Appendix A

Written Questions Format
Format for RFP-MQD-2021-012

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

Dental TPA RFP Notice of Intent to Propose

RFP Number and Title: RFP-MQD-2021-012

Offeror Name: _____

Name and Title of the Authorized Individual: _____

Signature and Date: _____

List up to five (5) Dental TPA contact person(s) who can upload, revise or edit the Mandatory and Technical 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 1.5.

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

Appendix C – Proposal Forms (14 documents)

(01) Proposal Application Identification Form (SPO-H 200)
(02) State of Hawaii DHS Proposal Letter
(03) Certification for Contracts, Grants, Loans and Cooperative Agreements Form
(04) Disclosure Statement (CMS Required)
(05) Disclosure Statement (Related Party Transactions and Attestation)
(06) Disclosure Statement (Ownership)
(07) Financial Reporting Guide Forms (Organization Structure and Financial Planning)
(08) Controlling Interest Form
(09) Background Check Information
(10) Operational Certification Submission Form
(11) Grievance System Form
(12) Insurance Requirements Certification Form
(13) Wage Certification Form
(14) Provider's Standards of Conduct Declaration

STATE OF HAWAII

STATE PROCUREMENT OFFICE

PROPOSAL APPLICATION IDENTIFICATION FORM

STATE AGENCY ISSUING RFP: _____

RFP NUMBER: _____

RFP TITLE: _____

Check one:

☐ Initial Proposal Application

☐ Final Revised Proposal (Completed Items _____ -_____ only)

1. APPLICANT INFORMATION

Legal Name:

Doing Business As:

Street Address:

Mailing Address:

Contact person for matters involving this application:
Name:

Title:

Phone Number:

Fax Number:

e-mail:

2. BUSINESS INFORMATION

Type of Business Entity *(check one)*:

☐ Non-Profit Corporation ☐ Limited Liability Company ☐ Sole Proprietorship

☐ For-Profit Corporation ☐ Partnership

If applicable, state of incorporation and date incorporated:

State: Date:

3. PROPOSAL INFORMATION

Geographic area(s):

Target group(s):

4. **FUNDING REQUEST**

FY	_____	_____	FY	_____	_____
FY	_____	_____	FY	_____	_____
FY	_____	_____	FY	_____	_____

Grand Total _____

I certify that the information provided above is to the best of my knowledge true and correct.

_____ _____

Authorized Representative Signature *Date Signed*

_____

Name and Title

STATE OF HAWAII

Department of Human Services

PROPOSAL LETTER

We propose to furnish and deliver any and all of the deliverables and services named in the attached Request for Proposal for Dental TPA. The administrative rates offered herein shall apply for the period of time stated in said RFP.

It is understood that this proposal constitutes an offer and when signed by the authorized State of Hawaii official will, with the RFP and any amendments thereto, constitute a valid and legal contract between the undersigned applicant and the State of Hawaii.

It is understood and agreed that we have read the State's specifications described in the RFP and that this proposal is made in accordance with the provisions of such specifications. By signing this proposal, we guarantee and certify that all items included in this proposal meet or exceed any and all such State specifications.

We agree, if awarded the contract, to deliver goods or services which meet or exceed the specifications.

_____ _____

Authorized Applicant's Signature/Corporate Seal Date

CERTIFICATION FOR CONTRACTS, GRANTS, LOANS AND COOPERATIVE AGREEMENTS

1. The undersigned certifies, to the best of his or her knowledge and belief, that no Federal appropriated funds have been paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence on officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of Federal grant, the making of any Federal loan, the entering into of any cooperative Federal contract, grant, loan or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit "Disclosure Form to Report Lobbying" in accordance with its instructions.

3. This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed under 31 U.S.C. §1352. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000.00 and not more than $100,000.00 for such failure.

Applicant: _____

Signature: _____

Title: _____

Date: _____

DISCLOSURE STATEMENT (CMS REQUIRED)

DHS may refuse to enter into a contract and may suspend or terminate an existing contract, if the applicant fails to disclose ownership or controlling information and related party transaction as required by this policy.

a) Disclosures in accordance with 42 CFR 455 Subpart B
§ 455.104
Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.
(a) Who must provide disclosures. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.
(b) What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:
(1) (i) The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
(ii) Date of birth and Social Security Number (in the case of an individual).
(iii) Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.
(2) Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
(3) The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
(4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).
(c) When the disclosures must be provided.
(1) Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:
(i) Upon the provider or disclosing entity submitting the provider application.
(ii) Upon the provider or disclosing entity executing the provider agreement.
(iii) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.
(iv) Within 35 days after any change in ownership of the disclosing entity.
(2) Disclosures from fiscal agents. Disclosures from fiscal agents are due at any of the following times:
(i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.
(ii) Upon the fiscal agent executing the contract with the State.
(iii) Upon renewal or extension of the contract.
(iv) Within 35 days after any change in ownership of the fiscal agent.
(3) Disclosures from managed care entities. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:
(i) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.
(ii) Upon the managed care entity executing the contract with the State.
(iii) Upon renewal or extension of the contract.

(iv) Within 35 days after any change in ownership of the managed care entity.
(d) To whom must the disclosures be provided. All disclosures must be provided to the Medicaid agency.
(e) Consequences for failure to provide required disclosures. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

§ 455.105
Disclosure by providers: Information related to business transactions.
(a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph (b) of this section.
(b) Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—
(1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
(2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
(c) Denial of Federal financial participation (FFP). (1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph (b) of this section or under § 420.205 of this chapter (Medicare requirements for disclosure).
(2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

§ 455.106
Disclosure by providers: Information on persons convicted of crimes.
(a) Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:
(1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and
(2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.
(b) Notification to Inspector General. (1) The Medicaid agency must notify the Inspector General of the Department of any disclosures made under paragraph (a) of this section within 20 working days from the date it receives the information.
(2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.
(c) Denial or termination of provider participation. (1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.
(2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph (a) of this section.

b) Additional information which must be disclosed to DHS is as follows:

1) Names and addresses of the Board of Directors of the disclosing entity.

2) Name, title and amount of compensation paid annually (including bonuses and stock participation) to the ten (10) highest management personnel.

3) Names and addresses of creditors whose loans or mortgages are secured by a five (5) percent or more interest in the assets of the disclosing entity.

c) Additional Related Party Transactions which must be disclosed to DHS is as follows:

1) Describe transactions between the disclosing entity and any related party in which a transaction or series or transactions during any one (1) fiscal year exceeds the lesser of $10,000 or two (2) percent of the total operating expenses of the disclosingentity. List property, goods, services, and facilities involved in detail. Note the dollar amounts or other consideration for each item and the date of the transaction(s). Also include justification of the transaction(s) as to the reasonableness, potential adverse impact on the fiscal soundness of the disclosing entity, and the nature and extent of any conflict of interest. This requirement includes, but is not limited to, the sale or exchange, or leasing of any property; and the furnishing for consideration of goods, services or facilities.

2) Describe all transactions between the disclosing entity and any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.

3) As used in this section, "related party" means one that has the power to control or significantly influence the applicant, or one that is controlled or significantly influenced by the applicant. "Related parties" include, but are not limited to agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, and their immediate families, subcontractors, wholly-owned subsidiaries or suppliers, parent companies, sister companies, holding companies, and other entities controlled or managed by any of such entities or persons.

§ 455.101
Definitions.
Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Other disclosing entity means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:
(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

(b) Any Medicare intermediary or carrier; and
(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment).

Health insuring organization (HIO) has the meaning specified in § 438.2.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Managed care entity (MCE) means managed care organizations (MCOs), PIHPs, PAHPs, PCCMs, and HIOs.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that—
(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means—
(a) An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreeement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Termination means—
(1) For a—
(i) Medicaid or CHIP provider, a State Medicaid program or CHIP has taken an action to revoke the provider's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired; and
(ii) Medicare provider, supplier or eligible professional, the Medicare program has revoked the provider or supplier's billing privileges, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired.
(2) (i) In all three programs, there is no expectation on the part of the provider or supplier or the State or Medicare program that the revocation is temporary.
(ii) The provider, supplier, or eligible professional will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.
(3) The requirement for termination applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include, but is not limited to—
(i) Fraud;
(ii) Integrity; or
(iii) Quality.

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

DISCLOSURE STATEMENT

Instructions

DHS is concerned with monitoring the existence of related party transactions in order to determine if any significant conflicts of interest exist in the offeror's ability to meet Dental Third Party Administrator (TPA) objectives. Related party transactions include transactions which are conducted in an arm's length manner or are not reflected in the accounting records at all (e.g., the provision of services without charge).

Transactions with related parties maybe in the normal course of business or they may represent something unusual for the offeror. In the normal course of business, there may be numerous routine and recurring transactions with parties that meet the definition of a related party. Although each party may be appropriately pursuing its respective best interests, this is usually not objectively determinable. In addition to transactions in the normal course of business, there may be transactions which are neither routine nor recurring and may be unusual in nature or in financial statement impact.

1) Describe transactions between the offeror and any related party in which a transaction or series of transactions during any one (1) fiscal year exceeds the lesser of $10,000 or two (2) percent of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting the dollar amounts or other consideration for each and the date of the transaction(s) including a justification as to the reasonableness of the transaction(s) and its potential adverse impact on the fiscal soundness of the disclosing entity.

a) The sale or exchange, or leasing of any property:

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

2. Describe all transactions between the disclosing entity *and* any related party which includes the lending of money, extensions of credit or any investments in a related party. This type of transaction requires advance administrative review by the Director before being made.

Description of Transaction(s)	Name of Related Party and Relationship	Dollar Amount for Reporting Period

Justification

DISCLOSURE STATEMENT

DENTAL TPA NAME/NO. _____

DISCLOSURE STATEMENT FOR THE YEAR ENDED _____

I hereby attest that the information contained in the Disclosure Statement Is current, complete and accurate to the best of my knowledge. I also attest that these reported transactions are reasonable, will not impact on the fiscal soundness of the Dental TPA, and are without conflict of interest. I understand that whoever knowingly and willfully makes or causes to be made a false statement or representation on the statement may be prosecuted under applicable state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate in Dental TPA services.

Date Signed	Chief Executive Officer (Name and Title Typewritten)
Notarized	Signature

D I S C L O S U R E S T A T E M E N T OWNERSHIP

Provider Name, Provider No.: _____
Address (City, State, Zip): _____
Telephone: _____

For the period beginning: _____ and ending _____ Type

of Provider:

- o Staff — A Provider that delivers services through a group practice established to provide health services to Provider members; doctors are salaried,
- o Group — A Provider that contracts with a group practice to provide health services; the group is usually compensated on a capitation basis.
- o IPA — A Provider that contracts with an association of doctors from various settings (some solo practitioners, some groups) to provide health services.
- o Network — A Provider that contracts with two or more group practices to provide health services.

Type of Entity:

- ☐ Sole Proprietorship
- ☐ Partnership
- ☐ Corporation
- ☐ Governmental

- ☐ For-Profit
- ☐ Not-For-Profit
- ☐ Other (specify)
- ☐ _____

455.104 Information on Ownership arid Control

a. List the names and addresses of any individuals or organizations with an ownership or controlling interest in the disclosing entity. "Ownership or control interest" means, with respect to the entity, an individual or organization who (A)(I) has a direct or indirect ownership interest of 5 per centum or more in the entity, or in the case of nonprofit corporation, is a member; or (ii) is the owner ofa whole or part interest in *any* mortgage, deed or trust, note, or other obligation secured (in whole or in part) *by* the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds 5 per centum of the total property and assets of the entity; or (B) has the ability to appoint or is otherwise represented by an officer or director of the entity, if the entity is organized as a corporation; or (C) is a partner in the entity, if the entity is organized as a partnership.

Name	Address	Percent of Ownership Control

b. List the names and addresses of any individuals or organizations with an ownership or controlling interest in any subcontractor in which the disclosing entity has direct or indirect ownership offive (5) percent or more.

Name	Address	Percent of Ownership Control

c. Names of persons named in (a) and (bl above who are related to another as spouse, parent, child, or sibling of those individuals or organizations with an ownership or controlling interest.

Name	Address	Percent of Ownership Control

d. List the names of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest.

Name	Address	Percent of Ownership Control

455.105 Information Related to Business Transactions

e. List the ownership of any subcontractor with whom the offerer has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

f. List any significant business transactions between the offeror and any wholly owned supplier or between the offerer and any subcontractor during the five-year period ending on the date of the request.

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction

455.106 Information on Persons Convicted of Crime

g. List the names of any person who has ownership or controlling interest in the offeror, or is an agent or managing employee of the offeror and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of those programs.

Name	Address	Title

2. Additional information which must be disclosed to DHS as follows: a. List the

names and addresses of the Board of Director of the Health Plan.

Name/Title	Address

b. Names and titles of the ten (10) highest paid management personnel including but not limited to the Chief Executive Officer, the Chief Financial Officer, Board of Chairman, Board of Secretary, and Board of Treasurer:

Name/Title	Address

c. List names and addresses of creditors whose loans or mortgages exceeding five percent (5) and are secured by the assets of the Health Plan.

Name	Address	Amount of Debt	Description of Security

Financial Reporting Guide Forms
Organization Structure and Financial Planning Form

1) If other than a government agency:
   a. When was your organization formed?

   b. If your organization is a corporation, attach a list of the names and addresses of the Board of Directors.

2) License/Certification
   a. Indicate all licenses and certifications (i.e., Federal HMO status or State certifications) your organization maintains. Use a separate sheet of paper using the following format:

Service Component	License/Requirement	Renewal Date

   b. Have any licenses been denied, revoked, or suspended?

   Yes _____ No _____ If yes, please explain:

3) Civil Rights Compliance Data

   Has any Federal or State agency ever made a finding of noncompliance with any relevant civil rights requirements with respect to your program?

   Yes _____ No _____ If yes, please explain:

4) Handicapped Assurance

   Does your organization provide assurance that no qualified handicapped person will be denied benefits of or excluded from participation in a program or activity because the offeror's facilities (including subcontractors) are inaccessible to or unusable by handicapped persons? (note: check with local zoning ordinances for handicapped requirements)

   Yes _____ If yes, briefly describe how such assurances are provided.
   No _____ If no, briefly describe how your organization is taking affirmative steps to provide assurance.

5) Prior Convictions

List all felony convictions of any key personnel (i.e., Chief Executive Officer, BHO Manager, Financial Officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal as unresponsive.

6) Federal Government Suspension/Exclusion

Has offeror been suspended or excluded from any federal government programs for any reason?

Yes _____ No _____ If yes, please explain:

Financial Planning Form

1) Is the offerors accounting system based on a cash, accrual, or modified method?
   a. Cash [ ]
   b. Accrual [ ]
   c. Modified [ ] Give brief explanation

2) Does the offeror prepare an annual financial statement?

   Yes _____ No _____ If yes, please explain:

3) Are interim financial statements prepared? Yes _____ No _____

   a. If yes, how often are they prepared? _____

   b. If yes, are footnotes and supplementary schedules an integral part of the statements?
      Yes _____ No _____

   c. If yes, are actuals analyzed and compared to budgeted amounts?
      Yes _____ No _____

   d. If yes, provide a copy of the latest statements including all necessary data to support your answers in (a) through (c) above.

4) Is the offeror audited by an independent accounting firm/accountant?
   Yes _____ No _____

   a. If yes, how often are audits conducted? _____

   b. By whom are they conducted? _____

   c. Did this auditor perform that offeror's last audit?
      Yes _____ No _____
      If no, provide the name, address, and telephone number of the firm that performed the offeror's last audit.

d. Are management letters on internal controls issued by the accounting firm?
Yes _____ No _____

If yes, attach a copy of the management letter from the latest audit. This must be on the auditor's letterhead and the offeror, by its submission, certifies the letter is unaltered.

If no, the offeror shall provide a comprehensive description of internal control systems. The offeror is responsible for instituting adequate procedures against irregularities and improprieties and enforcing adherence to generally accepted accounting principles.

e. Do you have any uncorrected audit exceptions?
Yes _____ No _____

If yes, provide a copy of the auditor's management letter (see 4(d) of this form for instructions regarding submittal).

5) Does the offeror have an accounting manual?
Yes _____ No _____

If no, the offeror must explain, if it has proper accounting policies and procedures, and how it provides for the dissemination of such accounting policies and procedures within its organization and what controls exist to ensure the integrity of its financial information. The offeror agrees to furnish copies of such written accounting policies and procedures for inspection upon request from the DHS.

6) Does the offeror have a formal basis to allocate indirect costs reflected in your financial statement?
Yes _____ No _____

Explain principal allocation techniques used or to be used. Note the allocation base used for each type of cost allocated.

7) What types of liability insurance does the offeror have?
a. With what company(s)? _____

b. What is the amount of coverage for each type of insurance? _____

8) Provide a complete analysis of revenues and expenses by business segment (lines of business) and by geographic area (by county) for the offeror or its owner(s).

9) Are there any suits, judgements, tax deficiencies, or claims pending against the offeror?
Yes _____ No _____

Briefly describe each item and indicate probable amount.

10) Has the offeror or its owner(s) ever gone through bankruptcy?
Yes _____ No _____

If yes, when? _____

11) Do(es) the offeror's owner(s) intend to provide all necessary funds to make full and timely payments for liabilities (reported or not recognized)?
Yes _____ No _____

If yes, describe the dollar amount(s) and source(s) of all funding.

If no, briefly describe how your organization is taking affirmative steps to provide funding.

12) Does the offeror have a performance bonding mechanism in accordance with DHS rules?
Yes _____ No _____

If yes, provide the following information:

Amount of Bond $ _____
Term of Bond _____
Bonding Company _____
Restrictions on Bond _____

If no, describe how the offeror intends to provide a bond and/or security to meet established DHS rules.

13) Does the offeror have a financial management system to account for incurred, but not reported liabilities?

Yes _____ No _____

If no, the offeror must describe in detail (and attach this description to this form) how it intends to manage, monitor and control IBNR's, The offeror, regardless of response (either yes or no) must complete items "a" through "h" below.

a. Is your system capable of accurately forecasting all significant claims prior to receipt of all billing? Yes _____ No _____

b. How often are IBNRs projected? _____

_____

c. Identify all major data sources most often used.

d. Are data from open referrals and prior notifications used?

Yes _____ No _____ If so, how?

e. Are detailed written procedures maintained? Yes _____

No _____

f. Are IBNR amounts compared with actuals and adjusted when necessary?

Yes _____ No _____

g. Is the basis of periodic IBNR estimates well documented?

Yes _____ No _____

h. The offeror must provide a copy of their IBNR procedures and a summary of their IBNR practices. If these procedures do not adequately support any response to this item the offeror is cautioned to provide additional data.

Please identify the developer and name of any computerized IBNR system utilized. Indicate if it is administered by internal or external staff. If administered by external staff, state by whom, define how the offeror will control this function. Specify what other IBNR estimation methods will be used to test the accuracy of IBNR estimates, along with the primary system previously identified. (For the purposes of this item "administered" refers to either performing computer related operations or to providing direct supervision of staff operating a system).

14) Does the offeror have a full-time (100%) controller or chief financial officer?

Yes _____ No _____ If yes, enter name: ____

_____

15) Are the following items reported on the offeror's financial statements?

a. Medicare reimbursement Yes _____ No ____

_____

b. Other third-party recoveries Yes _____ No ____

_____

If no, explain why.

Controlling Interest Form

The Dental TPA must provide the name and address of any individual which owns or controls more than ten percent (10%) of stock or that has a controlling interest (i.e., ability to formulate, determine or veto business policy decisions, etc.). Failure to make full disclosure may result in rejection of the Offeror's proposal as unresponsive.

