STATE OF HAWAII

Department of Human Services

REQUEST FOR PROPOSAL (RFP)

To Provide External Quality Reviews and Peer Review Organization Services of Medicaid QUEST Integration Managed Care Organizations/Prepaid Inpatient Health Plan for the Medicaid Program

RFP-MQD-2022-001

APPENDICES

APPENDIX A: OFFER FORM 1

To Provide External Quality Reviews and Peer Review Organization Services of Medicaid QUEST Integration Managed Care Organizations/ Prepaid Inpatient Health Plan for the Medicaid Program (RFP-MQD-2022-001)

Ms. Meredith Nichols
C/o Renee Souza
Department of Human Services/Med-QUEST Division
1001 Kamokila Boulevard, Suite 317
Kapolei, Hawaii 96707

Dear Sir:
The undersigned has carefully read and understands the terms and conditions specified in the Specifications and Special Provisions attached hereto, and in the General Conditions, Form AG-008 103D General Conditions, by reference made a part hereof and available upon request; and hereby submits the following offer to perform the work specified herein, all in accordance with the true intent and meaning thereof. The undersigned further understands and agrees that by submitting this offer, 1) he/she is declaring his/her offer is not in violation of Chapter 84, Hawaii Revised Statutes, concerning prohibited State contracts, and 2) he/she is certifying that the price(s) submitted was (were) independently arrived without collusion.

Offeror is:

☐ Sole Proprietor ☐ Partnership ☐ *Corporation ☐ Joint Venture

☐ Other

*State of incorporation: _____

Federal I.D. No**.:** _____

Hawaii General Excise Tax License **I.D. No.:** _____

Payment address (other than street address below): _____

City, State, Zip Code: _____

Business address (street address): _____

City, State, Zip Code: _____

Respectfully submitted,

(x) _____
Authorized (Original) Signature

_____
Name and Title (Please Print or Type)

Date: _____

Telephone No.: _____

Fax No: _____

Exact Legal Name of Company (Contractor)

*If Offeror is a "d.b.a." or a "division" of a corporation, furnish the exact legal name of the corporation under which the contract, if awarded, will be executed:

Email Address:_____ _____

Appendix B
Written Questions Format
EQRO/PRO SERVICES
RFP-MQD-2022-001

Applicant Name	Date Submitted	Question #	RFP Section #	RFP Page #	Paragraph #	Question

To Provide External Quality Reviews and Peer Review Organization Services of Medicaid QUEST Integration Managed Care Organizations/ Prepaid Inpatient Health Plan for the Medicaid Program Notice of Intent to Propose

RFP Number and Title: RFP-MQD-2022-001

Offeror Name: _____

Name and Title of the Authorized Individual: _____

Signature and Date: _____

Contact Person Information

First Name: _____ Last Name: _____

E-mail Address: _____

Telephone: _____

List up to five (5) contact person(s) who can upload, revise or edit the Technical and Business proposals in the DHS proposal designated electronic submission site. DHS will provide the submission site address to these five (5) staff no later than ten (10) calendar days before the proposal due date as described in Section 20.100.

	First Name, Last Name	Title	E-mail Address	Contact Phone Number
1				
2				
3				
4				
5				

APPENDIX D - GENERAL CONDITIONS

GENERAL CONDITIONS

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1. Coordination of Services by the STATE. The head of the purchasing agency ("HOPA") (which term includes the designee of the HOPA) shall coordinate the services to be provided by the CONTRACTOR in order to complete the performance required in the Contract. The CONTRACTOR shall maintain communications with HOPA at all stages of the CONTRACTOR'S work, and submit to HOPA for resolution any questions which may arise as to the performance of this Contract. "Purchasing agency" as used in these General Conditions means and includes any governmental body which is authorized under chapter 103D, HRS, or its implementing rules and procedures, or by way of delegation, to enter into contracts for the procurement of goods or services or both.

2. Relationship of Parties: Independent Contractor Status and Responsibilities, Including Tax Responsibilities.

   a. In the performance of services required under this Contract, the CONTRACTOR is an "independent contractor," with the authority and responsibility to control and direct the performance and details of the work and services required under this Contract; however, the STATE shall have a general right to inspect work in progress to determine whether, in the STATE'S opinion, the services are being performed by the CONTRACTOR in compliance with this Contract. Unless otherwise provided by special condition, it is understood that the STATE does not agree to use the CONTRACTOR exclusively, and that the CONTRACTOR is free to contract to provide services to other individuals or entities while under contract with the STATE.

   b. The CONTRACTOR and the CONTRACTOR'S employees and agents are not by reason of this Contract, agents or employees of the State for any purpose, and the CONTRACTOR and the CONTRACTOR'S employees and agents shall not be entitled to claim or receive from the State any vacation, sick leave, retirement, workers' compensation, unemployment insurance, or other benefits provided to state employees.

   c. The CONTRACTOR shall be responsible for the accuracy, completeness, and adequacy of the CONTRACTOR'S performance under this Contract. Furthermore, the CONTRACTOR intentionally, voluntarily, and knowingly assumes the sole and entire liability to the CONTRACTOR'S employees and agents, and to any individual not a party to this Contract, for all loss, damage, or injury caused by the CONTRACTOR, or the CONTRACTOR'S employees or agents in the course of their employment.

   d. The CONTRACTOR shall be responsible for payment of all applicable federal, state, and county taxes and fees which may become due and owing by the CONTRACTOR by reason of this Contract, including but not limited to (i) income taxes, (ii) employment related fees, assessments, and taxes, and (iii) general excise taxes. The CONTRACTOR also is responsible for obtaining all licenses, permits, and certificates that may be required in order to perform this Contract.

   e. The CONTRACTOR shall obtain a general excise tax license from the Department of Taxation, State of Hawaii, in accordance with section 237-9, HRS, and shall comply with all requirements thereof. The CONTRACTOR shall obtain a tax clearance certificate from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of the Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid and submit the same to the STATE prior to commencing any performance under this Contract. The CONTRACTOR shall also be solely responsible for meeting all requirements necessary to obtain the tax clearance certificate required for final payment under sections 103-53 and 103D-328, HRS, and paragraph 17 of these General Conditions.

   f. The CONTRACTOR is responsible for securing all employee-related insurance coverage for the CONTRACTOR and the CONTRACTOR'S employees and agents that is or may be required by law, and for payment of all premiums, costs, and other liabilities associated with securing the insurance coverage.

g. The CONTRACTOR shall obtain a certificate of compliance issued by the Department of Labor and Industrial Relations, State of Hawaii, in accordance with section103D-310, HRS, and section 3-122-112, HAR, that is current within six months of the date of issuance.

h. The CONTRACTOR shall obtain a certificate of good standing issued by the Department of Commerce and Consumer Affairs, State of Hawaii, in accordance with section 103D-310, HRS, and section 3-122-112, HAR, that is current within six months of the date of issuance.

i. In lieu of the above certificates from the Department of Taxation, Labor and Industrial Relations, and Commerce and Consumer Affairs, the CONTRACTOR may submit proof of compliance through the State Procurement Office's designated certification process.

3. Personnel Requirements.

a. The CONTRACTOR shall secure, at the CONTRACTOR'S own expense, all personnel required to perform this Contract.

b. The CONTRACTOR shall ensure that the CONTRACTOR'S employees or agents are experienced and fully qualified to engage in the activities and perform the services required under this Contract, and that all applicable licensing and operating requirements imposed or required under federal, state, or county law, and all applicable accreditation and other standards of quality generally accepted in the field of the activities of such employees and agents are complied with and satisfied.

4. Nondiscrimination. No person performing work under this Contract, including any subcontractor, employee, or agent of the CONTRACTOR, shall engage in any discrimination that is prohibited by any applicable federal, state, or county law.

5. Conflicts of Interest. The CONTRACTOR represents that neither the CONTRACTOR, nor any employee or agent of the CONTRACTOR, presently has any interest, and promises that no such interest, direct or indirect, shall be acquired, that would or might conflict in any manner or degree with the CONTRACTOR'S performance under this Contract.

6. Subcontracts and Assignments. The CONTRACTOR shall not assign or subcontract any of the CONTRACTOR'S duties, obligations, or interests under this Contract and no such assignment or subcontract shall be effective unless (i) the CONTRACTOR obtains the prior written consent of the STATE, and (ii) the CONTRACTOR'S assignee or subcontractor submits to the STATE a tax clearance certificate from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR'S assignee or subcontractor have been paid. Additionally, no assignment by the CONTRACTOR of the CONTRACTOR'S right to compensation under this Contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawaii, as provided in section 40-58, HRS.

a. Recognition of a successor in interest. When in the best interest of the State, a successor in interest may be recognized in an assignment contract in which the STATE, the CONTRACTOR and the assignee or transferee (hereinafter referred to as the "Assignee") agree that:

(1) The Assignee assumes all of the CONTRACTOR'S obligations;

(2) The CONTRACTOR remains liable for all obligations under this Contract but waives all rights under this Contract as against the STATE; and

(3) The CONTRACTOR shall continue to furnish, and the Assignee shall also furnish, all required bonds.

b. Change of name. When the CONTRACTOR asks to change the name in which it holds this Contract with the STATE, the procurement officer of the purchasing agency (hereinafter referred to as the "Agency procurement officer") shall, upon receipt of a document acceptable or satisfactory to the

Agency procurement officer indicating such change of name (for example, an amendment to the CONTRACTOR'S articles of incorporation), enter into an amendment to this Contract with the CONTRACTOR to effect such a change of name. The amendment to this Contract changing the CONTRACTOR'S name shall specifically indicate that no other terms and conditions of this Contract are thereby changed.

c. Reports. All assignment contracts and amendments to this Contract effecting changes of the CONTRACTOR'S name or novations hereunder shall be reported to the chief procurement officer (CPO) as defined in section 103D-203(a), HRS, within thirty days of the date that the assignment contract or amendment becomes effective.

d. Actions affecting more than one purchasing agency. Notwithstanding the provisions of subparagraphs 6a through 6c herein, when the CONTRACTOR holds contracts with more than one purchasing agency of the State, the assignment contracts and the novation and change of name amendments herein authorized shall be processed only through the CPO's office.

7. Indemnification and Defense. The CONTRACTOR shall defend, indemnify, and hold harmless the State of Hawaii, the contracting agency, and their officers, employees, and agents from and against all liability, loss, damage, cost, and expense, including all attorneys' fees, and all claims, suits, and demands therefore, arising out of or resulting from the acts or omissions of the CONTRACTOR or the CONTRACTOR'S employees, officers, agents, or subcontractors under this Contract. The provisions of this paragraph shall remain in full force and effect notwithstanding the expiration or early termination of this Contract.

8. Cost of Litigation. In case the STATE shall, without any fault on its part, be made a party to any litigation commenced by or against the CONTRACTOR in connection with this Contract, the CONTRACTOR shall pay all costs and expenses incurred by or imposed on the STATE, including attorneys' fees.

9. Liquidated Damages. When the CONTRACTOR is given notice of delay or nonperformance as specified in paragraph 13 (Termination for Default) and fails to cure in the time specified, it is agreed the CONTRACTOR shall pay to the STATE the amount, if any, set forth in this Contract per calendar day from the date set for cure until either (i) the STATE reasonably obtains similar goods or services, or both, if the CONTRACTOR is terminated for default, or (ii) until the CONTRACTOR provides the goods or services, or both, if the CONTRACTOR is not terminated for default. To the extent that the CONTRACTOR'S delay or nonperformance is excused under paragraph 13d (Excuse for Nonperformance or Delay Performance), liquidated damages shall not be assessable against the CONTRACTOR. The CONTRACTOR remains liable for damages caused other than by delay.

10. STATE'S Right of Offset. The STATE may offset against any monies or other obligations the STATE owes to the CONTRACTOR under this Contract, any amounts owed to the State of Hawaii by the CONTRACTOR under this Contract or any other contracts, or pursuant to any law or other obligation owed to the State of Hawaii by the CONTRACTOR, including, without limitation, the payment of any taxes or levies of any kind or nature. The STATE will notify the CONTRACTOR in writing of any offset and the nature of such offset. For purposes of this paragraph, amounts owed to the State of Hawaii shall not include debts or obligations which have been liquidated, agreed to by the CONTRACTOR, and are covered by an installment payment or other settlement plan approved by the State of Hawaii, provided, however, that the CONTRACTOR shall be entitled to such exclusion only to the extent that the CONTRACTOR is current with, and not delinquent on, any payments or obligations owed to the State of Hawaii under such payment or other settlement plan.

11. Disputes. Disputes shall be resolved in accordance with section 103D-703, HRS, and chapter 3-126, Hawaii Administrative Rules ("HAR"), as the same may be amended from time to time.

12. Suspension of Contract. The STATE reserves the right at any time and for any reason to suspend this Contract for any reasonable period, upon written notice to the CONTRACTOR in accordance with the provisions herein.

a. Order to stop performance. The Agency procurement officer may, by written order to the CONTRACTOR, at any time, and without notice to any surety, require the CONTRACTOR to stop all or any part of the performance called for by this Contract. This order shall be for a specified

period not exceeding sixty (60) days after the order is delivered to the CONTRACTOR, unless the parties agree to any further period. Any such order shall be identified specifically as a stop performance order issued pursuant to this section. Stop performance orders shall include, as appropriate: (1) A clear description of the work to be suspended; (2) Instructions as to the issuance of further orders by the CONTRACTOR for material or services; (3) Guidance as to action to be taken on subcontracts; and (4) Other instructions and suggestions to the CONTRACTOR for minimizing costs. Upon receipt of such an order, the CONTRACTOR shall forthwith comply with its terms and suspend all performance under this Contract at the time stated, provided, however, the CONTRACTOR shall take all reasonable steps to minimize the occurrence of costs allocable to the performance covered by the order during the period of performance stoppage. Before the stop performance order expires, or within any further period to which the parties shall have agreed, the Agency procurement officer shall either:

(1) Cancel the stop performance order; or

(2) Terminate the performance covered by such order as provided in the termination for default provision or the termination for convenience provision of this Contract.

b. Cancellation or expiration of the order. If a stop performance order issued under this section is cancelled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the CONTRACTOR shall have the right to resume performance. An appropriate adjustment shall be made in the delivery schedule or contract price, or both, and the Contract shall be modified in writing accordingly, if:

(1) The stop performance order results in an increase in the time required for, or in the CONTRACTOR'S cost properly allocable to, the performance of any part of this Contract; and

(2) The CONTRACTOR asserts a claim for such an adjustment within thirty (30) days after the end of the period of performance stoppage; provided that, if the Agency procurement officer decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract.

c. Termination of stopped performance. If a stop performance order is not cancelled and the performance covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop performance order shall be allowable by adjustment or otherwise.

d. Adjustment of price. Any adjustment in contract price made pursuant to this paragraph shall be determined in accordance with the price adjustment provision of this Contract.

13. Termination for Default.

a. Default. If the CONTRACTOR refuses or fails to perform any of the provisions of this Contract with such diligence as will ensure its completion within the time specified in this Contract, or any extension thereof, otherwise fails to timely satisfy the Contract provisions, or commits any other substantial breach of this Contract, the Agency procurement officer may notify the CONTRACTOR in writing of the delay or non-performance and if not cured in ten (10) days or any longer time specified in writing by the Agency procurement officer, such officer may terminate the CONTRACTOR'S right to proceed with the Contract or such part of the Contract as to which there has been delay or a failure to properly perform. In the event of termination in whole or in part, the Agency procurement officer may procure similar goods or services in a manner and upon the terms deemed appropriate by the Agency procurement officer. The CONTRACTOR shall continue performance of the Contract to the extent it is not terminated and shall be liable for excess costs incurred in procuring similar goods or services.

b. CONTRACTOR'S duties. Notwithstanding termination of the Contract and subject to any directions from the Agency procurement officer, the CONTRACTOR shall take timely, reasonable, and

necessary action to protect and preserve property in the possession of the CONTRACTOR in which the STATE has an interest.

c. Compensation. Payment for completed goods and services delivered and accepted by the STATE shall be at the price set forth in the Contract. Payment for the protection and preservation of property shall be in an amount agreed upon by the CONTRACTOR and the Agency procurement officer. If the parties fail to agree, the Agency procurement officer shall set an amount subject to the CONTRACTOR'S rights under chapter 3-126, HAR. The STATE may withhold from amounts due the CONTRACTOR such sums as the Agency procurement officer deems to be necessary to protect the STATE against loss because of outstanding liens or claims and to reimburse the STATE for the excess costs expected to be incurred by the STATE in procuring similar goods and services.

d. Excuse for nonperformance or delayed performance. The CONTRACTOR shall not be in default by reason of any failure in performance of this Contract in accordance with its terms, including any failure by the CONTRACTOR to make progress in the prosecution of the performance hereunder which endangers such performance, if the CONTRACTOR has notified the Agency procurement officer within fifteen (15) days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of a public enemy; acts of the State and any other governmental body in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather. If the failure to perform is caused by the failure of a subcontractor to perform or to make progress, and if such failure arises out of causes similar to those set forth above, the CONTRACTOR shall not be deemed to be in default, unless the goods and services to be furnished by the subcontractor were reasonably obtainable from other sources in sufficient time to permit the CONTRACTOR to meet the requirements of the Contract. Upon request of the CONTRACTOR, the Agency procurement officer shall ascertain the facts and extent of such failure, and, if such officer determines that any failure to perform was occasioned by any one or more of the excusable causes, and that, but for the excusable cause, the CONTRACTOR'S progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly, subject to the rights of the STATE under this Contract. As used in this paragraph, the term "subcontractor" means subcontractor at any tier.

e. Erroneous termination for default. If, after notice of termination of the CONTRACTOR'S right to proceed under this paragraph, it is determined for any reason that the CONTRACTOR was not in default under this paragraph, or that the delay was excusable under the provisions of subparagraph 13d, "Excuse for nonperformance or delayed performance," the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to paragraph 14.

f. Additional rights and remedies. The rights and remedies provided in this paragraph are in addition to any other rights and remedies provided by law or under this Contract.

