <input type="checkbox"/> Elevator | |
| OTHER: (Specify) | | | |

DESCRIBE OVERALL HOME CONDITIONS (cleanliness, physical condition, type of pets, etc.)

Is rent payment current? Yes No If no, how much rent is owed and for what period? \$ _____

III. CLIENT PROFILE

A. PRESENTING PROBLEMS - Why are home care services needed at this time? Change in medical status - Change in financial status - Change in social status/support systems

Explain changes that precipitated this need and how client(s) managed prior to request:

B. DESCRIBE THE CLIENT(S), IN ALL OF THE FOLLOWING AREAS, IN NARRATIVE FORM:

1. APPEARANCE: _____

2. ALERTNESS/RESPONSIVENESS: _____

3. PERCEPTION OF CIRCUMSTANCES AND PREFERENCES/MOTIVATION: _____

4. ABILITY/DESIRE TO COMMUNICATE: _____

5. ABILITY TO MANAGE FINANCIAL AFFAIRS: _____

6. ABILITY TO DIRECT: _____

C. CAPACITY FOR SELF-DIRECTION - Can client make choices, regarding ADLs, understand impact of choice and assume responsibility for the choice?

IV. SUPPORT SYSTEMS

Evaluation of persons who are currently providing any informal support or assistance (telephone service, chores, assistance with daily living, etc.) or who may potentially provide informal support or assistance.

A. RELATIVES AND OTHER SIGNIFICANT ADULTS LIVING IN THE HOME WITH THE CLIENT:

| Last Name | First Name | Relationship | Age | Date Contacted | Can Assist in Emerg. <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---------------------|------------|--------------------------|-----|----------------|--|
| Tasks Now Performed | | Tasks That Could Be Done | | | Needs Training <input type="checkbox"/> Yes <input type="checkbox"/> No |

Ability and Motivation to Assist in Care _____

Extent of Potential Involvement _____

Availability for Future Assistance _____

Acceptability to Client of Informal Support's Involvement in His/Her Care _____

A. RELATIVES AND OTHER SIGNIFICANT ADULTS LIVING IN THE HOME WITH THE CLIENT:

| Last Name | First Name | Relationship | Age | Date Contacted | Can Assist in Emerg. <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---------------------|------------|--------------------------|-----|--|--|
| Tasks Now Performed | | Tasks That Could Be Done | | Needs Training <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Ability and Motivation to Assist in Care _____

Extent of Potential Involvement _____

Availability for Future Assistance _____

Acceptability to Client of Informal Support's Involvement in His/Her Care _____

B. RELATIVES/FRIENDS/AGENCIES AND OTHER ADULTS NOT IN THE HOME:

| | | | | |
|-------------------------|------------------|-----------------|--|--|
| Name (Person or Agency) | Telephone Number | Relationship | Date Contacted | Can Assist in Emerg. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Address | | Tasks Performed | Needs Training <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Ability and Motivation to Assist in Care _____

Extent of Potential Involvement _____

Availability for Future Assistance _____

Acceptability to Client of Informal Support's Involvement in His/Her Case _____

B. RELATIVES/FRIENDS/AGENCIES AND OTHER ADULTS NOT IN THE HOME: (cont.)

| | | | | | |
|---------------------|------------|--------------------------|-----|--|--|
| Last Name | First Name | Relationship | Age | Date Contacted | Can Assist in Emerg. <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Tasks Now Performed | | Tasks That Could Be Done | | Needs Training <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Ability and Motivation to Assist in Care _____

Extent of Potential Involvement _____

Availability for Future Assistance _____

Acceptability to Client of Informal Support's Involvement in his or her Care _____

V. SERVICES

If client is currently attending or receiving any services listed below, enter the Provider's name, address and telephone number. If client needs any listed services, check "Needs" column and enter date referred.

| | Name | Address | Telephone No. | Needs | IF NEEDED | |
|--------------------|------|---------|---------------|-------|---------------|-----------------|
| | | | | | Date Referred | Date of Service |
| Senior Center | | | | | | |
| Adult Day Care | | | | | | |
| Meals on Wheels | | | | | | |
| Hospice | | | | | | |
| Transportation | | | | | | |
| Recreation Program | | | | | | |

B. PERSONAL CARE

Is client being currently assisted by personal care worker? YES NO - If yes, indicate name of worker, name of agency, if any, address, telephone number, # of hours daily and # of days service is provided, who pays for service, and relationship to client.

Name of Worker: _____ Name of Agency: _____

Telephone # _____ Hours of Care: _____

Name of Person Paying for Service and Relationship: _____

Telephone # of Person Paying for Service: _____

| NAME | SIGNATURE | CASELOAD | TELEPHONE NUMBER | DATE |
|--------------------|-----------|----------|------------------|------|
| 1. Case Manager | | | | |
| 2. Team Supervisor | | | | |

NURSE'S ASSESSMENT VISIT REPORT

| | | | |
|---|--|---|--------------------------|
| Field Office: | | Case Manager: | |
| 1A. Client's Name: Birthdate: | | <input type="checkbox"/> If Mutual Case, other Client's Name: S.S # | |
| Address: Apt. # Floor: | | Social Security # Medicaid # | |
| | | Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No Medicare # | |
| ASSESSMENT AGENCY: <input type="checkbox"/> Home Attendant <input type="checkbox"/> Housekeeper <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Other | | Billable Hours Per Week: Authorized Hours Per Week: | |
| | | Recommendation for Authorization of Services (in hours) <input type="checkbox"/> Start <input type="checkbox"/> Continue <input type="checkbox"/> Increase Tasks <input type="checkbox"/> Deny <input type="checkbox"/> Decrease Tasks <input type="checkbox"/> Discontinue | |
| PRESENT AT INTERVIEW: <input type="checkbox"/> HA <input type="checkbox"/> HK <input type="checkbox"/> HHA <input type="checkbox"/> Relative/Friend | | RECOMMENDED LEVEL OF CARE <input type="checkbox"/> Home Attendant <input type="checkbox"/> Home Health Aide <input type="checkbox"/> Housekeeper <input type="checkbox"/> Other | |
| Source of Information: Contact Person: Telephone #: | | PURPOSE OF VISIT: <input type="checkbox"/> Initial <input type="checkbox"/> Reassessment <input type="checkbox"/> Change | |
| B. DIAGNOSIS: Primary: ICD-9 CODE Secondary: If Available | | Significant Symptoms: Vital Signs: | |
| CLIENT PRIMARY MEDICAL PROVIDER: Name: Telephone #: | | Regularly Scheduled Appointments-Day/Time-Frequency | |
| IIA. IMPAIRMENTS: | | YES | NO |
| Speech | | <input type="checkbox"/> | <input type="checkbox"/> |
| Dom. Hand/Arm | | <input type="checkbox"/> | <input type="checkbox"/> |
| Other Hand/Arm | | <input type="checkbox"/> | <input type="checkbox"/> |
| Lower Extremities | | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Function | | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory Function | | <input type="checkbox"/> | <input type="checkbox"/> |
| Obesity | | <input type="checkbox"/> | <input type="checkbox"/> |
| COMMENTS: | | | |
| | | | |
| | | | |
| | | | |
| ADDITIONAL FUNCTIONAL IMPAIRMENTS | | | |
| B. BLADDER CONTROL <input type="checkbox"/> Continent <input type="checkbox"/> Sometimes Incontinent <input type="checkbox"/> Totally Incontinent <input type="checkbox"/> Catheter Indicate Type <input type="checkbox"/> Indwelling <input type="checkbox"/> Texas Frequency: Urgency: | | BOWEL CONTROL <input type="checkbox"/> Continent <input type="checkbox"/> Sometimes Incontinent <input type="checkbox"/> Totally Incontinent <input type="checkbox"/> Ostomy Frequency: Urgency: | |
| C. SIGHT: <input type="checkbox"/> Total Blindness <input type="checkbox"/> Legally Blind <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses | | HEARING: <input type="checkbox"/> Total Deafness <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Lip Reading <input type="checkbox"/> Can Interpret Loudness | |

NURSE'S ASSESSMENT VISIT REPORT

| | | | | | |
|---|--------------------------|--------------------------|---|--------------------------|---|
| III. A. MOBILITY | Can Indep. | Can W/ Mech Aid | Can W/Aid of Person | Can- not | B. CLIENT ENDURANCE |
| Walk or Wheel Inside | | | | | <input type="checkbox"/> Tolerates Distances(250Ft +) |
| Walk or Wheel Outside | | | | | <input type="checkbox"/> Needs Intermittent Rest |
| Get Up From Seated Position | | | | | <input type="checkbox"/> Barely Tolerates Short Activities |
| Get Up From Bed | | | | | <input type="checkbox"/> No Tolerance |
| Transfer To Commode | | | | | TELEPHONE USAGE |
| Transfer To Wheelchair | | | | | Is Client Able to Use Telephone |
| Use Bedpan | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No, Explain |
| C. CLIENT PREFERENCES FOR SERVICE | | | D. CLIENT STATUS VARIATIONS DURING DAY | | |
| HOURS AND ACTIVITIES: Use 24:00 Hour Clock | | | Include Any Peak Periods Of Functioning(e.g. Early Or Later In Day) | | |
| Rise Time | _____ | | | | |
| Breakfast | _____ | | | | |
| Bathing | _____ | | | | |
| Lunch | _____ | | | | |
| Dinner | _____ | | | | |
| Bedtime | _____ | | | | |
| IV. A. MENTAL STATUS | YES | NO | COMMENTS | | |
| Oriented To Time, Person, Place | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Alert | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Able To Learn | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Able To Direct Worker | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Able To Manage Affairs | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Impaired Recent Memory | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Agitated | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Wanders If Unsupervised | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Depressed | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| Anxious | <input type="checkbox"/> | <input type="checkbox"/> | _____ | | |
| B. JUDGEMENT: | | | Appropriate | Fair | Inappropriate |
| What If Your Home Attendant Could Not Get Here | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| What Would You Do If There Was A Fire While You Were Alone? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| What Would You Do If You Were Alone And You Got Chest Pain That Would Not Go Away? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If Someone Rings Your Bell, What Do You Do? | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If Any Evidence Of The Following, Please Describe. Include Source Of Information And Indicate Action Taken And Recommended Follow-up: | | | | | |
| <input type="checkbox"/> Verbally Abusive | | | | | |
| <input type="checkbox"/> Physically Assaultive | | | | | |
| <input type="checkbox"/> Suicidal Ideation | | | | | |
| <input type="checkbox"/> Self-Endangering Behavior | | | | | |
| <input type="checkbox"/> Known Psychiatric Disorder | | | | | |