Name	Address	Owner or Controller	Has Controlling Interest? Yes	No

Background Check Information

The Dental TPA must provide national criminal background check results for all the key personnel (i.e. Chief Executive Officer, Medical Director, Financial Officer, etc.) to DHS.

Operational Certification Submission Form

The Dental TPA must complete the attached certification as documentation that it shall maintain appointment procedures, referral procedures and other operating requirements in accordance with either DHS rules or policies and procedures.

By signing below, the Dental TPA certifies that it shall at all times during the term of this contract provide and maintain appointment procedures, referral procedures, quality assurance program, utilization management program and other operating requirements in accordance with either DHS rule(s) or policies and procedures. The Dental TPA warrants that in the event DHS discovers, through an operational review, that the Dental TPA has failed to maintain these operating procedures, the Dental TPA will be subject to a non-refundable, non-waivable sanction in accordance with DHS Rules.

_____

Signature

Date

Grievance System
Form

The Dental TPA must complete the form below and submit with this proposal.

I hereby certify that _____
Dental TPA Name

shall have in place on the commencement date of this contract a system for reviewing and adjudicating grievances and appeals by beneficiaries and providers arising from this contract in accordance with DHS Rules and as set forth in the Request for Proposal.

I understand such a system must provide for prompt resolution of grievances and appeals, and assure the participation of individuals with authority to require corrective action.

I further understand the Dental TPA must have a grievance and appeal policy for beneficiaries and providers which defines their rights regarding any adverse action by the Dental TPA. The grievance and appeal policy shall be in writing and shall meet the minimum standards set forth in this Request for Proposal.

I further understand evaluation of the grievance and appeal procedures shall be conducted through documentation submission, monitoring, reporting, and on-site audit, if necessary, by DHS and deficiencies are subject to sanction in accordance with DHS rules.

_____ _____
Authorized Signature Date

_____
Printed Name

_____
Title

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 Offeror certifies that the foregoing deficiencies will be corrected within five (5) business 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 (2009/09)[1])

This Checklist must accompany the completed COLI submitted with the proposal and subsequent contract. In the event of a conflict between this Checklist and the terms of the contract, the latter shall prevail.

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 ISSUED SHOULD NOT BE MORE THAN 15 DAYS FROM THE DATE OF ITS 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 CONTRACT LANGUAGE 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	

[1] The Contractor should use the Acord form currently in use at the time of submission with the contract.

NO.	CERTIFICATE OF INSURANCE LIABILITY REQUIRED ELEMENTS	✓
	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), OR 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 BOULEVARD, 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 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.	

ACORD

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY) (1)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:
	PHONE (A/C, No, Ext): FAX (A/C, No):
	E-MAIL ADDRESS:
	PRODUCER CUSTOMER ID #:

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
(2)	INSURER A:	
	INSURER B: (3)	
	INSURER C:	
	INSURER D:	
	INSURER E:	
	INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	(8) LIMITS	
	GENERAL LIABILITY	(13)		(5)	(6)	(7)	EACH OCCURRENCE	$
	☐ COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
	☐ CLAIMS-MADE ☐ OCCUR (4)						MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$ (10)
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY	(13)					COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO (9)						BODILY INJURY (Per person)	$
	☐ ALL OWNED AUTOS						BODILY INJURY (Per accident)	$
	☐ SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident)	$ (10)
	☐ HIRED AUTOS							$
	☐ NON-OWNED AUTOS							$
	☐ UMBRELLA LIAB ☐ OCCUR	(13)					EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DEDUCTIBLE							$ (10)
	☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N	N / A					☐ WC STATU-TORY LIMITS ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)						E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$ (11)
	(12)						E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER

(14)

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

(15)

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 as 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 Stale 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: _____

CONTRACT NO. _____

PROVIDER'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:

_____
(Name o]PROVIDER)

PROVIDER, the undersigned does declare as follows:

1. PROVIDER ☐ 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. PROVIDER 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. PROVIDER 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. PROVIDER 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).

PROVIDER 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, Hawai'i Revised Statutes, commonly referred to as the Code of Ethics, including the provisions which are the source of the

• 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 may not be awarded unless the agency 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).

CONTRACT NO. _____

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.

PROVIDER _____

By _____
(Signature)

Print Name _____

Print Title _____

_____

Date _____

AG Fonn 103F9 (10/08)

Appendix D – Dental TPA Financial Responsibilities

CDT Procedure Code	Description
D7340	Vestibuloplasty-ridge extension (secondary epithelialization)
D7350	Vestibuloplasty-ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)
	Excision of Intra-Osseous Lesions
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm
D7441	Excision of malignant tumor – lesion diameter over 1.25 cm
	Removal of Cysts and Neoplasms
D7450	Removal of benign odontogenic cyst or tumor lesion diameter up to 1.25 cm
D7451	Removal of benign odontogenic cyst or tumor lesion diameter over 1.25 cm
D7460	Removal of benign non-odontogenic cyst or tumor lesion diameter up to 1.25 cm
D7461	Removal of benign non-odontogenic cyst or tumor lesion diameter over 1.25 cm
D7465	Destruction of lesions by physical methods; electrosurgery, chemotherapy, cryotherapy or laser
	Excision of Bone Tissue
D7471	Removal of lateral exostosis – mandible or maxilla
D7472	Removal of torus palatinus
D7473	Removal of torus mandibularis
D7490	Radical resection of mandible or maxilla
	Surgical Incision
D7511	Incision and drainage of abscess-intra oral soft-tissue-complicated
D7520	Incision and drainage of abscess-extraoral soft tissue
D7530	Removal of foreign body, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction-producing foreign bodies, musculoskeletal system
D7550	Sequestrectomy for osteomyelitis
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
	Treatment of Fractures - Simple
D7610	Maxilla – open reduction (teeth immobilized if present)
D7620	Maxilla – closed reduction (teeth immobilized if present)
D7630	Mandible – open reduction (teeth immobilized if present)
D7640	Mandible closed reduction (teeth immobilized if present)
D7650	Malar and/or zygomatic arch-open reduction
D7660	Malar and/or zygomatic arch-closed reduction
D7670	Alveolus – Closed reduction, may include stabilization of teeth, splinting
D7671	Alveolus – Open reduction, may include stabilization of teeth, splinting
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches

	Treatment of fractures - Compound
D7710	Maxilla – open reduction
D7720	Maxilla – closed reduction
D7730	Mandible – open reduction
D7740	Mandible – closed reduction
D7750	Malar and/or zygomatic arch-open reduction
D7760	Malar and/or zygomatic arch-closed reduction
D7770	Alveolus – open reduction stabilization of teeth
D7771	Alveolus – closed reduction stabilization of teeth
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches
	Reduction of Dislocation and Management of Other Temporomandibular Joint Dysfunctions
D7810	Open reduction of dislocation
D7820	Closed reduction of dislocation
D7830	Manipulation under anesthesia
D7840	Condylectomy
D7850	Surgical discectomy, with/ without implant
D7852	Disc repair
D7854	Synovectomy
D7856	Myotomy
D7858	Joint reconstruction
D7860	Arthrotomy
D7870	Arthrocentesis
D7872	Arthroscopy – diagnosis, with or without biopsy
D7873	Arthroscopy – surgical; lavage and lysis of adhesions
D7874	Arthroscopy – surgical; disc repositioning and stabilization
D7875	Arthroscopy – surgical; synovectomy
D7876	Arthroscopy – surgical; discectomy
D7877	Arthroscopy – surgical; debridement
D7880	Occlusal – orthotic devise, by report
	Other Oral Surgery – Repaid of Traumatic Wounds
D7910	Suture of recent small wounds up to 5 cm
D7911	Complicated suture up to 5 cm
D7912	Complicated suture over 5 cm
D7920	Skin grafts (identify defect covered, location and type graft)
	Other Repair Procedures
D7940	Osteoplasty for orthognathic deformities
D7941	Osteotomy – mandibular rami
D7943	Osteotomy mandibular rami with bone graft; including obtaining the graft
D7944	Osteotomy, segmented or subapical, per sextant or quadrant
D7945	Osteotomy, body of mandible
D7946	Le Fort I (maxilla – total)
D7947	Le Fort I (maxilla – segmented)
D7948	Le Fort II or Le Fort III – (osteoplasty of facial bones for midface hypoplasia retrusion) without bone graft)

D7949	Le Fort II or Le Fort III – with bone graft
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla – autogenous or nonautogenous
D7955	Repair of maxillofacial soft and hard tissue defects
D7980	Sialolithotomy
D7981	Excision of salivary glands, by report
D7982	Sialodochoplasty
D7983	Closure of salivary fistula
D7990	Emergency tracheotomy
D7990	Coronoidectomy
D7995	Synthetic graft – mandible or facial bones, by report
D7996	Implant – mandible for augmentation purposes (excluding alveolar ridge), by report
D7997	Appliance removal (not by dentist who replaced appliance), includes removal or arch bar
D7999	Unspecified oral surgery procedure, by report
	Adjunctive General Services
D9222	Deep Sedation/ General Anesthesia – first 15 minutes
D9223	Deep Sedation/ General Anesthesia – each subsequent 15 minute increment
D9420	Hospital or Ambulatory Surgical Center Call (limitation: Confinement must be approved; only under Physician's request; no routine follow up visits)

Recommendations for Pediatric Oral Health Assessment, Preventive Services, and Anticipatory Guidance/Counseling

Since each child is unique, these recommendations are designed for the care of children who have no contributing medical conditions and are developing normally. These recommendations will need to be modified for children with special health care needs or if disease or trauma manifests variations from normal. The American Academy of Pediatric Dentistry (AAPD) emphasizes the importance of very early professional intervention and the continuity of care based on the individualized needs of the child. Refer to the text of this guideline for supporting information and references. Refer to the text in the Recommendations on the Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance, and Oral Treatment for Infants, Children, and Adolescents (*www.aapd.org/policies/*) for supporting information and references.

AMERICA'S PEDIATRIC DENTISTS **THE BIG AUTHORITY** on little teeth®	AGE				
	6 TO 12 MONTHS	12 TO 24 MONTHS	2 TO 6 YEARS	6 TO 12 YEARS	12 YEARS AND OLDER
Clinical oral examination [1]	•	•	•	•	•
Assess oral growth and development [2]	•	•	•	•	•
Caries-risk assessment [3]	•	•	•	•	•
Radiographic assessment [4]	•	•	•	•	•
Prophylaxis and topical fluoride [3,4]	•	•	•	•	•
Fluoride supplementation [5]	•	•	•	•	•
Anticipatory guidance/counseling [6]	•	•	•	•	•
Oral hygiene counseling [7]	Parent	Parent	Patient/parent	Patient/parent	Patient
Dietary counseling [8]	•	•	•	•	•
Injury prevention counseling [9]	•	•	•	•	•
Counseling for nonnutritive habits [10]	•	•	•	•	•
Counseling for speech/language development	•	•	•		
Assessment and treatment of developing malocclusion			•	•	•
Assessment for pit and fissure sealants [11]			•	•	•
Substance abuse counseling				•	•
Counseling for intraoral/perioral piercing				•	•
Assessment and/or removal of third molars					•
Transition to adult dental care					•

1 First examination at the eruption of the first tooth and no later than 12 months. Repeat every 6 months or as indicated by child's risk status/susceptibility to disease. Includes assessment of pathology and injuries.

2 By clinical examination.

3 Must be repeated regularly and frequently to maximize effectiveness.

4 Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

5 Consider when systemic fluoride exposure is suboptimal. Up to at least 16 years.

6 Appropriate discussion and counseling should be an integral part of each visit for care.

7 Initially, responsibility of parent; as child matures, jointly with parent; then, when indicated, only child.

8 At every appointment; initially discuss appropriate feeding practices, then the role of refined carbohydrates and frequency of snacking in caries development and childhood obesity.

9 Initially play objects, pacifiers, car seats; when learning to walk; then with sports and routine playing, including the importance of mouthguards.

10 At first, discuss the need for additional sucking: digits vs pacifiers; then the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

11 For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

CONTRACT NO. _____

GENERAL CONDITIONS FOR HEALTH & HUMAN SERVICES CONTRACTS
TABLE OF CONTENTS

Page(s)

1. Representations and Conditions Precedent 1

1.1 Contract Subject to the Availability of State and Federal Funds 1

1.1.1 State Funds 1

1.1.2 Federal Funds 1

1.2 Representations of the PROVIDER 1

1.2.1 Compliance with Laws 1

1.2.2 Licensing and Accreditation 1

1.3 Compliance with Laws 1

1.3.1 Smoking Policy 1

1.3.2 Drug Free Workplace 1

1.3.3 Persons with Disabilities 2

1.3.4 Nondiscrimination 2

1.4 Insurance Requirements 2

1.5 Notice to Clients 2

1.6 Reporting Requirements 3

1.7 Conflicts of Interest 3

2. Documents and Files 3

2.1 Confidentiality of Material 3

2.1.1 Proprietary or Confidential Information 3

2.1.2 Uniform Information Practices Act 3

2.2 Ownership Rights and Copyright 3

2.3 Records Retention 3

3. Relationship between Parties 4

3.1 Coordination of Services by the STATE 4

3.2 Subcontracts and Assignments 4

3.3 Change of Name 4

3.4 Independent Contractor Status and Responsibilities, Including Tax Responsibilities 4

3.4.1 Independent Contractor 4

3.4.2 Contracts with other individuals and entities 4
3.4.3 PROVIDER's employees and agents 5
3.4.4 PROVIDER's Responsibilites 5
3.5 Personnel Requirements 6
3.5.1 Personnel 6
3.5.2 Requirements 6
4. Modification and Termination of Contract 6
4.1 Modifications of Contract 6
4.1.1 In writing 6
4.1.2 No oral modification 6
4.1.3 Tax clearance 6
4.2 Termination in General 6
4.3 Termination for Necessity or Convenience 7
4.4 Termination by PROVIDER 7
4.5 STATE's Right of Offset 7
5. Indemnification 7
5.1 Indemnification and Defense 7
5.2 Cost of Litigation 7
6. Publicity 8
6.1 Acknowledgment of State Support 8
6.2 PROVIDER's publicity not related to contract 8
7. Miscellaneous Provisions 8
7.1 Nondiscrimination 8
7.2 Paragraph Headings 8
7.3 Antitrust Claims 8
7.4 Governing Law 8
7.5 Conflict between General Conditions and Procurement Rules 8
7.6 Entire Contract 8
7.7 Severability 9
7.8 Waiver 9

7.9 Execution in Counterparts 9
8. Confidentiality of Personal Information 9
8.1 Definitions 9
8.1.1 Personal Information 9
8.1.2 Technological Safeguards 9
8.2 Confidentiality of Material 10
8.2.1 Safeguarding of Material 10
8.2.2 Retention, Use, or Disclosure 10
8.2.3 Implementation of Technological Safeguards 10
8.2.4 Reporting of Security Breaches 10
8.2.5 Mitigation of Harmful Effect 10
8.2.6 Log of Disclosures 10
8.3 Security Awareness Training and Confidentiality Agreements 10
8.3.1 Certification of Completed Training 10
8.3.2 Certification of Confidentiality Agreements 10
8.4 Termination for Cause 11
8.5 Records Retention 11
8.5.1 Destruction of Personal Information 11
8.5.2 Maintenance of Files, Books, Records 11

GENERAL CONDITIONS FOR HEALTH & HUMAN SERVICES CONTRACTS

1. Representations and Conditions Precedent

1.1 Contract Subject to the Availability of State and Federal Funds.

1.1.1 State Funds. This Contract is, at all times, subject to the appropriation and allotment of state funds, and may be terminated without liability to either the PROVIDER or the STATE in the event that state funds are not appropriated or available.

1.1.2 Federal Funds. To the extent that this Contract is funded partly or wholly by federal funds, this Contract is subject to the availability of such federal funds. The portion of this Contract that is to be funded federally shall be deemed severable, and such federally funded portion may be terminated without liability to either the PROVIDER or the STATE in the event that federal funds are not available. In any case, this Contract shall not be construed to obligate the STATE to expend state funds to cover any shortfall created by the unavailability of anticipated federal funds.

1.2 Representations of the PROVIDER. As a necessary condition to the formation of this Contract, the PROVIDER makes the representations contained in this paragraph, and the STATE relies upon such representations as a material inducement to entering into this Contract.

1.2.1 Compliance with Laws. As of the date of this Contract, the PROVIDER complies 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 PROVIDER's performance of this Contract.

1.2.2 Licensing and Accreditation. As of the date of this Contract, the PROVIDER holds all licenses and accreditations required under applicable federal, state, and county laws, ordinances, codes, rules, and regulations to provide the Required Services under this Contract.

1.3 Compliance with Laws. The PROVIDER 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 PROVIDER's performance of this Contract, including but not limited to the laws specifically enumerated in this paragraph:

1.3.1 Smoking Policy. The PROVIDER shall implement and maintain a written smoking policy as required by Chapter 328K, Hawaii Revised Statutes (HRS), or its successor provision.

1.3.2 Drug Free Workplace. The PROVIDER shall implement and maintain a drug free workplace as required by the Drug Free Workplace Act of 1988.

1.3.3 Persons with Disabilities. The PROVIDER shall implement and maintain all practices, policies, and procedures required by federal, state, or county law, including but not limited to the Americans with Disabilities Act (42 U.S.C. §12101, et seq.), and the Rehabilitation Act (29 U.S.C.§701, et seq.).

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

1.4 Insurance Requirements. The PROVIDER shall obtain from a company authorized by law to issue such insurance in the State of Hawai‘i commercial general liability insurance ("liability insurance") in an amount of at least TWO MILLION AND NO/100 DOLLARS ($2,000,000.00) coverage for bodily injury and property damage resulting from the PROVIDER's performance under this Contract. The PROVIDER shall maintain in effect this liability insurance until the STATE certifies that the PROVIDER's work under the Contract has been completed satisfactorily.

The liability insurance shall be primary and shall cover the insured for all work to be performed under the Contract, including changes, and all work performed incidental thereto or directly or indirectly connected therewith.

A certificate of the liability insurance shall be given to the STATE by the PROVIDER. The certificate shall provide that the STATE and its officers and employees are Additional Insureds. The certificate shall provide that the coverages being certified will not be cancelled or materially changed without giving the STATE at least 30 days prior written notice by registered mail.

Should the "liability insurance" coverages be cancelled before the PROVIDER's work under the Contract is certified by the STATE to have been completed satisfactorily, the PROVIDER shall immediately procure replacement insurance that complies in all respects with the requirements of this section.

Nothing in the insurance requirements of this Contract shall be construed as limiting the extent of PROVIDER's responsibility for payment of damages resulting from its operations under this Contract, including the PROVIDER's separate and independent duty to defend, indemnify, and hold the STATE and its officers and employees harmless pursuant to other provisions of this Contract.

1.5 Notice to Clients. Provided that the term of this Contract is at least one year in duration, within 180 days after the effective date of this Contract, the PROVIDER shall create written procedures for the orderly termination of services to any clients receiving the Required Services under this Contract, and for the transition to services supplied by another provider upon termination of this Contract, regardless of the circumstances of such termination. These procedures shall include, at

the minimum, timely notice to such clients of the termination of this Contract, and appropriate counseling.

1.6 Reporting Requirements. The PROVIDER shall submit a Final Project Report to the STATE containing the information specified in this Contract if applicable, or otherwise satisfactory to the STATE, documenting the PROVIDER's overall efforts toward meeting the requirements of this Contract, and listing expenditures actually incurred in the performance of this Contract. The PROVIDER shall return any unexpended funds to the STATE.