14. Termination for Convenience.

a. Termination. The Agency procurement officer may, when the interests of the STATE so require, terminate this Contract in whole or in part, for the convenience of the STATE. The Agency procurement officer shall give written notice of the termination to the CONTRACTOR specifying the part of the Contract terminated and when termination becomes effective.

b. CONTRACTOR'S obligations. The CONTRACTOR shall incur no further obligations in connection with the terminated performance and on the date(s) set in the notice of termination the CONTRACTOR will stop performance to the extent specified. The CONTRACTOR shall also terminate outstanding orders and subcontracts as they relate to the terminated performance. The CONTRACTOR shall settle the liabilities and claims arising out of the termination of subcontracts and orders connected with the terminated performance subject to the STATE'S approval. The Agency procurement officer may direct the CONTRACTOR to assign the CONTRACTOR'S right, title, and interest under terminated orders or subcontracts to the STATE. The CONTRACTOR must still complete the performance not terminated by the notice of termination and may incur obligations as necessary to do so.

c. Right to goods and work product. The Agency procurement officer may require the CONTRACTOR to transfer title and deliver to the STATE in the manner and to the extent directed by the Agency procurement officer:

(1) Any completed goods or work product; and

(2) The partially completed goods and materials, parts, tools, dies, jigs, fixtures, plans, drawings, information, and contract rights (hereinafter called "manufacturing material") as the CONTRACTOR has specifically produced or specially acquired for the performance of the terminated part of this Contract.

The CONTRACTOR shall, upon direction of the Agency procurement officer, protect and preserve property in the possession of the CONTRACTOR in which the STATE has an interest. If the Agency procurement officer does not exercise this right, the CONTRACTOR shall use best efforts to sell such goods and manufacturing materials. Use of this paragraph in no way implies that the STATE has breached the Contract by exercise of the termination for convenience provision.

d. Compensation.

(1) The CONTRACTOR shall submit a termination claim specifying the amounts due because of the termination for convenience together with the cost or pricing data, submitted to the extent required by chapter 3-122, HAR, bearing on such claim. If the CONTRACTOR fails to file a termination claim within one year from the effective date of termination, the Agency procurement officer may pay the CONTRACTOR, if at all, an amount set in accordance with subparagraph 14d(3) below.

(2) The Agency procurement officer and the CONTRACTOR may agree to a settlement provided the CONTRACTOR has filed a termination claim supported by cost or pricing data submitted as required and that the settlement does not exceed the total Contract price plus settlement costs reduced by payments previously made by the STATE, the proceeds of any sales of goods and manufacturing materials under subparagraph 14c, and the Contract price of the performance not terminated.

(3) Absent complete agreement under subparagraph 14d(2) the Agency procurement officer shall pay the CONTRACTOR the following amounts, provided payments agreed to under subparagraph 14d(2) shall not duplicate payments under this subparagraph for the following:

(A) Contract prices for goods or services accepted under the Contract;

(B) Costs incurred in preparing to perform and performing the terminated portion of the performance plus a fair and reasonable profit on such portion of the performance, such profit shall not include anticipatory profit or consequential damages, less amounts paid or to be paid for accepted goods or services; provided, however, that if it appears that the CONTRACTOR would have sustained a loss if the entire Contract would have been completed, no profit shall be allowed or included and the amount of compensation shall be reduced to reflect the anticipated rate of loss;

(C) Costs of settling and paying claims arising out of the termination of subcontracts or orders pursuant to subparagraph 14b. These costs must not include costs paid in accordance with subparagraph 14d(3)(B);

(D) The reasonable settlement costs of the CONTRACTOR, including accounting, legal, clerical, and other expenses reasonably necessary for the preparation of settlement claims and supporting data with respect to the terminated portion of the Contract and for the termination of subcontracts thereunder, together with reasonable storage, transportation, and other costs incurred in connection with the protection or disposition of property allocable to the terminated portion of this Contract. The total sum to be paid the CONTRACTOR under this subparagraph shall not exceed the

total Contract price plus the reasonable settlement costs of the CONTRACTOR reduced by the amount of payments otherwise made, the proceeds of any sales of supplies and manufacturing materials under subparagraph 14d(2), and the contract price of performance not terminated.

(4) Costs claimed, agreed to, or established under subparagraphs 14d(2) and 14d(3) shall be in accordance with Chapter 3-123 (Cost Principles) of the Procurement Rules.

15. Claims Based on the Agency Procurement Officer's Actions or Omissions.

a. Changes in scope. If any action or omission on the part of the Agency procurement officer (which term includes the designee of such officer for purposes of this paragraph 15) requiring performance changes within the scope of the Contract constitutes the basis for a claim by the CONTRACTOR for additional compensation, damages, or an extension of time for completion, the CONTRACTOR shall continue with performance of the Contract in compliance with the directions or orders of such officials, but by so doing, the CONTRACTOR shall not be deemed to have prejudiced any claim for additional compensation, damages, or an extension of time for completion; provided:

(1) Written notice required. The CONTRACTOR shall give written notice to the Agency procurement officer:

(A) Prior to the commencement of the performance involved, if at that time the CONTRACTOR knows of the occurrence of such action or omission;

(B) Within thirty (30) days after the CONTRACTOR knows of the occurrence of such action or omission, if the CONTRACTOR did not have such knowledge prior to the commencement of the performance; or

(C) Within such further time as may be allowed by the Agency procurement officer in writing.

(2) Notice content. This notice shall state that the CONTRACTOR regards the act or omission as a reason which may entitle the CONTRACTOR to additional compensation, damages, or an extension of time. The Agency procurement officer, upon receipt of such notice, may rescind such action, remedy such omission, or take such other steps as may be deemed advisable in the discretion of the Agency procurement officer;

(3) Basis must be explained. The notice required by subparagraph 15a(1) describes as clearly as practicable at the time the reasons why the CONTRACTOR believes that additional compensation, damages, or an extension of time may be remedies to which the CONTRACTOR is entitled; and

(4) Claim must be justified. The CONTRACTOR must maintain and, upon request, make available to the Agency procurement officer within a reasonable time, detailed records to the extent practicable, and other documentation and evidence satisfactory to the STATE, justifying the claimed additional costs or an extension of time in connection with such changes.

b. CONTRACTOR not excused. Nothing herein contained, however, shall excuse the CONTRACTOR from compliance with any rules or laws precluding any state officers and CONTRACTOR from acting in collusion or bad faith in issuing or performing change orders which are clearly not within the scope of the Contract.

c. Price adjustment. Any adjustment in the price made pursuant to this paragraph shall be determined in accordance with the price adjustment provision of this Contract.

16. Costs and Expenses. Any reimbursement due the CONTRACTOR for per diem and transportation expenses under this Contract shall be subject to chapter 3-123 (Cost Principles), HAR, and the following guidelines:

a. Reimbursement for air transportation shall be for actual cost or coach class air fare, whichever is less.

b. Reimbursement for ground transportation costs shall not exceed the actual cost of renting an intermediate-sized vehicle.

c. Unless prior written approval of the HOPA is obtained, reimbursement for subsistence allowance (i.e., hotel and meals, etc.) shall not exceed the applicable daily authorized rates for inter-island or out-of-state travel that are set forth in the current Governor's Executive Order authorizing adjustments in salaries and benefits for state officers and employees in the executive branch who are excluded from collective bargaining coverage.

17. Payment Procedures; Final Payment; Tax Clearance.

a. Original invoices required. All payments under this Contract shall be made only upon submission by the CONTRACTOR of original invoices specifying the amount due and certifying that services requested under the Contract have been performed by the CONTRACTOR according to the Contract.

b. Subject to available funds. Such payments are subject to availability of funds and allotment by the Director of Finance in accordance with chapter 37, HRS. Further, all payments shall be made in accordance with and subject to chapter 40, HRS.

c. Prompt payment.

(1) Any money, other than retainage, paid to the CONTRACTOR shall be disbursed to subcontractors within ten (10) days after receipt of the money in accordance with the terms of the subcontract; provided that the subcontractor has met all the terms and conditions of the subcontract and there are no bona fide disputes; and

(2) Upon final payment to the CONTRACTOR, full payment to the subcontractor, including retainage, shall be made within ten (10) days after receipt of the money; provided that there are no bona fide disputes over the subcontractor's performance under the subcontract.

d. Final payment. Final payment under this Contract shall be subject to sections 103-53 and 103D-328, HRS, which require a tax clearance from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid. Further, in accordance with section 3-122-112, HAR, CONTRACTOR shall provide a certificate affirming that the CONTRACTOR has remained in compliance with all applicable laws as required by this section.

18. Federal Funds. If this Contract is payable in whole or in part from federal funds, CONTRACTOR agrees that, as to the portion of the compensation under this Contract to be payable from federal funds, the CONTRACTOR shall be paid only from such funds received from the federal government, and shall not be paid from any other funds. Failure of the STATE to receive anticipated federal funds shall not be considered a breach by the STATE or an excuse for nonperformance by the CONTRACTOR.

19. Modifications of Contract.

a. In writing. Any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract permitted by this Contract shall be made by written amendment to this Contract, signed by the CONTRACTOR and the STATE, provided that change orders shall be made in accordance with paragraph 20 herein.

b. No oral modification. No oral modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract shall be permitted.

c. Agency procurement officer. By written order, at any time, and without notice to any surety, the Agency procurement officer may unilaterally order of the CONTRACTOR:

(A) Changes in the work within the scope of the Contract; and

(B) Changes in the time of performance of the Contract that do not alter the scope of the Contract work.

d. Adjustments of price or time for performance. If any modification increases or decreases the CONTRACTOR'S cost of, or the time required for, performance of any part of the work under this Contract, an adjustment shall be made and this Contract modified in writing accordingly. Any adjustment in contract price made pursuant to this clause shall be determined, where applicable, in accordance with the price adjustment clause of this Contract or as negotiated.

e. Claim barred after final payment. No claim by the CONTRACTOR for an adjustment hereunder shall be allowed if written modification of the Contract is not made prior to final payment under this Contract.

f. Claims not barred. In the absence of a written contract modification, nothing in this clause shall be deemed to restrict the CONTRACTOR'S right to pursue a claim under this Contract or for a breach of contract.

g. Head of the purchasing agency approval. If this is a professional services contract awarded pursuant to section 103D-303 or 103D-304, HRS, any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract which increases the amount payable to the CONTRACTOR by at least $25,000.00 and ten per cent (10%) or more of the initial contract price, must receive the prior approval of the head of the purchasing agency.

h. Tax clearance. The STATE may, at its discretion, require the CONTRACTOR to submit to the STATE, prior to the STATE'S approval of any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract, a tax clearance from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid.

i. Sole source contracts. Amendments to sole source contracts that would change the original scope of the Contract may only be made with the approval of the CPO. Annual renewal of a sole source contract for services should not be submitted as an amendment.

20. Change Order. The Agency procurement officer may, by a written order signed only by the STATE, at any time, and without notice to any surety, and subject to all appropriate adjustments, make changes within the general scope of this Contract in any one or more of the following:

(1) Drawings, designs, or specifications, if the goods or services to be furnished are to be specially provided to the STATE in accordance therewith;

(2) Method of delivery; or

(3) Place of delivery.

a. Adjustments of price or time for performance. If any change order increases or decreases the CONTRACTOR'S cost of, or the time required for, performance of any part of the work under this Contract, whether or not changed by the order, an adjustment shall be made and the Contract modified in writing accordingly. Any adjustment in the Contract price made pursuant to this provision shall be determined in accordance with the price adjustment provision of this Contract. Failure of the parties to agree to an adjustment shall not excuse the CONTRACTOR from proceeding with the Contract as changed, provided that the Agency procurement officer promptly and duly makes the provisional adjustments in payment or time for performance as may be reasonable. By

proceeding with the work, the CONTRACTOR shall not be deemed to have prejudiced any claim for additional compensation, or any extension of time for completion.

b. Time period for claim. Within ten (10) days after receipt of a written change order under subparagraph 20a, unless the period is extended by the Agency procurement officer in writing, the CONTRACTOR shall respond with a claim for an adjustment. The requirement for a timely written response by CONTRACTOR cannot be waived and shall be a condition precedent to the assertion of a claim.

c. Claim barred after final payment. No claim by the CONTRACTOR for an adjustment hereunder shall be allowed if a written response is not given prior to final payment under this Contract.

d. Other claims not barred. In the absence of a change order, nothing in this paragraph 20 shall be deemed to restrict the CONTRACTOR'S right to pursue a claim under the Contract or for breach of contract.

21. Price Adjustment.

a. Price adjustment. Any adjustment in the contract price pursuant to a provision in this Contract shall be made in one or more of the following ways:

(1) By agreement on a fixed price adjustment before commencement of the pertinent performance or as soon thereafter as practicable;

(2) By unit prices specified in the Contract or subsequently agreed upon;

(3) By the costs attributable to the event or situation covered by the provision, plus appropriate profit or fee, all as specified in the Contract or subsequently agreed upon;

(4) In such other manner as the parties may mutually agree; or

(5) In the absence of agreement between the parties, by a unilateral determination by the Agency procurement officer of the costs attributable to the event or situation covered by the provision, plus appropriate profit or fee, all as computed by the Agency procurement officer in accordance with generally accepted accounting principles and applicable sections of chapters 3-123 and 3-126, HAR.

b. Submission of cost or pricing data. The CONTRACTOR shall provide cost or pricing data for any price adjustments subject to the provisions of chapter 3-122, HAR.

22. Variation in Quantity for Definite Quantity Contracts. Upon the agreement of the STATE and the CONTRACTOR, the quantity of goods or services, or both, if a definite quantity is specified in this Contract, may be increased by a maximum of ten per cent (10%); provided the unit prices will remain the same except for any price adjustments otherwise applicable; and the Agency procurement officer makes a written determination that such an increase will either be more economical than awarding another contract or that it would not be practical to award another contract.

23. Changes in Cost-Reimbursement Contract. If this Contract is a cost-reimbursement contract, the following provisions shall apply:

a. The Agency procurement officer may at any time by written order, and without notice to the sureties, if any, make changes within the general scope of the Contract in any one or more of the following:

(1) Description of performance (Attachment 1);

(2) Time of performance (i.e., hours of the day, days of the week, etc.);

(3) Place of performance of services;

(4) Drawings, designs, or specifications when the supplies to be furnished are to be specially manufactured for the STATE in accordance with the drawings, designs, or specifications;

(5) Method of shipment or packing of supplies; or

(6) Place of delivery.

b. If any change causes an increase or decrease in the estimated cost of, or the time required for performance of, any part of the performance under this Contract, whether or not changed by the order, or otherwise affects any other terms and conditions of this Contract, the Agency procurement officer shall make an equitable adjustment in the (1) estimated cost, delivery or completion schedule, or both; (2) amount of any fixed fee; and (3) other affected terms and shall modify the Contract accordingly.

c. The CONTRACTOR must assert the CONTRACTOR'S rights to an adjustment under this provision within thirty (30) days from the day of receipt of the written order. However, if the Agency procurement officer decides that the facts justify it, the Agency procurement officer may receive and act upon a proposal submitted before final payment under the Contract.

d. Failure to agree to any adjustment shall be a dispute under paragraph 11 of this Contract. However, nothing in this provision shall excuse the CONTRACTOR from proceeding with the Contract as changed.

e. Notwithstanding the terms and conditions of subparagraphs 23a and 23b, the estimated cost of this Contract and, if this Contract is incrementally funded, the funds allotted for the performance of this Contract, shall not be increased or considered to be increased except by specific written modification of the Contract indicating the new contract estimated cost and, if this contract is incrementally funded, the new amount allotted to the contract.

24. Confidentiality of Material.

a. All material given to or made available to the CONTRACTOR by virtue of this Contract, which is identified as proprietary or confidential information, will be safeguarded by the CONTRACTOR and shall not be disclosed to any individual or organization without the prior written approval of the STATE.

b. All information, data, or other material provided by the CONTRACTOR to the STATE shall be subject to the Uniform Information Practices Act, chapter 92F, HRS.

25. Publicity. The CONTRACTOR shall not refer to the STATE, or any office, agency, or officer thereof, or any state employee, including the HOPA, the CPO, the Agency procurement officer, or to the services or goods, or both, provided under this Contract, in any of the CONTRACTOR'S brochures, advertisements, or other publicity of the CONTRACTOR. All media contacts with the CONTRACTOR about the subject matter of this Contract shall be referred to the Agency procurement officer.

26. Ownership Rights and Copyright. The STATE shall have complete ownership of all material, both finished and unfinished, which is developed, prepared, assembled, or conceived by the CONTRACTOR pursuant to this Contract, and all such material shall be considered "works made for hire." All such material shall be delivered to the STATE upon expiration or termination of this Contract. The STATE, in its sole discretion, shall have the exclusive right to copyright any product, concept, or material developed, prepared, assembled, or conceived by the CONTRACTOR pursuant to this Contract.

27. Liens and Warranties. Goods provided under this Contract shall be provided free of all liens and provided together with all applicable warranties, or with the warranties described in the Contract documents, whichever are greater.

28. Audit of Books and Records of the CONTRACTOR. The STATE may, at reasonable times and places, audit the books and records of the CONTRACTOR, prospective contractor, subcontractor, or prospective subcontractor which are related to:

a. The cost or pricing data, and

b. A state contract, including subcontracts, other than a firm fixed-price contract.

29. Cost or Pricing Data. Cost or pricing data must be submitted to the Agency procurement officer and timely certified as accurate for contracts over $100,000 unless the contract is for a multiple-term or as otherwise specified by the Agency procurement officer. Unless otherwise required by the Agency procurement officer, cost or pricing data submission is not required for contracts awarded pursuant to competitive sealed bid procedures.