NURSE'S ASSESSMENT VISIT REPORT

| | | | | | | | |
|--|-----------|----------|---|---|--|-------|---|
| V. FUNCTIONAL AIDS What Functional Aids Does Client Have: | | | | | | | |
| Are Functional Aids Being Used Correctly? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Specify _____ | | | | | | | |
| What Functional Aids Does Client Need And Not Have? _____ Have They Been Ordered? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | | |
| Name of Supplier: _____ | | | | | | | |
| VI. A. SKILLED NEEDS: Does Client Need Any Of The following? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Specify Frequency and Provider | | | B. ADDITIONAL SERVICES/REFERRAL: Indicate Whether The Client Should Be Referred For, Or Is Receiving The Following: | | | | |
| | Frequency | Provider | | Referral Needed <input type="checkbox"/> Yes <input type="checkbox"/> No | Receiving Services <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Decubitus Care | | | Psychiatric Evaluation | _____ | _____ | | |
| Sterile Dressings | | | Rehabilitation Therapy | _____ | _____ | | |
| ROM/Therapeutic Exercises | | | Other: | | | | |
| Enema | | | | | | | |
| Ostomy Care | | | C. CURRENT MEDICATIONS | | | | |
| Oxygen Administration | | | Medication | Dosage | Frequency | Route | Can Client Self Administer? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Respiratory Therapy | | | | | | | |
| Catheter Irrigation/Insertion | | | | | | | |
| Tube Irrigation | | | | | | | |
| Tube Feeding | | | | | | | |
| Suctioning | | | | | | | |
| Monitor Vital Signs | | | | | | | |
| Other : | | | | | | | |
| | | | Does Medication Need To Be Prepared For Client? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Who Will Prepare? _____ | | | | |
| COMMENTS: | | | | | | | |

NURSE'S ASSESSMENT VISIT REPORT

VII. RECOMMENDED PLAN OF CARE: Indicate The Personal Care Services Required By The Client, Using The Following Codes To Identify The Providers.

Key: 1. Family Member 4. Home Attendant 7. Other - Specify
 2. Friend/Neighbor 5. Home Health Aide M = Minutes
 3. HouseKeeper 6. Nurse P.E. = Per Event qd= Daily

| PERSONAL CARE ACTIVITIES | Not Needed | Indep. | Client Assistance | | Frequency | | Total Weekly Time | Prov | Time of Day |
|--|------------|--------|-------------------|------------------|-----------|--------|-------------------|------|-------------|
| | | | Some | Total | Daily | Weekly | | | |
| 1. Bathing <input type="checkbox"/> Bed <input type="checkbox"/> Tub <input type="checkbox"/> Chair <input type="checkbox"/> Shower <input type="checkbox"/> Sponge | | | | 10m/qd 20m/qd | | | | | |
| 2. Dressing | | | | 10m/qd 15m/qd | | | | | |
| 3. Grooming <input type="checkbox"/> Soak Hands & Feet <input type="checkbox"/> Lotion On Skin <input type="checkbox"/> Clean And File Nails <input type="checkbox"/> Mouth Care <input type="checkbox"/> Teeth <input type="checkbox"/> Dentures <input type="checkbox"/> Comb, Brush Hair <input type="checkbox"/> Shampoo <input type="checkbox"/> Shaving | | | | 10m/qd 15m/qd | | | | | |
| 4. Toileting <input type="checkbox"/> Toilet <input type="checkbox"/> Commode/Bedpan <input type="checkbox"/> Diaper | | | | 30m/qd 60m/qd | | | | | |
| 5. Transferring From _____ To <input type="checkbox"/> Motor Lift (per event) <input type="checkbox"/> 15m/pe <input type="checkbox"/> Slide Board <input type="checkbox"/> Pivot (per event) Length Of Time Can Sit Up: <input type="checkbox"/> 5m/pe <input type="checkbox"/> 5m/pe | | | | | | | | | |
| 6. Mobility <input type="checkbox"/> Indoors <input type="checkbox"/> 20m/qd <input type="checkbox"/> 20m/qd <input type="checkbox"/> Outdoors <input type="checkbox"/> 120m/wk <input type="checkbox"/> 120m/wk | | | | | | | | | |
| SUB Total Time | | | | | | | | | |

NOTE: If you indicate "some" or "total" assistance with ambulating, transferring, or toileting, explain the assistance needed below. If assistance with these tasks is unscheduled, indicate the span of time over which the assistance of a home attendant is required _

COMMENTS:

NURSE'S ASSESSMENT VISIT REPORT

| | | | |
|---|-------------|-------------------|---------------------|
| VIII. A. ENVIRONMENT | | | |
| Are there any environmental problems in the apartment? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Explain: | | | |
| Do environmental problems affect task times? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, Explain: | | | |
| B. SLEEP-IN FACILITIES Describe facilities for a sleep-in home attendant | | | |
| Sleeping: | | | |
| Cooking: | | | |
| Space for personal belongings: | | | |
| Privacy: | | | |
| C. 1. Can the client ever be safely left alone in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain: | | | |
| 2. Can the client provide access to the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, who will provide access | | | |
| 3. Is the client appropriate for home care? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain: | | | |
| 4. Is the client appropriate for inclusion in a Home Care Cluster? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Explain: | | | |
| 5. Is the client currently included in a Home Care Cluster? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| D. COMMENTS, SPECIAL INSTRUCTIONS, PLANS OR GOALS FOR CONTINUED SERVICE: | | | |
| Month next visit to be made: | Nurse Name: | Nurse Signature: | Date of this Visit: |
| | Agency: | Telephone Number: | |

Attachment 22

MISCELLANEOUS / CONSULTANT SERVICES

Attachment 22

MISCELLANEOUS / CONSULTANT SERVICES

STATE AGENCY (Name and Address): . NYS COMPTROLLER'S NUMBER:
 . ORIGINATING AGENCY CODE: 12000
 .

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

CHARITIES REGISTRATION NUMBER: . CONTRACT TERM
 . FROM:
 . TO:

CONTRACTOR HAS () HAS NOT () TIMELY.
 FILED WITH THE ATTORNEY GENERAL'S . FUNDING AMOUNT FOR CONTRACT
 CHARITIES BUREAU ALL REQUIRED . TERM:
 PERIODIC OR ANNUAL WRITTEN REPORTS .

FEDERAL TAX IDENTIFICATION NUMBER: .

MUNICIPALITY NO. (if applicable): .

STATUS:
 CONTRACTOR IS () IS NOT () A .
 SECTARIAN ENTITY .

CONTRACTOR IS () IS NOT () A . () IF MARKED HERE, THIS CONTRACT'S
 NOT-FOR-PROFIT ORGANIZATION . RENEWABLE FOR ___ ADDITIONAL

CONTRACTOR IS () IS NOT () A . ONE-YEAR PERIOD(S) AT THE SOLE
 N Y STATE BUSINESS ENTERPRISE . OPTION OF THE STATE AND SUBJECT
 . TO APPROVAL OF THE OFFICE OF THE
 . STATE COMPTROLLER.
 .

BID OPENING DATE:

APPENDICES ATTACHED AND PART OF THIS AGREEMENT
 Precedence shall be given to these documents in the order listed below.

- APPENDIX A Standard Clauses as required by the Attorney General for all State Contracts.
- APPENDIX X Modification Agreement Form (to accompany modified appendices for changes in term or consideration on an existing period or for renewal periods)
- APPENDIX Q Modification of Standard Department of Health Contract Language
- STATE OF NEW YORK AGREEMENT
- APPENDIX D General Specifications
- APPENDIX B Request For Proposal (RFP)
- APPENDIX C Proposal
- APPENDIX E-1 Proof of Workers' Compensation Coverage
- APPENDIX E-2 Proof of Disability Insurance Coverage
- APPENDIX F Payment and Reporting Terms
- APPENDIX H Federal Health Insurance Portability and Accountability Act Business Associate Agreement
- APPENDIX I Medicaid Confidentiality and Data Use Agreements

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 formally requested contractors to submit bid proposals for the project described in Appendix B for which bids were opened on the date noted on the face pages of this AGREEMENT; and

WHEREAS, the STATE has determined that the CONTRACTOR is the successful bidder, and the CONTRACTOR covenants that it is willing and able to undertake the services and provide the necessary materials, labor and equipment in connection therewith;

NOW THEREFORE, in consideration of the terms hereinafter mentioned and also the covenants and obligations moving to each party hereto from the other, the parties hereto do hereby agree as follows:

I. Conditions of Agreement

- A. This AGREEMENT incorporates the face pages attached and all of the marked appendices identified on the face page hereof.
- B. The maximum compensation for the contract term of this AGREEMENT shall not exceed the amount specified on the face page hereof.
- C. This AGREEMENT may be renewed for additional periods (PERIOD), as specified on the face page hereof.
- D. To exercise any renewal option 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. The modification agreement is subject to the approval of the Office of the State Comptroller.
- E. Appendix A (Standard Clauses as required by the Attorney General for all State contracts) takes precedence over all other parts of the AGREEMENT.
- F. For the purposes of this AGREEMENT, the terms "Request For Proposal" and "RFP" include all Appendix B documents as marked on the face page hereof.
- G. For the purposes of this AGREEMENT, the term "Proposal" includes all Appendix C documents as marked on the face page hereof.

II. Payment and Reporting

- A. The CONTRACTOR shall submit invoices to the STATE's designated payment office:
 - .
 - .
- B. Payment of such invoices by the State (NYS Department of Health) shall be made in accordance with Article XI-A of the New York State Finance Law.

III. Term of Contract

- A. Upon approval of the NYS Office of the State Comptroller, this AGREEMENT shall be effective for the term as specified on the cover page.
- B. This Agreement may be terminated by mutual written agreement of the contracting parties.
- C. This Agreement may be terminated by the Department for cause upon the failure of the Contractor to comply with the terms and conditions of this Agreement, including the attachments hereto, provided that the Department shall give the contractor written notice via registered or certified mail, return receipt requested, or shall deliver same by hand-receiving Contractor's receipt therefor, such written notice to specify the Contractor's failure and the termination of this Agreement. Termination shall be effective ten (10) business days from receipt of such notice, established by the receipt returned to the Department. The Contractor agrees to incur no new obligations nor to claim for any expenses made after receipt of the notification of termination.
- D. This Agreement may be deemed terminated immediately at the option of the Department upon the filing of a petition in bankruptcy or insolvency, by or against the Contractor. Such termination shall be immediate and complete, without termination costs or further obligations by the Department to the Contractor.
- E. This agreement may be canceled at any time by the Department of Health giving to 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 canceled.

IV. Proof of Coverage

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:

- A. Workers' Compensation, for which one of the following is incorporated into this contract as Appendix E-1:
 - 1. CE-200, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
 - 2. 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
 - 3. SI-12 – Certificate of Workers' Compensation Self-Insurance, OR GSI-105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance.