1.7 Conflicts of Interest. In addition to the Certification provided in the Standards of Conduct Declaration to this Contract, the PROVIDER represents that neither the PROVIDER nor any employee or agent of the PROVIDER, 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 PROVIDER's performance under this Contract.

2. Documents and Files

2.1 Confidentiality of Material.

2.1.1 Proprietary or Confidential Information. All material given to or made available to the PROVIDER by virtue of this Contract that is identified as proprietary or confidential information shall be safeguarded by the PROVIDER and shall not be disclosed to any individual or organization without the prior written approval of the STATE.

2.1.2 Uniform Information Practices Act. All information, data, or other material provided by the PROVIDER to the STATE shall be subject to the Uniform Information Practices Act, chapter 92F, HRS, and any other applicable law concerning information practices or confidentiality.

2.2 Ownership Rights and Copyright. The STATE shall have complete ownership of all material, both finished and unfinished that is developed, prepared, assembled, or conceived by the PROVIDER 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 PROVIDER pursuant to this Contract.

2.3 Records Retention. The PROVIDER and any subcontractors shall maintain the books and records that relate to the Contract, and any cost or pricing data for three (3) years from the date of final payment under the Contract. In the event that any litigation, claim, investigation, audit, or other action involving the records retained under this provision arises, then such records shall be retained for three (3) years from the date of final payment, or the date of the resolution of the action, whichever occurs later. During the period that records are retained under this section, the

PROVIDER and any subcontractors shall allow the STATE free and unrestricted access to such records.

3. Relationship between Parties

3.1 Coordination of Services by the STATE. The STATE shall coordinate the services to be provided by the PROVIDER in order to complete the performance required in the Contract. The PROVIDER shall maintain communications with the STATE at all stages of the PROVIDER's work, and submit to the STATE for resolution any questions which may arise as to the performance of this Contract.

3.2 Subcontracts and Assignments. The PROVIDER may assign or subcontract any of the PROVIDER's duties, obligations, or interests under this Contract, but only if (i) the PROVIDER obtains the prior written consent of the STATE and (ii) the PROVIDER's assignee or subcontractor submits to the STATE a tax clearance certificate from the Director of Taxation, State of Hawai'i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state law against the PROVIDER's assignee or subcontractor have been paid. Additionally, no assignment by the PROVIDER of the PROVIDER's right to compensation under this Contract shall be effective unless and until the assignment is approved by the Comptroller of the State of Hawai'i, as provided in section 40-58, HRS.

3.3 Change of Name. When the PROVIDER asks to change the name in which it holds this Contract, the STATE, shall, upon receipt of a document acceptable or satisfactory to the STATE indicating such change of name such as an amendment to the PROVIDER's articles of incorporation, enter into an amendment to this Contract with the PROVIDER to effect the change of name. Such amendment to this Contract changing the PROVIDER's name shall specifically indicate that no other terms and conditions of this Contract are thereby changed, unless the change of name amendment is incorporated with a modification or amendment to the Contract under paragraph 4.1 of these General Conditions.

3.4 Independent Contractor Status and Responsibilities, Including Tax Responsibilities.

3.4.1 Independent Contractor. In the performance of services required under this Contract, the PROVIDER 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 PROVIDER in compliance with this Contract.

3.4.2 Contracts with Other Individuals and Entities. Unless otherwise provided by special condition, the STATE shall be free to contract with other individuals and entities to provide services similar to those performed by the Provider under this Contract, and the

PROVIDER shall be free to contract to provide services to other individuals or entities while under contract with the STATE.

3.4.3 PROVIDER's Employees and Agents. The PROVIDER and the PROVIDER's employees and agents are not by reason of this Contract, agents or employees of the State for any purpose. The PROVIDER and the PROVIDER'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. Unless specifically authorized in writing by the STATE, the PROVIDER and the PROVIDER's employees and agents are not authorized to speak on behalf and no statement or admission made by the PROVIDER or the PROVIDER's employees or agents shall be attributed to the STATE, unless specifically adopted by the STATE in writing.

3.4.4 PROVIDER's Responsibilities. The PROVIDER shall be responsible for the accuracy, completeness, and adequacy of the PROVIDER's performance under this Contract.

Furthermore, the PROVIDER intentionally, voluntarily, and knowingly assumes the sole and entire liability to the PROVIDER's employees and agents, and to any individual not a party to this Contract, for all loss, damage, or injury caused by the PROVIDER, or the PROVIDER's employees or agents in the course of their employment.

The PROVIDER shall be responsible for payment of all applicable federal, state, and county taxes and fees which may become due and owing by the PROVIDER 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 PROVIDER also is responsible for obtaining all licenses, permits, and certificates that may be required in order to perform this Contract.

The PROVIDER shall obtain a general excise tax license from the Department of Taxation, State of Hawai‘i, in accordance with section 237-9, HRS, and shall comply with all requirements thereof. The PROVIDER shall obtain a tax clearance certificate from the Director of Taxation, State of Hawai‘i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state law against the PROVIDER have been paid and submit the same to the STATE prior to commencing any performance under this Contract. The PROVIDER shall also be solely responsible for meeting all requirements necessary to obtain the tax clearance certificate required for final payment under section 103-53, HRS, and these General Conditions.

The PROVIDER is responsible for securing all employee-related insurance coverage for the PROVIDER and the PROVIDER'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.

3.5 Personnel Requirements.

3.5.1 Personnel. The PROVIDER shall secure, at the PROVIDER's own expense, all personnel required to perform this Contract, unless otherwise provided in this Contract.

3.5.2 Requirements. The PROVIDER shall ensure that the PROVIDER'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. Modification and Termination of Contract

4.1 Modification of Contract.

4.1.1 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 PROVIDER and the STATE.

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

4.1.3 Tax Clearance. The STATE may, at its discretion, require the PROVIDER 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 Hawai‘i, and the Internal Revenue Service showing that all delinquent taxes, if any, levied or accrued under state and federal law against the PROVIDER have been paid.

4.2 Termination in General. This Contract may be terminated in whole or in part because of a reduction of funds available to pay the PROVIDER, or when, in its sole discretion, the STATE determines (i) that there has been a change in the conditions upon which the need for the Required Services was based, or (ii) that the PROVIDER has failed to provide the Required Services adequately or satisfactorily, or (iii) that other good cause for the whole or partial termination of this Contract exists. Termination under this section shall be made by a written notice sent to the PROVIDER ten (10) working days prior to the termination date that includes a brief statement of the reason for the termination. If the Contract is terminated under this paragraph, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.

4.3 Termination for Necessity or Convenience. If the STATE determines, in its sole discretion, that it is necessary or convenient, this Contract may be terminated in whole or in part at the option of the STATE upon ten (10) working days' written notice to the PROVIDER. If the STATE elects to terminate under this paragraph, the PROVIDER shall be entitled to reasonable payment as determined by the STATE for satisfactory services rendered under this Contract up to the time of termination. If the STATE elects to terminate under this section, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.

4.4 Termination by PROVIDER. The PROVIDER may withdraw from this Contract after obtaining the written consent of the STATE. The STATE, upon the PROVIDER's withdrawal, shall determine whether payment is due to the PROVIDER, and the amount that is due. If the STATE consents to a termination under this paragraph, the PROVIDER shall cooperate with the STATE to effect an orderly transition of services to clients.

4.5 STATE's Right of Offset. The STATE may offset against any monies or other obligations that STATE owes to the PROVIDER under this Contract, any amounts owed to the State of Hawai'i by the PROVIDER under this Contract, or any other contract, or pursuant to any law or other obligation owed to the State of Hawai'i by the PROVIDER, including but not limited to the payment of any taxes or levies of any kind or nature. The STATE shall notify the PROVIDER in writing of any exercise of its right of offset and the nature and amount of such offset. For purposes of this paragraph, amounts owed to the State of Hawai'i shall not include debts or obligations which have been liquidated by contract with the PROVIDER, and that are covered by an installment payment or other settlement plan approved by the State of Hawai'i, provided, however, that the PROVIDER shall be entitled to such exclusion only to the extent that the PROVIDER is current, and in compliance with, and not delinquent on, any payments, obligations, or duties owed to the State of Hawai'i under such payment or other settlement plan.

5. Indemnification

5.1 Indemnification and Defense. The PROVIDER shall defend, indemnify, and hold harmless the State of Hawai'i, the contracting agency, and their officers, employees, and agents from and against any and all liability, loss, damage, cost, expense, including all attorneys' fees, claims, suits, and demands arising out of or in connection with the acts or omissions of the PROVIDER or the PROVIDER'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.

5.2 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 PROVIDER in connection with this Contract, the PROVIDER shall pay any cost and expense incurred by or imposed on the STATE, including attorneys' fees.

6. Publicity

6.1 Acknowledgment of State Support. The PROVIDER shall, in all news releases, public statements, announcements, broadcasts, posters, programs, computer postings, and other printed, published, or electronically disseminated materials relating to the PROVIDER's performance under this Contract, acknowledge the support by the State of Hawai'i and the purchasing agency.

6.2 PROVIDER's Publicity Not Related to Contract. The PROVIDER shall not refer to the STATE, or any office, agency, or officer thereof, or any state employee, or to the services or goods, or both provided under this Contract, in any of the PROVIDER's publicity not related to the PROVIDER's performance under this Contract, including but not limited to commercial advertisements, recruiting materials, and solicitations for charitable donations.

7. Miscellaneous Provisions

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

7.2 Paragraph Headings. The paragraph headings appearing in this Contract have been inserted for the purpose of convenience and ready reference. They shall not be used to define, limit, or extend the scope or intent of the sections to which they pertain.

7.3 Antitrust Claims. The STATE and the PROVIDER recognize that in actual economic practice, overcharges resulting from antitrust violations are in fact usually borne by the purchaser. Therefore, the PROVIDER hereby assigns to the 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.

7.4 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 Hawai'i. 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, Hawai'i.

7.5 Conflict between General Conditions and Procurement Rules. In the event of a conflict between the General Conditions and the Procurement Rules or a Procurement Directive, the Procurement Rules or any Procurement Directive in effect on the date this Contract became effective shall control and are hereby incorporated by reference.

7.6 Entire Contract. This Contract sets forth all of the contracts, conditions, understandings, promises, warranties, and representations between the STATE and the PROVIDER 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 contracts, conditions, understandings, promises, warranties, or representations, oral or written, express or implied, between the STATE and the PROVIDER other than as set forth or as referred to herein.

7.7 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.

7.8 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 Hawai'i 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 PROVIDER's obligations under the Procurement Rules or statutes.

7.9 Execution in Counterparts. This Contract may be executed in several counterparts, each of which shall be regarded as an original and all of which shall constitute one instrument.

8. Confidentiality of Personal Information

8.1 Definitions.

8.1.1 Personal Information. "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.

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

8.2 Confidentiality of Material.

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

8.2.2 Retention, Use, or Disclosure. PROVIDER agrees not to retain, use, or disclose personal information for any purpose other than as permitted or required by this Contract.

8.2.3 Implementation of Technological Safeguards. PROVIDER agrees to implement appropriate "technological safeguards" that are acceptable to the STATE to reduce the risk of unauthorized access to personal information.

8.2.4 Reporting of Security Breaches. PROVIDER shall report to the STATE in a prompt and complete manner any security breaches involving personal information.

8.2.5 Mitigation of Harmful Effect. PROVIDER agrees to mitigate, to the extent practicable, any harmful effect that is known to PROVIDER because of a use or disclosure of personal information by PROVIDER in violation of the requirements of this paragraph.

8.2.6 Log of Disclosures. PROVIDER shall complete and retain a log of all disclosures made of personal information received from the STATE, or personal information created or received by PROVIDER on behalf of the STATE.

8.3 Security Awareness Training and Confidentiality Agreements.

8.3.1 Certification of Completed Training. PROVIDER certifies that all of its employees who will have access to the personal information have completed training on security awareness topics related to protecting personal information.

8.3.2 Certification of Confidentiality Agreements. PROVIDER certifies that confidentiality agreements have been signed by all of its employees who will have access to the personal information acknowledging that:

1) The personal information collected, used, or maintained by the PROVIDER will be treated as confidential;

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

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

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

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

2) Immediately terminate this Contract.

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

8.5 Records Retention.

8.5.1 Destruction of Personal Information. Upon any termination of this Contract, PROVIDER shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

8.5.2 Maintenance of Files, Books, Records. The PROVIDER and any subcontractors shall maintain the files, books, and records, that relate to the Contract, including any personal information created or received by the PROVIDER on behalf of the STATE, and any cost or pricing data, for three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall not be disclosed without the prior written approval of the STATE. After the three (3) year retention period has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS.

CONTRACT NO. _____

STATE OF HAWAIʻI
CONTRACT FOR HEALTH AND HUMAN SERVICES: COMPETITIVE PURCHASE OF SERVICES

This Contract, executed on the respective dates indicated below, is effective as of _____, 20 _____ between the _____

_____,
(Name of the state department, agency board or commission)

_____

State of Hawaiʻi ("STATE"), by its _____
(Title of person signing for the STATE)

whose address is: _____

_____

_____

and _____,
(Name of PROVIDER)

("PROVIDER"), a _____,
(Legal form of PROVIDER i.e., Corporation, Limited Liability Company, etc.)

under the laws of the State of _____ whose business street address and taxpayer identification numbers are as follows:

Business street address:

_____

_____

_____

Mailing address if different than business street address:

_____

_____

_____

Federal employer identification number: _____

Hawaiʻi general excise tax number: _____

RECITALS

A. This Contract is for a competitive purchase of services (a "Competitive POS"), as defined in section 103F-402, Hawaii Revised Statutes ("HRS"), and chapter 3-143, Hawai'i Administrative Rules.

B. The STATE needs the health and human services described in this Contract and its attachments ("Required Services") and the PROVIDER agrees to provide the Required Services.

C. Money is available to fund this Contract pursuant to:

(1) _____,
(Identify state sources)

in the amount of _____, or
(state funding)

(2) _____,
(Identify federal sources)

in the amount of _____, or both.
(federal funding)

D. The STATE is authorized to enter into this Contract pursuant to:

_____
(Legal authority for Contracts)

E. The undersigned representative of the PROVIDER represents, and the STATE relies upon such representation, that he or she has authority to sign this Contract by virtue of (check any or all that apply):

☐ corporate resolutions of the PROVIDER or other authorizing documents such as partnership resolutions;

☐ corporate by-laws of the PROVIDER, or other similar operating documents of the PROVIDER, such as a partnership contract or limited liability company operating contract;

☐ the PROVIDER is a sole proprietor and as such does not require any authorizing documents to sign this Contract;

☐ other evidence of authority to sign:

_____

F. The PROVIDER has provided a "Certificate of Insurance" to the STATE that shows to the satisfaction of the STATE that the PROVIDER has obtained liability insurance

which complies with paragraph 1.4 of the General Conditions of this Contract and with any relevant special condition of this Contract.

G. The PROVIDER produced, and the STATE inspected, a tax clearance certificate as required by section 103-53, HRS.

NOW, THEREFORE, in consideration of the promises contained in this Contract, the STATE and the PROVIDER agree as follows:

1. Scope of Services. The PROVIDER shall, in a proper and satisfactory manner as determined by the STATE, provide the Required Services set forth in Attachment "1" to this Contract, which is hereby made a part of this Contract, and the Request for Proposals ("RFP"), and the PROVIDER's Proposal, which are incorporated in this Contract by reference. In the event that there is a conflict among the terms of this Contract, and either the Proposal or the RFP, or both, then the terms of this Contract shall control.

2. Time of Performance. The PROVIDER shall provide the Required Services from _____, 20 _____, to _____, 20 _____, as set forth in Attachment "2" to this Contract, which is hereby made a part of this Contract.

3. Compensation. The PROVIDER shall be compensated a total amount for all required services not to exceed _____ _____ DOLLARS ($_____),which amount includes all fees and costs incurred and any federal, state, and local taxes, as set forth in Attachment "3" to this Contract, which is hereby made a part of this Contract.

4. Certificate of Exemption from Civil Service. The Certificate of Exemption from Civil Service is attached and made a part of this Contract.

5. Standards of Conduct Declaration. The Standards of Conduct Declaration of the PROVIDER is attached and made a part of this Contract.

6. General and Special Conditions. The General Conditions for Health and Human Services Contracts ("General Conditions") and any Special Conditions are attached hereto and made a part of this Contract. In the event of a conflict between the General Conditions and the Special Conditions, the Special Conditions shall control.

7. Notices. Any written notice required to be given by any party under this Contract shall be (a) delivered personally, or (b) sent by United States first class mail, postage prepaid.

Notice required to be given to the STATE shall be sent to:

_____

_____.

Notice to the PROVIDER shall be sent to the mailing address as indicated on page 1. A notice shall be deemed to have been received three (3) days after mailing or at the time of actual receipt, whichever is earlier. The PROVIDER is responsible for notifying the STATE in writing of any change of address.

IN VIEW OF THE ABOVE, the parties execute this Contract by their signatures below.

STATE

By _____
(Signature)

Print Name _____

Print Title _____

_____

Date _____

FUNDING AGENCY (to be signed by head of funding agency if other than the Contracting Agency)

By _____
(Signature)

Print Name _____

Print Title _____

_____

Date _____

CONTRACT NO. _____

CORPORATE SEAL
(if available)

PROVIDER

By _____
(Signature)

Print Name _____

Print Title _____

_____

Date _____

APPROVED AS TO FORM:

_____
Deputy Attorney General

APPENDIX G – 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 H – 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 I - DENTAL TPA BUSINESS PROPOSAL

- **PRICE PROPOSAL**
- **BUDGET RELATED FORMS**
- **BUDGET RELATED FORMS INSTRUCTIONS**

APPENDIX I
DENTAL TPA BUSINESS PROPOSAL
PRICE PROPOSAL

Business Proposal RFP-MQD-2021-012

I,_____(Name of Official authorized to commit) 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-MQD-2021-012 for Dental Third Party Administrator (TPA) Services for the State of Hawaii Medicaid Population are met.