If certified cost or pricing data are subsequently found to have been inaccurate, incomplete, or noncurrent as of the date stated in the certificate, the STATE is entitled to an adjustment of the contract price, including profit or fee, to exclude any significant sum by which the price, including profit or fee, was increased because of the defective data. It is presumed that overstated cost or pricing data increased the contract price in the amount of the defect plus related overhead and profit or fee. Therefore, unless there is a clear indication that the defective data was not used or relied upon, the price will be reduced in such amount.

30. Audit of Cost or Pricing Data. When cost or pricing principles are applicable, the STATE may require an audit of cost or pricing data.

31. Records Retention.

(1) Upon any termination of this Contract or as otherwise required by applicable law, CONTRACTOR shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

(2) The CONTRACTOR and any subcontractors shall maintain the files, books, and records that relate to the Contract, including any personal information created or received by the CONTRACTOR on behalf of the STATE, and any cost or pricing data, for at least three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall only be disclosed as permitted or required by law. After the three (3) year, or longer retention period as required by law has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS or returned to the STATE at the request of the STATE.

32. Antitrust Claims. The STATE and the CONTRACTOR recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the purchaser. Therefore, the CONTRACTOR hereby assigns to STATE any and all claims for overcharges as to goods and materials purchased in connection with this Contract, except as to overcharges which result from violations commencing after the price is established under this Contract and which are not passed on to the STATE under an escalation clause.

33. Patented Articles. The CONTRACTOR shall defend, indemnify, and hold harmless the STATE, and its officers, employees, and agents from and against all liability, loss, damage, cost, and expense, including all attorneys fees, and all claims, suits, and demands arising out of or resulting from any claims, demands, or actions by the patent holder for infringement or other improper or unauthorized use of any patented article, patented process, or patented appliance in connection with this Contract. The CONTRACTOR shall be solely responsible for correcting or curing to the satisfaction of the STATE any such infringement or improper or unauthorized use, including, without limitation: (a) furnishing at no cost to the STATE a substitute article, process, or appliance acceptable to the STATE, (b) paying royalties or other required payments to the patent holder, (c) obtaining proper authorizations or releases from the patent holder, and (d) furnishing such security to or making such arrangements with the patent holder as may be necessary to correct or cure any such infringement or improper or unauthorized use.

34. Governing Law. The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, shall be governed by the laws of the State of Hawaii. Any action at law or in equity to enforce or interpret the provisions of this Contract shall be brought in a state court of competent jurisdiction in Honolulu, Hawaii.

35. Compliance with Laws. The CONTRACTOR shall comply with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the CONTRACTOR'S performance of this Contract.

36. Conflict Between General Conditions and Procurement Rules. In the event of a conflict between the General Conditions and the procurement rules, the procurement rules in effect on the date this Contract became effective shall control and are hereby incorporated by reference.

37. Entire Contract. This Contract sets forth all of the agreements, conditions, understandings, promises, warranties, and representations between the STATE and the CONTRACTOR relative to this Contract. This Contract supersedes all prior agreements, conditions, understandings, promises, warranties, and representations, which shall have no further force or effect. There are no agreements, conditions, understandings, promises, warranties, or representations, oral or written, express or implied, between the STATE and the CONTRACTOR other than as set forth or as referred to herein.

38. Severability. In the event that any provision of this Contract is declared invalid or unenforceable by a court, such invalidity or unenforceability shall not affect the validity or enforceability of the remaining terms of this Contract.

39. Waiver. The failure of the STATE to insist upon the strict compliance with any term, provision, or condition of this Contract shall not constitute or be deemed to constitute a waiver or relinquishment of the STATE'S right to enforce the same in accordance with this Contract. The fact that the STATE specifically refers to one provision of the procurement rules or one section of the Hawaii Revised Statutes, and does not include other provisions or statutory sections in this Contract shall not constitute a waiver or relinquishment of the STATE'S rights or the CONTRACTOR'S obligations under the procurement rules or statutes.

40. Pollution Control. If during the performance of this Contract, the CONTRACTOR encounters a "release" or a "threatened release" of a reportable quantity of a "hazardous substance," "pollutant," or "contaminant" as those terms are defined in section 128D-1, HRS, the CONTRACTOR shall immediately notify the STATE and all other appropriate state, county, or federal agencies as required by law. The Contractor shall take all necessary actions, including stopping work, to avoid causing, contributing to, or making worse a release of a hazardous substance, pollutant, or contaminant, and shall promptly obey any orders the Environmental Protection Agency or the state Department of Health issues in response to the release. In the event there is an ensuing cease-work period, and the STATE determines that this Contract requires an adjustment of the time for performance, the Contract shall be modified in writing accordingly.

41. Campaign Contributions. The CONTRACTOR is hereby notified of the applicability of 11-355, HRS, which states that campaign contributions are prohibited from specified state or county government contractors during the terms of their contracts if the contractors are paid with funds appropriated by a legislative body.

42. Confidentiality of Personal Information.

a. Definitions.

"Personal information" means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either name or data elements are not encrypted:

(1) Social security number;

(2) Driver's license number or Hawaii identification card number; or

(3) Account number, credit or debit card number, access code, or password that would permit access to an individual's financial information.

Personal information does not include publicly available information that is lawfully made available to the general public from federal, state, or local government records.

"Technological safeguards" means the technology and the policy and procedures for use of the technology to protect and control access to personal information.

b. Confidentiality of Material.

(1) All material given to or made available to the CONTRACTOR by the STATE by virtue of this Contract which is identified as personal information, shall be safeguarded by the CONTRACTOR and shall not be disclosed without the prior written approval of the STATE.

(2) CONTRACTOR agrees not to retain, use, or disclose personal information for any purpose other than as permitted or required by this Contract.

(3) CONTRACTOR agrees to implement appropriate "technological safeguards" that are acceptable to the STATE to reduce the risk of unauthorized access to personal information.

(4) CONTRACTOR shall report to the STATE in a prompt and complete manner any security breaches involving personal information.

(5) CONTRACTOR agrees to mitigate, to the extent practicable, any harmful effect that is known to CONTRACTOR because of a use or disclosure of personal information by CONTRACTOR in violation of the requirements of this paragraph.

(6) CONTRACTOR shall complete and retain a log of all disclosures made of personal information received from the STATE, or personal information created or received by CONTRACTOR on behalf of the STATE.

c. Security Awareness Training and Confidentiality Agreements.

(1) CONTRACTOR certifies that all of its employees who will have access to the personal information have completed training on security awareness topics relating to protecting personal information.

(2) CONTRACTOR certifies that confidentiality agreements have been signed by all of its employees who will have access to the personal information acknowledging that:

(A) The personal information collected, used, or maintained by the CONTRACTOR will be treated as confidential;

(B) Access to the personal information will be allowed only as necessary to perform the Contract; and

(C) Use of the personal information will be restricted to uses consistent with the services subject to this Contract.

d. Termination for Cause. In addition to any other remedies provided for by this Contract, if the STATE learns of a material breach by CONTRACTOR of this paragraph by CONTRACTOR, the STATE may at its sole discretion:

(1) Provide an opportunity for the CONTRACTOR to cure the breach or end the violation; or

(2) Immediately terminate this Contract.

In either instance, the CONTRACTOR and the STATE shall follow chapter 487N, HRS, with respect to notification of a security breach of personal information.

e. Records Retention.

(1) Upon any termination of this Contract or as otherwise required by applicable law, CONTRACTOR shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

(2) The CONTRACTOR and any subcontractors shall maintain the files, books, and records that relate to the Contract, including any personal information created or received by the CONTRACTOR on behalf of the STATE, and any cost or pricing data, for at least three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall only be disclosed as permitted or required by law. After the three (3) year, or longer retention period as required by law has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS or returned to the STATE at the request of the STATE.

APPENDIX E - FORMS

Appendix E – Forms contains the following disclosure statements:

- E.1 – Wage Certification
- E.2– Insurance Requirements Certification

Appendix E.1 - WAGE CERTIFICATION

Pursuant to Section 103-55, Hawaii Revised Statutes, I hereby certify that if awarded the contract in excess of $25,000, the services to be performed will be performed under the following conditions:

1. The services to be rendered shall be performed by employees paid at wages or salaries not less than wages paid to the public officers and employees for similar work, if similar positions are listed in the classification plan of the public sector.

2. All applicable laws of the Federal and State governments relating to worker's compensation, unemployment insurance, payment of wages, and safety will be fully complied with.

I understand that all payments required by Federal and State laws to be made by employers for the benefit of their employees are to be paid in addition to the base wages required by Section 103-55, HRS.

Offeror: _____

Signature: _____

Title: _____

Date: _____

Appendix E.2 - INSURANCE REQUIREMENTS CERTIFICATION

Proposals submitted in response to the RFP must include a Certificate of Liability Insurance (COLI) that meets the requirements of the RFP, summarized in the Checklist and sample Form Acord 25 attached hereto. The successful bidder will be required to provide an updated COLI upon contract award.

Time is of the essence in the execution and performance of the contract resulting from this RFP. Therefore, the Offeror must ensure that the COLI submitted with the proposal and, if applicable, the resulting contract, fully and timely complies with the insurance requirements of this RFP.

By signing below, the Offeror certifies that it has completed the attached Checklist and:
(Check and complete one)

❒Offeror has included a current COLI with its proposal that fully meets the insurance coverage requirements contained in the RFP and in the attached Checklist.

❒ Offeror has included a current COLI with its proposal that meets the insurance coverage requirements contained in the RFP and in the attached Checklist and Form, *except for the following* (explain in detail):

_____
_____
_____
_____
_____
_____

If Offeror is awarded a contract, then Contractor certifies that the foregoing deficiencies will be corrected within 30 days after contract award.

_____
Name of Offeror

_____ _____
Authorized Representative Signature Date

_____
Print Name and Title

CERTIFICATE OF LIABILITY INSURANCE (COLI)
CHECKLIST & SAMPLE FORM (ACORD 25 Form (2016/03)

This Checklist must accompany the completed COLI submitted with the proposal and subsequent contract.

If a requirement noted below is reflected in a current policy endorsement, a copy of the endorsement may be submitted in lieu of the statement on the COLI. Insurance requirements are subject to oversight by the State of Hawaii Department of Accounting and General Services, Risk Management Office.

NO.	CERTIFICATE OF INSURANCE LIABILITY REQUIRED ELEMENTS	➲·
(1)	The date the COLI was issued should not be more than 15 days from date of the request. The COLI should not be issued over 30 days from the date of submission.	
(2)	The name of the "Insured" must match the name of the Contractor/Provider.	
(3)	The insurer must be licensed to do business in the State of Hawaii or meet the requirements of Section 431:8-301, Hawaii Revised Statutes.	
(4)	The "Commercial General Liability" coverage should indicate coverage on a "Per Occurrence" basis.	
(5)	A "Policy Number" or binder number should be indicated.	
(6)	The "Effective Date" should be no later than the contract date or the first date that the Contractor commences work for the State.	
(7)	The "Expiration Date" should be after the effective date of the agreement or supplemental agreement, as applicable, and be monitored to ensure that renewal COLI are received on a timely basis.	
(8)	The Limits of Liability for the following types of coverage should be for at least as much as required by the contract, normally in the following amounts (check Section 5.6 for specifics): a. Commercial General Liability $1 million per occurrence, and $2 million in the aggregate b. Automobile – may be combined single limit: Bodily Injury: $1 million per person, $1 million per accident Property Damage: $1 million per accident c. Workers Compensation/Employers Liability (E.L.) E.L. each accident: $1 million E.L. disease: $1 million per employee, $1 million policy limit E.L. $1 million aggregate	

	d. Professional Liability $1 million per claim, and $2 million annual aggregate	
(9)	"Any Auto" coverage is required, or if not marked, "Hired Autos" and "Non-Owned Autos" should be indicated. If there are no corporate-owned autos, then the "Hired & Non-Owned Auto" may be endorsed to the Commercial General Liability to satisfy this requirement.	
(10)	If the limits of liability shown for General Liability or Automobile Liability are less than required by contract, then Umbrella Liability with combined limit may satisfy the minimum requirement and the State listed as "Additional Insured" on the Umbrella Policy or the Umbrella policy is noted as "Follow Form" on the certificate.	
(11)	NOTE: The State requires higher limits of $1 million, as compared to the basic limits required by State law regarding Workers Compensation coverage.	
(12)	The required "Professional Liability" coverage should be indicated in this section.	
(13)	The "ADDL INSR" box should be checked to indicate that the State is an additional insured under the policy(ies), and noted in the Description of Operation box at the bottom of the form.	
(14)	The "Certificate Holder" should be the name and address of the Department of Human Services/Med-QUEST Division, 1001 Kamokila Blvd, Suite 317, Kapolei, Hawaii 96707.	
(15)	The COLI should be signed by the insurance agent or an insurance company representative. DESCRIPTION OF OPERATIONS/LOCATIONS/VEHICLES box: This section should contain any waiver of subrogation, and the following language: "The State of Hawaii is an additional insured with respect to operations performed for the State of Hawaii. Any insurance maintained by the State of Hawaii shall apply in excess of, and not contribute with, insurance provided by this policy."	

APPENDIX F – STANDARDS OF CONDUCT DECLARATION

STATE OF HAWAII

CONTRACTOR'S STANDARDS OF CONDUCT DECLARATION

For the purposes of this declaration:

"Agency" means and includes the State, the legislature and its committees, all executive departments, boards, commissions, committees, bureaus, offices; and all independent commissions and other establishments of the state government but excluding the courts.

"Controlling interest" means an interest in a business or other undertaking which is sufficient in fact to control, whether the interest is greater or less than fifty per cent (50%).

"Employee" means any nominated, appointed, or elected officer or employee of the State, including members of boards, commissions, and committees, and employees under contract to the State or of the constitutional convention, but excluding legislators, delegates to the constitutional convention, justices, and judges. (Section 84-3, HRS).

On behalf of _____, CONTRACTOR, the undersigned does declare as follows:

1. CONTRACTOR ☐ is* ☐ is not a legislator or an employee or a business in which a legislator or an employee has a controlling interest. (Section 84-15(a), HRS).
2. CONTRACTOR has not been represented or assisted personally in the matter by an individual who has been an employee of the agency awarding this Contract within the preceding two years and who participated while so employed in the matter with which the Contract is directly concerned. (Section 84-15(b), HRS).
3. CONTRACTOR has not been assisted or represented by a legislator or employee for a fee or other compensation to obtain this Contract and will not be assisted or represented by a legislator or employee for a fee or other compensation in the performance of this Contract, if the legislator or employee had been involved in the development or award of the Contract. (Section 84-14 (d), HRS).
4. CONTRACTOR has not been represented on matters related to this Contract, for a fee or other consideration by an individual who, within the past twelve (12) months, has been an agency employee, or in the case of the Legislature, a legislator, and participated while an employee or legislator on matters related to this Contract. (Sections 84-18(b) and (c), HRS).

CONTRACTOR understands that the Contract to which this document is attached is voidable on behalf of the STATE if this Contract was entered into in violation of any provision of chapter 84, Hawaii Revised Statutes, commonly referred to as the Code of Ethics, including the provisions which are the source of the declarations above. Additionally, any fee, compensation, gift, or profit received by any person as a result of a violation of the Code of Ethics may be recovered by the STATE.

CONTRACTOR

By _____
(Signature)

Print Name _____

Print Title _____

Name of Contractor _____

Date _____

* Reminder to Agency: If the "is" block is checked and if the Contract involves goods or services of a value in excess of $10,000, the Contract must be awarded by competitive sealed bidding under section 103D-302, HRS, or a competitive sealed proposal under section 103D-303, HRS. Otherwise, the Agency may not award the Contract unless it posts a notice of its intent to award it and files a copy of the notice with the State Ethics Commission. (Section 84-15(a), HRS).

APPENDIX G – BAA – BUSINESS ASSOCIATE AGREEMENT

EXHIBIT A
BUSINESS ASSOCIATE AGREEMENT

The State of Hawaii Department of Human Services (STATE) is a Covered Entity or a Health Care Component of a Covered Entity under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA), as amended, and its implementing regulations at 45 CFR parts 160 and 164 (the HIPAA Rules).

The CONTRACTOR (BUSINESS ASSOCIATE), under the CONTRACT will provide to STATE certain services described in the CONTRACT to which this Exhibit A is attached, and may have access to Protected Health Information (PHI) (as defined below) in fulfilling its responsibilities under the CONTRACT. To the extent BUSINESS ASSOCIATE needs to create, receive, maintain or transmit PHI to perform services under the CONTRACT, it will be acting as a Business Associate[1] of STATE and will be subject to the HIPAA Rules and the terms of this Business Associate Agreement (this Agreement).

In consideration of STATE's and BUSINESS ASSOCIATE's (collectively referred to as "the Parties") continuing obligations under the CONTRACT, and the provisions below, the Parties agree as follows:

1. DEFINITIONS.

Except for terms otherwise defined herein, and unless the context indicates otherwise, any capitalized terms used in this Agreement and the terms "person," "use," and "disclosure" shall have the same meaning as defined by the HIPAA Rules. An amendment to the HIPAA Rules that modifies any defined term, or which alters the regulatory citation for the definition, shall only be incorporated into this Agreement by written ratification of the Parties.

Breach[2] means the acquisition, access, use, or disclosure of PHI in a manner not permitted under the HIPAA Privacy Rule or as provided for by this Agreement, which compromises the security or privacy of the PHI.

An acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Rule is presumed to be a breach unless the BUSINESS ASSOCIATE demonstrates to the STATE's satisfaction that there is a low probability that the PHI has been compromised based on a risk assessment that identifies at least the following: (i) the nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification; (ii) the unauthorized person who used the PHI or to whom the disclosure was made; (iii) whether the PHI was actually acquired or viewed; and (iv) the extent to which the risk to the PHI has been mitigated.