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

1. CE-200, Affidavit For New York Entities And Any Out-Of-State Entities With No Employees, That New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage Is Not Required; OR
2. DB-120.1 – Certificate of Disability Benefits Insurance OR
3. DB-155 – Certificate of Disability Benefits Self-Insurance

Attachment 23

Appendix A - Standard Clauses for New York State Contracts

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, licenser, 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 previous consent, in writing, of the State and any attempts to assign the contract without the State's written consent are null and void. The Contractor may, however, assign its right to receive payment 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.

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, 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:

(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, 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; or (iii) banking services, insurance policies or the sale of securities. 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 Governor's Office 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 State Finance Law §165. (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. PURCHASES OF APPAREL. In accordance with State Finance Law 162 (4-a), the State shall not purchase any apparel from any vendor unable or unwilling to certify that: (i) such apparel was manufactured in compliance with all applicable labor and occupational safety laws, including, but not limited to, child labor laws, wage and hours laws and workplace safety laws, and (ii) vendor will supply, with its bid (or, if not a bid situation, prior to or at the time of signing a contract with the State), if known, the names and addresses of each subcontractor and a list of all manufacturing plants to be utilized by the bidder.

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Attachment 24

Appendix D - GENERAL SPECIFICATIONS

APPENDIX D
GENERAL SPECIFICATIONS

- A. By signing the "Bid Form" each bidder attests to its express authority to sign on behalf of this company or other entity and acknowledges and accepts that:
- All specifications, general and specific appendices, including Appendix-A, the Standard Clauses for all New York State contracts, and all schedules and forms contained herein will become part of any contract entered, resulting from the Request for Proposal. Anything which is not expressly set forth in the specification, appendices and forms and resultant contract, but which is reasonable to be implied, shall be furnished and provided in the same manner as if specifically expressed.
- B. The work shall be commenced and shall be actually undertaken within such time as the Department of Health may direct by notice, whether by mail, telegram, or other writing, whereupon the undersigned will give continuous attention to the work as directed, to the end and with the intent that the work shall be completed within such reasonable time or times, as the case may be, as the Department may prescribe.
- C. The Department reserves the right to stop the work covered by this proposal and the contract at any time that the Department deems the successful bidder to be unable or incapable of performing the work to the satisfaction of the Department and in the event of such cessation of work, the Department shall have the right to arrange for the completion of the work in such manner as the Department may deem advisable and if the cost thereof exceeds the amount of the bid, the successful bidder and its surety be liable to the State of New York for any excess cost on account thereof.
- D. Each bidder is under an affirmative duty to be informed by personal examination of the specifications and location of the proposed work and by such other means as it may select, of character, quality, and extent of work to be performed and the conditions under which the contract is to be executed.
- E. The Department of Health will make no allowances or concession to a bidder for any alleged misunderstanding or deception because of quantity, quality, character, location or other conditions.
- F. The bid price is to cover the cost of furnishing all of the said services, materials, equipment, and labor to the satisfaction of the Department of Health and the performance of all work set forth in said specifications.
- G. The successful bidder will be required to complete the entire work, or any part thereof as the case may be, to the satisfaction of the Department of

Health in strict accordance with the specifications and pursuant to a contract therefore.

H. 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.

I. Non-Collusive Bidding

By submission of this proposal, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies as to its own organization, under penalty of perjury, that to the best of their knowledge and belief:

- a. The prices of this bid have been arrived at independently without collusion, consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor;
- b. Unless otherwise required by law, the prices which have been quoted in this bid have not been knowingly disclosed by the bidder and will not knowingly be disclosed by the bidder prior to opening, directly or indirectly to any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition;
- c. No attempt has been made or will be made by the bidder to induce any other person, partnership or corporation to submit or not to submit a bid for the purpose of restricting competition.

NOTE: Chapter 675 of the Laws of New York for 1966 provides that every bid made to the state or any public department, agency or official thereof, where competitive bidding is required by statute, rule or regulation, for work or services performed or to be performed or goods sold or to be sold, shall contain the foregoing statement subscribed by the bidder and affirmed by such bidder as true under penalties of perjury.

A bid shall not be considered for award nor shall any award be made where (a), (b) and (c) above have not been complied with; provided however, that if in any case the bidder cannot make the foregoing certification, the bidder shall so state and shall furnish with the bid a signed statement which sets forth in detail the reasons therefore. Where (a), (b) and (c) above have not been complied with, the bid shall not be considered for award nor shall any award be made unless the head of the purchasing unit of the state, public department or agency to which the bid is made or its designee, determines that such disclosure was not made for the purpose of restricting competition.

The fact that a bidder has published price lists, rates, or tariffs covering items being procured, has informed prospective customers of proposed or pending publication of new or revised price lists for such items, or has sold the same items to other customers at the same price being bid, does not constitute, without more, a disclosure within the meaning of the above quoted certification.

Any bid made to the State or any public department, agency or official thereof by a corporate bidder for work or services performed or to be performed or goods, sold or to be sold, where competitive bidding is required by statute, rule or regulation and where such bid contains the certification set forth above shall be deemed to have been authorized by the board of directors of the bidder, and such authorization shall be deemed to include the signing and submission of the bid and the inclusion therein of the certificate as to non-collusion as the act and deed of the corporation.

- J. A bidder may be disqualified from receiving awards if such bidder or any subsidiary, affiliate, partner, officer, agent or principal thereof, or anyone in its or its employ, has previously failed to perform satisfactorily in connection with public bidding or contracts.
- K. The Department reserves the right to make awards within ninety (90) days after the date of the bid opening, during which period bids shall not be withdrawn unless the bidder distinctly states in the bid that acceptance thereof must be made within a shorter specified time.
- L. **Work for Hire Contract**
Any contract entered into resultant from this request for proposal will be considered a "Work for Hire Contract." The Department will be the sole owner of all source code and any software which is developed or included in the application software provided to the Department as a part of this contract.
- M. **Technology Purchases Notification --** The following provisions apply if this Request for Proposal (RFP) seeks proposals for "Technology"
 - 1. For the purposes of this policy, "technology" applies to all services and commodities, voice/data/video and/or any related requirement, major software acquisitions, systems modifications or upgrades, etc., that result in a technical method of achieving a practical purpose or in improvements of productivity. The purchase can be as simple as an order for new or replacement personal computers, or for a consultant to design a new system, or as complex as a major systems improvement or innovation that changes how an agency conducts its business practices.

2. If this RFP results in procurement of software over \$20,000, or of other technology over \$50,000, or where the department determines that the potential exists for coordinating purchases among State agencies and/or the purchase may be of interest to one or more other State agencies, PRIOR TO AWARD SELECTION, this RFP and all responses thereto are subject to review by the New York State Office for Technology.
3. Any contract entered into pursuant to an award of this RFP shall contain a provision which extends the terms and conditions of such contract to any other State agency in New York. Incorporation of this RFP into the resulting contract also incorporates this provision in the contract.
4. The responses to this RFP must include a solution to effectively handle the turn of the century issues related to the change from the year 1999 to 2000.

N. YEAR 2000 WARRANTY

1. Definitions

For purposes of this warranty, the following definitions shall apply:

- a. Product shall include, without limitation: any piece or component of equipment, hardware, firmware, middleware, custom or commercial software, or internal components or subroutines therein which perform any date/time data recognition function, calculation, comparing or sequencing. Where services are being furnished, e.g. consulting, systems integration, code or data conversion or data entry, the term Product shall include resulting deliverables.
- b. Vendor's Product shall include all Product delivered under this Agreement by Vendor other than Third Party Product.
- c. Third Party Product shall include products manufactured or developed by a corporate entity independent from Vendor and provided by Vendor on a non-exclusive licensing or other distribution Agreement with the third party manufacturer. Third Party Product does not include product where Vendor is: a) corporate subsidiary or affiliate of the third party manufacturer/developer; and/or b) the exclusive re-seller or distributor of product manufactured or developed by said corporate entity.

2. Warranty Disclosure

At the time of bid, Product order or Product quote, Vendor is required to disclose the following information in writing to Authorized User:

- a. For Vendor Product and for Products (including, but not limited to, Vendor and/or Third Party Products and/or Authorized User's Installed Product) which have been specified to perform as a system: Compliance or non-compliance of the Products individually or as a system with the Warranty Statement set forth below; and
- b. For Third Party Product Not Specified as Part of a System: Third Party Manufacturer's statement of compliance or non-compliance of any Third Party Product being delivered with Third Party Manufacturer/Developer's Year 2000 warranty. If such Third Party Product is represented by Third Party Manufacturer/Developer as compliant with Third Party Manufacturer/Developer's Year 2000 Warranty, Vendor shall pass through said third party warranty from the third party manufacturer to the Authorized User but shall not be liable for the testing or verification of Third Party's compliance statement.

An absence or failure to furnish the required written warranty disclosure shall be deemed a statement of compliance of the product(s) or system(s) in question with the year 2000 warranty statement set forth below.

3. Warranty Statement

Year 2000 warranty compliance shall be defined in accordance with the following warranty statement:

Vendor warrants that Product(s) furnished pursuant to this Agreement shall, when used in accordance with the Product documentation, be able to accurately process date/time data (including, but not limited to, calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000, including leap year calculations. Where a purchase requires that specific Products must perform as a package or system, this warranty shall apply to the Products as a system.

In the event of any breach of this warranty, Vendor shall restore the Product to the same level of performance as warranted herein, or repair or replace the Product with conforming Product so as to minimize interruption to Authorized User's ongoing business processes, time being of the essence, at Vendor's sole cost and

expense. This warranty does not extend to correction of Authorized User's errors in data entry or data conversion.

This warranty shall survive beyond termination or expiration of the Agreement.

Nothing in this warranty shall be construed to limit any rights or remedies otherwise available under this Agreement.

- O. No Subcontracting
Subcontracting by the contractor shall not be permitted except by prior written approval and knowledge of the Department of Health.
- P. Superintendence by Contractor
The Contractor shall have a representative to provide supervision of the work which Contractor employees are performing to ensure complete and satisfactory performance with the terms of the Contract. This representative shall also be authorized to receive and put into effect promptly all orders, directions and instructions from the Department of Health. A confirmation in writing of such orders or directions will be given by the Department when so requested from the Contractor.
- Q. Sufficiency of Personnel and Equipment
If the Department of Health is of the opinion that the services required by the specifications cannot satisfactorily be performed because of insufficiency of personnel, the Department shall have the authority to require the Contractor to use such additional personnel, to take such steps necessary to perform the services satisfactorily at no additional cost to the State.
- R. Experience Requirements
The Contractor shall submit evidence to the satisfaction of the Department that it possesses the necessary experience and qualifications to perform the type of services required under this contract and must show that it is currently performing similar services. The Contractor shall submit at least two references to substantiate these qualifications.
- S. Contract Amendments
This agreement may be amended by written agreement signed by the parties and subject to the laws and regulations of the State pertaining to contract amendments. This agreement may not be amended orally.