Cost of Contract SFY 2022:
July 1, 2021 to June 30, 2022

- On-going Operation Price $ _____

Cost of Contract SFY 2023:
July 1, 2022 to June 30, 2023

- On-going Operation Price $ _____

Cost of Contract SFY 2024:
July 1, 2023 to June 30, 2024

- On-going Operation Price $ _____

Personnel Billing Rates Proposal Price

Dental TPA shall provide the hourly rate for the following contract years:

Contract SFY2021 (July 1, 2021 to June 30, 2022) $_____

Contract SFY2022 (July 1, 2022 to June 30, 2023) $_____

Contract SFY2023 (July 1, 2023 to June 30, 2024) $_____

APPENDIX I

Summary of Budget Sheets

SPO-H-205	$_____
SPO-H-205A	$_____
SPO-H-205B	$_____
SPO-H-206A	$_____
SPO-H-206B	$_____
SPO-H-206C	$_____
SPO-H-206D	$_____
SPO-H-206E	$_____
SPO-H-206F	$_____
SPO-H-206G	$_____
SPO-H-206H	$_____
SPO-H-206I	$_____
SPO-H-206J	$_____

BUDGET

(Period_____to_____)

Applicant/Provider: _____

RFP No.: _____

Contract No. (As Applicable): _____

BUDGET CATEGORIES	Budget Request (a)	(b)	(c)	(d)
A. PERSONNEL COST				
1. Salaries				
2. Payroll Taxes & Assessments				
3. Fringe Benefits				
TOTAL PERSONNEL COST				
B. OTHER CURRENT EXPENSES				
1. Airfare, Inter-Island				
2. Airfare, Out-of-State				
3. Audit Services				
4. Contractual Services - Administrative				
5. Contractual Services - Subcontracts				
6. Insurance				
7. Lease/Rental of Equipment				
8. Lease/Rental of Motor Vehicle				
9. Lease/Rental of Space				
10. Mileage				
11. Postage, Freight & Delivery				
12. Publication & Printing				
13. Repair & Maintenance				
14. Staff Training				
15. Substance/Per Diem				
16. Supplies				
17. Telecommunication				
18. Transportation				
19. Utilities				
20				
21.				
22.				
23.				
TOTAL OTHER CURRENT EXPENSES				
C. EQUIPMENT PURCHASES				
D. MOTOR VEHICLE PURCHASES				
TOTAL (A+B+C+D)				

SOURCES OF FUNDING		Budget Prepared By:
(a) Budget Request		Name (Please type or print) Phone
(b)		
(c)		Signature of Authorized Official Date
(d)		Name and Title (Please type or print)
TOTAL REVENUE		For State Agency Use Only
		Signature of Reviewer Date

Form SPO-H-205 (Effective10/01/98)

ORGANIZATION - WIDE BUDGET BY SOURCE OF FUNDS

(Period_____to_____)

Applicant/Provider: _____

RFP No.: _____

Contract No. (As Applicable): _____

BUDGET CATEGORIES	Total Funds (a)	(b)	(c)	(d)
A. PERSONNEL COST				
1. Salaries				
2. Payroll Taxes & Assessments				
3. Fringe Benefits				
TOTAL PERSONNEL COST				
B. OTHER CURRENT EXPENSES				
1. Airfare, Inter-Island				
2. Airfare, Out-of-State				
3. Audit Services				
4. Contractual Services - Administrative				
5. Contractual Services - Subcontracts				
6. Insurance				
7. Lease/Rental of Equipment				
8. Lease/Rental of Motor Vehicle				
9. Lease/Rental of Space				
10. Mileage				
11. Postage, Freight & Delivery				
12. Publication & Printing				
13. Repair & Maintenance				
14. Staff Training				
15. Substance/Per Diem				
16. Supplies				
17. Telecommunication				
18. Transportation				
19. Utilities				
20				
21.				
22.				
23.				
TOTAL OTHER CURRENT EXPENSES				
C. EQUIPMENT PURCHASES				
D. MOTOR VEHICLE PURCHASES				
TOTAL (A+B+C+D)				

SOURCES OF FUNDING		Budget Prepared By:
(a) Total Funds		Name (Please type or print) Phone
(b)		
(c)		Signature of Authorized Official Date
(d)		Name and Title (Please type or print)
TOTAL REVENUE		For State Agency Use Only
		Signature of Reviewer Date

ORGANIZATION - WIDE BUDGET BY PROGRAMS

(Period_____to_____)

Applicant/Provider _____

RFP No. : _____

Contract No. (As Applicable): _____

	(a)	(b)	(c)	(d)
B U D G E T C A T E G O R I E S	**Contract/RFP#:**	**Contract/RFP#:**	**Contract/RFP#:**	**Contract/RFP#:**
	Program:	**Program:**	**Program:**	**Program:**
A. PERSONNEL COST				
1. Salaries				
2. Payroll Taxes & Assessments				
3. Fringe Benefits				
TOTAL PERSONNEL COST				
B. OTHER CURRENT EXPENSES				
1. Airfare, Inter-Island				
2. Airfare, Out-of-State				
3. Audit Services				
4. Contractual Services - Administrative				
5. Contractual Services - Subcontracts				
6. Insurance				
7. Lease/Rental of Equipment				
8. Lease/Rental of Motor Vehicle				
9. Lease/Rental of Space				
10. Mileage				
11. Postage, Freight & Delivery				
12. Publication & Printing				
13. Repair & Maintenance				
14. Staff Training				
15. Substance/Per Diem				
16. Supplies				
17. Telecommunication				
18. Transportation				
19. Utilities				
20				
21.				
22.				
23.				
TOTAL OTHER CURRENT EXPENSES				
C. EQUIPMENT PURCHASES				
D. MOTOR VEHICLE PURCHASES				
TOTAL (A+B+C+D)				
SOURCES OF FUNDING				
(a) Budget Request				
(b)				
(c)				
(d)				
TOTAL REVENUE				

For State Agency Use Only	Budget Prepared By:
Signature of Reviewer Dat	Name (Please type or print) Phone Signature of Authorized Official Date

Form SPO-H-205B (Effective 10/01/98)

BUDGET JUSTIFICATION
PERSONNEL - SALARIES AND WAGES

Applicant/Provider: _____
RFP No.: _____ Period: _____ to _ Date Prepared: _
Contract No. (As Applicable):

POSITION NO.	POSITION TITLE	FULL TIME EQUIVALENT TO ORGANIZATION	ANNUAL SALARY INCLUDING BUDGETED SALARY INCREASE A	% OF TIME BUDGETED TO THE CONTRACT B	TOTAL SALARY BUDGETED TO THE CONTRACT A x B
TOTAL:					

JUSTIFICATION/COMMENTS:

BUDGET JUSTIFICATION
PERSONNEL - SALARIES AND WAGES

BUDGET JUSTIFICATION
PERSONNEL: PAYROLL TAXES, ASSESSMENTS, AND FRINGE BENEFITS

Applicant/Provider: _____

RFP No.: _____ Period: _____ to _____ Date Prepared: _____

Contract No.: _____
(As Applicable)

TYPE	BASIS OF ASSESSMENTS OR FRINGE BENEFITS	% OF SALARY	TOTAL
PAYROLL TAXES & ASSESSMENTS:			
Social Security	As required by law	As required by law	
Unemployment Insurance (Federal)	As required by law	As required by law	
Unemployment Insurance (State)	As required by law	As required by law	
Worker's Compensation	As required by law	As required by law	
Temporary Disability Insurance	As required by law	As required by law	
SUBTOTAL:			
FRINGE BENEFITS:			
Health Insurance			
Retirement			
SUBTOTAL:			
TOTAL:			

JUSTIFICATION/COMMENTS:

BUDGET JUSTIFICATION
TRAVEL - INTER-ISLAND

Applicant/Provider:

RFP No.: Period:_____ to _____ Date Prepared: _____

Contract No.
(As Applicable)

NAME OF EMPLOYEE & TITLE	DESTINATION	NO. DAYS	PER DIEM OR SUBSISTENCE A	AIR FARE B	TRANSPORTATION C	TOTAL A+B+C
TOTAL:						

JUSTIFICATION/COMMENTS:

Form SPO-H-206C (Effective 10/01/98)

BUDGET JUSTIFICATION
TRAVEL - OUT OF STATE

Applicant/Provider:

RFP No.: Period:_____ to _____ Date Prepared: _____

Contract No.
(As Applicable)

NAME OF EMPLOYEE & TITLE	DESTINATION	NO. DAYS	PER DIEM OR SUBSISTENCE A	AIR FARE B	TRANSPORTATION C	TOTAL A+B+C
TOTAL:						

JUSTIFICATION/COMMENTS:

Form SPO-H-206D (Effective 10/01/98)

BUDGET JUSTIFICATION
CONTRACTUAL SERVICES - ADMINISTRATIVE

Applicant/Provider: _____

RFP No.: _____ Period: _____ to _____ Date Prepared: _____

Contract No. _____
(As Applicable)

NAME OF BUSINESS OR INDIVIDUAL	TOTAL BUDGETED	SERVICES PROVIDED	JUSTIFICATION/COMMENTS
TOTAL:			

BUDGET JUSTIFICATION
CONTRACTUAL SERVICES - SUBCONTRACTS

Applicant/Provider: _____

RFP No.: _____ Period: _____ to _____ Date Prepared: _____

Contract No. _____
(As Applicable)

NAME OF BUSINESS OR INDIVIDUAL	TOTAL BUDGETED	SERVICES PROVIDED	JUSTIFICATION/COMMENTS
TOTAL:			

BUDGET JUSTIFICATION
DEPRECIATION

Applicant/Provider: _____

RFP No.: _____

Contract No. (As Applicable): _____ Period: _____ to _____ Date Prepared: _____

ITEM PLEASE IDENTIFY EACH ASSET. DO NOT GROUP BY ASSET TITLE.	ACQUISITION DATE	ACQUISITION COST	USEFUL LIFE	METHOD OF DEPRECIATION	PREVIOUS DEPRECIATION TAKEN	DEPRECIATION EXPENSE	% ALLOCATED	DEPRECIATION ALLOCATED
Total:								

JUSTIFICATION/COMMENTS:

BUDGET JUSTIFICATION
PROGRAM ACTIVITIES

Applicant/Provider: _____

RFP No.: _____ Period: _____ to _____ Date Prepared: _____

Contract No. : _____
(As Applicable)

DESCRIPTION	AMOUNT	JUSTIFICATION/COMMENTS
Total:		

Form SPO-H-206H (Effective 10/01/98)

BUDGET JUSTIFICATION
EQUIPMENT PURCHASES

Applicant/Provider: _____

RFP No.: _____ Period: _____ to _____ Date Prepared: _____

Contract No.: _____
(As Applicable)

DESCRIPTION OF EQUIPMENT	NO. OF ITEMS	COST PER ITEM	TOTAL COST	TOTAL BUDGETED
	[redacted]			

JUSTIFICATION/COMMENTS:

BUDGET JUSTIFICATION
MOTOR VEHICLE

Applicant/Provider: _____

RFP No.: _____ Period: _____ to _____ Date Prepared: _____

Contract No.: _____
(As Applicable)

DESCRIPTION OF MOTOR VEHICLE	NO. OF ITEMS	COST PER ITEM	TOTAL COST	TOTAL BUDGETED
	[redacted]			

JUSTIFICATION/COMMENTS:

COST PROPOSAL (BUDGET) FORMS

(INSTRUCTIONS AND SAMPLES)

ON

PURCHASES OF HEALTH AND HUMAN SERVICES

(Chapter 103F, Hawaii Revised Statutes)

Form No.	Form Title
SPO-H-205	Budget
SPO-H-205A	Organization-Wide Budget by Source of Funds
SPO-H-205B	Organization-Wide Budget by Programs
SPO-H-206A	Budget Justification-Personnel: Salaries & Wages
SPO-H-206B	Budget Justification-Personnel: Payroll Taxes, Assessments & Fringe Benefits
SPO-H-206C	Budget Justification-Travel: Inter-Island
SPO-H-206D	Budget Justification-Travel: Out of State
SPO-H-206E	Budget Justification-Contractual Services: Administrative
SPO-H-206F	Budget Justification-Contractual Services: Subcontracts
SPO-H-206G	Budget Justification-Depreciation
SPO-H-206H	Budget Justification-Program Activities
SPO-H-206I	Budget Justification-Equipment Purchases
SPO-H-206J	Budget Justification-Motor Vehicle

Instructions for Completing
FORM SPO-H-205 BUDGET

Applicant/Provider:	Enter the Applicant's legal name.
RFP#:	Enter the Request for Proposal (RFP) identifying number for this service activity.
Column (a) **Budget Request**	Budget Request. Enter the requested budget amounts for each cost item listed. Use the Cost Principles included in the RFP as a guide to determine which costs are allowed.
TOTAL (A+B+C+D)	Sum the subtotals for Budget Categories A, B, C and D, for columns (a) through (d).
SOURCES OF FUNDING: **(a)** **(b)** **(c)** **(d)**	Identify all sources of funding to be used for this service activity.
TOTAL REVENUE	Enter the sum of all revenue sources cited above.
Budget Prepared by:	Type or print the name of the person who prepared the budget request and their telephone number. If there are any questions or comments, this person will be contacted for further information and clarification. Provide signature of Applicant's authorized representative, and date of approval.

SPECIAL INSTRUCTIONS:

Column (b):
Column (c):
Column (d):

BUDGET

(Period _____ to _____)

Applicant/Provider: XYZ Hawai'i, Inc.

RFP No.: ABC-123

Contract No. (As Applicable): DHS-97-001

BUDGET CATEGORIES	Budget Request (a)	(b)	(c)	(d)
A. PERSONNEL COST				
1. Salaries	70,250			
2. Payroll Taxes & Assessments	7,643			
3. Fringe Benefits	11,451			
TOTAL PERSONNEL COST	**89,344**			
B. OTHER CURRENT EXPENSES				
1. Airfare, Inter-Island	500			
2. Airfare, Out-of-State	800			
3. Audit Services	500			
4. Contractual Services - Administrative	900			
5. Contractual Services - Subcontracts	900			
6. Insurance	2,000			
7. Lease/Rental of Equipment				
8. Lease/Rental of Motor Vehicle				
9. Lease/Rental of Space				
10. Mileage	400			
11. Postage, Freight & Delivery	200			
12. Publication & Printing	100			
13. Repair & Maintenance	200			
14. Staff Training	100			
15. Substance/Per Diem	1,200			
16. Supplies	1,000			
17. Telecommunication	1,200			
18. Transportation	215			
19. Utilities	3,000			
20				
21.				
22.				
23.				
TOTAL OTHER CURRENT EXPENSES	**13,215**			
C. EQUIPMENT PURCHASES	500			
D. MOTOR VEHICLE PURCHASES	9,750			
TOTAL (A+B+C+D)	**$112,809**			

SOURCES OF FUNDING	
(a) Budget Request	$112,809
(b) Funds Raised	
(c) Program Income	
(d)	
TOTAL REVENUE	**$112,809**

Budget Prepared By:

Joe E. Hawai'i — Name (Please type or print)

999-9999 — Phone

02/14/97 — Date

Signature of Authorized Official

Dee B. Boss, Executive Director — Name and Title (Please type or print)

For State Agency Use Only

Signature of Reviewer — Date

Form SPO-H-205 (Effective 10/01/98)

Instructions for Completing
FORM SPO-H-205A ORGANIZATION - WIDE BUDGET BY SOURCE OF FUNDS

Applicant/Provider:	Enter the Applicant's legal name.
RFP#:	Enter the Request For Proposal (RFP) identifying number of this service activity.
For all columns (a) thru (d)	Report your total organization-wide budget for this fiscal year by **source of funds**. Your organization's budget should reflect the total budget of the "organization" legally named. Report each source of fund in separate columns, by budget line item. For the first column on the first page of this form, use the column heading, "Organization Total". For the remaining columns you may use column headings such as: Federal, State, Funds Raised, Program Income, etc. If additional columns are needed, use additional copies of this form.
Columns (b), (c) & (d)	Identify sources of funding in space provided for column titles.
TOTAL (A+B+C+D)	Sum the subtotals for Budget Categories A, B, C and D, for columns (a) through (d).
SOURCE OF FUNDING: **(a)** **(b)** **(c)** **(d)**	Identify all sources of funding to be used by your organization.
TOTAL REVENUE	Enter the sum of all revenue sources cited above.
Budget Prepared by:	Type or print the name of the person who prepared the budget request and their telephone number. If there are any questions or comments, this person will be contacted for further information and clarification. Provide signature of Applicant's authorized representative, and date of approval.

ORGANIZATION - WIDE BUDGET BY SOURCE OF FUNDS

(Period _____ to _____)

Applicant/Provider: XYZ Hawai'i, Inc.

RFP No.: ABC-123

Contract No. (As Applicable): DHS-97-001

BUDGET CATEGORIES	Total Funds (a)	State Funds (b)	Privately Raised Funds (c)	Program Income (d)
A. PERSONNEL COST				
1. Salaries	200,504	70,250	79,105	51,149
2. Payroll Taxes & Assessments	21,810	7,643	7,624	6,543
3. Fringe Benefits	32,682	11,451	13,923	7,308
TOTAL PERSONNEL COST	**254,996**	**89,344**	**100,652**	**65,000**
B. OTHER CURRENT EXPENSES				
1. Airfare, Inter-Island	2,288	500	1,788	
2. Airfare, Out-of-State	6,488	800	5,688	
3. Audit Services	2,955	500	45	2,410
4. Contractual Services - Administrative	2,195	900		1,295
5. Contractual Services - Subcontracts	2,195	900		1,295
6. Insurance	5,141	2,000	3,141	
7. Lease/Rental of Equipment				
8. Lease/Rental of Motor Vehicle				
9. Lease/Rental of Space				
10. Mileage	1,055	400	655	
11. Postage, Freight & Delivery	785	200	585	
12. Publication & Printing	5,550	100	5,450	
13. Repair & Maintenance	598	200	398	
14. Staff Training	245	100	145	
15. Substance/Per Diem	3,678	1,200	2,478	
16. Supplies	4,905	1,000	3,905	
17. Telecommunication	3,232	1,200	2,032	
18. Transportation	885	215	670	
19. Utilities	4,235	3,000	1,235	
20				
21.				
22.				
23.				
TOTAL OTHER CURRENT EXPENSES	**46,430**	**13,215**	**28,215**	**5,000**
C. EQUIPMENT PURCHASES		500		
D. MOTOR VEHICLE PURCHASES		9,750		
TOTAL (A+B+C+D)	**$301,426**	**$112,809**	**$128,867**	**$70,000**

SOURCES OF FUNDING	
(a) Total Funds	**$301,426**
(b) State Funds	$112,809
(c) Privately Raised Funds	$128,867
(d) Program Income	$70,000
TOTAL REVENUE	**$301,426**

Budget Prepared By:

Joe E. Hawai'i — Name (Please type or print)

999-9999 — Phone

Signature of Authorized Official

02/14/97 — Date

Dee B. Boss, Executive Director — Name and Title (Please type or print)

For State Agency Use Only

Signature of Reviewer — Date

Form SPO-H-205A (Effective 10/01/98 Rev.12/04)

Instructions for Completing
FORM SPO-H-205B ORGANIZATION - WIDE BUDGET BY PROGRAMS

Applicant/Provider:	Enter the Applicant's legal name.
Columns (a) thru (d) **Contract/RFP #**	Report your total organization-wide budget by **programs**. Enter the name of the program, and the contract number or RFP number if applicable, at the top of the column. Enter anticipated expenditures for each program by line item. Include expenditures from all sources of funding to be used by your organization for this program (including the contract amount). If additional columns are needed, use additional copies of this form. For the first column on the first page of this form, use the column heading, "Organization Total".
SOURCE OF FUNDING: **(a) Budget request** **(b)** **(c)** **(d)**	Identify all sources of funding to be used by your organization.
TOTAL REVENUE	Enter the sum of all revenue sources cited above.
Budget Prepared by:	Type or print the name of the person who prepared the budget request and their telephone number. If there are any questions or comments, this person will be contacted for further information and clarification. Provide signature of Applicant's authorized representative, and date of approval.

ORGANIZATION - WIDE BUDGET BY PROGRAMS

(Period _____ to _____)

Applicant/Provider: XYZ Hawai'i, Inc.