[1] Business Associate is defined at 45 CFR §160.103
[2] Breach: 45 CFR §164.402.

Breach excludes:

A. Any unintentional acquisition, access or use of PHI by a Workforce member or person acting under the authority of the BUSINESS ASSOCIATE if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under the Privacy Rule.

B. Any inadvertent disclosure by a person who is authorized to access PHI at the BUSINESS ASSOCIATE to another person authorized to access PHI at the same BUSINESS ASSOCIATE, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the Privacy Rule.

C. A disclosure of PHI where the BUSINESS ASSOCIATE has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Designated Record Set means records, including but not limited to PHI maintained, collected, used, or disseminated by or for the STATE relating to (i) medical and billing records about Individuals maintained by or for a covered Health Care Provider, (ii) enrollment, Payment, claims adjudication, and case or medical management records systems maintained by or for a Health Plan, or (iii) that are used in whole or in part by the STATE to make decisions about Individuals.[3]

Electronic Protected Health Information (EPHI) means PHI that is transmitted by Electronic Media or maintained in Electronic Media.[4]

HIPAA Rules shall mean the Privacy, Security, Breach Notification, and Enforcement Rules in 45 CFR Parts 160 and 164.

Individual shall have the same meaning as defined in 45 CFR §160.103, and shall include a person who qualifies as a personal representative as provided by 45 CFR §164.502(g).

Privacy Rule means the HIPAA Standards for Privacy of Individually Identifiable Health Information found at 45 CFR part 160, and part 164, subparts A and E.

Protected Health Information (PHI) means any oral, paper or electronic information, data, documentation, and materials, including, but not limited to, demographic, medical, genetic, and financial information that is created or received by a Health Care Provider, Health Plan, Employer, or Health Care Clearinghouse, and relates to the past, present, or future physical or mental health or condition of an Individual; the provision of health care to an Individual; or the past, present, or future payment for the provision of health care to an Individual; and that identifies the Individual or with respect to which there is a reasonable basis to believe the information can be used to identify the Individual. For purposes of this Agreement, the term

[3] Designated Record Set: 45 CFR §164.501.
[4] Electronic Protected Health Information: 45 CFR §160.103

Protected Health Information is limited to the information created, maintained, received, or transmitted by BUSINESS ASSOCIATE on behalf of or from the STATE under the CONTRACT. Protected Health Information includes without limitation EPHI, and excludes education records under 20 U.S.C. §1232(g), employment records held by the STATE as an employer, and records regarding an Individual who has been deceased for more than 50 years.[5] For purposes of this Agreement, PHI also includes information required to be safeguarded by the STATE pursuant to 42 C.F.R. §431, Subpart 300.

Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system under 45 CFR §164.304.

Security Rule means the HIPAA Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR part 160, and part 164, subpart C.

Unsecured Protected Health Information means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized persons through the use of technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.[6]

2. BUSINESS ASSOCIATE'S OBLIGATIONS.

BUSINESS ASSOCIATE agrees to:

a. Not use or disclose PHI other than as permitted or required by this Agreement or as Required by Law. In no event may BUSINESS ASSOCIATE use or further disclose PHI in a manner that would violate the Privacy Rule if done by the STATE, except as expressly provided in this Agreement and as required by 45 CFR §§ 164.502(a)(3), 164.502(a)(4) and 164.504(e)(2(ii)(A).

b. Implement appropriate safeguards, and comply, where applicable, with the Security Rule to ensure the confidentiality, integrity, and availability of all EPHI the BUSINESS ASSOCIATE creates, receives, maintains, or transmits on behalf of the STATE; protect against any reasonably anticipated threats or hazards to the security or integrity of such information; prevent uses or disclosures of such information other than as provided for by this Agreement or as Required by Law; and ensure compliance with the HIPAA Rules by BUSINESS ASSOCIATE's Workforce.[7] These safeguards include, but are not limited to:

    (i) Administrative Safeguards. BUSINESS ASSOCIATE shall implement policies and procedures to prevent, detect, contain, and correct security violations, and reasonably preserve and protect the confidentiality, integrity

[5] Protected Health Information: 45 CFR §160.103
[6] 45 CFR §164.402.
[7] 45 CFR §164.306(a)

and availability of EPHI, and enforce those policies and procedures, including sanctions for anyone not found in compliance;

(ii) Physical Safeguards. BUSINESS ASSOCIATE shall implement appropriate physical safeguards to protect PHI, including, but not limited to, facility access, facility security, workstation use, workstation security, device and media controls, and disposal;[8]

(iii) Technical Safeguards. BUSINESS ASSOCIATE shall implement appropriate technical safeguards to protect PHI, including, but not limited to, access controls, authentication, and transmission security;[9] and

(iv) Security Awareness and Training. BUSINESS ASSOCIATE shall provide training to relevant workforce members, including management, on how to prevent the improper access, use, or disclosure of PHI; and update and repeat training on a regular basis.[10]

c. In accordance with 45 CFR §164.316, document the required policies and procedures and keep them current, and cooperate in good faith in response to any reasonable requests from STATE to discuss, review, inspect, and/or audit BUSINESS ASSOCIATE's safeguards. BUSINESS ASSOCIATE shall retain the documentation required for six (6) years from the date of its creation or the date when it last was in effect, whichever is later.[11]

d. Comply with the provisions found in 45 CFR §164.308 (a)(1) (ii)(A) and (B), requiring BUSINESS ASSOCIATE to conduct an accurate and thorough risk analysis, and to periodically update the risk analysis (no less than once every 3 years); and to implement risk management measures to reduce the risk and vulnerabilities to a reasonable and appropriate level to comply with 45 CFR §164.306(a).

e. As applicable only to the PHI that BUSINESS ASSOCIATE receives from STATE, BUSINESS ASSOCIATE shall ensure that any subcontractor of BUSINESS ASSOCIATE that creates, receives, maintains, or transmits PHI on behalf of BUSINESS ASSOCIATE agrees in writing to the same restrictions, conditions, and requirements that apply to BUSINESS ASSOCIATE through this Agreement with respect to such PHI.[12]

f. BUSINESS ASSOCIATE shall provide STATE with copies of all business associate agreements between BUSINESS ASSOCIATE and BUSINESS ASSOCIATE's subcontractor within 14 calendar days of execution.

[8] 45 CFR §164.310
[9] 45 CFR §§ 164.310, 164.312
[10] 45 CFR §164.308(a)(5)
[11] 45 CFR §§164.306 – 164.316; 164.504(e)(2)(ii)(B)
[12] 45 CFR §§164.308(b), 164.314(a)(2), 164.502(e), 164.504(e)(2)(ii)(D)

g. Notify the STATE following discovery of any use or disclosure of PHI not permitted by this Agreement of which it becomes aware, or any Breach of Unsecured PHI.[13]

(i) BUSINESS ASSOCIATE shall immediately notify the STATE's HIPAA Privacy or Security Officer verbally.

(ii) BUSINESS ASSOCIATE shall subsequently notify the STATE's HIPAA Privacy or Security Officer in writing, without unreasonable delay, and in no case later than two (2) business days following discovery of the impermissible use or disclosure of PHI, or Breach of Unsecured PHI.

(iii) A Breach of Unsecured PHI shall be treated as discovered by the BUSINESS ASSOCIATE as of the first day on which such breach is known to the BUSINESS ASSOCIATE or, by exercising reasonable diligence, would have been known to the BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall be deemed to have knowledge of a Breach if the Breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the Breach, who is an employee, officer, or other agent of the BUSINESS ASSOCIATE.[14]

h. Take prompt corrective action to mitigate, to the extent practicable, any harmful effect that is known to BUSINESS ASSOCIATE of a Security Incident or a misuse or unauthorized disclosure of PHI by BUSINESS ASSOCIATE in violation of this Agreement, and any other action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations. BUSINESS ASSOCIATE shall reasonably cooperate with the STATE's efforts to seek appropriate injunctive relief or otherwise prevent or curtail potential or actual Breaches, or to recover its PHI, including complying with a reasonable corrective action plan.[15]

i. Investigate such Breach and provide a written report of the investigation and resultant mitigation to STATE's HIPAA Privacy and/or Security Officer within thirty (30) calendar days of the discovery of the Breach.

j. Provide the following information with respect to a Breach of Unsecured PHI, to the extent possible, as the information becomes available, to the STATE's HIPAA Privacy or Security Officer:

(i) The identification of each Individual whose Unsecured PHI has been, or is reasonably believed by BUSINESS ASSOCIATE to have been accessed, acquired, used, or disclosed during the breach; and

[13] 45 CFR §§164.314(a)(2), 164.410(a), 164.504(e)(2)(ii)(C)
[14] 45 CFR §164.410(a)(2)
[15] 45 CFR §§164.308(a)(6)(ii); 164.530(f)

(ii) Any other available information that the STATE is required to include in notification to the Individual under the HIPAA Rules, including, but not limited to the following:[16]

A. Contact information for Individuals who were or who may have been impacted by the HIPAA Breach (e.g., first and last name, mailing address, street address, phone number, and email address);

B. A brief description of the circumstances of the Breach, including the date of the Breach and date of discovery, if known;

C. A description of the types of Unsecured PHI involved in the Breach (such as whether the full name, social security number, date of birth, address, account number, diagnosis, disability and/or billing codes, or similar information was involved);

D. A brief description of what the BUSINESS ASSOCIATE has done or is doing to investigate the Breach, mitigate harm to the Individual(s) impacted by the Breach, and protect against future Breaches; and

E. Contact information for BUSINESS ASSOCIATE's liaison responsible for investigating the Breach and communicating information relating to the Breach to the STATE.

k. Promptly report to STATE's HIPAA Privacy and/or Security Officer any Security Incident of which BUSINESS ASSOCIATE becomes aware with respect to EPHI that is in the custody of BUSINESS ASSOCIATE, including breaches of Unsecured PHI as required by 45 CFR §164.410, by contacting the STATE's HIPAA Privacy and/or Security Officer.[17]

l. Prior to submitting any report to the Office of Civil Rights, BUSINESS ASSOCIATE will provide to STATE a reasonable opportunity to review a finalized draft of the report.

m. Provide the applicable notifications to individuals or media in the event of a breach of unsecured PHI.[18]

n. Implement reasonable and appropriate measures, including training, to ensure compliance with the requirements of this Agreement by Workforce members who assist in the performance of functions or activities on behalf of the STATE under this Agreement and use or disclose PHI, and discipline such Workforce members who intentionally violate

[16] 45 CFR §§164.404(c)(1), 164.408, 164.410(c)(1) and (2)
[17] 45 CFR §§164.314(a)(2), 164.410
[18] 45 CFR §§164.404, 164.406

any provisions of these special conditions, which may include termination of employment.[19]

o. Make its internal policies, procedures, books, and records relating to the use and disclosure of PHI received from or created or received by BUSINESS ASSOCIATE on behalf of the STATE available to the Secretary of Health and Human Services or to STATE if necessary or required to assess BUSINESS ASSOCIATE's or the STATE's compliance with the HIPAA Rules. BUSINESS ASSOCIATE shall promptly notify STATE of communications with the U.S. Department of Health and Human Services (HHS) regarding PHI provided by or created by STATE and shall provide STATE with copies of any information BUSINESS ASSOCIATE has made available to HHS under this paragraph.[20]

p. Upon notice from STATE, accommodate any restriction to the use or disclosure of PHI and any request for confidential communications to which STATE has agreed in accordance with the Privacy Rule.[21]

q. Make available PHI held by BUSINESS ASSOCIATE, which the STATE has determined to be part of its Designated Record Set, to the STATE as necessary to satisfy the STATE's obligations to provide an Individual with access to their PHI under 45 CFR §164.524, in the time and manner designated by the STATE.[22]

r. Make available PHI held by BUSINESS ASSOCIATE, which the STATE has determined to be part of its Designated Record Set, for amendment, and incorporate any amendments to PHI that the STATE directs or agrees to in accordance with 45 CFR §164.526, upon request of the STATE or an Individual, subject to State law and BUSINESS ASSOCIATE policies regarding amending vital records.

s. Document disclosures of PHI made by BUSINESS ASSOCIATE, which are required to be accounted for under 45 CFR §164.528(a)(1), and make this information available as necessary to satisfy the STATE's obligation to provide an accounting of disclosures to an Individual within two (2) business days notice by the STATE of a request by an Individual of a request for an accounting of disclosures of PHI. If an Individual directly requests an accounting of disclosures of PHI from BUSINESS ASSOCIATE, BUSINESS ASSOCIATE shall notify STATE's HIPAA Privacy and/or Security Officer of the request within two (2) business days, and STATE shall either direct BUSINESS ASSOCIATE to provide the information directly to the Individual, or it shall direct that the information required for the accounting be forwarded to STATE for compilation and distribution to the Individual.[23]

[19] 45 CFR §§164.308(a), 164.530(b) and (e)
[20] 45 CFR §164.504(e)(2)(ii)(I)
[21] 45 CFR §164.522
[22] 45 CFR §§164.504(e)(2)(ii)(E), 164.524
[23] 45 CFR §§164.504(e)(2)(ii)(G) and (H), 164.528; HAR ch. 2-71, subch. 2.

t. Comply with any other requirements of the HIPAA Rules not expressly specified in this Agreement, as and to the extent that such requirements apply to Business Associates under the HIPAA Rules.

3. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE.

BUSINESS ASSOCIATE may, except as otherwise limited in this Agreement:

a. General Use and Disclosure: Create, receive, maintain or transmit PHI only for the purposes listed in the CONTRACT and this Agreement, provided that the use or disclosure would not violate the HIPAA Rules or other applicable privacy rules if done by the STATE or violate the Minimum Necessary requirements applicable to the STATE.[24]

b. Limited Use of PHI for BUSINESS ASSOCIATE's Benefit. Use PHI received by the BUSINESS ASSOCIATE in its capacity as the STATE's BUSINESS ASSOCIATE, if necessary, for the proper management and administration of the BUSINESS ASSOCIATE or to carry out the legal responsibilities of the BUSINESS ASSOCIATE. BUSINESS ASSOCIATE's proper management and administration does not include the use or disclosure of PHI by BUSINESS ASSOCIATE for Marketing purposes or for sale of PHI. [25]

c. Limited Disclosure of PHI for BUSINESS ASSOCIATE's Benefit. Disclose PHI for BUSINESS ASSOCIATE's proper management and administration or to carry out its legal responsibilities only if the disclosure is Required by Law, and the person notifies BUSINESS ASSOCIATE of any instances of which it is aware in which the confidentiality of PHI has been breached. [26] BUSINESS ASSOCIATE must maintain a record of these disclosures with all applicable information and provide an audit to the STATE upon request by the STATE, upon termination of the CONTRACT, and on an annual basis if the CONTRACT continues for longer than one year.

d. Minimum Necessary. BUSINESS ASSOCIATE shall only request, use, and disclose the minimum amount of PHI necessary to accomplish the purpose of the request, use, or disclosure.[27]

e. Data Aggregation. Use PHI to provide Data Aggregation services relating to the STATE's Health Care Operations as permitted by 45 CFR §164.504(e)(2)(i)(B).

f. Disclosures by Whistleblowers: Disclose PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR §164.502(j)(1).

4. STATE'S OBLIGATIONS.

[24] 45 CFR §§164.502(a) and (b), 164.504(e)(2)(i)
[25] 45 CFR §§164.502(a)(5)(ii), 164.504(e)(2)(i)(A), 164.504(e)(4)(i), 164.508(a)(3) and (a)(4)
[26] 45 CFR §164.504(e)(4)(ii)
[27] 45 CFR §164.502(b)

a. STATE shall not request BUSINESS ASSOCIATE to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by STATE.

b. STATE shall not provide BUSINESS ASSOCIATE with more PHI than is minimally necessary for BUSINESS ASSOCIATE to provide the services under the CONTRACT and STATE shall provide any PHI needed by BUSINESS ASSOCIATE to perform under the CONTRACT only in accordance with the HIPAA Rules.

5. TERM AND TERMINATION.

a. This Agreement shall be effective as of the date of the CONTRACT or CONTRACT amendment to which this Agreement is attached and shall terminate on the date the STATE terminates this Agreement or when all PHI is destroyed or returned to STATE.

b. In addition to any other remedies provided for by this Agreement or the CONTRACT, upon the STATE's knowledge of a material Breach by BUSINESS ASSOCIATE of this Agreement, the BUSINESS ASSOCIATE authorizes the STATE to do any one or more of the following, upon written notice to BUSINESS ASSOCIATE describing the violation and the action it intends to take:

(i) Exercise any of its rights to reports, access and inspection under this Agreement or the CONTRACT;

(ii) Require BUSINESS ASSOCIATE to submit a plan of monitoring and reporting, as STATE may determine necessary to maintain compliance with this Agreement;

(iii) Provide BUSINESS ASSOCIATE with a reasonable period of time to cure the Breach, given the nature and impact of the Breach; or

(iv) Immediately terminate this Agreement if BUSINESS ASSOCIATE has breached a material term of this Agreement and sufficient mitigation is not possible.[28]

c. Effect of Termination.[29]

(i) Upon any termination of this Agreement, until notified otherwise by the STATE, BUSINESS ASSOCIATE shall extend all protections, limitations, requirements and other provisions of this Agreement to all PHI received from or on behalf of STATE or created or received by BUSINESS ASSOCIATE on behalf of the STATE, and all EPHI created, received, maintained or transmitted by BUSINESS ASSOCIATE on behalf of the STATE.