The contractor shall not make any changes in the scope of work as outlined herein at any time without prior authorization in writing from the Department of Health and without prior approval in writing of the amount of compensation for such changes.

T. Provisions Upon Default

1. In the event that the Contractor, through any cause, fails to perform any of the terms, covenants or promises of this agreement, the Department acting for and on behalf of the State, shall thereupon have the right to terminate this agreement by giving notice in writing of the fact and date of such termination to the Contractor
2. If, in the judgement of the Department of Health, the Contractor 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 this agreement 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 judgement 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.

U. Termination Provision

Upon termination of this agreement, the following shall occur:

1. Contractor shall make available to the State for examination all data, records and reports relating to this Contract; and
2. Except as otherwise provided in the Contract, the liability of the State for payments to the Contractor and the liability of the Contractor for services hereunder shall cease.

V. Conflicts

If, in the opinion of the Department of Health, (1) the specifications conflict, or (2) if the specifications are not clear as to (a) the method of performing any part of the work, or as to (b) the types of materials or equipment necessary, or as to (c) the work required to be done in every such situation, the Contractor shall be deemed to have based his bid upon performing the work and furnishing materials or equipment in the most inexpensive and efficient manner. If such conflicts and/or ambiguities arise, the Department of Health will furnish the Contractor supplementary information showing the manner in which the work is to be performed and the type or types of material or equipment that shall be used.

W. MINORITY AND WOMEN OWNED BUSINESS POLICY STATEMENT

The New York State Department of Health recognizes the need to take

affirmative action to ensure that Minority and Women Owned Business Enterprises are given the opportunity to participate in the performance of the Department of Health's contracting program. This opportunity for full participation in our free enterprise system by traditionally, socially and economically disadvantaged persons is essential to obtain social and economic equality and improve the functioning of the State economy.

It is the intention of the New York State Department of Health to fully execute the mandate of Executive Law, Article 15-A and provide Minority and Women Owned Business Enterprises with equal opportunity to bid on contracts awarded by this agency in accordance with the State Finance Law.

To implement this affirmative action policy statement, the contractor agrees to file with the Department of Health within 10 days of notice of award, a staffing plan of the anticipated work force to be utilized on this contract or, where required, information on the contractor's total work force, including apprentices, broken down by specified ethnic background, gender, and Federal occupational categories or other appropriate categories specified by the Department. The form of the staffing plan shall be supplied by the Department.

After an award of this contract, the contractor agrees to submit to the Department a work force utilization report, in a form and manner required by the Department, of the work force actually utilized on this contract, broken down by specified ethnic background, gender and Federal occupational categories or other appropriate categories specified by the Department.

X. Contract Insurance Requirements

1. The successful bidder must without expense to the State procure and maintain, until final acceptance by the Department of Health of the work covered by this proposal and the contract, insurance of the kinds and in the amounts hereinafter provided, in insurance companies authorized to do such business in the State of New York covering all operations under this proposal and the contract, whether performed by it or by subcontractors. Before commencing the work, the successful bidder shall furnish to the Department of Health a certificate or certificates, in a form satisfactory to the Department, showing that it has complied with the requirements of this section, which certificate or certificates shall state that the policies shall not be changed or canceled until thirty days written notice has been given to the Department. The kinds and amounts of required insurance are:
 - a. A policy covering the obligations of the successful bidder in accordance with the provisions of Chapter 41, Laws of 1914, as amended, known as the Workers' Compensation Law, and the

contract shall be void and of no effect unless the successful bidder procures such policy and maintains it until acceptance of the work (reference Appendix E).

- b. Policies of Bodily Injury Liability and Property Damage Liability Insurance of the types hereinafter specified, each within limits of not less than \$500,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by one person in any one occurrence, and subject to that limit for that person, not less than \$1,000,000 for all damages arising out of bodily injury, including death at any time resulting therefrom sustained by two or more persons in any one occurrence, and not less than \$500,000 for damages arising out of damage to or destruction of property during any single occurrence and not less than \$1,000,000 aggregate for damages arising out of damage to or destruction of property during the policy period.
 - i. Contractor's Liability Insurance issued to and covering the liability of the successful bidder with respect to all work performed by it under this proposal and the contract.
 - ii. Protective Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.
 - iii. Automobile Liability Insurance issued to and covering the liability of the People of the State of New York with respect to all operations under this proposal and the contract, by the successful bidder or by its subcontractors, including omissions and supervisory acts of the State.

Y. 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 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 and 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 5 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 exclude 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.

Z. Confidentiality Clauses

1. Any materials, articles, papers, etc., developed by the CONTRACTOR under or in the course of performing this AGREEMENT shall contain the following, or similar acknowledgment: "Funded by the New York State Department of Health". Any such materials must be reviewed and approved by the STATE for conformity with the policies and guidelines for the New York State Department of Health prior to dissemination and/or publication. It is agreed that such review will be conducted in an expeditious manner. Should the review result in any unresolved disagreements regarding content, the CONTRACTOR shall be free to publish in scholarly journals along with a disclaimer that the views within the Article or the policies reflected are not necessarily those of the New York State Department of Health. The Department reserves the right to disallow funding for any educational materials not approved through its review process.
2. Any publishable or otherwise reproducible material developed under or in the course of performing this AGREEMENT, dealing with any aspect of performance under this AGREEMENT, or of the results and accomplishments attained in such performance, shall be the sole and exclusive property of the STATE, and shall not be published or otherwise disseminated by the CONTRACTOR to any other party unless prior written approval is secured from the STATE or under circumstances as indicated in paragraph 1 above. Any and all net proceeds obtained by the CONTRACTOR resulting from any such publication shall belong to and be paid over to the STATE. The STATE shall have a perpetual royalty-free, non-exclusive and irrevocable right to reproduce, publish or otherwise use, and to authorize others to use, any such material for governmental purposes.

3. No report, document or other data produced in whole or in part with the funds provided under this AGREEMENT may be copyrighted by the CONTRACTOR or any of its employees, nor shall any notice of copyright be registered by the CONTRACTOR or any of its employees in connection with any report, document or other data developed pursuant to this AGREEMENT.
4. All reports, data sheets, documents, etc. generated under this contract shall be the sole and exclusive property of the Department of Health. Upon completion or termination of this AGREEMENT the CONTRACTOR shall deliver to the Department of Health upon its demand all copies of materials relating to or pertaining to this AGREEMENT. The CONTRACTOR shall have no right to disclose or use any of such material and documentation for any purpose whatsoever, without the prior written approval of the Department of Health or its authorized agents.
5. The CONTRACTOR, its officers, agents and employees and subcontractors shall treat all information, which is obtained by it through its performance under this AGREEMENT, as confidential information to the extent required by the laws and regulations of the United States and laws and regulations of the State of New York.
6. All subcontracts shall contain provisions specifying:
 - a. that the work performed by the subcontractor must be in accordance with the terms of this AGREEMENT, and
 - b. that the subcontractor specifically agrees to be bound by the confidentiality provisions set forth in the AGREEMENT between the STATE and the CONTRACTOR.

AA. Provision Related to Consultant Disclosure Legislation

1. If this contract is for the provision of consulting services as defined in Subdivision 17 of Section 8 of the State Finance Law, the CONTRACTOR shall submit a "State Consultant Services Form B, Contractor's Annual Employment Report" no later than May 15th following the end of each state fiscal year included in this contract term. This report must be submitted to:
 - a. The NYS Department of Health, at the STATE's designated payment office address included in this AGREEMENT; and

- b. The NYS Office of the State Comptroller, Bureau of Contracts, 110 State Street, 11th Floor, Albany NY 12236 ATTN: Consultant Reporting - or via fax at (518) 474-8030 or (518) 473-8808; and
- c. The NYS Department of Civil Service, Alfred E. Smith Office Building, Albany NY 12239, ATTN: Consultant Reporting.

BB. Provisions Related to New York State Procurement Lobbying Law

- 1. The STATE reserves the right to terminate this AGREEMENT in the event it is found that the certification filed by the CONTRACTOR in accordance with New York State Finance Law §139-k was intentionally false or intentionally incomplete. Upon such finding, the STATE may exercise its termination right by providing written notification to the CONTRACTOR in accordance with the written notification terms of this AGREEMENT.

CC. Provisions Related to New York State Information Security Breach and Notification Act

- 1. 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.

DD. Lead Guidelines

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.

Attachment 25

Appendix F - PAYMENT AND REPORTING SCHEDULE

APPENDIX F

PAYMENT AND REPORTING SCHEDULE

1. Payment and Reporting Terms and Conditions

- A. No payment under this AGREEMENT 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.
- B. 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.
- C. The CONTRACTOR will be entitled to receive payments for work, projects, and services rendered as detailed and described in the program workplan submitted as part of the proposal (Appendix C). All payments shall be in conformance with the rules and regulations of the Office of the State Comptroller.
- D. 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 60 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.
- E. The CONTRACTOR shall submit to the STATE quarterly voucher claims on such forms and in such detail as the STATE shall require. The CONTRACTOR shall submit vouchers to the State's designated payment office located in the Office of Long Term Care, Division of Long Term Care Resources, Claims and Payment Unit, 1 Commerce Plaza, 8th Floor, Albany, NY, 12210, or such other place as the STATE may direct during the term of the AGREEMENT.

All vouchers submitted by the CONTRACTOR pursuant to this AGREEMENT shall be submitted to the STATE no later than fifteen (15) 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.

- F. 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 shall be made separate from payments under this AGREEMENT. Before payment of a COLA can be made, the STATE shall notify the CONTRACTOR, in writing, of eligibility for any COLA. 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

The CONTRACTOR shall to submit the following periodic reports that will include, but not be limited to, an assessment of the project, an analysis of the level and costs of services managed under the AGREEMENT, recipient satisfaction and other matters as may be pertinent, including submission of data requested by DOH. Examples of such data and information are shown below. The CONTRACTOR will also facilitate and participate in meetings of stakeholders to discuss implementation and operation of this demonstration program. Such meetings must be held at least twice a year.

- A. During the development and implementation phase, the CONTRACTOR shall submit monthly reports, including, but not limited to:
- Discussion of milestones achieved and evaluation of project status;
 - Discussion of any delays or other issues encountered;
 - Plan of action for addressing any delays or other issues encountered;
 - Objectives for the next reporting period;
 - Objectives for the time remaining in the start up period.
- B. Following initial delivery of Assessment Center services, on a quarterly basis, a narrative report which at the minimum, shall include:
- Discussion of milestones achieved and evaluation of project status;
 - Discussion of any delays or other issues encountered;
 - Plan of action for addressing any delays or other issues encountered;

- Discussion of activities that have met and not met timelines set forth in the Workplan;
- Objectives for the next reporting period;
- Objectives for the remaining demonstration period;
- Financial report of project expenses.