RFP No. : ABC-123

Contract No. (As Applicable): DHS-97-001

	(a)	(b)	(c)	(d)
B U D G E T C A T E G O R I E S		**Contract/RFP#: ABC-123**	**Contract/RFP#: DEF-456**	**Contract/RFP#: GHI-789**
	Program: Total	**Program: ABC Service**	**Program: Special #1**	**Program: Special #2**
A. PERSONNEL COST				
1. Salaries	200,500	70,250	65,125	65,125
2. Payroll Taxes & Assessments	21,815	7,643	7,086	7,086
3. Fringe Benefits	32,681	11,451	10,615	10,615
TOTAL PERSONNEL COST	**254,996**	**89,344**	**82,826**	**82,826**
B. OTHER CURRENT EXPENSES				
1. Airfare, Inter-Island	2,288	500	899	899
2. Airfare, Out-of-State	6,488	800	2,789	2,899
3. Audit Services	2,955	500	2,455	
4. Contractual Services - Administrative	2,195	900	1,295	
5. Contractual Services - Subcontracts	2,195	900	1,295	
6. Insurance	5,141	2,000	3,141	
7. Lease/Rental of Equipment				
8. Lease/Rental of Motor Vehicle				
9. Lease/Rental of Space				
10. Mileage	1,055	400	655	
11. Postage, Freight & Delivery	785	200	585	
12. Publication & Printing	5,550	100	5,450	
13. Repair & Maintenance	598	200	398	
14. Staff Training	245	100	145	
15. Substance/Per Diem	3,678	1,200	1,235	1,243
16. Supplies	4,905	1,000	2,345	1,560
17. Telecommunication	3,232	1,200	1,574	458
18. Transportation	885	215	545	125
19. Utilities	4,235	3,000	1,235	
20				
21.				
22.				
23.				
TOTAL OTHER CURRENT EXPENSES	**46,430**	**13,215**	**26,041**	**7,184**
C. EQUIPMENT PURCHASES	500	500		
D. MOTOR VEHICLE PURCHASES	9,750	9,750		
TOTAL (A+B+C+D)	**311,676**	**112,809**	**108,867**	**90,010**
SOURCES OF FUNDING				
(a) Budget Request	112,809	112,809		
(b) Funds Raised	128,867		100,000	30,000
(c) Program Income	70,000		10,000	60,000
(d)				
TOTAL REVENUE	**311,676**	**112,809**	**110,000**	**90,000**

For State Agency Use Only

Budget Prepared By:

Joe E. Hawai'i **999-9999** **02/14/97**

Signature of Reviewer Date | Name (Please type or print) Phone | Signature of Authorized Official Date

Form SPO-H-205B (Effective 10/01/98)

Instructions for Completing
FORM SPO-H-206A BUDGET JUSTIFICATION
PERSONNEL - SALARIES & WAGES

Applicant/Provider:	Enter the Applicant's legal name.
Period:	Enter the time period for which this budget will cover; usually, this will cover a fiscal year.
Date Prepared	Enter the date this justification was prepared.
POSITION NO.	Enter each employee's position number.
POSITION TITLE	Enter the position title for each identified position.
FULL TIME EQUIVALENT to Organization.	Enter the full-time equivalency of employees to the organization (i.e., full-time is 1.0; half-time is 0.5). If the employee is employed on an hourly basis, estimate the FTE and indicate it is an estimation in the justification/comments section.
ANNUAL SALARY Including Budgeted Salary Increase (A)	Enter the employee's annual salary. If part-time, report what employee actually earns for the year. If employed on an hourly basis, estimate the annual salary and indicate the hourly wage in the comments section (e.g., $6.00/hr).
% OF TIME BUDGETED to the Contract (B)	Enter the percentage of employees' time charged to the budget for this contract. (e.g., if the employee is employed by the organization at 0.5 FTE and half of that time is for this contract, the percentage will be 50%).
TOTAL SALARY BUDGETED to the Contract (AxB)	Enter the salary budgeted. This should be the result of multiplying (A) x (B). If it is not, a full explanation must be given. At the bottom of this column, enter the TOTAL of this column. It must correspond to the Salaries budgeted for the contract.
JUSTIFICATION/ COMMENTS:	Provide any other comments or explanations. Attach additional sheets, if necessary.

BUDGET JUSTIFICATION
PERSONNEL - SALARIES AND WAGES

Applicant/Provider: XYZ Hawai'i, Inc.
RFP No.: ABC-123 Period: 07/01/95 to 06/30/96 Date Prepared: 02/14/95
Contract No. (As Applicable): DHS-97-001

POSITION NO.	POSITION TITLE	FULL TIME EQUIVALENT TO ORGANIZATION	ANNUAL SALARY INCLUDING BUDGETED SALARY INCREASE A	% OF TIME BUDGETED TO THE CONTRACT B	TOTAL SALARY BUDGETED TO THE CONTRACT A x B
25708	Accountant	0.50	36,000	0.75%	27,000
25712	Registered Professional Nurse	1.00	52,000	0.50%	26,000
25719	Executive Director	1.00	60,000	0.10%	6,000
25720	Physician	0.50	84,000	0.25%	21,000
25725	Social Worker	0.75	38,000	0.50%	19,000
TOTAL:					$99,000

JUSTIFICATION/COMMENTS:

Instructions for Completing
FORM SPO-H-206B BUDGET JUSTIFICATION
PERSONNEL: PAYROLL TAXES, ASSESSMENTS, & FRINGE BENEFITS

Applicant/Provider:	Enter the Applicant's legal name.
Period:	Enter the time period for which this budget will cover; usually, this will cover a fiscal year.
Date Prepared	Enter the date this justification was prepared.
TYPE	
Payroll Taxes-Social Security and Unemployment	Indicate the total amount for Social Security and Unemployment Insurance.
Assessments - Workers' Compensation & TDI	Indicate the total amount charged for Workers' Compensation and Temporary Disability Insurance assessments.
BASIS OF FRINGE ASSESSMENTS	
Health Insurance	Indicate the basis of the fringe benefit assessment for health insurance. For example, if an employer is contributing toward the cost of a health insurance plan for its employees and is passing the cost on to the budget, the basis for the assessment to the budget should be indicated, e.g., the percentage of the employer's contribution toward the plan.
Retirement	Indicate the basis of the fringe benefit assessment for retirement. For example, if an employer is making a contribution towards a retirement plan for employees, the basis for the assessment to the budget should be indicated, e.g., the employer's contribution toward the plan based on a percentage (specify) of employee's salaries.
JUSTIFICATION/ COMMENTS:	Provide any other comments or explanations. Attach additional sheets, if necessary.

BUDGET JUSTIFICATION
PERSONNEL: PAYROLL TAXES, ASSESSMENTS, AND FRINGE BENEFITS

Applicant/Provider: XYZ Hawai'i, Inc.
RFP No.: ABC-123
Contract No. (As Applicable): DHS-97-001

Period: 07/01/95 to 06/30/96

Date Prepared: 02/14

TYPE	BASIS OF ASSESSMENTS OR FRINGE BENEFITS	% OF SALARY	TOTAL
PAYROLL TAXES & ASSESSMENTS:			
Social Security	As required by law	As required by law	5,374
Unemployment Insurance (Federal)	As required by law	As required by law	281
Unemployment Insurance (State)	As required by law	As required by law	1,370
Worker's Compensation	As required by law	As required by law	520
Temporary Disability Insurance	As required by law	As required by law	98
SUBTOTAL:			7,643
FRINGE BENEFITS:			
Health Insurance	Personnel Policy	6.35	4,461
Retirement	Personnel Policy	9.95	6,990
SUBTOTAL:			$11,451
TOTAL:			**$19,094**

JUSTIFICATION/COMMENTS:

Instructions for Completing
FORM SPO-H-206C BUDGET JUSTIFICATION
TRAVEL - INTER-ISLAND

Applicant/Provider:	Enter the Applicant's legal name.
Period:	Enter the time period for which this budget will cover; usually, this will cover a fiscal year.
Date Prepared	Enter the date this justification was prepared.
NAME OF EMPLOYEE & TITLE	Enter name and/or position title for individual(s) who will be traveling.
DESTINATION	Enter destination and purpose of travel (e.g., training, provision of services, etc.) Travel must be directly related to the program.
NO. DAYS	Enter the estimated number of days of travel.
PER DIEM A	Enter the per diem or subsistence amount requested (i.e., per diem rate multiplied by the number of days of travel.) Per diem should be based on the applicant's per diem policy and should not exceed the maximum allowed by the state purchasing agency.
AIR FARE B	Enter the cost of airfare. First-class travel is not allowed.
TRANSPORTATION C	Enter the estimated cost of ground transportation, based on the applicant's ground transportation policy.
TOTAL	Enter column totals for columns A, B and C and the total travel cost (A+B+C). If the purpose of travel relates to two or more programs, costs for the per diem or subsistence, airfare, and taxi/bus/car should be prorated in accord with a cost allocation method approved by the state purchasing agency.
JUSTIFICATION/ COMMENTS:	Justify the need for travel for the delivery of this service activity. Enter additional explanations. Attach additional sheets, if necessary.

BUDGET JUSTIFICATION
TRAVEL - INTER-ISLAND

Applicant/Provider: XYZ Hawai'i, Inc.
RFP No.: ABC-123
Contract No. (As Applicable): DHS-97-001

Period: 07/01/95 to 06/30/96

Date Prepared: 02/14/95

NAME OF EMPLOYEE & TITLE	DESTINATION	NO. DAYS	PER DIEM OR SUBSISTENCE A	AIR FARE B	TRANSPORTATION C	TOTAL A+B+C
1 Mary Smith, Program Director	O'ahu (Training)	2	100	100	30	230
2 Susan Yamamoto, Case Manager	O'ahu (Training)	2	100	100	10	210
3 Jane Taylor, Social Worker	Moloka'i (Provider Services)	1	30	100	5	135
4 Patrick Lau, Counselor	Moloka'i (Provider Services)	1	30	100	5	135
5 John Ota, Social Worker	Moloka'i (Provider Services)	1	30	100	5	135
TOTAL:		7	$290	$500	$55	$845

JUSTIFICATION/COMMENTS:

1 and 2 = To attend training related to the provision of advocacy services for clients.

3, 4, and 5 = To provide advocacy services for clients living on Molokai as contracted.

Instructions for Completing
FORM SPO-H-206D BUDGET JUSTIFICATION
TRAVEL - OUT OF STATE

Applicant/Provider:	Enter the Applicant's legal name.
Period:	Enter the time period for which this budget will cover; usually, this will cover a fiscal year.
Date Prepared	Enter the date this justification was prepared.
NAME OF EMPLOYEE & TITLE	Enter name and/or position title for individual(s) who will be traveling.
DESTINATION	Enter destination and purpose of travel (e.g., training, provision of services, etc.) Travel must be directly related to the program.
NO. DAYS	Enter the estimated number of days of travel.
PER DIEM A	Enter the per diem or subsistence amount requested (i.e., per diem rate multiplied by the number of days of travel.) Per diem should be based on the applicant's per diem policy and should not exceed the maximum allowed by the state purchasing agency.
AIR FARE B	Enter the cost of airfare. First-class travel is not allowed.
TRANSPORTATION C	Enter the estimated cost of ground transportation, based on the applicant's ground transportation policy.
TOTAL	Enter column totals for columns A, B and C and the total travel cost (A+B+C). If the purpose of travel relates to two or more programs, costs for the per diem or subsistence, airfare, and taxi/bus/car should be prorated in accord with a cost allocation method approved by the state purchasing agency.
JUSTIFICATION/ COMMENTS:	Explain need for travel, for delivery of this service activity. Attach additional sheets, if necessary. Prior approval from the state purchasing agency is needed for out-of-state travel.

Applicant/Provider: XYZ Hawai'i, Inc.
RFP No.: ABC-123
Contract No. (As Applicable): DHS-97-001

BUDGET JUSTIFICATION
TRAVEL - OUT OF STATE

Period: 07/01/95 to 06/30/96

Date Prepared: 02/14/95

NAME OF EMPLOYEE & TITLE	DESTINATION	NO. DAYS	PER DIEM OR SUBSISTENCE A	AIR FARE B	TRANSPORTATION C	TOTAL A+B+C
1 Mary Smith, Program Director	Portland, Oregon (Training)	4	455	400	80	935
2 Patrick Lau, Case Manager	Portland, Oregon (Training)	4	455	400	80	935
3						
4						
5						
TOTAL:		8	$910	$800	$160	$1,870

JUSTIFICATION/COMMENTS:

1. and 2. = To attend the national conference on client advocacy, presenting the nation's foremost advocacy experts and to make a presentation on Hawai'i's advocacy programs.

Instructions for Completing
FORM SPO-H-206E BUDGET JUSTIFICATION
CONTRACTUAL SERVICES - ADMINISTRATIVE

Applicant/Provider:	Enter the Applicant's legal name.
Period:	Enter the time period for which this budget will cover; usually, this will cover a fiscal year.
Date Prepared	Enter the date this justification was prepared.
NAME OF BUSINESS OR INDIVIDUAL	Enter the business or individual you are contracting with. If the firm or individual is not known at the time of preparation, enter "(UNKNOWN, to be selected)"
TOTAL BUDGETED	Enter the projected cost to be charged to the budget.
SERVICES PROVIDED	Identify the specific service(s) you are contracting for, with the business or individual (e.g., payroll services, occupational therapy, physical therapy, etc.)
TOTAL	Add the "Total Budgeted" column and enter the sum of the amounts listed.
JUSTIFICATION/ COMMENTS:	Justify the need for contractual services in the delivery of this service activity. Enter additional comments. Attach additional sheets, if necessary.

BUDGET JUSTIFICATION
CONTRACTUAL SERVICES - ADMINISTRATIVE

Applicant/Provider: XYZ Hawai'i, Inc.
RFP No.: ABC-123 Period: 07/01/98 to 06/30/98 Date Prepared: 02/14/95
Contract No. (As Applicable): DHS-97-001

NAME OF BUSINESS OR INDIVIDUAL	TOTAL BUDGETED	SERVICES PROVIDED	JUSTIFICATION/COMMENTS
Accountants, Inc.	600	Payroll Services	Personnel payroll services
Life Therapeutic	1200	Occupational Therap	Required for periodic client evaluations.
TOTAL:	$1,800		

Instructions for Completing
FORM SPO-H-206F BUDGET JUSTIFICATION
CONTRACTUAL SERVICES - SUBCONTRACTS

Applicant/Provider:	Enter the Applicant's legal name.
Period:	Enter the time period for which this budget will cover; usually, this will cover a fiscal year.
Date Prepared	Enter the date this justification was prepared.
NAME OF ORGANIZATION OR INDIVIDUAL	Enter the organization or individual you are contracting with. If the firm or individual is not known at the time of preparation, enter "(UNKNOWN, to be selected)"
TOTAL BUDGETED	Enter the projected cost to be charged to the budget.
SERVICES PROVIDED	Identify the specific service(s) you are contracting for, with the organization or individual (e.g., payroll services, occupational therapy, physical therapy, etc.)
TOTAL	Add the "Total Budgeted" column and enter the sum of the amounts listed.
JUSTIFICATION/ COMMENTS:	Justify the need for contractual services in the delivery of this service activity. Enter additional comments. Attach additional sheets, if necessary.

BUDGET JUSTIFICATION
CONTRACTUAL SERVICES - SUBCONTRACTS

Applicant/Provider: XYZ Hawai'i, Inc.
RFP No.: ABC-123 Period: 07/01/95 to 06/30/96 Date Prepared: 02/14/95
Contract No. (As Applicable): DHS-97-001

NAME OF ORGANIZATION OR INDIVIDUAL	TOTAL BUDGETED	SERVICES PROVIDED	JUSTIFICATION/COMMENTS
Med Eval, Inc.	2,500	client evaluations	specialized services
TOTAL:	$2,500		

Instructions for Completing
FORM SPO-H-206G BUDGET JUSTIFICATION
DEPRECIATION

Applicant/Provider:	Enter the Applicant's legal name.
Period:	Enter the time period for which this budget will cover; usually, this will cover a fiscal year.
Date Prepared	Enter the date this justification was prepared.
ITEM	Identify the item to be depreciated individually. Do not group items by asset title.
AQUISITION COST	Purchase price paid to acquire the item(s).
AQUISITION DATE	Date item was acquired.
USEFUL LIFE	Estimate the useful life of the item as determined by Internal Revenue Service guidelines.
METHOD OF DEPREC.	Use the straight line method of depreciation. Other methods require prior approval from the state purchasing agency.
PREVIOUS DEPREC. TAKEN	Enter total amount of any depreciation claim previously taken (i.e., depreciation taken on income tax returns.)
DEPRECIATED EXPENSE	Enter the amount for each depreciation expense item.
PERCENT ALLOCATED	Enter the percentage of the depreciation allocated to this proposal.
DEPRECIATION ALLOCATED	Enter the amount requested for each depreciation expense item. This should be the depreciated expense multiplied by the percent allocated.
JUSTIFICATION/ COMMENTS:	Describe the need for the depreciated items, for the delivery of the contracted service. Explain why depreciation of the expense is appropriate. Provide other comments or explanations. Attach additional sheets, if necessary.

BUDGET JUSTIFICATION
DEPRECIATION

Applicant/Provider: XYZ Hawai'i, Inc.
RFP No.: ABC-123
Contract No. (As Applicable): DHS-97-001 Period: 07/01/98 to 06/30/98 Date Prepared: 02/14/98

ITEM PLEASE IDENTIFY EACH ASSET DO NOT GROUP BY ASSET TITLE	ACQUISITION DATE	ACQUISITION COST	USEFUL LIFE	METHOD OF DEPRECIATION	PREVIOUS DEPRECIATION TAKEN	DEPRECIATION EXPENSE	% ALLOCATED	DEPRECIATION ALLOCATED
Computer	07/01/93	1600	5	SL	640	320	10	32.00
File Cabinet	07/01/93	322	10	SL	32	32	10	3.20
Desk	07/01/93	266	10	SL	74	27	10	2.70
Chair	07/01/93	200E	10	SL	0	20	10	2.00
TOTAL:								$39.90

JUSTIFICATION/COMMENTS:
Office equipment to be used for Kona program office exclusively
E = Estimate
SL = Straight Line Method

Instructions for Completing
FORM SPO-H-206H BUDGET JUSTIFICATION
PROGRAM ACTIVITIES

Applicant/Provider:	Enter the Applicant's legal name.
Period:	Enter the time period for which this budget will cover; usually, this will cover a fiscal year.
Date Prepared	Enter the date this justification was prepared.
DESCRIPTION	Identify item(s) individually. Do not group by category titles.
AMOUNT	Enter the dollar amount of the item that will be charged to the budget for this service activity.
TOTAL	Enter total amount.
JUSTIFICATION/ COMMENTS:	Justify the need for the item, for delivery of this service activity. Enter additional comments. Attach additional sheets, if necessary.

BUDGET JUSTIFICATION
PROGRAM ACTIVITIES

Applicant/Provider: XYZ Hawai'i, Inc.
RFP No.: ABC-123 Period: 07/01/95 to 06/30/96 Date Prepa
Contract No. (As Applicable): DHS-97-001

DESCRIPTION	AMOUNT	JUSTIFICATION/COMMENTS
Client excursions	800	Transportation, admission & related costs for children's excursions.
TOTAL:	800	

Instructions for Completing
FORM SPO-H-206I BUDGET JUSTIFICATION
EQUIPMENT PURCHASES

Applicant/Provider:	Enter the Applicant's legal name.
Period:	Enter the time period for which this budget will cover; usually, this will cover a fiscal year.
Date Prepared	Enter the date this justification was prepared.
DESCRIPTION OF EQUIPMENT	Identify the type of equipment to be purchased.
NO. OF ITEMS	Enter the number of unit(s) to be purchased.
COST PER ITEM	Enter the estimated costs for each unit.
TOTAL COST	Calculate the total cost for each type of equipment, by multiplying number of units by cost per unit.
TOTAL BUDGETED	Enter the dollar amount of the equipment costs that will be charged to the budget for this service activity. This amount will be entered as budget "category C. EQUIPMENT" in your budget.
JUSTIFICATION/ COMMENTS:	Justify the need for equipment for the delivery of this service activity. Enter additional explanations. Attach additional sheets, if necessary.