(ii) Except as otherwise provided in subsection 5(c)(iii) below, upon termination of this Agreement for any reason, BUSINESS ASSOCIATE shall, at the STATE's option, return or destroy all PHI received from the STATE, or created or received

[28] 45 CFR §164.504(e)(2)(iii)
[29] 45 CFR §164.504(e)(2)(ii)(J)

by the BUSINESS ASSOCIATE on behalf of the STATE, that the BUSINESS ASSOCIATE still maintains in any form, and BUSINESS ASSOCIATE shall retain no copies of the information. This provision shall also apply to PHI that is in the possession of subcontractors or agents of BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall notify the STATE in writing of any and all conditions that make return or destruction of such information not feasible and shall provide STATE with any requested information related to the STATE's determination as to whether the return or destruction of such information is feasible.

(iii) If the STATE determines that returning or destroying any or all PHI is not feasible or opts not to require the return or destruction of such information, the protections of this Agreement shall continue to apply to such PHI, including but not limited to the protections in the Section 2. BUSINESS ASSOCIATE'S OBLIGATIONS and Section 6. MISCELLANEOUS regarding Interpretation, Determination of Breach, Costs Related to Breach, and Subpoenas. In addition, BUSINESS ASSOCIATE shall limit further uses and disclosures of PHI to those purposes that make the return or destruction infeasible, for so long as BUSINESS ASSOCIATE maintains such PHI. STATE hereby acknowledges and agrees that infeasibility includes BUSINESS ASSOCIATE's need to retain PHI for purposes of complying with its work product documentation standards.

6. MISCELLANEOUS.

a. Amendment. BUSINESS ASSOCIATE and the STATE agree to take such action as is necessary to amend this Agreement from time to time for compliance with the requirements of the HIPAA Rules and any other applicable law.

b. Interpretation. In the event that any terms of this Agreement are inconsistent with the terms of the CONTRACT, then the terms of this Agreement shall control. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Rules, as amended, the HIPAA Rules shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Rules, but are nonetheless permitted by the HIPAA Rules, the provisions of this Agreement shall control. Any ambiguity in this Agreement shall be resolved to permit STATE to comply with the HIPAA Rules. Notwithstanding the foregoing, nothing in this Agreement shall be interpreted to supersede any federal or State law or regulation related to confidentiality of health information or vital record information that is more stringent than the HIPAA Rules.

c. Determination of Breach. If STATE and BUSINESS ASSOCIATE are in conflict as to whether BUSINESS ASSOCIATE committed a breach or otherwise disclosed PHI inconsistent with this Agreement, then the STATE in its sole discretion shall decide whether BUSINESS ASSOCIATE committed a breach or otherwise disclosed PHI inconsistent with this agreement.

d. Indemnification. BUSINESS ASSOCIATE shall defend, indemnify, and hold harmless the STATE and STATE's officers, employees, agents, contractors and subcontractors to the extent required under the Contract for incidents that are caused by or arise out of a Breach or failure to comply with any provision of this Agreement or the HIPAA Rules by BSUSINESS Associates or any of BUSINESS ASSOCIATE's officers, employees, agents, contractors or subcontractors.

e. Costs Related to Breach. BUSINESS ASSOCIATE shall be responsible for any and all costs incurred by the STATE as a result of any Breach of PHI by BUSINESS ASSOCIATE, its officers, directors, employees, contractors, or agents, or by a third party to which the BUSINESS ASSOCIATE disclosed PHI under this Agreement, including but not limited to notification of individuals or their representatives of a Breach of Unsecured PHI,[30] civil monetary penalties, and the cost of mitigating any harmful effect of the Breach.[31]

f. Response to Subpoenas. In the event BUSINESS ASSOCIATE receives a subpoena or similar notice or request from any judicial, administrative, or other party which would require the production of PHI received from, or created for, the STATE, BUSINESS ASSOCIATE shall promptly forward a copy of such subpoena, notice or request to the STATE to afford the STATE the opportunity to timely respond to the demand for its PHI as the STATE determines appropriate according to its State and federal obligations.

g. Survival. The respective rights and obligations of STATE and BUSINESS ASSOCIATE under sections 5.c., Effect of Termination, 6.c., Indemnification, and 6.d., Costs Related to Breach, shall survive the termination of this Agreement.

h. Notices: Whenever written notice is required by one party to the other under this Agreement, it should be mailed, faxed, or e-mailed to the appropriate address noted below. If notice is sent by e-mail, then a confirming written notice should be sent by mail or fax within two (2) business days after the date of the e-mail. The sender of any written notice required under this Agreement is responsible for confirming receipt by the recipient.

STATE:	**BUSINESS ASSOCIATE:**
DHS Information Security / HIPAA Compliance Manager P.O. Box 700190 Kapolei, Hawaii 96709-0190 Fax: (808) 692-8173 Email: LYong@dhs.hawaii.gov	_____ _____ _____ Fax: (_____) _____ Email: _____

[30] 45 CFR Part 164, Subpart D
[31] 45 CFR §164.530(f)

IN WITNESS WHEREOF, the Parties have executed this Agreement effective as of the date and year first written above.

BUSINESS ASSOCIATE

Dated: _____ By _____

Representative

DEPARTMENT OF HUMAN SERVICES, STATE OF HAWAII

Dated: _____ By _____

Director

APPENDIX H. REMEDIES FOR NON-PERFORMANCE OF EQRO and PRO CONTRACT

This Appendix includes Contract non-performance for which DHS may assess Liquidated Damages.

No.	Non-performance of Contract	Liquidated Damages
	Readiness Reviews and Implementation Activities	
1.	Failure to be operational by the agreed upon operational start date of the contract, based on DHS determination as to when the EQRO and PRO Contractor is considered to be fully operational.	Up to $5,000.00 per day for each day beyond the start date of the contract that the EQRO and PRO Contractor is not operational.
	Administration and Management	
2.	Failure to meet with EQRO and PRO certification, qualification, as set forth in Section 40.510.	Up to $5,000.00 per day that EQRO and PRO Contractor is not certified, qualified as required by applicable Federal or state law.
3.	Violation of a subcontracting requirement as set forth in Section 50.900**,** Subcontractor Agreements, and other sections of the contract as applicable.	Up to $5,000.00 per violation.
4.	Failure to comply with the EQRO and PRO Contractor staffing requirements, as set forth in Section 60.271, EQRO and PRO Contractor Key Personnel.	Up to $1,000.00 per day for each separate failure to comply, for the first thirty (30) days non-compliance. At its discretion, DHS may double this amount for each day after thirty (30) days for each specific instance that the EQRO and PRO Contractor remains non-compliant.

No.	Non-performance of Contract	Liquidated Damages
5.	Failure to have appropriate staff member(s) attend meetings as requested and designated by DHS.	Up to $250.00 per appropriate staff person per meeting as requested by DHS.
6.	Failure of the EQRO and PRO Contractor to respond to a Notice of Concern within the requested time frame as set forth in Section 50.950.	Up to $500.00 per day for each day until the response is received and $1,000.00 for failure to respond sufficiently to Notice of Concern.
7.	Failure of the EQRO and PRO to submit a Corrective Action Plan within the requested time frame as set forth in Section 50.950.	Up to $1000.00 per day for each day until the Corrective Action Plan is received.
8.	Failure to timely implement and comply with an accepted Corrective Action Plan as set forth in Section 50.950.	Up to $500.00 per day for each day the EQRO and PRO Contractor fails to comply with an accepted Corrective Action Plan as determined by DHS.
9.	Failure to complete quality measures reviews including HEDIS audit within required timeframes.	Up to $1,000.00 per day for every day reports are late.
10.	Failure to validate Performance Improvement Projects (PIPs) as listed in Section 40 within required timeframes.	Up to $1,000.00 per day beyond the due date until the PIP(s) are validated.

No.	Non-performance of Contract	Liquidated Damages
11.	Failure to validate performance measures as listed in Section 40 within required timeframes.	Up to $1,000.00 per day beyond the due date until the performance measures are validated.
12.	Failure to determine Compliance of Quality Assessment and Performance Improvement (QAPI) Standards) as listed in Section 40 within required timeframes.	Up to $1,000.00 per day beyond the due date until the QAPI compliance are determined.
13.	Failure to perform Level of Care (LOC) determination and Pre-admission Screening Resident Review (PASRR) as listed in Section as required.	Up to $1,000.00 per day beyond agreed due date until the LOC are determined and the PASRR are completed.
	Information Systems	
14.	Failure of the EQRO and PRO Contractor `s Level of Care (LOC) determination and Pre-admission Screening Resident Review (PASRR) electronic submission system to meet all requirements in Section 40, at any given time during operations.	Up to $2,500.00 per day of non-compliance.

No.	Non-performance of Contract	Liquidated Damages
15.	Failure of the EQRO and PRO Contractor to provide notice to the Department, at least 30 days prior to implementation of any significant system changes that may impact the services provided under this contract.	Up to $2,500.00 per day of non-compliance.
	Reporting Requirements	
16.	Failure to provide a required report set forth in Section 40 in the required timeframe; for which submission is incomplete or incorrect; or failure to resolve identified reporting errors within five (5) business days or other required timelines upon notification by DHS.	$250 per day until the violation is remedied.
	Confidentiality and Protected Health Information	
17.	Failure to ensure that all Hawaii Medicaid data containing protected health information (PHI), as defined by HIPAA, is secured as set forth in Section 50.800, Confidentiality of Information.	Up to $500.00 per Member per occurrence, and if DHS deems credit monitoring and/or identity theft safeguards are needed to protect those Members whose PHI was placed at risk by the Contractor's failure to comply with the terms of this contract.
18.	Failure to timely report violations in the access, use and disclosure of PHI or timely report a security incident or timely make a notification of breach or notification of provisional breach.	$500.00 per Member per occurrence, not to exceed $10,000,000.00.

APPENDIX I – DHS 1178 FORM

APPENDIX I-1 – DHS1178 FORM INSTRUCTIONS

STATE OF HAWAII **Med-QUEST Division**

Department of Human Services

PREADMISSION SCREENING RESIDENT REVIEW (PAS/RR) **LEVEL I SCREEN**	**PATIENT'S NAME: (Last Name, First, M.I.)**	**DATE OF BIRTH: (MM/DD/YY)**
	PRIMARY DIAGNOSIS:	**MEDICAID I.D. NUMBER:**
	REFERRAL SOURCE: (Physician's Name; Nursing Facility; Hospital; Etc.)	

PART A: SERIOUS MENTAL ILLNESS (SMI): **YES** **NO**

1. The individual has symptom(s) and/or a current diagnosis of a Major Mental disorder and/or a Substance Related disorder, which seriously affects interpersonal functioning (difficulty interacting with others; altercations, evictions, unstable employment, frequently isolated, avoids others), and/or completing tasks (difficulty completing tasks, required assistance with tasks, errors with tasks; concentration; persistence; pace), and/or adapting to change (self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, hallucinations, delusions, serious loss of interest, tearfulness, irritability, withdrawal): ( ) ( )
   a. A **SCHIZOPHRENIC** disorder, **MOOD** disorder, **DELUSIONAL (PARANOID)** disorder, **PANIC OR OTHER SEVERE ANXIETY** disorder, **SOMATOFORM** disorder, **PERSONALITY** disorder, **SUBSTANCE RELATED** disorder or **PSYCHOTIC** disorder not elsewhere classified that may lead to a chronic disability; **BUT**
   b. **NOT** a primary or secondary diagnosis of **DEMENTIA**, including **ALZHEIMER'S DISEASE OR A RELATED DISORDER.**
2. Does the SMI individual have Dementia? If yes, include evidence/presence of workup, comprehensive mental status exam. ( ) ( )
3. Has psychoactive drug(s) been prescribed on a regular basis to treat behavioral/mental health symptom(s) for the individual within the last two (2) years with or without current diagnosis of SMI? ( ) ( )

PART B: INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITIES (ID/DD): **YES** **NO**

1. The individual has a diagnosis of **ID** or has a history indicating the presence of **ID prior** to age 18. ( ) ( )
2. The individual has a diagnosis of **DD/related condition** (evidence/affects intellectual functioning, adaptive functioning; autism, epilepsy, blindness, cerebral palsy, closed head injury, deaf) or has a history indicating the presence of **DD prior** to age 22. Age of diagnosis/presence: ____ ( ) ( )
3. Does the ID/DD individual have a primary diagnosis or presence of **Dementia**? If yes, include evidence/presence of Dementia work-up, comprehensive mental status exam, if available. ( ) ( )
4. The individual has functional limitations relating to **ID/DD** (mobility, self-care/direction, learning, understanding/use of language, capacity for living independently). ( ) ( )
5. The individual received/receives **ID/DD** services from an agency serving individuals with ID/DD; (past and/or present; referred/referrals). Describe past AND present receipt of services and referrals made from agencies that serve individuals with ID/DD. _____ ( ) ( )

_____

DETERMINATION:

1. If any of the answers in Parts A or B are **YES, COMPLETE PART C (page 2)** of this form.
2. If all of the answers in Parts A or B are **NO, SIGN** and **DATE** BELOW:

LEVEL I SCREEN IS NEGATIVE FOR SMI OR ID/DD
THE PATIENT MAY BE ADMITTED TO THE NF:

DATE AND TIME COMPLETED:

_____ _____

SIGNATURE OF PHYSICIAN, APRN, HOSPITAL DC PLANNER RN **MM/DD/YY**

_____ _____

PRINT NAME **Time**

PART C:		**YES**	**NO**
1.	Is this individual being discharged from an acute care hospital and admitted to the NF for recovery from an illness or surgery **not to exceed 120 days** and is not considered a danger to self and/or others?	( )	( )
2.	Is this individual **certified** by his physician to be terminally ill **(prognosis of a life expectancy of 6 months or less),** serviced by a certified, licensed hospice agency at the time of admission and is not considered a danger to self and/or others?	( )	( )
3.	Is this individual comatose, ventilator dependent, functioning at the brain stem level or diagnosed as having a **severe physical illness,** such as, COPD, Parkinson's Disease, Huntington's Chorea, or amyotrophic lateral sclerosis; which result in a level of impairment so severe that the person cannot be expected to benefit from specialized services?	( )	( )
4.	Does this individual require **provisional admission** pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears?	( )	( )
5.	Does this individual require **provisional admission which is <u>not to exceed 7 days</u>,** for further assessment in emergency situations that require protective services?	( )	( )
6.	Does this individual require admission for **a brief stay of 30 days for respite care**? <u>The individual is expected to return to the same caregivers following this brief NF stay.</u>	( )	( )

……

<u>CHECK ONLY ONE:</u>

[ ] If **any** answer to Part C is **Yes, <u>NO REFERRAL for LEVEL II</u>** <u>evaluation and determination is necessary at this time.</u> **<u>NOTE TIME CONSTRAINTS!</u>**

[ ] If **all** answers to Part C are **No, <u>REFERRAL for LEVEL II</u>** <u>evaluation and determination</u> **<u>MUST BE MADE.</u>**

SIGN and DATE this form.

	DATE & TIME COMPLETED:
SIGNATURE OF PHYSICIAN, APRN, HOSPITAL DC PLANNER RN	**MM/DD/YY**
PRINT NAME	**Time**

INSTRUCTIONS

DHS 1178 (Rev. 03/20)

PREADMISSION SCREENING RESIDENT REVIEW (PAS/RR) LEVEL I SCREEN

PURPOSE:

This form shall be used as a uniform preadmission screening tool to identify serious mental illness (SMI) or Intellectual Disabilities/Developmental Disabilities (ID/DD) individuals or individuals with both conditions. This form shall be completed by the applicant's *attending or primary care physician, advance practice registered nurse, or registered nurse (discharge planner in hospital only)*.

GENERAL INSTRUCTIONS:

ALL applicants for admission to a Medicaid certified NF shall have a *"PREADMISSION SCREENING RESIDENT REVIEW LEVEL I SCREEN"* form completed *prior to admission*. The date of the PASRR Level I screen is no later than the day of admission to the facility for compliance.

INSTRUCTIONS FOR USING THE LEVEL I SCREEN FORM

Each question listed under the two (2) major sections of *PART A: Serious Mental Illness (SMI), PART B: Intellectual Disabilities/Developmental Disabilities (ID/DD)* must be answered as directed before the section on *Determination* can be completed:

(1) PART A: Serious Mental Illness

(a) The individual has symptom(s) and/or current diagnosis of serious mental illness as listed under the broad diagnostical categories defined in the *"Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised (DSM-III-R)"* of SCHIZOPHRENIA, MOOD DISORDER, DELUSIONAL (PARANOID) DISORDER, PANIC OR OTHER SEVERE ANXIETY DISORDERS, SOMATAFORM DISORDERS, PERSONALITY DISORDERS, SUBSTANCE RELATED DISORDER, OR PSYCHOTIC DISORDERS NOT ELSEWHERE CLASSIFIED that may lead to chronic disability;

(b) The level of impairment seriously affects the individual's interpersonal functioning:

(i) Difficulty interacting appropriately and communicating effectively with other persons, possibly has history of altercations, evictions, unstable employment, frequently isolated, avoids others.

(ii) Has serious difficulty in completion of tasks in work, requires assistance with tasks, errors with tasks, concentration, persistence, or pace.

(iii) Has serious difficulty in adapting to change such as suicidal self-injurious, self-mutilation behavior, physical violence or threats, having appetite disturbance(s), hallucinations, delusions, serious loss of interest/withdrawals, tearfulness, and irritability.

(c) *FOR PASRR PURPOSES ONLY*: Individuals with a primary or secondary diagnosis of SMI (ONLY) under Dementia as defined in the DSM-III-R (including Alzheimer's disease or a related condition) will not be considered as SMI and is excluded from the Level II process:

(i) The individual has a current diagnosis of dementia (including Alzheimer's Disease or a related disorder) as defined in the DSM-III-R;
(ii) Meets the diagnostic criteria for dementia. For e.g., there are global impairments of cognitive functioning; personality changes; and disturbances in behavior and affect; and social and occupational functioning; and
(iii) There should be collaborative evidence, to include a comprehensive mental status exam from the history, physical examination, or laboratory tests to support the diagnosis.
(iv) In the absence of such evidence an organic factor can be presumed if the disturbance can't be accounted for by a functional mental disorder.