This report will detail how the CONTRACTOR has progressed toward attaining the qualitative goals enumerated in the Workplan. This report should address all goals and objectives of the project and include a discussion of problems encountered and steps taken to solve them.

C. After initial assessment center services are delivered, a quarterly statistical reports including at a minimum the following data:

- Number of assessments completed;
- Number of reassessments completed;
- Number of assessments completed that did not result in authorization of any of the listed services, delineated by category of reason for services not being authorized;
- Number of nursing home level of care determinations completed;
- Number of consumers authorized to receive services delineated by program/service;
- The percentage of occurrences when reassessments resulted in one of the following, delineated by program/service:
 - Additional hours of the service(s) previously being received;
 - Reduction in hours of service(s) previously being received;
 - Termination of all services;
 - A new service replacing the service(s) previously being received;
 - An new service provided in addition to the service(s) previously being received;
- Number of Fair Hearing requests received, number that occurred and the percentage of Fair Hearings in which the consumer's position prevailed;
- Number and type of inquiries and complaints received from consumers;
- Number and type of inquiries and complaints received from providers;
- Ratio of non-administrative and non-supervisory FTEs to number of assessments and reassessments conducted as delineated by type of staff (e.g. nurse, social worker);

- Results of consumer satisfaction surveys developed by the contractor and approved by DOH;
- Other data and information as may be requested by DOH.

D. Semi-annual reports including at a minimum the following:

- Key implementation issues or challenges, and the manner in which they were resolved;
- Key operational issues or challenges, and the manner in which they were resolved;
- Best practices;
- Principal lessons learned that would have applicability to an expansion of Assessment Centers in New York State.

E. An Annual Report in form required by DOH.

F. 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 demonstration program funds were utilized in achieving the goals set forth in the Workplan.

Attachment 26

Appendix H - HIPAA Business Associate Agreement

Appendix H

Federal Health Insurance Portability and Accountability Act ("HIPAA") Business Associate Agreement ("Agreement") Governing Privacy and Security

I. Definitions:

- (a) "Business Associate" shall mean the 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"), Health Information Technology for Economic and Clinical Health Act ("HITECH") and implementing regulations, including those at 45 CFR Parts 160 and 164 (the "Privacy Rule").

II. Obligations and Activities of the Business Associate:

- (a) The Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by this Agreement or as required by law.
- (b) The Business Associate agrees to use the appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement and to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Covered Entity pursuant to this Agreement.
- (c) The Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of Protected Health Information by the Business Associate in violation of the requirements of this Agreement.
- (d) The Business Associate agrees to report to the Covered Program, any use or disclosure of the Protected Health Information not provided for by this Agreement, as soon as reasonably practicable of which it becomes aware. The Business Associate also agrees to report to the Covered Entity any security incident of which it becomes aware. Such report shall include the identification of each individual whose unsecured protected health information has been, or is reasonably believed by the Business Associate to have been, accessed, acquired or disclosed during any breach of such information.

- (e) **The 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 the Business Associate on behalf of the Covered Program agrees to the same restrictions and conditions that apply through this Agreement to the Business Associate with respect to such information.**
- (f) **The Business Associate agrees to provide access, at the request of the Covered Program, and in the time and manner designated by the Covered Program, to Protected Health Information in a Designated Record Set, to the Covered Program or, as directed by the Covered Program, to an Individual in order to meet the requirements under 45 CFR 164.524, if the business associate has protected health information in a designated record set.**
- (g) **The Business Associate agrees to make any amendment(s) to Protected Health Information in a designated record set that the Covered Program directs or agrees to pursuant to 45 CFR 164.526 at the request of the Covered Program or an Individual, and in the time and manner designated by Covered Program, if the business associate has protected health information in a designated record set.**
- (h) **The Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by the Business Associate on behalf of, the Covered Program available to the Covered Program, or to the Secretary of Health and Human Services, in a time and manner designated by the Covered Program or the Secretary, for purposes of the Secretary determining the Covered Program's compliance with the Privacy Rule.**
- (i) **The 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) **The Business Associate agrees to provide to the Covered Program or an Individual, in time and manner designated by Covered Program, information collected in accordance with this Agreement, to permit 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.**
- (k) **Effective February 17, 2010, the Business Associate agree 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) **General Use and Disclosure Provisions**

Except as otherwise limited in this Agreement, the Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the Covered Program as specified in the Agreement to which this is an addendum, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Program.

(b) Specific Use and Disclosure Provisions:

- (1) Except as otherwise limited in this Agreement, the Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.**
- (2) Except as otherwise limited in this Agreement, Business Associate may use Protected Health Information for the proper management and administration of the business associate or to carry out its legal responsibilities and to provide Data Aggregation services to Covered Program as permitted by 45 CFR 164.504(e)(2)(i)(B). Data Aggregation includes the combining of protected information created or received by a business associate through its activities under this contract with other information gained from other sources.**
- (3) The Business Associate may use Protected Health Information to report violations of law to appropriate federal and State authorities, consistent with 45 CFR §164.502(j)(1).**

IV. Obligations of Covered Program

Provisions for the Covered Program To Inform the Business Associate of Privacy Practices and Restrictions

- (a) The Covered Program shall notify the Business Associate of any limitation(s) in its notice of privacy practices of the Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect the Business Associate's use or disclosure of Protected Health Information.**
- (b) The Covered Program shall notify the Business Associate of any changes in, or revocation of, permission by the Individual to use or disclose Protected Health Information, to the extent that such changes may affect the Business Associate's use or disclosure of Protected Health Information.**

- (c) **The Covered Program shall notify the Business Associate of any restriction to the use or disclosure of Protected Health Information that the Covered Program has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of Protected Health Information.**

V. Permissible Requests by Covered Program

The Covered Program shall not request the Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Program, except if the Business Associate will use or disclose protected health information for, and the contract includes provisions for, data aggregation or management and administrative activities of Business Associate.

VI. Term and Termination

- (a) ***Term.* The Term of this Agreement shall be effective during the dates noted on page one 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, or, if it is infeasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in The Agreement.**
- (b) ***Termination for Cause.* Upon the Covered Program's knowledge of a material breach by Business Associate, Covered Program may provide an opportunity for the Business Associate to cure the breach and end the violation or may terminate this Agreement and the master Agreement if the Business Associate does not cure the breach and end the violation within the time specified by Covered Program, or the Covered Program may immediately terminate this Agreement and the master Agreement if the 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, the Business Associate shall return or destroy all Protected Health Information received from the Covered Program, or created or received by the Business Associate on behalf of the Covered Program. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of the Business Associate. The Business Associate shall retain no copies of the Protected Health Information.**

- (2) **In the event that the Business Associate determines that returning or destroying the Protected Health Information is infeasible, the Business Associate shall provide to the Covered Program notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, the 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.**

VII. Violations

- (a) **It is further agreed that any violation of this agreement may cause irreparable harm to the State, therefore the State may seek any other remedy, including an injunction or specific performance for such harm, without bond, security or necessity of demonstrating actual damages.**
- (b) **The business associate shall indemnify and hold the State harmless against all claims and costs resulting from acts/omissions of the business associate in connection with the business associate's obligations under this agreement.**

VIII. Miscellaneous

- (a) ***Regulatory References.* A reference in this Agreement to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.**
- (b) ***Amendment.* The Parties 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 the Privacy Rule, HIPAA, Public Law 104-191, and HITECH, Public Law 111-5, Division A, Title XIII and Division B, Title IV.**
- (c) ***Survival.* The respective rights and obligations of the Business Associate under Section VI 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 the Covered Program to comply with the Privacy Rule.**
- (e) **If anything in this agreement conflicts with a provision of any other agreement on this matter, this agreement is controlling.**
- (f) **HIV/AIDS. If HIV/AIDS information is to be disclosed under this agreement, the business associate acknowledges that it has been informed of the confidentiality requirements of Public Health Law Article 27-F.**

Attachment 27

Appendix I – Medicaid Confidentiality and Data Use Agreements

NOTE: The following document will be edited prior to the release of the RFP to conform with pagination, headings and specifics of this procurement.

Appendix I

Medicaid Confidential Data / Protected Health Information

Medicaid Confidential Data (MCD) includes, but is not limited to, names and addresses of Medicaid Bidders/beneficiaries, the medical services provided, social and economic conditions or circumstances, the Department's evaluation of personal information, medical data, including diagnosis and past history of disease and disability, any information regarding income eligibility-and amount of medical assistance payment, income information, and/or information regarding the identification of third parties. Income information received from the Social Security Administration or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data. MCD also includes any information received in connection with the identification of legally liable third party resources under 42 C.F.R. § 433.138. Each element of MCD is confidential regardless of the document or mode of communication or storage in which it is found.

NOTE that this contract involves the MCD of beneficiaries and possibly Bidders, both of which are confidential pursuant to Section 367b(4) of the N.Y. Social Services Law, 42 U.S.C. Section 1396(a)(7), Section 1902(a)(7) of the Social Security Act and 42 C.F.R. Section 431.300 et seq.

NO DISCLOSURE OF MCD IN YOUR POSSESSION CAN BE MADE TO ANY OTHER PERSON OR ENTITY WITHOUT THE PRIOR WRITTEN PERMISSION OF THE NEW YORK STATE DEPARTMENT OF HEALTH (NYSDOH), MEDICAID CONFIDENTIAL DATA REVIEW COMMITTEE (MCDRC). LIKewise, NO USE(S), OTHER THAN THE USE(S) OF MCD APPROVED IN THIS CONTRACT AND DATA EXCHANGE AGREEMENT, CAN BE MADE OF THE MCD WITHOUT THE PRIOR WRITTEN APPROVAL OF NYSDOH, MCDRC.

Also, pursuant to Section 367b(4) of the NY Social Services Law, information relating to persons APPLYING FOR medical assistance shall also be considered confidential and shall not be disclosed to persons or agencies without the prior written approval of the New York State Department of Health.

AIDS/HIV Related Confidentiality Restrictions:

ALSO NOTE that MCD may contain HIV related confidential information, as defined in Section 2780(7) of the N.Y. Public Health Law. As required by N.Y. Pub. Health Law Section 2782(5), the New York State Department of Health hereby provides you with the following notice:

HIV/AIDS NOTICE

This information has been disclosed to you from confidential records which are protected by state law. State law prohibits you from making

any further disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. Any unauthorized further disclosure in violation of state law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient authorization for further disclosure.

The Contractor agrees that any further disclosure of MCD requires the prior, written approval of the New York State Department of Health (NYSDOH), Medicaid Confidential Data Review Committee (MCDRC). The Contractor will require and ensure that any approved agreement, contract or document with a subContractor or employee contains the above Notice and a statement that the subContractor, employee or other party may not disclose the MCD without the prior, written approval of the NYSDOH MCDRC.

Alcohol and Substance Abuse Related Confidentiality Restrictions

Alcohol and substance abuse information is confidential pursuant to 42 C.F.R. Part 2. General authorizations are ineffective to obtain the release of such data. The federal regulations provide for a specific release for such data.