BUDGET JUSTIFICATION
EQUIPMENT PURCHASES

Applicant/Provider: XYZ Hawai'i, Inc.
RFP No.: ABC-123 Period: 07/01/95 to 06/30/96 Date Prepared:
Contract No. (As Applicable): DHS-97-001

DESCRIPTION OF EQUIPMENT	NO. OF ITEMS	COST PER ITEM	TOTAL COST	TOTAL BUDGETED
Printer (Model DXZ-2)	2	250	500	500
TOTAL:				$500

JUSTIFICATION/COMMENTS:
Printer needed for production of work books used by clients. Printers will be located at our Pearl City office.

Instructions for Completing
FORM SPO-H-206J BUDGET JUSTIFICATION
MOTOR VEHICLE

Applicant/Provider:	Enter the Applicant's legal name.
Period:	Enter the time period for which this budget will cover; usually, this will cover a fiscal year.
Date Prepared	Enter the date this justification was prepared.
DESCRIPTION OF MOTOR VEHICLE	Enter make and model of vehicle; or, provide a brief specification such as type of vehicle (i.e., sedan, van, pick-up truck), and no. of passengers (i.e., 8-passenger van). Indicate whether a new or used vehicle will be purchased, whether another vehicle will be traded-in, and indicate the approximate trade-in value, if applicable.
NO. OF ITEMS	Enter the number of vehicles to be purchased.
COST PER ITEM	Enter the estimated cost per vehicles.
TOTAL COST	Calculate the total cost for each type of vehicle, by multiplying number of units by cost per unit.
TOTAL BUDGETED	Enter the dollar amount of the motor vehicle costs that will be charged to the budget for this service activity. This amount will be entered as budget "category D. MOTOR VEHICLE" in your budget.
JUSTIFICATION/ COMMENTS:	Explain purpose for the vehicle(s) as it relates to the delivery of the contracted service. Enter additional explanations. Attach additional sheets, if necessary.

BUDGET JUSTIFICATION
MOTOR VEHICLE

Applicant/Provider: XYZ Hawai'i, Inc.

RFP No.: ABC-123 Period: 07/01/95 to 06/30/96 Date Prepared:

Contract No. (As Applicable): DHS-97-001

DESCRIPTION OF MOTOR VEHICLE	NO. OF ITEMS	COST PER ITEM	TOTAL COST	TOTAL BUDGETED
1993 Toyata Van (Previa)	1	$9,750	$9,750	$9,750
TOTAL:				$9,750

JUSTIFICATION/COMMENTS:

A van is needed to transport clients to and from service sites.

APPENDIX J

CLIENT REFERENCES

The Dental TPA is required to supply the State with names, addressed, and telephone numbers of three (3) customers for which the Dental TPA 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: _____

STATE of HAWAII
DEPARTMENT of HUMAN SERVICES
MED-QUEST DIVISION

Standard Companion Guide
Transaction Information

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010

Companion Guide Version Number: 1.2
December 2020

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Table of Contents

Transaction Instruction (TI) 4

1. TI Introduction 4
1.1 Background 4
1.1.1 Overview of HIPAA Legislation 4
1.1.2 Compliance according to HIPAA 4
1.1.3 Compliance according to ASC X12 4
1.2 Intended Use 5

2. Included ASC X12 Implementation Guides 5

3. Instruction Tables 5
3.1 834 Benefit Enrollment and Maintenance 5
3.2 820 Payroll Deducted and Other Group Premium Payment for Insurance Products 7

4. TI Additional Information 8
4.1 Business Scenarios 8
4.1.1 834 Transaction Notes 8
4.1.2 820 Examples 62
4.2 Payer Specific Business Rules and Limitations 66
4.2.1 834 Enrollment Transaction 66
4.2.2 820 Capitation Transaction 66
4.3 Frequently Asked Questions 67
4.4 Other Resources 68
4.4.1 Med-QUEST Action Code Translation Table 68

5. TI Change Summary 70

Transaction Instruction (TI)

1. TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for translations to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements documents. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

2. Included ASC X12 Implementation Guides

Unique ID	Name
005010X220	Benefit Enrollment and Maintenance (834)
005010X218	Payroll Deducted and Other Group Premium Payment for Insurance Products (820)

3. Instruction Tables

3.1 834 Benefit Enrollment and Maintenance

Loop ID	Reference	Name	Codes	Notes/Comments
1000A	N1	Sponsor Name		
1000A	N102	Name	MED-QUEST	
1000A	N104	Identification Code	996001089	
2300	HD	Health Coverage		
2300	HD03	Insurance Line Code	HMO AK DCP	PLAN-TYPE dependent on 834 Receiver
2750	N1	Reporting Category		
2750	N102	Name	Action Code	Populated with literal "Action Code"
2750	REF	Reporting Category Reference		
2750	REF02	Reference Identification		Populated with an Action Code
2750	N1	Reporting Category		
2750	N102	Name	CFA Code	Populated with literal "CFA Code"
2750	REF	Reporting Category Reference		
2750	REF02	Reference Identification	 MC MR PI	CFA codes for: Micronesia Marshall Islands Palau
2750	N1	Reporting Category		

Loop ID	Reference	Name	Codes	Notes/Comments
2750	N102	Name	Prior Plan New Plan	Populated with literal “Prior Plan” only when last member enrollment was within 90 days and with a different plan. Populated with literal “New Plan” only when member is enrolled in a different plan the day after the term date.
2750	REF	Reporting Category Reference		
2750	REF02	Reference Identification		Prior Plan uses: PRIOR PLAN ID (6) + PRIOR PLAN NAME (25) New Plan uses: HMO PLAN ID (6) + HMO PLAN NAME (25)
2750	N1	Reporting Category		
2750	N102	Name	Nursing Home	Populated with literal “Nursing Home”
2750	REF	Reporting Category Reference		
2750	REF02	Reference Identification		NURSING HOME ID (6) + NURSING HOME NAME (25)

3.2 820 Payroll Deducted and Other Group Premium Payment for Insurance Products

Loop ID	Reference	Name	Codes	Notes/Comments
2300B	RMR	Individual Premium Remittance Detail		
2300B	RMR02	Insurance Remittance Reference Number		Med-QUEST strings the following fixed-length fields: CONTRACT TYPE (1) + ISLAND CODE (2) + RATE CODE (4) + VOUCHER NUMBER (9) + VOUCHER DATE (8)

4. TI Additional Information

4.1 Business Scenarios

4.1.1 834 Transaction Notes

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	INTERCHANGE														
ISA11	Repetition Separator		^	^	^	^	^	^	^	^	^	^	^	^	^
ISA12	Interchange Control Version Number		00501	00501	00501	00501	00501	00501	00501	00501	00501	00501	00501	00501	00501
	FUNCTIONAL GROUP														
GS01	Functional Identifier Code		BE	BE	BE	BE	BE	BE	BE	BE	BE	BE	BE	BE	BE
GS08	Version / Release / Industry Identifier Code; no addenda		005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1
	HEADER														
ST	**Transaction Set Header**														
ST01	Transaction Set Identifier Code		834	834	834	834	834	834	834	834	834	834	834	834	834
ST02	Transaction Set Control Number														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
ST03	Implementation Convention Reference		005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1	005010X 220A1
BGN	**Beginning Segment**														
BGN01	Transaction Set Purpose Code		00	00	00	00	00	00	00	00	00	00	00	00	00
BGN02	Reference Identification														
BGN03	Date		PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE
BGN04	Time														
BGN05	Time Code														
BGN08	Action Code		2	2	2	2	2	2	2	2	2	2	2	4	4
REF	**Transaction Set Policy Number**														
REF01	Reference Identification Qualifier		38	38	38	38	38	38	38	38	38	38	38	38	38
REF02	Reference Identification		HP ID	HP ID	HP ID	HP ID	HP ID	HP ID	HP ID	HP ID	HP ID	HP ID	HP ID	HP ID	HP ID
DTP	**File Effective Date**														
DTP01	Date/Time Qualifier		303	303	303	303	303	303	303	303	303	303	303	303	303
DTP02	Date Time Period Format Qualifier		D8	D8	D8	D8	D8	D8	D8	D8	D8	D8	D8	D8	D8
DTP03	Date Time Period		PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE
QTY	**Transaction Set Control Totals**														
QTY01	Quantity Qualifier	Use 'TO'	TO	TO	TO	TO	TO	TO	TO	TO	TO	TO	TO	TO	TO

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
		Total													
QTY02	Quantity	INS Count	INS Count	INS Count	INS Count	INS Count	INS Count	INS Count	INS Count	INS Count	INS Count	INS Count	INS Count	INS Count	INS Count
	1000A SPONSOR NAME(1)														
N1	**Sponsor Name**														
N101	Entity Identifier Code		P5	P5	P5	P5	P5	P5	P5	P5	P5	P5	P5	P5	P5
N102	Name		MED-QUEST	MED-QUEST	MED-QUEST	MED-QUEST	MED-QUEST	MED-QUEST	MED-QUEST	MED-QUEST	MED-QUEST	MED-QUEST	MED-QUEST	MED-QUEST	MED-QUEST
N103	Identification Code Qualifier		FI	FI	FI	FI	FI	FI	FI	FI	FI	FI	FI	FI	FI
N104	Identification Code		996001089	996001089	996001089	996001089	996001089	996001089	996001089	996001089	996001089	996001089	996001089	996001089	996001089
	1000B PAYER (1)														
N1	**Payer**														
N101	Entity Identifier Code		IN	IN	IN	IN	IN	IN	IN	IN	IN	IN	IN	IN	IN
N102	Name		HP NAME	HP NAME	HP NAME	HP NAME	HP NAME	HP NAME	HP NAME	HP NAME	HP NAME	HP NAME	HP NAME	HP NAME	HP NAME
N103	Identification Code Qualifier		FI	FI	FI	FI	FI	FI	FI	FI	FI	FI	FI	FI	FI
N104	Identification Code		HP TAX ID	HP TAX ID	HP TAX ID	HP TAX ID	HP TAX ID	HP TAX ID	HP TAX ID	HP TAX ID	HP TAX ID	HP TAX ID	HP TAX ID	HP TAX ID	HP TAX ID
	2000 MEMBER LEVEL DETAIL(>1)														
INS	**Member Level**														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	Detail														
INS01	Yes/No Condition or Response Code		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
INS02	Individual Relationship Code		18	18	18	18	18	18	18	18	18	18	18	18	18
INS03	Maintenance Type Code		021	024	001	001	001	001	001	001	001	001	Daily: 001 Monthly: 030	030	030
INS04	Maintenance Reason Code		02 - Birth 22 - Plan Change 28 – Initial Enrollment 41 - Re-enrollment	03 - Death 07 – Termination of Benefits 14 - Voluntary Withdrawal 22 - Plan Change AH - Patient Moved	43 - Change of location	25 - Change in Identifying Data Element	25 - Change in Identifying Data Element	22 - Plan Change	07- Termination of Benefits 22 - Plan Change 33- Personnel Data	33 - Personnel Data AH - Patient moved to a new location AI - No Reason Given	33- Personnel Data	29 - Benefit Selection	Daily: 33- Personnel Data Monthly: XN- Notification Only	XN - Notification Only	XN - Notification Only
INS05	Benefit Status Code		A	A	A	A	A	A	A	A	A	A	A	A	A
INS06-1	Medicare Plan Code		MED-CODE	MED-CODE	MED-CODE	MED-CODE	MED-CODE	MED-CODE	MED-CODE	MED-CODE	MED-CODE	MED-CODE		MED-CODE	MED-CODE
INS08	Employment Status Code		AC	TE	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC	AC
INS11	Date Time Period Format Qualifier			D8											

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
INS12	Date Time Period	Use for Date of Death only, if present		DAT OF DTH											
REF	**Subscriber Identifier**														
REF01	Reference Identification Qualifier	0F-Subscriber Number	0F	0F	0F	0F	0F	0F	0F	0F	0F	0F	0F	0F	0F
REF02	Reference Identification		HAWI ID	HAWI ID	HAWI ID	HAWI ID	HAWI ID	HAWI ID	HAWI ID	HAWI ID	HAWI ID	HAWI ID	HAWI ID	HAWI ID	"No Data"
REF	POLICY NUMBER-SEE 2700 CAP RATE CODE, PREG, ARREARS, ACTION CODE. CTY CD-SEE ADDRESS														
REF	**Member Supplemental Identifier**														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
REF01	Reference Identification Qualifier	DX - Section/Unit worker . F6 - Medicare Claim ID 3H- Case ID+Relationship code ZZ- Primary client ID 17- Voucher	DX F6 3H ZZ 17	17					F6	3H 17				DX F6 3H ZZ 17	
REF02	Reference Identification		SEC/UNIT/WRKR MEDICARE ID CASE ID+REL CODE PRIM ID VOUCHER ID	VOUCHER					MEDICARE ID	CASE ID+REL CODE				SEC/UNIT/WRKR MEDICARE ID CASE ID+REL CODE PRIM ID VOUCHER ID	
DTP	**Member Level Dates**														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
DTP01	Date/Time Qualifier		356 357	356 357	303	303	303	303	303	303	303	356 357	303	356	
DTP02	Date Time Period Format Qualifier		D8	D8	D8	D8	D8	D8	D8	D8	D8	D8	D8	D8	
DTP03	Date Time Period		ENROLL BEG ENROLL END	ENROLL BEG ENROLL END	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	PROCESS DATE	ENROLL BEG ENROLL END	PROCESS DATE	ENROLL BEG	
	2100A MEMBER NAME (1)														
NM1	**Member Name**														
NM101	Entity Identifier Code		IL	IL	IL	IL	74 IL for 'PN' Action code	IL	IL	IL	IL	IL	IL	IL	IL
NM102	Entity Type Qualifier		1	1	1	1	1	1	1	1	1	1	1	1	1
NM103	Name Last or Organization Name		LAST NAME	LAST NAME	LAST NAME	LAST NAME	LAST NAME	LAST NAME	LAST NAME	LAST NAME	LAST NAME	LAST NAME	LAST NAME	LAST NAME	"No Last Name"
NM104	Name First		FIRST NAME	FIRST NAME	FIRST NAME	FIRST NAME	FIRST NAME	FIRST NAME	FIRST NAME	FIRST NAME	FIRST NAME	FIRST NAME	FIRST NAME	FIRST NAME	"No First Name"
NM105	Name Middle		MIDDLE INIT	MIDDLE INIT	MIDDLE INIT	MIDDLE INIT	MIDDLE INIT	MIDDLE INIT	MIDDLE INIT	MIDDLE INIT	MIDDLE INIT	MIDDLE INIT	MIDDLE INIT	MIDDLE INIT	***END***
PER	**Member Communications Numbers**														
PER01	Contact Function Code		IP		IP					IP				IP	
PER03	Communication Number Qualifier		TE		TE					TE				TE	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
PER04	Communication Number		HOME PHONE		HOME PHONE					HOME PHONE				HOME PHONE	
PER05	Communication Number Qualifier		EM		EM					EM				EM	
PER06	Communication Number		EMAIL		EMAIL					EMAIL				EMAIL	
N3	**Member Residence Street Address**														
N301	Address Information	2015-0060-05-ED: Address Increase to 55 characters, 11/10/2015 LG	RES STR1		RES STR1									RES STR1	
N302	Address Information	2015-0060-05-ED: Address Increase to 55 characters, 11/10/2015 LG	RES STR2		RES STR2									RES STR2	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
N4	**Member Residence City, State, ZIP Code**														
N401	City Name		CITY		CITY									CITY	
N402	State or Province Code		STATE		STATE									STATE	
N403	Postal Code		ZIP		ZIP									ZIP	
N405	Location Qualifier		CY		CY									CY	
N406	Location Identifier		ISLAND CODE		ISLAND CODE									ISLAND CODE	
DMG	**Member Demographics**														
DMG01	Date Time Period Format Qualifier		D8	D8		D8	D8			D8		D8		D8	
DMG02	Date Time Period		DOB	DOB		DOB	DOB			DOB		DOB		DOB	
DMG03	Gender Code		GENDER	GENDER		GENDER	GENDER			GENDER		GENDER		GENDER	
DMG04	Marital Status Code		MARITAL STA											MARITAL STA	
DMG05-1	Race or Ethnicity Code		RACE							RACE				RACE	
DMG05-2	Code List qualifier		RET							RET				RET	
DMG05-3	Race or Ethnicity Code	Hispanic or Latino = 2135-2 Non-Hispanic or Latino	ETHNICITY							ETHNICITY				ETHNICITY	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
		= 2186-5													
LUI	**Member Language**														
LUI01	Identification Code Qualifier		LE							LE				LE	
LUI02	Identification Code		LANGUAGE							LANGUAGE				LANGUAGE	
LUI04	Use of Language Indicator	7 - Language Spoken	7							7				7	
LUI	**Member Language**														
LUI01	Identification Code Qualifier		LE							LE				LE	
LUI02	Identification Code		LANGUAGE							LANGUAGE				LANGUAGE	
LUI04	Use of Language Indicator	5 - Language Read	5							5				5	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	2100B INCORRECT MEMBER NAME(1)														
NM1	**Incorrect Member Name**														
NM101	Entity Identifier Code					70	70								
NM102	Entity Type Qualifier					1	1								
NM103	Name Last or Organization Name					LAST-NAME	PRIOR-LNAME else LAST-NAME								
NM104	Name First					FNAME	PRIOR-FNAME else FIRST-NAME								
NM105	Name Middle					PRIOR-MI	PRIOR-MI								
DMG	**Incorrect Member Demographics**					Used when Action codes DB, SX, or C3	Used when Action codes NC, C1, C2, or C4								
DMG01	Date Time Period Format Qualifier					D8	D8								

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
DMG02	Date Time Period					PRIOR DOB	PRIOR DOB								
DMG03	Gender Code					PRIOR GENDER	PRIOR GENDER								
DMG04	Marital Status Code														
DMG05	Race or Ethnicity Code														
	2100C MEMBER MAILING ADDRESS (1)	Only present if different from Residential Address													
NM1	**Member Mailing Address**														
NM101	Entity Identifier Code		31		31									31	
NM102	Entity Type Qualifier		1		1									1	
N3	**Member Mail Street Address**														
N301	Address Information	11/10/2015 / 2015-0060-05-ED: Address Increase to 55	MAIL STR1		MAIL STR1									MAIL STR1	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
		characters, 10/21/2015 LG													
N302	Address Information	11/10/2015 / 2015-0060-05-ED: Address Increase to 55 characters, 10/21/2015 LG	MAIL STR2		MAIL STR2									MAIL STR2	
N4	**Member Mail City, State, Zip**														
N401	City Name		MAIL CITY		MAIL CITY									MAIL CITY	
N402	State or Province Code		MAIL ST		MAIL ST									MAIL ST	
N403	Postal Code		MAIL ZIP		MAIL ZIP									MAIL ZIP	