(d) Psychoactive Drugs within the last two (2) years
(i) Refers to drugs that affect the mind and behavior;
(ii) Examples of classes of psychoactive drug include: antipsychotic, antidepressant and antianxiety drugs;
(iii) The prescription of a psychoactive drug on a regular basis in the absence of a neurological disorder is an indication that Level II screening is necessary; and
(iv) Evidence of psychoactive drug use alone need not be taken as an indication that further review is needed when there is a medical diagnosis and justification for its use that is not in connection with a mental disorder. For e.g., the use of Valium as an adjunct in seizure disorders, such as, epilepsy.

(2) PART B: Intellectual Disabilities/Developmental Disabilities (ID/DD) /Related Conditions:
(a) Level of intellectual disabilities (mild, moderate, severe, or profound) described in the *American Association on Mental Retardation's Manual on Classification in Mental Retardation (1983)* manifested before age 18; or
Related conditions refers to severe, chronic disability, such as, CP, epilepsy or autism that is attributed to a mental or physical impairment or combination of mental and physical impairments, is manifested before age 22, is likely to continue indefinitely, and results in substantial functional limitations in three or more areas of major life activities (mobility, self-care/direction, learning, understanding/use of language, capacity for living independently).

(b) There should be collaborative evidence if an ID/DD individual has or have presence of Dementia (including Alzheimer's disease or a related condition) as these individuals are NOT excluded from PASRR.

(c) Indicate if the individual is receiving ID/DD services.

(3) DETERMINATION: The decision made in the *Determination* section must be based on the answers and corresponding evidence given on *PART A: SERIOUS MENTAL ILLNESS (SMI)* or *PART B: INTELLECTUAL DISABILITIES/DEVELOPMENTAL DISABILITIES (ID/DD)* in order to be valid:

(a) If **ALL** of the answers in PARTS A or B are **"NO", SIGN** and **DATE** in the box indicating the Level I Screen is **NEGATIVE** for **SMI** or **DD/ID**.

Note: The attending physician, Advanced Practice Registered Nurse (APRN) or Hospital Discharge Planner Registered Nurse (RN) must date and sign the form in the box provided.

(b) If **ANY** of the answers in PARTS A or B are **"YES", COMPLETE PART C (backside)** of this form.

(c) PART C: are conditions that make an exception for the SMI or DD/ID individual from going on to the Level II evaluation and determination process. ONLY one item may be selected:

(i) Items #1 through #6 are self-explanatory and are medical decisions made by the individual's attending or primary care physician.

(ii) If any answer to PART C is "YES", no referral for Level II evaluation and determination is necessary at the time form is completed. **NOTE THE TIME CONSTRAINTS.**

(iii) If all of the answers to PART C are "NO", a referral for Level II evaluation and determination must be made.

(iv) The attending physician, Advanced Practice Registered Nurse (APRN) or Hospital Discharge Planner Registered Nurse (RN) must date and sign the form in the box provided at the bottom of the page to indicate that PART C is completed.

FILING/DISTRIBUTION INSTRUCTIONS:

(1) The EW shall scan form into KOLEA.

(2) Copies of this form and all attachment(s) as appropriate shall be submitted with the facility's monthly census report for all admissions to State's designee, Health Services Advisory Group (HSAG).

(3) The LEVEL I SCREENING FORM is available:

Contract Monitoring and Compliance Section Health Care Services Branch
Med-QUEST Division
P.O. Box 339
Honolulu, Hawaii 96809-0339

APPENDIX J – Litigation Events

Litigation Events

Disclosure of Pending or Recent Litigation	
Date litigation brought against Entity including case title and case ID	
Name of Entity (Health Plan or subcontractor)	
Type of Contract and Contracting Entity (e.g., full risk managed care contract with State of Hawaii MQD, etc.)	
Describe nature of litigation, including action leading to the litigation.	
Indicate amount of damages sought or awarded.	
Does the pending or recent litigation have the potential to or will impair your organization's performance in a Hawaii Medicaid managed care Contract? Please explain if "yes."	
Indicate the status of the litigation.	
Indicate outcome of litigation, if resolved.	

APPENDIX K – PHI Breach Events

PHI Breach Events

Date of Breach	Did the breach result in the exposure of PHI?	Where did the exposure occur? (i.e. internal, subcontractor, etc.)	How many Members' data were included in the breach?	How many total records of data were breached?	To what extent was the breached data seen or used?	What steps were taken to mitigate the breach?

APPENDIX L

BUSINESS PROPOSAL

I, _____ (Name of Official authorized to commit, copy attached) hereby enter the official proposal prices indicated below on behalf _____ (Name of Firm entering proposal), and warrant that all terms and conditions of the RFP for External Quality Reviews and Peer Review Organization of the Medicaid QUEST Integration Managed Care Organizations/Prepaid Inpatient Health Plan are met.

Payment Schedule

(January 1, 2022 to December 31, 2022)

Annual Cost of Contract 2022: $_____

(To be Divided into Twelve Equal Payments to Billed Monthly)

Annual Cost of Contract 2023: $_____

(To be Divided into Twelve Equal Payments to Billed Monthly)

Annual Cost of Contract 2024: $_____

(To be Divided into Twelve Equal Payments to Billed Monthly)

Total Cost of Proposal : $

Cost justification information as set forth in section 70.200 shall be attached to this section or referenced separately as deemed appropriate by the respondent.

EQRO and PRO Scope of Work (1)	2022	2023	2024	Pricing Assumptions
				EQRO ACTIVITIES
Validation of PIPs				Validate 3 PIPs per plan (6 plans/3 reports) for 18 total PIPs; TA to plans/MQD on new PIP process [2021=validated total 12 PIPs/6 plans, previous PIP methodology]
HEDIS Audit/Performance Measure Validation				Validate all MQD-required measures per plan (6 plans/reports) [2020=validated 13 measures/same for each plan/reports]
Compliance Review				For QI and CCS, on-site review of compliance with standards, review/approve CAP, and reevaluate compliance following CAP approval. (1 plan/1 report) [2020=performed 6 reviews for 6 plans and CAP follow-ups]
Expenditures on travel				Including but not limited to HEDIS and Compliance Review related travels. List anticipated number of travel trips and number of participating staff.
TOTAL EQRO				
PASRR Reviews				Generate sample, record reviews, 1,000 reviews annually; reports monthly, quarterly, annually, ad hoc, and interrater reliability reviews.
LTC LOC Determinations				Daily processing of requests, deferral and denial/non-approval. Process approximate 17,000 reviews annually; reports monthly, quarterly, annually, ad hoc, and interrater reliability reviews.
Determinations Data Base				Maintenance/support of the database. Backups and system updates/enhancements. Program and process nightly file to state's eligibility system. Add, modify, and remove users (annually) as appropriate.
Expenditures on Travel				Including but not limited to training related travels. List anticipated number of travel trips including neighbor island training trips and number of participating staff.
Peer Review/Quality Care Concern				Intake identification/referral of case, utilize specialty physician advisor(s) to determine LOC and at risk determination appropriateness. Approximately five (5) cases annually.
Total PRO				

(1) Assumes 5 QUEST Integration plans (WCCS, AlohaCare, HMSA, Kaiser, 'Ohana, UHC CP; and 1 BH PIHP: 'Ohana CCS

(*Exception to above assumption: HEDIS audit/PMV will be performed on measurement year 2014 data, when there were 5 QUEST plans, 2 QExA plans, and 1 CCS plan.)

Technical Assistance				600 hours of Technical Assistance including but not limited to scheduled telephonic, webinars, recorded, and in person training for LOC DHS 1147, PASRR, database, technical assistance to State staff and MCO/PIHP on PIPs, Performance Measure Validation, P4P activities consultations and other performance measurement and qualify improvement activities.
GRAND TOTAL				

(1) Assumes 5 QUEST Integration plans (MCOs): AlohaCare, HMSA, Kaiser, ‘Ohana, UHC CP; and 1 BH PIHP: ‘Ohana CCS
(*Exception to above assumption: HEDIS audit/PMV will be performed on measurement year 2014 data, when there were 5 QUEST plans, 2 QExA plans, and 1 CCS plan.)

APPENDIX M – DHS1137 FORM

APPENDIX M-1 – DHS1137 FORM INSTRUCTIONS

Department of Human Services

Return to: Health Services Advisory Group, Inc.
1440 Kapiolani Blvd., Suite 1110
Honolulu, HI 96814
Phone: (808) 440-6000
Fax: (808) 440-6009

Medicaid Certified Nursing Facility CENSUS REPORT

Admissions & Readmissions

FACILITY NAME:			
TYPE OF REPORT:	Monthly		
PERIOD COVERED:	*Start Date (MM/DD/YY)*	*End Date (MM/DD/YY)*	

GENERAL INSTRUCTIONS:

- Please PRINT/TYPE all information.
- Monthly reports list all admissions during the month, and are due by the 15th of the following month.
- Please use additional forms if more than 25 residents are listed.
- Please include the four-digit year when entering a resident's date of birth.

LIST RESIDENTS (Regardless of Payor Source) *(Last Name, First Name)*	**MEDICAID ID NUMBER** *(If none, put N/A)*	**DATE OF BIRTH** *MM/DD/YYYY*	**ADMISSION DATE** *MM/DD/YY*	**COMMENTS**
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				

THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE FOR THE REPORTING PERIOD.

Print Name/Title _____ Date _____

INSTRUCTIONS

DHS 1137 (Rev. 03/18)

Medicaid Certified Nursing Facility CENSUS REPORT

PURPOSE:

The DHS 1137, Medicaid Certified Nursing Facility Census Report form, shall be used by a Medicaid Certified Nursing Facility in reporting all admissions and readmissions.

GENERAL INSTRUCTIONS:

1. Facility Name: Enter facility name.
2. Type of Report: Prefilled: Monthly.
3. Period Covered: Enter *Start Date* and *End Dat*e of the period covered in MM/DD/YY format. The start and end dates should align with the beginning and end of the prior month (e.g., 09/01/17—09/30/17). **Dates must be on or before the date the form is submitted.**
4. Name of All Residents: In alphabetical order, enter legibly last name, first name. Excel form can be sorted.
5. Medicaid ID Number (If none, put N/A): Ten (10) digits. Example: 0000999999.
6. Date of Birth: Put resident's date of birth in MM/DD/YYYY format.
7. Admission Date: Date resident was admitted to facility regardless of payment source in MM/DD/YY format.
8. Comments: As appropriate.
9. Submitter: Enter submitter's name and submitter's title.
10. Submittal Date: Enter submission date. This report shall be submitted monthly by the 15th of the following month.

FILING/DISTRIBUTION INSTRUCTIONS:

Original to HCSB.

APPENDIX N: DHS 1147 FORM

APPENDIX N-1: DHS 1147 FORM INSTRUCTIONS

APPENDIX N-2: DHS 1147A FORM

APPENDIX N-3: DHS 1147A FORM INSTRUCTIONS

APPENDIX N-4: DHS 1147E FORM

APPENDIX N-5: DHS 1147E FORM INSTRUCTIONS

APPENDIX N-6: LTC LOC Determinations

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

COMPLETE ALL SECTIONS OF THE FORM EXCEPT SECTION 14

1. PLEASE PRINT OR TYPE ☐ Initial Request ☐ Annual Review ☐ Reconsideration ☐ Other review

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. MEDICARE	6. MEDICAID ELIGIBLE?
			Part A ☐ Yes ☐ No Part B ☐ Yes ☐ No ID#:_____	☐ Yes ID # _____ ☐ No If no, date applied for Medicaid (Required)_____

7. PRESENT ADDRESS: Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other: _____

8. Medicaid Provider Number: (If applicable)

9. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial) _____
Phone: ( )_____ Fax: ( )_____

10. RETURN FORM TO (SERVICE COORDINATOR OR CONTACT PERSON):_____
MANAGED CARE PLAN NAME (IF APPLICABLE): _____
Phone ( )_____ Fax ( ) _____ Email _____

11. REFERRAL INFORMATION (Completed by Referring Party)

A. SOURCE(S) OF INFORMATION
☐ Client ☐ Records ☐ Other _____

B. RESPONSIBLE PERSON
Name _____
Last First MI
Relationship _____
PHONE ( )_____ FAX ( )_____

C. Language ☐ English ☐ Other _____

12. ASSESSMENT INFORMATION (Completed by RN, Physician, PCP)

A. ASSESSMENT DATE ____/____/____

B. ASSESSOR'S NAME
Name _____
Last First MI
Title _____
Signature _____
☐ Hard copy signature on file.
PHONE: ( ) _____ FAX: ( ) _____
EMAIL: _____

13. REQUESTING

CHECK ONE BOX:
[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)
[ ] At Risk

BEGIN and END DATES: _____ TO _____

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months [ ] 1 year

[ ] Other: _____

14. MEDICAL NECESSITY DETERMINATION – DO NOT COMPLETE

APPROVAL:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)
[ ] At Risk

BEGIN AND END DATES: _____ TO _____

LENGTH OF APPROVAL (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months [ ] 1 year

[ ] Other: _____

DEFERRED: [ ] Current 1147 Version Needed [ ] Missing Information [ ] Clinical Question

NOT APPROVED:

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] DOES NOT MEET AT RISK CRITERIA [ ] INCOMPLETE INFORMATION TO MAKE DETERMINATION

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.

DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

COMPLETE ALL SECTIONS OF THE FORM

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (Last, First, Middle Initial)	2. **BIRTHDATE**

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

I. LIST SIGNIFICANT CURRENT DIAGNOSIS(ES):

PRIMARY: _____

SECONDARY: _____

II. COMATOSE ☐ No ☐ Yes If "Yes," go to **XVIII.**

III. VISION / HEARING / SPEECH:
[0] a. Individual has normal or minimal impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[1] b. Individual has impairment (with/without corrective device) of: ☐ Hearing ☐ Vision ☐ Speech
[2] c. Individual has complete absence of: ☐ Hearing ☐ Vision ☐ Speech

IV. COMMUNICATION:
[0] a. Adequately communicates needs/wants.
[1] b. Has difficulty communicating needs/wants.
[2] c. Unable to communicate needs/wants.

V. MEMORY:
[0] a. Normal or minimal impairment of memory.
[1] b. Problem with [ ] long-term or [ ] short-term memory.
[2] c. Individual has a problem with both long-term and short-term memory.

VI. MENTAL STATUS / BEHAVIOR: (only one selection for orientation – items a through c. Aggressive and/or abusive and wandering may also be checked with appropriate orientation.) *

[0] a. Oriented (mentally alert and aware of surroundings).
[1] b. Disoriented (partially or intermittently; requires supervision).
[2] c. Disoriented and/or disruptive.
[3] d. Aggressive and/or abusive. (Examples required in section XX)
[4] e. Wanders at [ ] Day [ ] Night [ ] Both, and/or [ ] in danger of self-inflicted harm or self-neglect. (Examples required in section XX)

VII. FEEDING:
[0] a. Independent with or without an assistive device.
[1] b. Needs supervision or assistance with feeding.
[2] c. Is spoon / syringe / tube fed, does not participate.

VIII. TRANSFERRING:
[0] a. Independent with or without a device.
[2] b. Transfers with minimal /stand-by help of another person.
[3] c. Transfers with physical / moderate assistance of another person.
[4] d. Does not assist in transfer / requires maximum assist / or is bedfast.

IX. MOBILITY / AMBULATION: (Check a maximum of 2 for items b through e. If an individual is either independently mobile or unable to walk, no other selections can be made.)
[0] a. Independently mobile with or without device / self-propels wheelchair.
[1] b. Ambulates with/without device / stand-by assist / unsteady / risk for falls.
[2] c. Able to walk/be mobile with minimal assistance.
[3] d. Able to walk/be mobile with one-person hands-on/moderate assistance.
[4] e. Able to walk/be mobile with more than one-person hands-on assistance.
[5] f. Unable to walk / immobile.

X. BOWEL FUNCTION / CONTINENCE:
[0] a. Continent / able to independently perform bowel care.
[1] b. Continent with cues / requires reminders to perform bowel care.
[2] c. Incontinent (at least once daily) / requires help with bowel care on a regular basis.
[3] d. Incontinent (more than once daily) / dependent for all bowel care.

XI. BLADDER FUNCTION / CONTINENCE:
[0] a. Continent / able to independently perform bladder care.
[1] b. Continent with cues / requires reminders to perform bladder care.
[2] c. Incontinent (at least once daily) / requires help with bladder care on a regular basis.
[3] d. Incontinent (more than once daily) / dependent for all bladder care.

XII. BATHING:
[0] a. Independent bathing.
[1] b. Unable to safely bathe without minimal assistance and supervision.
[2] c. Unable to safely bathe without moderate assistance.
[3] d. Cannot bathe without total assistance (tub, shower, whirlpool or bed bath).

XIII. DRESSING AND PERSONAL GROOMING:
[0] a. Appropriate and independent dressing, undressing and grooming.
[1] b. Can groom/dress self with cueing. (Can dress, but unable to choose or lay out clothes).
[2] c. Physical assistance needed on a regular basis.
[3] d. Requires total help in dressing, undressing, and grooming.

Complete questions XIV to XVII for At Risk requests only:

XIV. HOUSECLEANING:
[0] a. Independent
[2] b. Needs Assistance
[3] c. Unable to safely clean the home

XV. SHOPPING:
[0] a. Independent
[2] b. Needs Assistance
[3] c. Unable to safely go shopping

XVI. LAUNDRY:
[0] a. Independent
[1] b. Needs Assistance
[2] c. Unable to safely do the laundry

XVII. MEAL PREPARATION:
[0] a. Independent
[1] b. Needs Assistance
[2] c. Unable to safely prepare a meal

XVIII. TOTAL POINTS:

Comatose = 30 points Total Points Indicated: _____

XIX MEDICATIONS/TREATMENTS:

(List all Significant Medications, Dosage, Frequency, and mode) Attach additional sheet if necessary	Administers Independently	Requires Supervision/ Monitoring	Requires Admin	PRNs Only Actual Freq
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____
_____	[ ]	[ ]	[ ]	_____

XX. ADDITIONAL INFORMATION CONCERNING PATIENT'S FUNCTIONAL STATUS *Include examples, frequency of occurrences, and interventions for aggressive and/or abusive behaviors, wandering, and/or self-inflicted harm or self-neglect behaviors.