ANY AGREEMENT, CONTRACT OR DOCUMENT WITH A SUBCONTRACTOR OR EMPLOYEE MUST CONTAIN ALL OF THE ABOVE PROVISIONS PERTAINING TO CONFIDENTIALITY. IT MUST CONTAIN THE HIV/AIDS NOTICE AS WELL AS A STATEMENT THAT THE SUBCONTRACTOR, EMPLOYEE OR OTHER PERSON MAY NOT USE OR DISCLOSE THE MCD WITHOUT THE PRIOR WRITTEN APPROVAL OF THE NYSDOH, MCDRC.

Bidder/Contractor

Signature.....Date...../...../.....

Name Printed.....

Company.....

SubContractor / Employee

Signature.....Date...../...../.....

Name Printed.....

Company.....

The Contractor must maintain a copy of this agreement in its permanent records for each employee performing services pursuant to any contract awarded pursuant to RFP # 0907070849.

DUA # _____

MEDICAID AGENCY DATA USE AGREEMENT

AGREEMENT FOR USE OF CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) DATA CONTAINING INDIVIDUAL-SPECIFIC INFORMATION

In order to secure Medicare data that resides in a CMS Privacy Act System of Records, and in order to ensure the integrity, security, and confidentiality of information maintained by CMS, and to permit appropriate disclosure and use of such data as permitted by law, CMS and the State of _____ enter into this agreement to comply with the following specific paragraphs.

1. This Agreement is by and between CMS, a component of the U.S. Department of Health and Human Services (DHHS), and the State of _____, hereinafter termed "User."
2. This Agreement addresses the conditions under which CMS will disclose and the User will obtain and use the Medicare Long Term Care Minimum Data Set (LTC/MDS) in section 7. This Agreement supersedes any and all agreements between the parties with respect to the use of the LTC/MDS and preempts and overrides any instructions, directions, agreements or other prior communication from the Department of Health and Human Services with respect to the data specified herein. Further, the terms of this Agreement can be changed only by a written modification to this Agreement, or by the parties adopting a new agreement. The parties agree further that instructions or interpretations issued to the User concerning this Agreement or the data specified herein, shall not be valid unless issued in writing by the CMS point-of-contact specified in section 5, or the CMS signatory to this Agreement shown in section 18. CMS reserves the right to terminate this agreement at any time if there is evidence that: (1) the agreement is not being complied with; (2) there is a violation of law in the manner of compliance; or (3) the agreement no longer complies with changes to statutory or regulatory requirements. Upon such notice, CMS will cease releasing data to the User under this Agreement and will notify the User either to return all previously released data files to CMS at the User's expense or destroy such data.
3. The parties mutually agree that CMS retains all ownership rights to the data file(s) referred to in this Agreement, and that the User does not obtain any right, title, or interest in any of the data furnished by CMS.
4. The parties mutually agree that the following named individual is designated as "Custodian" of the file(s) on behalf of the User, and will be responsible for the observance of all conditions of use and for establishment and maintenance of security arrangements as specified in this Agreement to prevent unauthorized use. The User agrees to notify CMS within fifteen (15) days of any change of custodianship. The parties mutually agree that CMS may disapprove the appointment of a custodian, or may require the appointment of a new custodian at any time.

(Name of Custodian)

(Company/Organization)

(Street Address)

(City/State/ZIP Code)

(Phone Number Including Area Code and E-mail Address if applicable)

5. The parties mutually agree that the following named individual will be designated as “point-of-contact” for the Agreement on behalf of CMS.

(Name of CMS Contact)

(Title/Component)

(Street Address)

(City/State/ZIP Code)

(Phone Number Including Area Code and E-mail Address if applicable)

6. The User represents, and in furnishing the Medicare LTC/MDS, CMS relies upon such representation, that this file(s) will be used solely for the purpose(s) outlined below.

To facilitate the administration of a Federal health program for the purposes of determining participation requirements, evaluating and/or assessing cost effectiveness, and/or the quality of health care services provided, and/or for setting long term care Nursing Facility reimbursement rates in the State that are directly related to the administration of the State Medicaid Program. To facilitate State compliance with the requirements of the Americans for Disabilities Act.

The User shall not, unless explicitly provided for under contract, disclose, release, reveal, show, sell, rent, lease, loan, or otherwise grant access to the data covered by this Agreement to any person(s). The User agrees that, within the User organization, access to the data covered by this Agreement shall be limited to the minimum number of individuals necessary to achieve the purpose stated in this section. The User may issue reports, based on data

covered by this Agreement, that are directly related to the administration of the State Medicaid Program to the specific long term care Nursing Facility that has submitted the data.

7. The following file(s) and timeframe are covered under this Agreement:

| <u>File</u> | <u>Year(s)</u> |
|--|----------------|
| LTC/MDS Resident Assessment Data File(s) | |

8. The parties mutually agree that the aforesaid file(s) (and/or any derivative file(s), including any file that maintains or continues identification of individuals) may be retained by the User for a maximum period of 10 years from the effective date of this agreement, hereinafter known as the retention date. The User agrees to notify CMS at least 30 days prior to the expiration of the aforementioned retention date in order to renegotiate this agreement. The User acknowledges that stringent adherence to the aforementioned retention date is required.
9. The User agrees to establish appropriate administrative, technical, and physical safeguards to protect the confidentiality of the data, and to prevent its unauthorized use or access. The safeguards shall provide a level and scope of security that is not less than the level and scope of security established by the Office of Management and Budget (OMB) in OMB Circular No. A-130, Appendix III--Security of Federal Automated Information Resources (<http://www.whitehouse.gov/omb/circulars/a130/a130.html>), which sets forth guidelines for security plans for automated information systems in Federal agencies. The User acknowledges that the use of unsecured telecommunications, including the Internet, to transmit individually identifiable or deducible information derived from the file(s) specified in section 7 is strictly prohibited. Further, the User agrees that the data must not be physically moved or transmitted in any way without written approval from CMS.
10. The User agrees that the authorized representatives of CMS, DHHS Office of the Inspector General or Comptroller General, will be granted access to premises where the aforesaid file(s) are kept for the purpose of inspecting security arrangements confirming whether the User is in compliance with the security requirements specified in section 9.
11. The User agrees that no findings, listing, or information derived from the file(s) specified in section 7, with or without identifiers, may be released if such findings, listing, or information contain any combination of data elements that might allow the deduction of a beneficiary's identification without first obtaining written authorization from the appropriate System Manager or the person designated in item number 18 of this Agreement unless the information derived from the files specified in section 7 are being used for purposes outlined in section 6. The User will notify any entity to which the data is transferred of the need to maintain the confidentiality of the data provided. Examples of such data elements include but are not limited to geographic indicator, age, sex, diagnosis, procedure, admission/discharge date(s), or date of death. The User agrees further that CMS shall be the sole judge as to whether any finding, listing, information, or any combination of data extracted or derived from CMS's files identifies or would, with reasonable effort, permit one to identify an individual or to deduce the identity of an individual to a reasonable degree of certainty.

12. The User agrees that in the event CMS determines or has a reasonable belief that the User has made or may have made disclosure of the aforesaid file(s) that is not authorized by this Agreement, or other written authorization from the appropriate Systems Manager or the person designated in section 18, CMS in its sole discretion may require the User to: (a) promptly investigate and report to CMS the User's determinations regarding any alleged or actual unauthorized disclosure, (b) promptly resolve any problems identified by the investigation; (c) if requested by CMS, submit a formal written response to an allegation of unauthorized disclosure; (d) if requested by CMS, submit a corrective action plan with steps designed to prevent any future unauthorized disclosures; and (e) if requested by CMS, return data files to CMS immediately. The User understands that as a result of CMS's determination or reasonable belief that unauthorized disclosures have taken place, CMS may refuse to release further CMS data to the User for a period of time to be determined by CMS.
13. The User hereby acknowledges that criminal penalties under §1106(a) of the Social Security Act (42 U.S.C. §1306(a)), the Privacy Act (5 U.S.C. §552a(i)(3)), and 18 U.S.C. §641, which govern the use of these data, may apply to disclosures of information that are covered by this agreement.
14. By signing this Agreement, the User agrees to abide by all provisions set out in this Agreement for protection of the data file(s) specified in section 7.
15. The disclosure provision(s) that allow the discretionary release of CMS data for the purpose(s) stated in paragraph 6 follow(s).

Long Term Care Minimum Data Set, System of Records #09-70-1517, routine use #2(c)

16. On behalf of the User, the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

(Name/Title of Individual)

(State Agency/Organization)

(Street Address)

(City/State/ZIP Code)

(Phone Number Including Area Code and E-mail Address if applicable)

Signature

Date

17. The Custodian, as named in paragraph 4, hereby acknowledges his/her appointment as custodian of the aforesaid file(s) on behalf of the User, and agrees to comply with all of the provisions of this Agreement on behalf of the User.

(Typed or Printed Name and Title of Custodian of File(s))

Signature Date

18. On behalf of CMS the undersigned individual hereby attests that he or she is authorized to enter into this Agreement and agrees to all the terms specified herein.

a. _____
(Typed or Printed Name and Title of CMS Representative)

(Signature) (Date)

b. Concur/Nonconcur _____ Date: _____
(Signature of CMS System Manager or Business Owner)

c. Concur/Nonconcur _____ Date: _____
(Signature of CMS Protocol or Project Review Representative)

INSTRUCTIONS FOR COMPLETING THE MEDICAID AGENCY DATA USE AGREEMENT (DUA)

This agreement, which ensures compliance with the requirements of the Privacy Act, is required for a State Medicaid Agency to receive LTC/MDS data deriving from Medicare and private pay residents, and must be completed prior to the release of these files to the Medicaid Agency. No DUA is needed for release of LTC/MDS data derived exclusively from Medicaid residents; however, see the instruction below for item #7 in regard to this. Note that all data releases to the Medicaid Agency, including releases for Medicaid-only residents, must be electronically tracked for purposes of HIPAA compliance.

Instructions for the completion of the agreement follow:

Before completing the DUA, please note that the language contained in this agreement cannot be altered in any form.

- First paragraph, enter the name of the State.
- Item #1, enter the name of the State.
- Item #4, enter the Custodian's name, the State Medicaid Agency organizational unit, Address, Phone Number (including area code), and E-Mail Address (if applicable). The Custodian of files is defined as that person who will have actual possession of and responsibility for the data files. This will typically be the manager of the Medicaid agency unit with responsibility for the data files. If the person signing for the Medicaid agency as User is the same person as the Custodian, that person can appear and sign in both places.

If there are additional Custodians who are not direct Medicaid agency employees, such as academic or other consulting contractors, who assist the Medicaid agency in its use of the data for the purposes indicated in Item #6, an appropriate lead or managerial person from each such organization must complete and sign the Multi-Signature Addendum form.