	2100G RESPONSIBLE PERSON (13)	**1st occurrence - MED-PAYEE**								For 'OC' Other Change Action code only					
NM1	**Responsible Person**														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
NM101	Entity Identifier Code		QD		QD		QD							QD	
NM102	Entity Type Qualifier		1		1		1							1	
NM103	Name Last or Organization Name		MED PAYEE LNAME		MED PAYEE LNAME		MED PAYEE LNAME							MED PAYEE LNAME	
NM104	Name First		MED PAYEE FNAME		MED PAYEE FNAME		MED PAYEE FNAME							MED PAYEE FNAME	
NM105	Name Middle		MED PAYEE MI		MED PAYEE MI		MED PAYEE MI							MED PAYEE MI	
NM108	Identification Code Qualifier														
NM109	Identification Code														
N3	**Responsible Person Street Address**														
N301	Address Information		MED PAYEE ADDR1		MED PAYEE ADDR1		MED PAYEE ADDR1							MED PAYEE ADDR1	
N302	Address Information		MED PAYEE ADDR2		MED PAYEE ADDR2		MED PAYEE ADDR2							MED PAYEE ADDR2	
N4	**Responsible Person City, State, Zip**														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
N401	City Name		MED PAYEE CITY		MED PAYEE CITY		MED PAYEE CITY							MED PAYEE CITY	
N402	State or Province Code		MED PAYEE ST		MED PAYEE ST		MED PAYEE ST							MED PAYEE ST	
N403	Postal Code	5 or 9 digit Zip Code	MED PAYEE ZIP		MED PAYEE ZIP		MED PAYEE ZIP							MED PAYEE ZIP	
	2100G RESPONSIBLE PERSON (13)	**2nd occurrence - CASE NAME**								For 'OC' Other Change Action code only					
NM1	**Responsible Person**														
NM101	Entity Identifier Code		9K		9K					9K				9K	
NM102	Entity Type Qualifier		1		1					1				1	
NM103	Name Last or Organization Name		CASE LNAME		CASE LNAME					CASE LNAME				CASE LNAME	
NM104	Name First		CASE FNAME		CASE FNAME					CASE FNAME				CASE FNAME	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
NM105	Name Middle		CASE MI		CASE MI					CASE MI				CASE MI	
NM108	Identification Code Qualifier														
NM109	Identification Code														
N3	**Responsible Person Street Address**														
N301	Address Information														
N302	Address Information														
N4	**Responsible Person City, State, Zip**														
N401	City Name														
N402	State or Province Code														
N403	Postal Code	5 or 9 digit Zip Code													
	2300 HEALTH COVERAGE(99)	**HMO LOOP**													

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
HD	**Health Coverage**														
HD01	Maintenance Type Code		021	024									001	030	
HD03	Insurance Line Code	PLAN-TYPE dependent on 834 Receiver: HMO=Medical AK=Mental Health DCP=Dental	HMO AK DCP	HMO AK DCP									HMO AK DCP	HMO AK DCP	
DTP	**Health Coverage Dates**														
DTP01	Date/Time Qualifier		348 349	348 349									303	348	
DTP02	Date Time Period Format Qualifier		D8	D8									D8	D8	
DTP03	Date Time Period		BEGIN/ END DATE	BEGIN/ END DATE									PROCESS DATE	BEGIN DATE	
AMT	**Health Coverage Policy**														
AMT01	Amount Qualifier Code														
AMT02	Monetary Amount														
REF	**Health Coverage Policy Number**														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
REF01	Reference Identification Qualifier		CE	CE										CE	
REF02	Reference Identification		Contract Type	Contract Type										Contract Type	

	2320 COORDINATION OF BENEFITS (5)	**COB Loop 1 TPLs 1-5 (Does not include Medicare records)**													
COB	**Coordination of Benefits**												**D: Last mod date M: Only active and TPL dates intersects parm date**		
COB01	Payer Responsibility Sequence Number Code	U-Unknown											U	U	
COB02	Reference Identification												TPL POLICY	TPL POLICY	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
													ID	ID	
COB03	Coordination of Benefits Code	5-Unknown											5	5	
REF	**Additional Coordination of Benefits Identifiers**														
REF01	Reference Identification Qualifier	6P-Group Number											6P	6P	
REF02	Reference Identification												TPL-INS-TYP ~~TPL-COVG-TYPE~~	TPL-INS-TYP ~~TPL-COVG-TYPE~~	
REF	**Additional Coordination of Benefits Identifiers**														
REF01	Reference Identification Qualifier	6P-Group Number											6P	~~60~~	
REF02	Reference Identification	Change Reason: ER-Entered in error (does not apply to Medica											ER (mainframe generate this?, map does TPL-CHG-RSN)	~~TPL-CHG-RSN~~	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
		re)													
DTP	**Coordination of Benefits Eligibility Dates**														
DTP01	Date/Time Qualifier												344 345	344	
DTP02	Date Time Period Format Qualifier												D8	D8	
DTP03	Date Time Period												BEGIN/ END DATE	TPL-BEG-DAT	
	2330 COORDINATION OF BENEFITS RELATED ENTITY(3)														
NM1	**Coordination of Benefits Related Entity**	Note: This segment partially existed in 4010 at 2320/N1.													
NM101	Entity Identifier	IN-											IN	IN	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	Code	Insurer													
NM102	Entity Type Qualifier	2-Non-Person Entity											2	2	
NM103	Name Last or Organization Name												TPL CODE+ TPL DESC+ TPL SEQUENCE+ ABSENT PARENT IND	TPL-CAR-INFO	
N3	**Coordination of Benefits Related Entity Address**														
N301	Address Information														
N302	Address Information														
N4	**Coordination of Benefits Other Insurance Company City, State, ZIP Code**														
N401	City Name														
N402	State or Province Code														
N403	Postal Code														
PER	**Administrative Communications Contact**														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
PER01	Contact Function Code														
PER03	Communication Number Qualifier														
PER04	Communication Number														

	2300 HEALTH COVERAGE (99)	SOC LOOP													
HD	**Health Coverage**														
HD01	Maintenance Type Code		001							001				030	
HD03	Insurance Line Code		LTC							LTC				LTC	
HD04	Plan Coverage Description		SHARE OF COST/SPENDDOWN							SHARE OF COST/SPENDDOWN				SHARE OF COST/SPENDDOWN	
DTP	**Health Coverage Dates**														
DTP01	Date/Time Qualifier		348							348				348	
DTP02	Date Time Period Format Qualifier		D8							D8				D8	
DTP03	Date Time Period		SOC Begin Date							SOC Begin Date				SOC Begin Date	
AMT	**Health Coverage Policy**														
AMT01	Amount Qualifier Code		C1							C1				C1	
AMT02	Monetary Amount		SOC-AMT							SOC-AMT				SOC-AMT	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
REF	**Health Coverage Policy Number**														
REF01	Reference Identification Qualifier														
REF02	Reference Identification														

	2300 HEALTH COVERAGE (99)	**COB LOOP 2 TPLs 6-10**													
HD	**Health Coverage**														
HD01	Maintenance Type Code												001		
HD03	Insurance Line Code	Distinguishes the COB loop MM-Major Medical											HMO AK DCP		
DTP	**Health Coverage Dates**														
DTP01	Date/Time Qualifier												303		
DTP02	Date Time Period Format Qualifier												D8		
DTP03	Date Time Period												PROCESS DATE		

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
AMT	**Health Coverage Policy**														
AMT01	Amount Qualifier Code														
AMT02	Monetary Amount														
REF	**Health Coverage Policy Number**														
REF01	Reference Identification Qualifier												ZZ		
REF02	Reference Identification												ACTION -CD		
	2320 COORDINATION OF BENEFITS (> 5 TPL)														
COB	**Coordination of Benefits**														
COB01	Payer Responsibility Sequence Number Code												U		
COB02	Reference Identification												TPL POLICY ID		
COB03	Coordination of Benefits Code	5-Unknown											5		

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
REF	**Additional Coordination of Benefits Identifiers**	Occurrence #1													
REF01	Reference Identification Qualifier	6P-Group Number											6P (Only when TPL-Absent-Parent-Ind is present)		
REF02	Reference Identification												TPL-ABSENT-PARENT + TPL-INS-TYP + TPL-CHG-RSN ~~TPL-COVG-TYPE~~		
REF	**Additional Coordination of Benefits Identifiers**	Occurrence #2													
REF01	Reference Identification Qualifier	60-Account Sufficx code											60		

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
REF02	Reference Identification	Change Reason: ER-Entered in error (does not apply to Medicare)											ER (TPL-CHG-RSN)		
DTP	**Coordination of Benefits Eligibility Dates**														
DTP01	Date/Time Qualifier												344 345		
DTP02	Date Time Period Format Qualifier												D8		
DTP03	Date Time Period												BEGIN/ END DATE		
	2330 COORDINATION OF BENEFITS RELATED ENTITY (3)														
NM1	**Coordination of Benefits Related Entity**														
NM101	Entity Identifier Code												IN		
NM102	Entity Type												2		

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	Qualifier														
NM103	Name Last or Organization Name	Concatenated fixed fields TPL-CAR-INFO [Carrier Code x(5), Carrier Name x(45)] + TPL-SEQ-NO x(2) + TPL-ABS-PARENT x(1)											TPL-SEQ-NO x(2) + TPL-ABS-PARENT x(1) + TPL-CAR-INFO x(50)		
N3	**Coordination of Benefits Related Entity Address**														
N301	Address Information														
N302	Address Information														
N4	**Coordination of Benefits Other Insurance Company City, State, ZIP Code**														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
N401	City Name														
N402	State or Province Code														
N403	Postal Code														
PER	**Administrative Communications Contact**														
PER01	Contact Function Code														
PER03	Communication Number Qualifier														
PER04	Communication Number														
													END		
	2700 ADDITIONAL REPORTING CATEGORIES(1)														
LS	**Additional Reporting Categories**														
LS01	Loop Identifier Code		2700	2700	2700	2700	2700	2700	2700	2700	2700	2700		2700	

	2710 MEMBER REPORTING CATEGORIES (>1)	ACTION CODE													
LX	**Member Reporting Categories**														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier Code		75	75	75	75	75	75	75	75	75	75			
N102	Name		"Action Code"	"Action Code"	"Action Code"	"Action Code"	"Action Code"	"Action Code"	"Action Code"	"Action Code"	"Action Code"	"Action Code"			
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier		ZZ	ZZ	ZZ	ZZ	ZZ	ZZ	ZZ	ZZ	ZZ	ZZ			
REF02	Reference Identification		ACTION CODE	ACTION CODE	ACTION CODE	ACTION CODE	ACTION CODE	ACTION CODE	ACTION CODE	ACTION CODE	ACTION CODE	ACTION CODE			
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier														
DTP02	Date Time Period Format Qualifier														
DTP03	Date Time Period														

	2710 MEMBER REPORTING CATEGORIES (>1)	**RATE CODE**													

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier Code		75	75								75		75	
N102	Name		"Rate Code"	"Rate Code"								"Rate Code"		"RATE CODE"	
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier		9V	9V								9V		9V	
REF02	Reference Identification		RATE CODE	RATE CODE								RATE CODE		RATE CODE	
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier											007		007	
DTP02	Date Time Period Format Qualifier											D8		D8	
DTP03	Date Time Period											BEGIN DATE		BEGIN DATE	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	2750 REPORTING CATEGORY (1)	**RENEWAL DATE**								For 'OC' Other Change Action code only					
N1	**Reporting Category**														
N101	Entity Identifier Code		75							75				75	
N102	Name		"RENEWAL DATE"							"RENEWAL DATE"				"RENEWAL DATE"	
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier														
REF02	Reference Identification														
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier		007							007				007	
DTP02	Date Time Period Format Qualifier		D8							D8				D8	
DTP03	Date Time Period		RENEWAL DATE							RENEWAL DATE				RENEWAL DATE	

	2710 MEMBER REPORTING CATEGORIES (>1)	**CFA EXCEPTION CODE**													

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier Code		75											75	
N102	Name		CFA CODE											CFA CODE	
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier	PID-Program Identification Number	PID											PID	
REF02	Reference Identification	MC-Micronesia MR-Marshall Islands PL-Palau	MC, MR, OR PL											MC, MR, OR PL	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier														
DTP02	Date Time Period Format Qualifier														
DTP03	Date Time Period														
	2710 MEMBER REPORTING CATEGORIES (>1)	**PRIOR PLAN**													
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier Code		75												

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
N102	Name	ADD - Use Prior Plan only when last member enrollment was within 90 days and with a different plan. DISENROLL - Use New Plan only when member is enrolled in a different plan the day after the term	"Prior Plan"												

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
		date.													
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier		18												
REF02	Reference Identification	ADD - Use Prior Plan only when last member enrollment was within 90 days and with a	PRIOR PLAN ID (6) + PRIOR PLAN NAME (25)												

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
		different plan. DISENROLL - Use New Plan only when member is enrolled in a different plan the day after the term date.													
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier														
DTP02	Date Time Period Format Qualifier														
DTP03	Date Time Period														
	2710 MEMBER REPORTING CATEGORIES (>1)	**MEDICAL ENROLLMENT**													

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)	Health plans listed in 2700 loop is other than receiver of 834													
N1	**Reporting Category**														
N101	Entity Identifier Code		75					75						75	
N102	Name		"MEDICAL"					"MEDICAL"						"MEDICAL"	
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier		XX1					XX1						XX1	
REF02	Reference Identification		MEDICAL PLAN NAME					MEDICAL PLAN NAME						MEDICAL PLAN NAME	
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier		007					007						007	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
DTP02	Date Time Period Format Qualifier		D8 RD8					D8 RD8						D8	
DTP03	Date Time Period		BEGIN DATE END DATE					BEGIN DATE END DATE						BEGIN DATE	
	2710 MEMBER REPORTING CATEGORIES (>1)	**DENTAL PLAN (Includes PACE DENTAL)**													
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier Code		75					75						75	
N102	Name		"DENTAL"					"DENTAL"						"DENTAL"	
REF	**Reporting Category Reference**														
REF01	Reference Identification		XX1					XX1						XX1	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	Qualifier														
REF02	Reference Identification		DENTAL PLAN NAME					DENTAL PLAN NAME						DENTAL PLAN NAME	
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier		007					007						007	
DTP02	Date Time Period Format Qualifier		D8 RD8					D8						D8	
DTP03	Date Time Period		BEGIN DATE END DATE					BEGIN DATE						BEGIN DATE	
	2710 MEMBER REPORTING CATEGORIES (>1)	**BHS ENROLLMENT (FOR MEDICAL PLAN ONLY)**													
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting**														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	Category														
N101	Entity Identifier Code		75						75					75	
N102	Name		"BHS"						"BHS"					"BHS"	
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier		XX1						XX1					XX1	
REF02	Reference Identification		BHS PLAN NAME						BHS PLAN NAME					BHS PLAN NAME	
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier		007						007					007	
DTP02	Date Time Period Format Qualifier		D8 RD8						D8 RD8					D8	
DTP03	Date Time Period		BEGIN DATE END DATE						BEGIN DATE END DATE					BEGIN DATE	

	2710 MEMBER REPORTING CATEGORIES (>1)	**NURSING HOME**													
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier Code	75-Participant	75							75				75	
N102	Name		"NURSING HOME"							"NURSING HOME" or "NURSING HOME REMOVED"				"NURSING HOME"	
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier	ZZ-Mutually Defined	ZZ							ZZ				ZZ	
REF02	Reference Identification		NURSING HOME ID (6) + NURSING HOME NAME (25)							NURSING HOME ID (6) + NURSING HOME NAME (25)				NURSING HOME ID (6) + NURSING HOME NAME (25)	
DTP	**Reporting Category Date**														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
DTP01	Date/Time Qualifier		007							007				007	
DTP02	Date Time Period Format Qualifier	CCYY MMDD - CCYY MMDD	RD8							RD8				RD8	
DTP03	Date Time Period		NH-START-DAT NH-END-DAT							NH-START-DAT NH-END-DAT				NH-START-DAT NH-END-DAT	
	2710 MEMBER REPORTING CATEGORIES (>1)	**PENALIZED NH**													
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier Code		75							75				75	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
N102	Name		"PENALIZED NURSING HOME"							"PENALIZED NURSING HOME" or "PENALIZED NURSING HOME REMOVED"				"PENALIZED NURSING HOME"	
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier														
REF02	Reference Identification														
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier		007							007				007	
DTP02	Date Time Period Format Qualifier		RD8							RD8				RD8	
DTP03	Date Time Period		BEGIN/ END DATE							BEGIN/ END DATE				BEGIN/ END DATE	

	2710 MEMBER REPORTING CATEGORIES (>1)	**NH LEVEL OF CARE**													

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier Code		75							75				75	
N102	Name		If NHL-DEL-IND = "Y", Autoplug 'NURSING HOME LEVEL OF CARE REMOVED', else when BLANK, Autoplug "NURSING HOME LEVEL OF CARE"							If NHL-DEL-IND = "Y", Autoplug 'NURSING HOME LEVEL OF CARE REMOVED', else when BLANK, Autoplug "NURSING HOME LEVEL OF CARE"				"NURSING HOME LEVEL OF CARE"	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier		17							17				17	
REF02	Reference Identification		Use NHL-APPROVAL-STA + NHL-NUM-RISK-PTS. If NHL-APPROVAL-STA or NHL-NUM-RISK-PTS are blank then 'NA'. If both are blank REF*17 has REF02 = "NANA".							Use NHL-APPROVAL-STA + NHL-NUM-RISK-PTS. If NHL-APPROVAL-STA or NHL-NUM-RISK-PTS are blank then 'NA'. If both are blank REF*17 has REF02 = "NANA".				Use NHL-APPROVAL-STA + NHL-NUM-RISK-PTS. If NHL-APPROVAL-STA or NHL-NUM-RISK-PTS are blank then 'NA'. If both are blank REF*17 has REF02 = "NANA".	
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier		007							007				007	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
DTP02	Date Time Period Format Qualifier		RD8							RD8				RD8	
DTP03	Date Time Period		NHL-START-DAT NHL-END-DAT							NHL-START-DAT NHL-END-DAT				NHL-START-DAT NHL-END-DAT	
	2710 MEMBER REPORTING CATEGORIES (>1)	**LTE ELIGIBILITY**													
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier Code		75							75				75	
N102	Name	When Interpreter Indicator=Y	"INTERPRETER REQUESTED"							LTC DELETE IND				LTC DELETE IND	
REF	**Reporting Category Reference**														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
REF01	Reference Identification Qualifier														
REF02	Reference Identification														
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier									007				007	
DTP02	Date Time Period Format Qualifier									RD8				RD8	
DTP03	Date Time Period									LTC-START-DAT LTC-END-DAT				LTC-START-DAT LTC-END-DAT	
	2710 MEMBER REPORTING CATEGORIES (>1)	**INTERPRETER**													
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier		75							75				75	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	Code														
N102	Name	When Interpreter Indicator=Y	"INTERPRETER REQUESTED"							"INTERPRETER REQUESTED"				"INTERPRETER REQUESTED"	
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier														
REF02	Reference Identification														
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier														
DTP02	Date Time Period Format Qualifier														
DTP03	Date Time Period														

	2710 MEMBER REPORTING CATEGORIES (>1)	**ARREARS**													
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier Code		75							75				75	
N102	Name	When Arrears Indicator=Y	"ARREARS"							"ARREARS"				"ARREARS"	
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier														
REF02	Reference Identification														
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier														
DTP02	Date Time Period Format Qualifier														
DTP03	Date Time Period														
	2710 MEMBER REPORTING CATEGORIES (>1)	**EXPECTED DELIVERY DATE (UP**													