_____

_____

_____

_____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) and At Risk Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

COMPLETE ALL SECTIONS OF THE FORM

APPLICANT/CLIENT BACKGROUND INFORMATION (Please Type or Print)

1. **NAME** (PRINT Last, First, Middle Initial)	2. **BIRTHDATE**

XXI. SKILLED PROCEDURES: D = Daily Indicate number of times per day **L** = Less than once per day **N** = Not applicable / Never

D #	L √	N √	PROFESSIONAL NURSING ASSESSMENT/CARE RELATED TO MANAGEMENT OF:
___	[ ]	[ ]	Tracheostomy care/suctioning in ventilator dependent person
___	[ ]	[ ]	Tracheostomy care/suctioning in non-ventilator dependent person
___	[ ]	[ ]	Nasopharyngeal suctioning in persons with no tracheostomy
___	[ ]	[ ]	Total Parenteral Nutrition (TPN) {Specify number of hours per day}: _____
___	[ ]	[ ]	Maintenance of peripheral/central IV lines
___	[ ]	[ ]	IV Therapy (Specify agent & frequency):_____
___	[ ]	[ ]	Decubitus ulcers (Stage III and above)
___	[ ]	[ ]	Decubitus ulcers (less than Stage III); wound care {Specify nature of ulcer/wound and care prescribed} _____
___	[ ]	[ ]	Wound care (Specify nature of wound and care prescribed) ☐ debridement ☐ Irrigation ☐ packing ☐ wound vac. _____
___	[ ]	[ ]	Instillation of medications via indwelling urinary catheters (Specify agent): _____ _____
___	[ ]	[ ]	Intermittent urinary catheterization
___	[ ]	[ ]	IM/SQ Medications (Specify agent.):_____
___	[ ]	[ ]	Difficulty with administration of oral medications (Explain): _____
___	[ ]	[ ]	Swallowing difficulties and/or choking
___	[ ]	[ ]	Stable Gastrostomy/Nasogastric/Jejunostomy tube feedings; Enteral Pump? ☐ Yes ☐ No
___	[ ]	[ ]	Gastrostomy/Nasogastric/Jejunostomy tube feedings in persons at risk for aspiration (Specify reason person at risk for aspiration) _____
___	[ ]	[ ]	Initial phase of Oxygen therapy
___	[ ]	[ ]	Nebulizer treatment
___	[ ]	[ ]	Complicating problems of patients on [ ] renal dialysis, [ ] chemotherapy, [ ] radiation therapy, [ ] with orthopedic traction (Check problem(s) and describe) : _____
___	[ ]	[ ]	Behavioral problems related to neurological impairment (Describe): _____ _____
___	[ ]	[ ]	Other (Specify condition and describe nursing intervention): _____ _____
☐ Yes	☐ No		Therapeutic Diet (Describe): _____
☐ Yes	☐ No		Restorative Therapy (check therapy and submit/attach evaluation and treatment plan): ☐ PT ☐ OT ☐ Speech
☐ Yes	☐ No		The patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XXII. SOCIAL SITUATION:

A. Person can return home ☐ Yes ☐ No ☐ N/A Community setting can be considered as an alternative to facility? ☐ Yes ☐ No ☐ N/A

B. If person has a home; caregiving support system is willing to provide/continue care. ☐ Yes ☐ No

Caregiver requires assistance? ☐ Yes ☐ No

Assistance required by Caregiver: _____ _____

C. Caregiver name:

Name: _____ Relationship: _____
Last First MI

Address: _____ Phone: (___) _____ Fax (___) _____

XXIII. COMMENTS ON NURSING REQUIREMENTS OR SOCIAL SITUATION:

_____

_____

I HAVE REVIEWED AND AGREE WITH THIS ASSESSMENT.

PHYSICIAN/PCP/RN SIGNATURE: _____

☐ Hard copy signature on file. This plan of care has been discussed with the MD/PCP/RN. **DATE:** ___/___/___

Physician/PCP/RN Name (PRINT): _____

INSTRUCTIONS

DHS 1147 (Rev. 01/2021)

LEVEL OF CARE (LOC) AND AT RISK EVALUATION

PURPOSE:

A Medicaid Provider or QUEST Integration Health Plan shall use the DHS 1147 "Level of Care (LOC) and At Risk Evaluation" form to evaluate an applicant or Medicaid recipient level of care as documentation for requested Medicaid long-term care eligibility and long-term services and supports.

SPECIFIC INSTRUCTIONS:

1. ***Check the appropriate box for the evaluation:*** Check type of request - initial, annual, reconsideration or other review, i.e. 3-month review to determine continued stay.

2. ***Patient Name***: Self-explanatory.

3. ***Birthdate***: Self-explanatory.

4. ***Gender***: Indicate whether the patient is "M" for male or "F" for female.

5. ***Medicare***: Check the appropriate box indicating whether patient has Medicare Part A and B and enter patient's Medicare I.D. number, if eligible for either Part A or B.

6. ***Medicaid Eligible***: Check "Yes" or "No" to indicate whether the patient is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible. If the patient has applied for Medicaid but has not yet been deemed eligible, print or type in "pending" for I.D. # and print or type in date applied. Forms will be processed only if patient has a Medicaid number or has the date of the Medicaid application.

7. ***Present Address***: Indicate patient's present address, i.e. Home, Hospital, Nursing Facility (NF), Care Home, Extended Adult Residential Care Home (EARCH – Type I & Type II), Community Care Family Foster Home (CCFFH), or other.

   Home: Patient is at his or her residential home or is homeless.
   Hospital: Patient is currently residing in an Acute Care Hospital, i.e. waitlisted at an acute waitlisted level of care.
   Nursing Facility (NF): Patient is currently residing in a nursing facility.
   Care Home: Patient is currently residing in a care home – not at nursing facility level of care.
   Extended Adult Resident Care Home (EARCH): Patient is currently residing in a Department of Health or Shared Home with the

Department of Human Services which include Patients at a care home and nursing facility level of care.
Community Care Foster Family Home (CCFFH): Patient is currently residing in a Department of Human Services Foster Home which includes Patients at a nursing facility level of care.
Other: Check this box if the patient's present address is not listed above. Write in the description.

8. ***Medicaid Provider Number***: Enter only if applicable. Patient must be pending Medicaid and currently NOT a patient in a managed care health plan.
9. ***Attending Physician/Primary Care Provider (PCP)***: Enter the name of the attending physician or primary care provider, telephone and fax number.

10. ***Return Form to***: Enter the name of the service coordinator or the contact person. Indicate the managed care plan name if applicable, telephone, fax number and email address of the person able to provide additional information about the patient.

11. ***Referral Information***: Complete all sections for an initial request. Skip this section, if this is an annual or "other" review.

    A. Source(s) of Information: Identify the source(s) of patient information received.

    B. Responsible Person: Provide the name, relationship, phone and fax numbers of the family member/personal agent who will be making decisions for the patient.

    C. Language: Check the box of the primary language spoken by the patient. If checking "Other," indicate the language spoken. Information is used to obtain interpreters.

12. ***Assessment Information***: Complete all sections.

    A. Assessment Date: Indicate the date of the most current assessment.

    B. Assessor's Name, Title, Signature, Phone and Fax Numbers: A registered nurse (RN), physician or primary care provider must perform the assessment. Enter the name, title and telephone, fax number and email address of the assessor. The assessor must sign the form.

    Electronic submittal of form(s) will be accepted with the box checked that a signature of the RN, physician or primary care provider has signed a hard copy of this form and the hard copy of the form(s) can be found in the patient's file.

13. ***Requesting***: Check what is being requested (either level of care or at risk). Indicate the begin and end date of the request. If hospice services have been elected by the patient AND the services will be provided in a nursing facility, attach

the hospice election and physician certification of terminal illness form signed by two different physicians. *Hospice services in other settings do not require an 1147 form.*

Indicate the length of approval requested. Check one box.

14. ***Medical Necessity Determination***: Completed by DHS reviewer or designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 AND 3– APPLICANT/PATIENT BACKGROUND INFORMATION

1. ***Name***: Self-explanatory.
2. ***Birthdate***: Self-explanatory.

3. ***Functional Status Related to Health Conditions***: Complete all sections.

   I. **List significant current diagnosis(es)**: List the primary and secondary diagnosis(es) or medical conditions related to the patient's need for long- term care.

   II. **Comatose**: If patient is comatose, check "Yes" box and go directly to Section XIV. If patient is not comatose, check "No" and complete rest of section.

   III. **Vision/Hearing/Speech through XIII Dressing and Personal Grooming**: Select the description that best describes the patient's functioning.

   Note: Make only one selection in all sections except VI. Mental Status/Behavior and IX. Mobility/Ambulation. For Mental Status/Behavior, make only one selection for orientation (items a through c). Aggressive and/or abusive and wandering may also be checked with the appropriate orientation. For Mobility/Ambulation, check a maximum of 2 for items b through e. If an individual is either independently mobile or unable to walk, no other selections can be made.

   XIV. **House Cleaning through XVII Meal Preparation:** Complete these for At Risk requests only.

   XVIII. **Total Points**: Add the points from each section to obtain total. Comatose patients are assigned 30 points.

   XIX. **Medications/Treatments**: List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than significant medications than available lines, attach orders or treatment sheet.

XX. **Additional Information Concerning Patient's Functional Status**: Use the space to provide additional information on the patient's functional status. This section may be used to identify the extent of the assistance (minimal, with assistance or total) that is required. Attach a separate sheet if more space is required. See attachment Functional Status related to Health Conditions on scoring this section.

XXI. **Skilled Procedures**: Check the particular skilled procedure(s) that the patient requires. If the care is daily (D), indicate the number of times per day that care is required. If care is less than once per day check "L". If the care is not applicable, check "N".

If restorative therapy is being requested, attach the evaluation and treatment plan(s) AND indicate whether the patient is able to participate in therapy a minimum of 45 minutes per session 5 days a week.

XXII. **Social Situation**:

a. **Person can return home**: Identify whether the patient can return home. The home can be a family member's (daughter, son, brother, sister, parents, etc.) home as well as the patient's own home. Check "NA" if the patient is already in a home environment. If the individual does not have a home, indicate whether the patient can be placed in a community setting. Check "NA" if the patient is already in a community setting.

b. **Caregiving support**: If the patient has a home, identify whether the caregiving support is willing/able to provide care. If caregiver requires assistance, identify the assistance required.

c. **Caregiver name**. Provide the caregiver's name, relationship, address, phone and fax numbers.

XXIII. **Comments on Nursing Requirements or Social Situation:** Provide any additional information that would help explain the Patient's nursing requirements or social situation.

Physician/PCP/RN Signature: Self-explanatory.

Electronic submittal of form(s) will be accepted with the box checked that the physician, the primary care provider, or the registered nurse has signed a hard copy of the form(s) and that the plan of care has been discussed with the physician, primary care provider, or registered nurse. The hard copy of the form(s) must be kept in the Patient's file.

Date: Indicate the date of the physician, Primary Care Provider, or Registered Nurses' signature.

Physician's/PCP/RN Name (Print): Self-explanatory.

FILING/DISTRIBUTION:

Mail, fax, or send forms electronically to:

Health Services Advisory Group, Inc.
1011 Kamokila Blvd., Suite 311
Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
Level of Care (LOC) Re-Evaluation

HEALTH SERVICES ADVISORY GROUP, INC.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

Please Print or Type

1. PATIENT NAME (Last, First, M.I.)	2. BIRTHDATE Month/Day/Year	3. SEX	4. MEDICAID ID NUMBER

5. PRESENT ADDRESS: Present Address is ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other _____

6. Medicaid Provider Number: (If applicable)

7. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial)

_____

Phone ( )_____ Fax ( ) _____

8. RETURN FORM TO (SERVICE COORDINATOR OR CONTACT PERSON): _____

MANAGED CARE PLAN NAME (IF APPLICABLE): _____

VIA [ ] FAX (Print Fax Number Below)
Phone ( )_____ Fax ( )_____ Email ( ) _____

9. REASON(S) FOR LOC RE-EVALUATION

[ ] Change in LOC
[ ] Extension of Current LOC
[ ] At home and waitlisted for Long Term Care Services: ☐ NF or ☐ Home and Community Based Services
[ ] No longer meeting LOC (NOT in acute, NF ICF, NF SNF, NF Hospice, NF Subacute I or II, Acute waitlisted ICF or SNF or Subacute) as of date: _____. Fill out #10, then do not proceed.

10. APPROVED LOC ON MOST CURRENT FORM (Date Span) From: _____ TO _____	**11. LOC BEING REQUESTED LOC BEGIN and END DATES: _____ TO _____**
[ ] Nursing Facility (ICF)	[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)	[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)	[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)	[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)	[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)	[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)	[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)	[ ] Acute Waitlist (Subacute)

12. CURRENT STATUS

Specify Current Primary Diagnosis _____

[ ] Additional Diagnoses (list diagnoses) _____

[ ] Functional Capabilities ( ) No Change ( ) Change(s) {Specify} _____

[ ] Nursing needs ( ) No Change ( ) Change(s) {Specify} _____

DOCUMENT NEED AT REQUESTED LOC: _____

_____

PHYSICIAN'S/PCP SIGNATURE: _____ **DATE:** _____

☐ Hard copy signature on file. This plan of care has been discussed with the MD/PCP.

Physician's/PCP Name (PRINT): _____

13. MEDICAL NECESSITY/LEVEL OF CARE DETERMINATION – DO NOT COMPLETE

LEVEL OF CARE APPROVAL:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)

LOC BEGIN AND END DATES: _____ TO _____

LENGTH OF APPROVAL (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months [ ] 1 year

[ ] Other: _____

DEFERRED: [ ] Current 1147 Version Needed [ ] Missing Information

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] INCOMPLETE INFORMATION TO DETERMINE LEVEL OF CARE

DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____

INSTRUCTIONS
DHS 1147A (Rev. 01/2021)

LEVEL OF CARE (LOC) Re-EVALUATION

PURPOSE:

A Medicaid Provider or QUEST Integration Health Plan shall use the DHS 1147A "Level of Care (LOC) Re-Evaluation" form to evaluate a beneficiary level of care as needed as documentation for requested Medicaid services long-term services and supports.

SPECIFIC INSTRUCTIONS:

1. ***Patient Name***: Self-explanatory

2. ***Birthdate***: Self-explanatory

3. ***Sex***: Indicate whether the patient is "M" for male or "F" for female.

4. ***Medicaid I.D. Number***: Enter Medicaid I.D. number assigned by the Department of Human Services. If the I.D. number is unknown, use one of the availability eligibility verification systems to find the I.D. number of the patient. If the patient has applied for Medicaid but has not yet been deemed eligible, write in "pending".

5. ***Present Address:*** Indicate patient's present address, i.e. Home, Hospital, Nursing Facility (NF), Care Home, Extended Adult Residential Care Home (EARCH – Type I & Type II), Community Care Family Foster Home (CCFFH), or other.

   Home: Patient is at his or her residential home or is homeless.
   Hospital: Patient is currently residing in an Acute Care Hospital, i.e. waitlisted at an acute waitlisted level of care.
   Nursing Facility (NF): Patient is currently residing in a nursing facility
   Care Home: Patient is currently residing in a care home – not at nursing facility level of care.
   Extended Adult Resident Care Home (EARCH): Patient is currently residing in a Department of Health or Shared Home with the Department of Human Services which include patients at a care home and nursing facility level of care.
   Community Care Foster Family Home (CCFFH): Patient is currently residing in a Department of Human Services Foster Home which includes patients at a nursing facility level of care.
   Other: Check this box if the patient's present address is not listed above. Write in the description.

6. ***Medicaid Provider Number.***: Enter only if applicable. Patient must be pending Medicaid and currently NOT a patient in a managed care health plan.

7. ***Attending Physician/Primary Care Provider (PCP)***: Print last name, first name, and middle initial, telephone and fax number.

8. ***Return Form to***: Enter the name of the service coordinator or the contact person. Indicate the managed care plan name if applicable, telephone, fax number and email address of the person able to provide additional information about the patient.

9. ***Reasons for LOC Re-Evaluation***: Indicate whether the request is for:

    a. Change in LOC. The change in LOC should be a minor change in functional or skilled nursing status, i.e. waitlisted skilled level of care (IV therapy) to nursing facility intermediate care (discontinued IV therapy – no change in functional status).
    b. Extension of Current LOC, i.e. acute waitlisted, at home and waitlisted for Long Term Care Services,
    c. At home and waitlisted for Long-Term Care Services. If a patient is waitlisted for a Long-Term Care Service and is at home, check this box.
    d. No longer meeting LOC <u>(NOT meeting an Acute, NF ICF, NF SNF, NF Hospice, NF Subacute I or II, Acute Waitlisted ICF or SNF or Subacute LOC).</u>

        <u>If "No longer meeting LOC" is selected, indicate date of when the patient did not meet the LOC. Must fill out #10 "Date Span" Enter current date span of this patient's LOC on most current APPROVED form.</u>

10. ***Approved LOC on Most Current Form***: Enter the date span on most current approved 1147/1147a/1147e form and check the LOC.

11. ***LOC Being Requested***: Enter date span of LOC being requested and check the requested LOC and enter the requested LOC begin and end dates.