Additional Custodian individuals or organizations can be included under the primary DUA as necessary over the life of the primary DUA. Each such individual or organization must be approved by CMS before they are permitted to function under the DUA. To include a new Custodian under an existing Medicaid agency DUA, submit the following to the CMS Regional Office: a letter from the Medicaid agency describing the activities planned for the new Custodian and the length of time over which the Custodian will serve; and a Multi-Signature Addendum completed and signed by an appropriate lead or managerial person from the Custodian organization. The Multi-Signature Addendum must show the DUA number of the existing primary Medicaid agency DUA. [end of 3rd bullet]

- Item #5 will be completed by the CMS Regional Office.

- Item #7, "Files," is pre-completed to show "LTC/MDS Resident Assessment Data File(s)." This wording is general and covers all MDS data. This all-inclusive language will reliably guide the technical staff who must retrieve the data.
- Medicaid Agencies must remain aware that the use of all the MDS data, regardless of program source, is limited to the purpose indicated in Item #6, i.e., for Medicaid program use. In addition, Medicaid Agencies must abide by all the restrictions regarding the MDS data, regardless of source, that are based on the Privacy Act and other law and regulation, and as expressed throughout this DUA.
- Item #7, Year(s): The Medicaid Agency may choose the time period for which it wishes to receive data, from a point in the past through up to 10 years into the future (see the Item #8 discussion of retention date). Examples are: "1998-2000;" "2001;" and "From 1998 through [insert date 10 years in the future]."
- Item #8 says that the group of data files indicated in Item #7 may be retained by the Medicaid Agency for a period of 10 years after the approval date (CMS' signature date) of the DUA. This date, which is 10 years in the future, is called the "retention date." For cases in which the Medicaid Agency receives data in an ongoing manner, the retention date does not move forward with each data release. For example, data released two months prior to the retention date (9 years and 10 months after the DUA approval date) may only be kept by the Medicaid Agency for two months. If it wishes to continue receiving data beyond the 10 year point, the Medicaid Agency must contact CMS at least 30 days prior to the retention date (and preferably 3-4 months prior) to request another DUA covering the period following the 10 year retention date.
- Item #16 is to be completed by the State Medicaid Agency.
- Item #17 is to be completed by the State Medicaid Agency Custodian.
- Item #18 will be completed by the CMS Regional Office.

ADDENDUM TO DATA USE AGREEMENT (DUA)

Addendum to DUA for _____. If this is an addendum to a previously approved DUA, insert the CMS assigned DUA number here: _____. The following individual(s) may/will have access to CMS data that is being requested for this agreement. Their signatures attest to their agreement to the terms of this Data Use Agreement:

| | | |
|---|------------------------|---------------------------------------|
| Name and Title of Individual <i>(typed or printed)</i> | | |
| Task / Role of this individual in this project | Company / Organization | |
| Street Address | | |
| City | State | ZIP Code |
| Office Telephone <i>(Include Area Code)</i> | | E-Mail Address <i>(If applicable)</i> |
| Signature of Individual | | Date |
| Signature of CMS Representative | | Date |
| Signature of CMS Project Officer <i>(If applicable)</i> | | Date |

| | | |
|---|------------------------|---------------------------------------|
| Name and Title of Individual <i>(typed or printed)</i> | | |
| Task / Role of this individual in this project | Company / Organization | |
| Street Address | | |
| City | State | ZIP Code |
| Office Telephone <i>(Include Area Code)</i> | | E-Mail Address <i>(If applicable)</i> |
| Signature of Individual | | Date |
| Signature of CMS Representative | | Date |
| Signature of CMS Project Officer <i>(If applicable)</i> | | Date |

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0734. The time required to complete this information collection is estimated to average 30 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Attachment 28

New York State Vendor Responsibility Questionnaire

**NEW YORK STATE
VENDOR RESPONSIBILITY QUESTIONNAIRE
NOT-FOR-PROFIT BUSINESS ENTITY**

| BUSINESS ENTITY INFORMATION | | | | |
|---|------|---------|-----------------------------|------------|
| Legal Business Name | | | EIN | |
| Address of the Principal Place of Business/Executive Office | | | Phone Number | Fax Number |
| E-mail | | Website | | |
| Authorized Contact for this Questionnaire | | | | |
| Name: | | | Phone Number | Fax Number |
| Title | | | Email | |
| List any other DBA, Trade Name, Other Identity, or EIN used in the last five (5) years, the state or county where filed, and the status (active or inactive): (if applicable) | | | | |
| Type | Name | EIN | State or County where filed | Status |
| | | | | |
| | | | | |

| I. BUSINESS CHARACTERISTICS | |
|---|---|
| 1.0 Business Entity Type – Please check appropriate box and provide additional information: | |
| a) <input type="checkbox"/> Corporation (including PC) | Date of Incorporation |
| b) <input type="checkbox"/> Limited Liability Co. (LLC or PLLC) | Date Organized |
| c) <input type="checkbox"/> Limited Liability Partnership | Date of Registration |
| d) <input type="checkbox"/> Limited Partnership | Date Established |
| e) <input type="checkbox"/> General Partnership | Date Established County (if formed in NYS) |
| f) <input type="checkbox"/> Sole Proprietor | How many years in business? |
| g) <input type="checkbox"/> Other | Date Established |
| If Other, explain: | |
| 1.1 Was the Business Entity formed in New York State? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If 'No' indicate jurisdiction where Business Entity was formed: | |
| <input type="checkbox"/> United States State _____ | |
| <input type="checkbox"/> Other Country _____ | |
| 1.2 Is the Business Entity currently registered to do business in New York State with the Department of State? <i>Note: Select 'not required' if the Business Entity is a General Partnership.</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required |
| If "No" explain why the Business Entity is not required to be registered in New York State. | |
| 1.3 Is the Business Entity registered as a Sales Tax vendor with the New York State Department of Tax and Finance? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Explain and provide detail, such as 'not required', 'application in process', or other reasons for not being registered. | |
| 1.4 Is the Business Entity a Joint Venture? <i>Note: If the submitting Business Entity is a Joint Venture, also submit a separate questionnaire for the Business Entity comprising the Joint Venture.</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**NEW YORK STATE
VENDOR RESPONSIBILITY QUESTIONNAIRE
NOT-FOR-PROFIT BUSINESS ENTITY**

I. BUSINESS CHARACTERISTICS

| | | |
|--|-------------|--|
| 1.5 Does the Business Entity have an active Charities Registration Number? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Enter Number: _____ If Exempt/Explain: _____ If an application is pending, enter date of application: _____ Attach a copy of the application | | |
| 1.6 Does the Business Entity have a DUNS Number? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Enter DUNS Number _____ | | |
| 1.7 Is the Business Entity's principal place of business/Executive Office in New York State? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If 'No', does the Business Entity maintain an office in New York State? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Provide the address and telephone number for one New York Office. | | |
| 1.8 Is the Business Entity's principal place of business/executive office: | | |
| <input type="checkbox"/> Owned <input type="checkbox"/> Rented Landlord Name (if 'rented') _____ <input type="checkbox"/> Other Provide explanation (if 'other') _____ | | |
| Is space shared with another Business Entity? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Name of other Business Entity _____ | | |
| Address _____ | | |
| City _____ | State _____ | Zip Code _____ Country _____ |
| 1.9 Is the Business Entity a Minority Community Based Organization (MCBO)? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 1.10 Identify current Key Employees of the Business Entity. Attach additional pages if necessary. | | |
| Name | Title | |
| 1.11 Identify current Trustees/Board Members of the Business Entity. Attach additional pages if necessary. | | |
| Name | Title | |

II. AFFILIATES AND JOINT VENTURE RELATIONSHIPS

| | | |
|--|-------------------------------|--|
| 2.0 Does the Business Entity have any Affiliates? Attach additional pages if necessary (If no proceed to section III) | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Affiliate Name | Affiliate EIN (If available) | Affiliate's Primary Business Activity |
| Explain relationship with the Affiliate and indicate percent ownership, if applicable (enter N/A, if not applicable): | | |
| Are there any Business Entity Officials or Principal Owners that the Business Entity has in common with this Affiliate? | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Individual's Name | Position/Title with Affiliate | |

**NEW YORK STATE
VENDOR RESPONSIBILITY QUESTIONNAIRE
NOT-FOR-PROFIT BUSINESS ENTITY**

| III. CONTRACT HISTORY | |
|--|--|
| 3.0 Has the Business Entity held any contracts with New York State government entities in the last three (3) years? ? If “Yes” attach a list including the Contract Number, Agency Name, Contract Amount, Contract Start Date, Contract End Date, and the Contract Description. | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| IV. INTEGRITY – CONTRACT BIDDING | |
|---|--|
| Within the past five (5) years, has the Business Entity or any Affiliate | |
| 4.0 been suspended or debarred from any government contracting process or been disqualified on any government procurement? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4.1 been subject to a denial or revocation of a government prequalification? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4.2 been denied a contract or had a bid rejected based upon a finding of non-responsibility by a government entity? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4.3 agreed to a voluntary exclusion from bidding/contracting with a government entity? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4.4 initiated a request to withdraw a bid submitted to a government entity or made any claim of an error on a bid submitted to a government entity? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| For each “Yes” answer provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses. | |

| V. INTEGRITY – CONTRACT AWARD | |
|---|--|
| Within the past five (5) years, has the Business Entity or any Affiliate | |
| 5.0 been suspended, cancelled or terminated for cause on any government contract? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5.1 been subject to an administrative proceeding or civil action seeking specific performance or restitution in connection with any government contract? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5.2 entered into a formal monitoring agreement as a condition of a contract award from a government entity? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| For each “Yes” answer provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses. | |

| VI. CERTIFICATIONS/LICENSES | |
|--|--|
| 6.0 Within the past five (5) years, has the Business Entity or any Affiliate had a revocation, suspension or disbarment of any business or professional permit and/or license? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If “Yes” provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses. | |

| VII. LEGAL PROCEEDINGS | |
|--|--|
| Within the past five (5) years, has the Business Entity or any Affiliate | |
| 7.0 been the subject of an investigation, whether open or closed, by any government entity for a civil or criminal violation? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7.1 been the subject of an indictment, grant of immunity, judgment or conviction (including entering into a plea bargain) for conduct constituting a crime? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7.2 received any OSHA citation and Notification of Penalty containing a violation classified as serious or willful? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**NEW YORK STATE
VENDOR RESPONSIBILITY QUESTIONNAIRE
NOT-FOR-PROFIT BUSINESS ENTITY**

| | |
|--|--|
| VII. LEGAL PROCEEDINGS | |
| Within the past five (5) years, has the Business Entity or any Affiliate | |
| 7.3 had any New York State Labor Law violation deemed willful? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7.4 entered into a consent order with the New York State Department of Environmental Conservation, or a federal, state or local government enforcement determination involving a violation of federal, state or local environmental laws? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7.5 other than the previously disclosed: (i) Been subject to the imposition of a fine or penalty in excess of \$1,000, imposed by any government entity as a result of the issuance of citation, summons or notice of violation, or pursuant to any administrative, regulatory, or judicial determination; or (ii) Been charged or convicted of a criminal offense pursuant to any administrative and/or regulatory action taken by any government entity? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| For each "Yes" answer provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses. | |

| | |
|---|--|
| VIII. LEADERSHIP INTEGRITY | |
| Note: If the Business Entity is a Joint Venture, answer 'N/A- Not Applicable' to questions 8.0 through 8.4. | |
| Within the past five (5) years has any individual previously identified, any other Key Employees not previously identified or any individual having the authority to sign execute or approve bids, proposals, contracts or supporting documentation with New York State been subject to | |
| 8.0 a sanction imposed relative to any business or professional permit and/or license? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 8.1 an investigation, whether open or closed, by any government entity for a civil or criminal violation for any business related conduct? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 8.2 an indictment, grant of immunity, judgment, or conviction of any business related conduct constituting a crime including, but not limited to, fraud, extortion, bribery, racketeering, price fixing, bid collusion or any crime related to truthfulness? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 8.3 a misdemeanor or felony charge, indictment or conviction for: (i) any business-related activity including but not limited to fraud, coercion, extortion, bribe or bribe-receiving, giving or accepting unlawful gratuities, immigration or tax fraud, racketeering, mail fraud, wire fraud, price fixing or collusive bidding; or (ii) any crime, whether or not business related, the underlying conduct of which related to truthfulness, including but not limited to the filing of false documents or false sworn statements, perjury or larceny? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| 8.4 a debarment from any government contracting process? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| For each "Yes" answer provide an explanation of the issue(s), the individual involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses. | |

**NEW YORK STATE
VENDOR RESPONSIBILITY QUESTIONNAIRE
NOT-FOR-PROFIT BUSINESS ENTITY**

| IX. FINANCIAL AND ORGANIZATIONAL CAPACITY | |
|---|--|
| 9.0 Within the past five (5) years, has the Business Entity or any Affiliates received any formal unsatisfactory performance assessment(s) from any government entity on any contract? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If "Yes" provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses. | |
| 9.1 Within the past five (5) years, has the Business Entity or any Affiliates had any liquidated damages assessed over \$25,000? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If "Yes" provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the contracting party involved, the amount assessed and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses. | |
| 9.2 Within the past five (5) years, has the Business Entity or any Affiliates had any liens, claims or judgments over \$15,000 filed against the Business Entity which remain undischarged or were unsatisfied for more than 120 days? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If "Yes" provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, relevant dates, the lien holder or claimant's name(s), the amount of the lien(s), claim(s), or judgments(s) and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses. | |
| 9.3 Within the last seven (7) years, has the Business Entity or any Affiliate initiated or been the subject of any bankruptcy proceedings, whether or not closed, regardless of the date of filing, or is any bankruptcy proceeding pending? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If "Yes" provide the Business Entity involved, the relationship to the submitting Business Entity, the Bankruptcy Chapter Number, the Court name, the Docket Number. Indicate the current status of the proceedings as "Initiated," "Pending" or "Closed". Provide answer below or attach additional sheets with numbered responses. | |
| 9.4 During the past three (3) years, has the Business Entity and any Affiliates failed to file or pay any tax returns required by federal, state or local tax laws? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If "Yes" provide the Business Entity involved, the relationship to the submitting Business Entity, the taxing jurisdiction (federal, state or other), the type of tax, the liability year(s), the Tax Liability amount the Business Entity failed to file/pay, and the current status of the Tax Liability. Provide answer below or attach additional sheets with numbered responses. | |
| 9.5 During the past three (3) years, has the Business Entity and any Affiliates failed to file or pay any New York State unemployment insurance returns? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If "Yes" provide the Business Entity involved, the relationship to the submitting Business Entity, the year(s) the Business Entity failed to file/pay the insurance, explain the situation, and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses. | |
| 9.6 During the past three (3) years, has the Business Entity or any Affiliates had any government audits? If "Yes", did any audit reveal material weaknesses in the Business Entity's system of internal controls If "Yes", did any audit reveal non-compliance with contractual agreements or any material disallowance (if not previously disclosed in 9.6)? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No |
| For each "Yes" answer provide an explanation of the issue(s), the Business Entity involved, the relationship to the submitting Business Entity, the government entity involved, relevant dates and any remedial or corrective action(s) taken and the current status of the issue(s). Provide answer below or attach additional sheets with numbered responses. | |

**NEW YORK STATE
VENDOR RESPONSIBILITY QUESTIONNAIRE
NOT-FOR-PROFIT BUSINESS ENTITY**

| X. FREEDOM OF INFORMATION LAW (FOIL) | |
|---|--|
| 10.0 Indicate whether any information supplied herein is believed to be exempt from disclosure under the Freedom of Information Law (FOIL). Note: A determination of whether such information is exempt from FOIL will be made at the time of any request for disclosure under FOIL. | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Indicate the question number(s) and explain the basis for your claim. | |

**NEW YORK STATE
VENDOR RESPONSIBILITY QUESTIONNAIRE
NOT-FOR-PROFIT BUSINESS ENTITY**

Certification

The undersigned: (1) recognizes that this questionnaire is submitted for the express purpose of assisting New York State contracting entities in making responsibility determinations regarding an award of a contract or approval of a subcontract; (2) recognizes that the Office of the State Comptroller (OSC) will rely on information disclosed in the questionnaire in making responsibility determinations and in approving a contract or subcontract; (3) acknowledges that the New York State contracting entities and OSC may, in their discretion, by means which they may choose, verify the truth and accuracy of all statements made herein; and (4) acknowledges that intentional submission of false or misleading information may constitute a misdemeanor or felony under New York State Penal Law, may be punishable by a fine and/or imprisonment under Federal Law, and may result in a finding of non-responsibility, contract suspension or contract termination.

The undersigned certifies that he/she:

- is knowledgeable about the submitting Business Entity's business and operations;
- has read and understands all of the questions contained in the questionnaire;
- has not altered the content of the questionnaire in any manner;
- has reviewed and/or supplied full and complete responses to each question;
- to the best of his/her knowledge, information and belief, confirms that the Business Entity's responses are true, accurate and complete, including all attachments, if applicable;
- understands that New York State will rely on the information disclosed in the questionnaire when entering into a contract with the Business Entity; and
- is under obligation to update the information provided herein to include any material changes to the Business Entity's responses at the time of bid/proposal submission through the contract award notification, and may be required to update the information at the request of the New York State contracting entities or OSC prior to the award and/or approval of a contract, or during the term of the contract.

Signature of Owner/Officer _____

Printed Name of Signatory _____

Title _____

Name of Business _____

Address _____

City, State, Zip _____

Sworn to before me this _____ day of _____, 20____;

_____ Notary Public

Attachment 29

BIDDERS' CHECKLIST – PROPOSAL ORGANIZATION

BIDDERS' CHECKLIST – PROPOSAL ORGANIZATION

| | Technical Proposal | Part of RFP |
|--------------------------|--|---------------------|
| <input type="checkbox"/> | Transmittal Letter | D.3.b.I. |
| <input type="checkbox"/> | Subcontractor Letters of Intent, if any | |
| <input type="checkbox"/> | Table of Contents | D.3.b.II. |
| <input type="checkbox"/> | Executive Summary | D.3.b.III. |
| <input type="checkbox"/> | Bidder's Assurances | D.3.b.VII., Att.10 |
| <input type="checkbox"/> | Preferred Eligibility Form | B.3.b.IV(A), Att. 9 |
| <input type="checkbox"/> | Narrative: Organization Mission | B.3.b.IV(B) |
| <input type="checkbox"/> | Narrative: Applicant Capability | D.3.b.IV(C) |
| <input type="checkbox"/> | Narrative: Experience | D.3.b.IV(D) |
| <input type="checkbox"/> | Narrative: Staffing | D.3.b.IV(E) |
| <input type="checkbox"/> | Direct Staffing Summary | Att. 7 |
| <input type="checkbox"/> | Indirect Staffing Summary | Att. 8 |
| <input type="checkbox"/> | Narrative: Work Plan | D.3.b.IV(F) |
| <input type="checkbox"/> | Narrative: Service Units | D.3.b.V., C.2. |
| <input type="checkbox"/> | Service Units Technical Form | Att. 6 |
| <input type="checkbox"/> | Narrative: Data Security | D.3.b.VI. |
| <input type="checkbox"/> | HIPAA Business Associate Agreement | Att. 26 |
| <input type="checkbox"/> | Narrative: Conflict of Interest Plan | D.3.b.VIII. |
| <input type="checkbox"/> | Conflict of Interest Statement | Att. 11 |
| <input type="checkbox"/> | Narrative: Medicaid Confidentiality | D.3.b.IX. |
| <input type="checkbox"/> | Medicaid Confidentiality and Data Use Agreements | Att. 27 |
| <input type="checkbox"/> | Narrative: Start Up Activities | D.3.b.X. |
| <input type="checkbox"/> | Narrative: General Administration | D.3.b.XI(A) |
| <input type="checkbox"/> | Narrative: Administrative Case Management | D.3.b.XI(B) |
| <input type="checkbox"/> | Narrative: Training | D.3.b.XII. |
| <input type="checkbox"/> | Narrative: Travel | D.3.b.XIII. |

General Documentation & Vendor Responsibility

| | | |
|--------------------------|---|--------|
| <input type="checkbox"/> | Curricula Vitae, Licenses and Certifications for Staff Managing the Contract and Assigned to Contract Functions | D.5.a. |
| <input type="checkbox"/> | Audited Financial Statements | D.5.b. |
| <input type="checkbox"/> | Subcontractor Financial Information, if applicable | D.5.b. |
| <input type="checkbox"/> | References | D.5.c. |

| | | |
|--|---|--------------------|
| | Vendor Responsibility Questionnaire, if applicable | |
| | Vendor Responsibility Attestation | D.5.d., Att. 13 |
| | Proof of Incorporation, Copy of Partnership Agreement, DBA, or Authority to Do Business in New York | D.5.e. |
| | Certificate of Authority, if applicable | D.5.f. |
| | NYS DTF Contractor Certification Forms | D.5.g, Att.16 & 17 |
| | Additional Documentation | D.5.h. |

Cost Proposal

| | | |
|--|--|--------------------|
| | Bid Form | D.4.b., Att.3 |
| | Line Item Bid Form | D.4.c., Att. 5 |
| | Minority / Women's Business Enterprise (M/WBE) Forms | D.4.d.I., Att.12 |
| | Consultant Services Form A | D.4.d.II., Att.14. |