12. ***Current Status***: Specify current primary diagnosis(es). Check if there are additional diagnosis(es), list the most significant diagnosis first. Specify changes in functional capabilities (increases/decreases in ADLs, behavioral and cognitive functioning) and/or nursing needs.

    Document Need at Requested LOC: If the answers to "current status" are sufficient to the document the need, enter "see above." Use this space to provide additional information as to the reasons for the continuation of long-term care services.

    Physician's/PCP Signature: Self-explanatory

    Date: Date of physician or PCP's signature

Electronic submittal of form(s) will be accepted with the box checked that the physician or the primary care provider has signed a hard copy of the form(s) and that the plan of care has been discussed with the physician or primary care provider. The hard copy of the form(s) must be kept in the patient's file.

Physician's/PCP Name: Self-explanatory

13. ***Medical Necessity/Level of Care Determination***: Completed by DHS reviewer or designee. Leave Blank. DO NOT COMPLETE.

FILING/DISTRIBUTION:

Mail, fax, or send forms electronically to:

Health Services Advisory Group, Inc.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
CHILDREN/YOUTH UNDER AGE 21
Level of Care Evaluation

HEALTH SERVICES ADVISORY GROUP
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

1. PLEASE PRINT OR TYPE ☐ Initial Request ☐ Six Months ☐ Annual Review ☐ Other review

2. PATIENT NAME (Last, First, M.I.)	3. BIRTHDATE Month/Day/Year	4. SEX	5. Private/Other Insurance ☐ Yes ☐ No Ins. Co.:_____ ID#: _____	6. MEDICAID ELIGIBLE? ☐ Yes ID # _____ ☐ No If no, date applied for Medicaid (Required)_____

7. PRESENT ADDRESS (Specify Facility Name When Applicable) Present Address is: ☐ Home ☐ Hospital ☐ NF ☐ Care Home ☐ EARCH ☐ CCFFH ☐ Other: _____

8. Medicaid Provider Number: (If applicable)

9. ATTENDING PHYSICIAN/PRIMARY CARE PROVIDER (PCP) (Last Name, First Name, Middle Initial)

Phone : ( )_____ Fax: ( )_____

10. RETURN FORM TO (SERVICE COORDINATOR OR CONTACT PERSON): _____

MANAGED CARE PLAN NAME (IF APPLICABLE): _____

[ ] VIA FAX (Print Fax Number Below)
Phone ( )_____ Fax ( ) _____ Email ( ) _____

11. REFERRAL INFORMATION (Completed by Referring Party)

A. SOURCE(S) OF INFORMATION
☐ Client ☐ Records ☐ Other _____

B. PARENT/LEGAL GUARDIAN/RESPONSIBLE PARTY:
Name _____
Last First MI
Relationship _____
PHONE ( ) _____ FAX ( ) _____

C. Language ☐ English ☐ Other _____

12. ASSESSMENT INFORMATION (Completed by RN, Physician, PCP)

A. ASSESSMENT DATE ____/____/____

B. ASSESSOR'S NAME
Name _____
Last First MI
Title _____ Signature _____
☐ Hard copy signature on file.
PHONE: ( ) _____ FAX: ( ) _____
EMAIL: ( ) _____

13. REQUESTING LEVEL OF CARE

CHECK ONE BOX:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)

LEVEL OF CARE BEGIN and END DATES: _____ TO _____

LENGTH OF APPROVAL REQUESTED (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months

[ ] Other: _____

14. MEDICAL NECESSITY / LEVEL OF CARE DETERMINATION – DO NOT COMPLETE

LEVEL OF CARE APPROVAL:

[ ] Nursing Facility (ICF)
[ ] Nursing Facility (SNF)
[ ] Nursing Facility (HOSPICE)
[ ] Nursing Facility (Subacute I)
[ ] Nursing Facility (Subacute II)
[ ] Acute Waitlist (ICF)
[ ] Acute Waitlist (SNF)
[ ] Acute Waitlist (Subacute)

LEVEL OF CARE BEGIN and END DATES: _____ TO _____

LENGTH OF APPROVAL (CHECK ONE BOX):

[ ] 1 month [ ] 3 months

[ ] 6 months

[ ] Other: _____

Comments: _____

DEFERRED: [ ] Current 1147e Version Needed [ ] Missing Information

[ ] DOES NOT MEET LEVEL OF CARE REQUESTED [ ] INCOMPLETE INFORMATION TO DETERMINE LEVEL OF CARE

NOTE: THIS IS NOT AN AUTHORIZATION FOR PAYMENT OR APPROVAL OF CHARGES. PAYMENT BY THE MEDICAID PROGRAM IS CONTINGENT ON THE INDIVIDUAL BEING ELIGIBLE, THE SERVICES BEING COVERED BY MEDICAID AND THE PROVIDER BEING MEDICAID CERTIFIED AT THE TIME SERVICES ARE RENDERED. INDIVIDUAL'S ELIGIBILITY MUST BE VERIFIED BY THE PROVIDER AT THE TIME OF SERVICE.

DHS REVIEWER'S / DESIGNEE'S SIGNATURE: _____ DATE: _____

STATE OF HAWAII
Department of Human Services
Med-QUEST Division

STATE OF HAWAII
CHILDREN/YOUTH UNDER AGE 21
Level of Care Evaluation

HEALTH SERVICES ADVISORY GROUP
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

1. **NAME** (PRINT Last Name, First Name, Middle Initial)

2. **BIRTHDATE**

3. FUNCTIONAL STATUS RELATED TO HEALTH CONDITIONS

A. LIST CURRENT SIGNIFICANT DIAGNOSIS(ES):

PRIMARY:

SECONDARY:

B. MEDICATION/TREATMENTS (Attach additional sheet if necessary)
List all Significant Medications, Dosage and Frequency

1.
2.
3.
4.
5.
6.

C. ACTIVITIES OF DAILY LIVING: Identify only assistance required due to developmental delays:

☐ Feeding ☐ Transferring ☐ Mobility/Ambulation

☐ Toileting ☐ Bathing ☐ Dressing/Grooming

D. FAMILY/SOCIAL CONSIDERATIONS

1. Child can return home ☐ Yes ☐ No ☐NA
2. Community setting can be considered as an alternative to facility? ☐ Yes ☐ No ☐NA
3. If child has a home, caregiving support system is willing to provide/continue care? ☐ Yes ☐ No
   a. Assistance required by Caregiver:_____
   _____
   b. Caregiver Name/relationship: _____/_____
   Address: _____ Phone: _____
   Fax: _____ Email address: _____

E. Additional information concerning functional status and justification for LOC, i.e. apnea events, transitioning from tube feeds, isolette, parent teaching/training, behavior, communication, vision etc:

_____
_____
_____
_____
_____
_____

4. Nursing Intervention		**Frequency/Complexity**
☐	Ventilator	Continuous
☐		Intermittent, specify time on ventilator:
☐	Tracheostomy	
☐	Oxygen therapy	Continuous
☐		Intermittent
☐	Nebulized Medications	TID or less
☐		>TID
☐	Vascular access catheter	
☐	Parenteral nutrition	Continuous
☐		Intermittent
☐	Gastrostomy/jejunostomy/nasogastric tube	Gravity feedings
☐		Pump feedings
☐	Ileostomy/colostomy	
☐	Urinary bladder catheterization	Intermittent or continuous
☐	Orthopedic appliance	Splint/cast (each)
☐		Complex (describe)
☐	Isolation/reverse isolation	
☐	Enteral Medications	8 doses/day or less
☐		>8 doses/day
☐	IM/SQ medications	4 doses/day or less
☐		>4 doses/day
☐	IV medications	4 doses/day or less
☐		>4 doses/day
☐	Oral medications	Less than 12 doses/day
☐		12 or more doses/day
☐	Monitor (Apnea, Pulse Oximeter, C-R)	
☐	Special Skin Care (Burn, decubiti)	Localized
☐		Extensive (describe)
☐	Wound Care (describe):	
☐	Restorative therapy (PT, OT, Speech – include treatment plan)	
☐	Initial discharge from hospital	
☐	Readmission for exacerbation of existing medical condition or new diagnosis	
☐	Acute, episodic illness requiring physician or emergency room visits	
☐	Other specialized nurse interventions (explain):	
☐	Comatose	

I HAVE REVIEWED AND AGREE WITH THE LEVEL OF CARE ASSESSMENT.

Physician's/PCP Signature: _____ Physician's/PCP Name (Print): _____

☐ Hard copy signature on file. This plan of care has been discussed with the MD/PCP. Date: _____

INSTRUCTIONS
DHS 1147E (Rev. 10/2020)

CHILDREN/YOUTH Under Age 21 LEVEL OF CARE (LOC) EVALUATION

PURPOSE:

A Medicaid Provider shall use the DHS 1147E "Children/Youth Under Age 21 Level of Care" form to evaluate a child or youth under age 21 level of care as documentation for requested Medicaid services.

SPECIFIC INSTRUCTIONS:

1. ***Check the appropriate box for the evaluation***: Check type of request – initial, six month, annual or other review, i.e. 3-month review to determine continued stay.

2. ***Patient Name***: Self-explanatory

3. ***Birthdate***: Self-explanatory

4. ***Sex***: Indicate whether the patient is "M" for male or "F" for female.

5. **Private/Other Insurance**: Check the appropriate box indicating whether patient has private or other insurance. Indicate the insurer's company name and ID number.

6. ***Medicaid Eligible***: Check "Yes" or "No" to indicate whether the patient is currently Medicaid eligible. Enter Medicaid I.D. number assigned by the Department of Human Services, if eligible.

   If the patient has applied for Medicaid but has not yet been deemed eligible, print or type in "pending" for I.D. # and print or type in date applied for Medicaid. Forms will be processed only if patient has a Medicaid number or has the date of the Medicaid application.

7. ***Present Address***: Indicate patient's present address, i.e. Home, Hospital, Nursing Facility (NF), Care Home, Extended Adult Residential Care Home (EARCH – Type I & Type II), Community Care Family Foster Home (CCFFH), or other.

   Home: Patient is at his or her residential home or is homeless.
   Hospital: Patient is currently residing in an Acute Care Hospital, i.e. waitlisted at an acute waitlisted level of care.
   Nursing Facility (NF): Patient is currently residing in a nursing facility.
   Care Home: Patient is currently residing in a care home – not at nursing facility level of care.
   Extended Adult Resident Care Home (EARCH): Patient is currently residing in a Department of Health or Shared Home with the Department of Human Services which include patients at a care home and nursing facility level of care.

Community Care Foster Family Home (CCFFH): Patient is currently residing in a Department of Human Services Foster Home which includes patients at a nursing facility level of care.
Other: Check this box if the patient's present address is not listed above. Write in the description.

8. ***Medicaid Provider Number***: Enter only if applicable. Patient must be pending Medicaid and currently NOT a patient in a managed care health plan. If the patient is pending Medicaid and the provider requests EPSDT services, submit an 1144 form to Affiliated Computer Services (ACS) with the approved 1147e or 1147a.

9. ***Attending Physician/Primary Care Provider (PCP)***: Enter the name of the attending physician or primary care provider, telephone and fax number.

10. ***Return Form to***: Enter the name of the service coordinator or the contact person. Indicate the managed care plan name if applicable, telephone, fax number and email address of the person able to provide additional information about the patient.

11. ***Referral Information***: Complete all sections for an initial request. Skip this section, if this is an annual or "other" review.

    a. **Source(s) of Information**: Identify the source(s) of patient information received.

    b. **Parent/Legal Guardian/Responsible Party**: Provide the name, relationship, phone and fax numbers of the Parent/Legal Guardian/Responsible Party who will be making decisions for the patient.

    c. **Language**: Check the box of the primary language spoken by the patient. If checking "Other," indicate the language spoken. Information is used to obtain interpreters.

12. ***Assessment Information***: Sections must be completed by a RN, Physician, or PCP.

    A. Assessment Date: Indicate the date of the most current assessment.

    B. Assessor's Name, Title, Signature, Phone and Fax Numbers: A registered nurse (RN), physician or primary care provider must perform the assessment. Enter the name, title and telephone, fax number and email address of the assessor. The assessor must sign the form.

    Electronic submittal of form(s) will be accepted with the box checked that a signature of the RN, physician or primary care provider has signed a hard copy of this form and the hard copy of the form(s) can be found in the patient's file.

13. ***Requesting Level of Care***: Check service that is being requested. Indicate the begin and end date of the request. If hospice services have been elected by the patient AND the services will be provided in a nursing facility, attach the hospice election and physician certification of terminal illness form signed by two different physicians. Hospice services in other settings do not require an 1147 form.

Indicate the length of approval requested. Check one box.

14. ***Medical Necessity/Level of Care Determination***: Completed by DHS reviewer or designee. Leave Blank. DO NOT COMPLETE.

PAGE 2 – APPLICANT/PATIENT BACKGROUND INFORMATION

1. ***Name***: Self-explanatory

2. ***Birthdate***: Self-explanatory

3. ***Functional Status Related to Health Conditions***: Complete all sections.

   A. **List current significant diagnosis(es)**: List the primary and secondary diagnosis(ses) or medical conditions related to the person's need for long-term care.

   B. **Medications/Treatments**: List the significant medications prescribed by a physician. They may be chronic and given on a fixed schedule (such as antihypertensives), or short term (such as antibiotics), or significant PRN medications (such as narcotics and sedatives). Do not list stool softeners, enemas, and other agents to treat constipation, acetaminophen, non-steroidal anti-inflammatory agents (NSAIDs) unless they are given at least daily. If a patient has more than five (6) significant medications, attach orders or treatment sheet. As an option to completing this section, the most current prescription listing can be attached. If using this option, please indicate "attached" in this area.

   C. **Activities of Daily Living**: Check all of the areas that the individual requires assistance on a regular basis, considering developmental age. If the patient is a newborn, he/she is not expected to toilet, feed, transfer and dress him/herself. Therefore, these areas would NOT be checked. However, in the case of a 3-year old, the developmentally appropriate child would be expected to walk, toilet and feed himself. If the child requires assistance in those areas, the appropriate boxes should be checked.

   D. **Family/Social Considerations**:

      1. **Child can return home**: Identify whether the patient can return home. The home can be a family member's (daughter, son, brother, sister, parents, etc.) home as well as the patient's own home. Check "NA" if the patient is already in a home environment.

      2. **Community Setting:** If the individual does not have a home, indicate whether the patient can be placed in a community setting. Check "NA" if the patient is already in a community setting.

      3. **Caregiving support**: If the patient has a home, identify whether the caregiving support is willing/able to provide care. If caregiver requires assistance, identify the assistance required.

4. **Caregiver name**. Provide the caregiver's name, relationship, address, phone and fax numbers.

E. **Additional Information:** Provide any additional information, comments or explanation of the child's functional assessment, nursing intervention requirements.

4. **Nursing Interventions**: Check the nursing intervention(s) that apply. Include frequency and complexity as applicable.

Physician's/PCP Signature: Self-explanatory.

Electronic submittal of the form(s) will be accepted with the box checked that the physician or the primary care provider has signed a hard copy of the form(s) and that the plan of care has been discussed with the physician or primary care provider. The hard copy of the form(s) must be kept in the patient's file.

Date: Date that physician signs the form.

Physician or Primary Care Provider's Name: Self-explanatory.

FILING/DISTRIBUTION:

Mail, fax, or send forms electronically to:

Health Services Advisory Group, Inc.
1001 Kamokila Blvd., Suite 311, Kapolei, HI 96707
Phone: (808) 440-6000 Fax: (808) 440-6009

Appendix N-6

Long Term Care Level of Care (LOC) Determinations
1147 Quarterly Report
Quarter: ____ Year: ___

1. Number of LOC requests received summary. Indicate number:
   Received, not approved, deferred, approved, pending review, no longer meeting level of care

2. Requests sorted by Managed Care Plan. Indicate Health Plan:
   NA, Aloha Care, HMSA, Kaiser, Ohana, UHC CP

3. Total forms LOC approved. Indicate LOC:
   Acute Waitlisted Subacute
   SNF Waitlisted LOC
   ICF Waitlisted LOC
   SNF LOC
   ICF LOC
   Sub-Acute, Group 1, 2
   Hospice

4. Comatose Scores/number of Comatose Patients and in which LOC:
   Functional Status Average Points. Indicate LOC:
   Acute Waitlisted Subacute
   SNF Waitlisted LOC
   ICF Waitlisted LOC
   SNF LOC
   ICF LOC
   Sub-Acute, Group 1, 2
   Hospice

5. Functional Status Average Points on nursing facility LOC. Indicate LOC. Indicate functional category (vision, hearing, speech, communication, memory, etc.). Approved only and do not report comatose approvals.

6. Functional Status Average Points on at risk category.

7. Denial Rates by reason (administrative, does not meet LOC requested, incomplete information, approved at different LOC).

8. Deferral Rates

APPENDIX O

CLIENT REFERENCES

The Offeror is required to supply the State with names, addressed, and telephone numbers of three (3) customers for which the Offeror has supplied products and services that are similar to those being requested in this RFP. All work for these references must have been performed within the past two- (2) years. Only three (3) references should be submitted in the proposal submission packet.

1. Client Name: _____

   Client Address: _____

   _____

   Reference Name _____

   Current Phone: _____

2. Client Name: _____

   Client Address: _____

   _____

   Reference Name _____

   Current Phone: _____

3. Client Name: _____

   Client Address: _____

   _____

   Reference Name _____

   Current Phone: _____

APPENDIX P - CONFIDENTIAL AND PROPRIETARY INFORMATION

By signing below, the Offeror confirms that those pages that are indicated in the table and marked throughout the response should be considered as "Confidential" or "Proprietary". For all areas that are listed, the Offeror must provide an explanation to MQD of how substantial competitive harm would occur if the information is released. Please list these "Confidential" or "Proprietary" areas and provide explanations below.

_____ _____

Signature Title

PAGE #	SECTION	EXPLANATION