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
		TO 3 OCCURS)													
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier Code		75								75			75	
N102	Name		"EXPECTED DELIVERY DATE"								"EXPECTED DELIVERY DATE"			"EXPECTED DELIVERY DATE"	
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier														
REF02	Reference Identification														
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier		007								007			007	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
DTP02	Date Time Period Format Qualifier		D8								D8			D8	
DTP03	Date Time Period		EDD								EDD			EDD	
	2710 MEMBER REPORTING CATEGORIES (>1)	**MEDICAL CONDITION (UP TO 3 OCCURS)**													
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier Code		75								75			75	
N102	Name		"MEDICAL CONDITION"								"MEDICAL CONDITION"			"MEDICAL CONDITION"	
REF	**Reporting Category Reference**														
REF01	Reference Identification														

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	Qualifier														
REF02	Reference Identification														
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier		7								7			7	
DTP02	Date Time Period Format Qualifier		D8 or RD8								D8 or RD8			D8 or RD8	
DTP03	Date Time Period		Begin/End Date								Begin/End Date			Begin/End Date	
	2710 MEMBER REPORTING CATEGORIES (>1)	**Homeless CIS Status Code (UP TO 3 OCCURS)**													
LX	**Member Reporting Categories**														
LX01	Assigned Number	Incrementing number													
	2750 REPORTING CATEGORY (1)														
N1	**Reporting Category**														
N101	Entity Identifier		75							75					

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
	Code														
N102	Name		If "CIS-DEL-IND" = "Y", Autoplug "HOMELESS CODE REMOVED" else "HOMELESS PROJECT"							If "CIS-DEL-IND" = "Y", Autoplug "HOMELESS CODE REMOVED" else "HOMELESS PROJECT"					
REF	**Reporting Category Reference**														
REF01	Reference Identification Qualifier		PID							PID					
REF02	Reference Identification		Use either CIS-CD: H1, H2, H3, H4, H5, H6, H7, H8							Use either CIS-CD: H1, H2, H3, H4, H5, H6, H7, H8					
DTP	**Reporting Category Date**														
DTP01	Date/Time Qualifier		7								7			7	

Element	Identifier Description	HI Note	ADD	DISENROLL	ADDRESS CHANGE	DOB/GENDER CHANGE (DB or SX or C3 actions)	NAME DOB GENDER CHANGE (C1 or C2 or C4 or NC or PN actions)	HEALTH PLAN CHANGE (HC; FOR BHS ONLY)	MH CHANGE (MC) OR TERM (TM) CHANGE IN MEDICARE (CM)	OTHER CHANGE (ER, OC, SC, NH, LO, PZ, LA, AR, EM)	PREGNANT (PG) MEDICAL CONDITION (ME)	RATE CODE CHANGE (RC) (Last Daily)	COB (Separate from ROS record)	MONTHLY	EMPTY DAILY
DTP02	Date Time Period Format Qualifier		D8 or RD8								D8 or RD8			D8 or RD8	
DTP03	Date Time Period		Begin/End Date								Begin/End Date			Begin/End Date	
LE	**Additional reporting Categories Loop Termination**														
LE01	Loop Identifier Code		2700	2700	2700	2700	2700	2700	2700	2700	2700	2700		2700	
	TRAILER														
SE	**Transaction Set Trailer**														
SE01	Number of Included Segments														
SE02	Transaction Set Control Number														

4.1.2 820 Examples

4.1.2.1 Normal 820 Example

Member #1 – Normal capitation payment of $89.30 for 10/01/09-10/14/09
Member #2 – Recoupment amount of $-94.06 for 10/01/09-10/31/09 and a capitation payment of $54.62 for 10/01/09-10/18/09.
Note that Member #2 has one occurrence of the 2000B/ENT loop with multiple 2300/RMR loops. This is a change from the 4010 to the 5010.

Element	Identifier Description	Values
ISA11	Repetition Separator	^
ISA12	Interchange Control Version Number	00501
GS01	Functional Identifier Code	RA
GS02	Application Sender's Code	MQD996001089
GS03	Application Receiver's Code	MQDPLN
GS04	Functional group creation date	CCYYMMDD
GS05	Time	02190182
GS06	Group Control Number	294021901
GS07	Responsible Agency Code	X
GS08	Version / Release / Industry Identifier Code; no addenda	005010X218
ST	**820 Header**	
ST01	Transaction Set Identifier Code	820
ST02	Transaction Set Control Number	000000001
ST03	Implementation Convention Reference	005010X218
BPR	**Financial Information**	
BPR01	Transaction Handling Code	I - Remittance Info Only
BPR02	**Total Premium Payment Amount**	**49.86**
BPR03	Credit/Debit Flag Code	C
BPR04	Payment Method Code	NON - Non-payment Data
BPR10	Originating Company Identifier	1996001089
BPR16	Check Issue or EFT Effective Date	20091028
TRN	**Re-association Trace Number**	
TRN01	Trace Type Code	3 - Financial Re-association Trace Number
TRN02	Reference Identification	000000000075939
TRN03	Originating Company Identifier	1996001089
REF	**Premium Receivers Identification Key**	
REF01	Reference Identification Qualifier	14-Master Account Number
REF02	Premium Receiver Reference Identifier	MQDPLN
DTM	**Coverage Period**	
DTM01	Date/Time Qualifier	582 - Report Period
DTM05	Date Time Period Format Qualifier	RD8
DTM06	Coverage Period	20091001-20091031
	1000A PREMIUM RECEIVER'S NAME	
N1	**Premium Receiver's Name**	
N101	Entity Identifier Code	PE-Payee
N102	Premium Receiver's Last or Organization Name	HI HEALTH PLAN
N3	**Premium Receiver's Address**	
N301	Address Information	123 ADDRESS1 ST
N302	Address Information	SUITE #99
N4	**Premium Receiver's City, State, and Zip Code**	

Element	Identifier Description	Values
N401	City Name	KAPOLEI
N402	State or Province Code	HI
N403	Postal Code	96707
	1000B PREMIUM PAYER'S NAME	
N1	**Premium Payer's Name**	
N101	Entity Identifier Code	PR
N102	Premium Payer Name	HAWAII MEDICAID
N3	**Premium Payer's Address**	
N301	Premium Payer Address Line	1001 KAMOKILA BLVD
N4	**Premium Payer's City, State, Zip Code**	
N401	City Name	KAPOLEI
N402	State or Province Code	HI
N403	Postal Code	96707
	2000B INDIVIDUAL REMITTANCE	**MEMBER #1**
ENT	Individual Remittance	
ENT01	Assigned Number	1
ENT02	Entity Identifier Code	2J - Individual
ENT03	Identification Code Qualifier	EI – Employee Identification Number
ENT04	Identification Code	0001234567
	2100B INDIVIDUAL NAME	
NM1	Individual Name	
NM101	Entity Identifier Code	IL - Insured/Subscriber ID
NM102	Entity Type Qualifier	1 - Person
NM103	Name Last or Organization Name	**REGAN**
NM104	Name First	**RONALD**
NM105	Name Middle	**A**
NM108	Identification Code Qualifier	N - Insured's Unique Identification Number
NM109	Identification Code	0001234567
	2300B INDIVIDUAL PREMIUM	
RMR	Individual Premium Remittance Detail	
RMR01	Reference Identification Qualifier	AZ - Health Insurance Policy Number
RMR02	Insurance Remittance Reference Number	A01GM16H0037918**20091001**
RMR04	**Detail Premium Payment Amount**	**89.30**
DTM	**Individual Coverage Period**	
DTM01	Date/Time Qualifier	582 - Report Period
DTM05	Date Time Period Format Qualifier	RD8
DTM06	Date Time Period	20091001-20091014
	2000B INDIVIDUAL REMITTANCE	**MEMBER#2**
ENT	Individual Remittance	
ENT01	Assigned Number	2
ENT02	Entity Identifier Code	2J - Individual
ENT03	Identification Code Qualifier	EI – Employee Identification Number
ENT04	Identification Code	0007654321
	2100B INDIVIDUAL NAME	
NM1	Individual Name	
NM101	Entity Identifier Code	IL - Insured/Subscriber ID
NM102	Entity Type Qualifier	1 - Person
NM103	Name Last or Organization Name	**REGAN**
NM104	Name First	**NANCY**
NM105	Name Middle	**A**

Element	Identifier Description	Values
NM108	Identification Code Qualifier	N - Insured's Unique Identification Number
NM109	Identification Code	0007654321
	2300B INDIVIDUAL PREMIUM	***OCCURRENCE #1***
RMR	Individual Premium Remittance Detail	
RMR01	Reference Identification Qualifier	AZ - Health Insurance Policy Number
RMR02	Insurance Remittance Reference Number	A01GF16H00379445**20091001**
RMR04	**Detail Premium Payment Amount**	**-94.06**
DTM	**Individual Coverage Period**	
DTM01	Date/Time Qualifier	582 - Report Period
DTM05	Date Time Period Format Qualifier	RD8
DTM06	Date Time Period	20091001-20091031
	2300B INDIVIDUAL PREMIUM	***OCCURRENCE #2***
RMR	Individual Premium Remittance Detail	
RMR01	Reference Identification Qualifier	AZ - Health Insurance Policy Number
RMR02	Insurance Remittance Reference Number	A01GF16H00379445**20091001**
RMR04	**Detail Premium Payment Amount**	**54.62**
DTM	**Individual Coverage Period**	
DTM01	Date/Time Qualifier	582 - Report Period
DTM05	Date Time Period Format Qualifier	RD8
DTM06	Date Time Period	20091001-20091018
SE	**Transaction Set Trailer**	
SE01	Number of Included Segments	
SE02	Transaction Set Control Number	

4.1.2.2 Empty File Example

Element	Identifier Description	Values
ISA11	Repetition Separator	**^**
ISA12	Interchange Control Version Number	00501
GS01	Functional Identifier Code	RA
GS02	Application Sender's Code	MQD996001089
GS03	Application Receiver's Code	MQDPLN
GS04	Functional group creation date	CCYYMMDD
GS05	Time	02190182
GS06	Group Control Number	294021901
GS07	Responsible Agency Code	X
GS08	Version / Release / Industry Identifier Code; no addenda	005010X218
ST	**820 Header**	
ST01	Transaction Set Identifier Code	820
ST02	Transaction Set Control Number	000000001
ST03	Implementation Convention Reference	005010X218
BPR	**Financial Information**	
BPR01	Transaction Handling Code	I - Remittance Info Only
BPR02	**Total Premium Payment Amount**	**0**
BPR03	Credit/Debit Flag Code	C
BPR04	Payment Method Code	NON - Non-payment Data
BPR10	Originating Company Identifier	1996001089
BPR16	Check Issue or EFT Effective Date	20091028
TRN	**Re-association Trace Number**	

Element	Identifier Description	Values
TRN01	Trace Type Code	3 - Financial Re-association Trace Number
TRN02	Reference Identification	"NO DATA"
TRN03	Originating Company Identifier	1996001089
REF	**Premium Receivers Identification Key**	
REF01	Reference Identification Qualifier	14-Master Account Number
REF02	Premium Receiver Reference Identifier	MQDPLN
DTM	**Coverage Period**	
DTM01	Date/Time Qualifier	582 - Report Period
DTM05	Date Time Period Format Qualifier	RD8
DTM06	Coverage Period	20091015-20091015
	1000A PREMIUM RECEIVER'S NAME	
N1	**Premium Receiver's Name**	
N101	Entity Identifier Code	PE-Payee
N102	Premium Receiver's Last or Organization Name	"NO CAPITATION PAYMENT"
	1000B PREMIUM PAYER'S NAME	
N1	**Premium Payer's Name**	
N101	Entity Identifier Code	PR
N102	Premium Payer Name	HAWAII MEDICAID
N3	**Premium Payer's Address**	
N301	Premium Payer Address Line	1001 KAMOKILA BLVD
N4	**Premium Payer's City, State, Zip Code**	
N401	City Name	KAPOLEI
N402	State or Province Code	HI
N403	Postal Code	96707
SE	**Transaction Set Trailer**	
SE01	Number of Included Segments	
SE02	Transaction Set Control Number	

4.2 Payer Specific Business Rules and Limitations

4.2.1 834 Enrollment Transaction

The 834 Enrollment Transactions transmit enrollment information from the sponsor of the insurance coverage (Med-QUEST) to a health care payer (a Med-QUEST Health Plan) on a daily and monthly basis. The daily version of this transaction provides data on initial enrollments, enrollment terminations, and subsequent changes to member-level enrollment data. The monthly version provides a listing of active members that is the basis for the health plan's monthly capitation pre-payment.

The Daily 834 Enrollment Transaction is used to identify:

- New members for whom the health plan is responsible for
- Terminated or deceased members for whom the health plan is no longer responsible
- Demographic changes for each member such as changes in name, address or date of birth
- Other changes for each member such as changes in Rate Code, TPL coverage or Spend down/Share of Cost.

The Monthly 834 Enrollment Transaction is used to:

- Reconcile health plan and Med-QUEST member files
- Audit updates to health plan data applied from Daily 834 Transactions during the previous month
- Identify the current month's Spend down/Share of Cost
- Obtain cumulative Spend down/Share of Cost for every month that a recipient has Spend down/Share of Cost (limited to a maximum of the last 6 months)

Data elements on both Daily and Monthly 834 Transactions carry Voucher Numbers when they result in capitation payments or adjustments. Corresponding Voucher Numbers also appear on payment lines in the 820 Capitation Payment Transaction and can be used to link enrollments to member level capitation payments.

4.2.2 820 Capitation Transaction

The 820 Capitation Transaction is a monthly file that provides each Med-QUEST health plan with an electronic remittance advice for its capitation payments. Med-QUEST makes all capitation payments on a monthly basis with an electronic payment or check to each health plan. The Monthly 820 can accumulate and report capitation payments generated during the prior month by Daily Rosters, Monthly Rosters, and Mass Adjustment runs. Settlements, financial sanctions and other

payments to and recoupments from health plans that are not member specific can also be carried on the 820.

The Med-QUEST Fiscal Agent, Affiliated Computer Services (ACS) produces checks to the health plans through the Financial System. ACS specifies the Check Numbers (derived from Voucher Numbers generated in HPMMIS) for each monthly payment. Check Numbers are available to the 820 creation process by manual entry from ACS payment data.

The 820 Transaction is used to:

- Show monthly capitation pre-payments for each health plan member
- Show pro-rated payments for each health plan member who joined during the previous month
- Show positive or negative adjustments that reflect changes to previous capitation payments
- Show positive or negative payment adjustments based on retroactive capitation rate changes by Med-QUEST, usually done through a mass adjustment
  Show Med-QUEST payments, and other adjustments that are not member specific

4.3 Frequently Asked Questions

None available at this time.

4.4 Other Resources

4.4.1 Med-QUEST Action Code Translation Table

Action Type	Maintenance Type Code	Action Code	Description	834 Translation/Maintenance Reason Code Value
A	021	AA	Algorithm Assigned	28 – Initial Enrollment
A	021	AI	Admin-In	28 – Initial Enrollment
A	021	BI	Enrollment Block In	28 – Initial Enrollment
A	021	CI	County Move-In	28 – Initial Enrollment
A	021	EC	Enrollment Choice	28 – Initial Enrollment
A	021	EI	Open Enrollment-In	22 – Plan Change
A	021	FI	Family Continuity Enrollment	28 – Initial Enrollment
A	021	NB	Newborn	02 – Birth
A	021	NE	Normal Enrollment	28 – Initial Enrollment
A	021	PA	End of Contract-In - Auto Assign	22 – Plan Change
A	021	RA	Retroactive Enrollment	28 – Initial Enrollment
A	021	RE	Re-Enrollment	41 – Re-enrollment
C	001	AC	Address Change	43 – Change of location
C	001	AR	Number of At-Risk Points	33 – Personnel Data
C	001	C1	"Combination Action Code" DB, NC, SX	25 – Change in Identifying Data Element
C	001	C2	"Combination Action Code" DB, NC	25 –Change in Identifying Data Element
C	001	C3	"Combination Action Code" DB, SX	25 –Change in Identifying Data Element
C	001	C4	"Combination Action Code" NC, SX	25 –Change in Identifying Data Element
C	001	CM	Change in Medicare	33 – Personnel Data
C	001	CS	Community Integrated Services	33 – Personnel Data
C	001	DB	Date of Birth Change	25 –Change in Identifying Data Element
C	001	EM	Email Change	33 – Personnel Data
C	001	ER	Ethnicity and/or Race Change	33 – Personnel Data
C	001	HC	Acute Health Plan Change	22 – Plan Change
C	001	LA	Level of Care Approval Status	33 – Personnel Data
C	001	LE	LTC Eligibility Change	AI – No Reason Given
C	001	LO	Level of Care Change	AI – No Reason Given
C	001	MC	Mental Health Change	22 – Plan Change
C	001	ME	Medical Condition Change	33 – Personnel Data
C	001	NC	Name Change	25 – Change in Identifying Data Element
C	001	NH	Nursing Home Change	AH – Moved to New Location
C	001	OC	Other Change	33 – Personnel Data
C	001	PG	Pregnant Women	21 – Disability
C	001	PM	Prospective Medicare	33 – Personnel Data
C	001	PN	Payee Name Change	33 – Personnel Data
C	001	PZ	Penalized Nursing Home Change	AI – No Reason Given

Action Type	Maintenance Type Code	Action Code	Description	834 Translation/Maintenance Reason Code Value
C	001	RC	Rate Code Change	29 – Benefit Selection
C	001	SC	Share of Cost / Spend down Change	33 – Personnel Data
C	001	SX	Sex Change	25 – Change in Identifying Data Element
C	001	TM	Mental Health Termination	07 – Termination of Benefits
D	024	AG	Age Term	07 – Termination of Benefits
D	024	AO	Admin Out	07 – Termination of Benefits
D	024	BO	Enrollment Block Out	07 – Termination of Benefits
D	024	CG	90-Day Grace Period Disenroll	22 – Plan Change
D	024	CH	Eligibility Change - Disenroll	07 – Termination of Benefits
D	024	CO	County Move-Out	07 – Termination of Benefits
D	024	DE	Deceased	03 – Death
D	024	EO	Open Enrollment-Out	22 – Plan Change
D	024	IE	Ineligible	07 – Termination of Benefits
D	024	IN	Incarcerated/Institutionalized	07 – Termination of Benefits
D	024	OS	Out of State Move	07 – Termination of Benefits
D	024	PT	End of Contract-Out - %, AA,	22 – Plan Change
D	024	RD	Retroactive Disenrollment	07 – Termination of Benefits
D	024	VW	Voluntary Withdrawal	14 – Voluntary Withdrawal

5. TI Change Summary

#	Location & Section	Revision
0.6		Draft Version
1.0	Pages 1-2	• Removed DRAFT watermark • Removed copyright box
1.0	Pages 5-7 3.1 & 3.2	• Reformat Instruction Tables for readability
1.0	Pages 8-33 4.1.1	• Format Changes o Rename table from Crib Notes to Transaction Notes o Removed columns 3-5 (usage, ID, Min/Max) & reformat table
1.0	Pages 28-30 4.1.1	• Corrected 2700 Loops for Medical, Dental, and BHS for 2750/DTP to include 'RD8' Date Range for Add, Health Plan change and Mental Health Change actions
1.0	Pages 17 4.1.1	• 2320/COB - Added note "Does not include Medicare records"
1.0	Pages 10 4.1.1	• COB only: • INS03: Daily: 001 • Monthly: 030 • INS04: Daily: 33-Personnel Data • Monthly: XN-Notification Only • Added 'END'
1.0	Pages 12 & 14 4.1.1	• DOB-Gender Change and Name, DOB, Gender tabs: Updates to 2100A and 2100B loops
1.0	Pages 13 4.1.1	• RCR01 - 2100A/N3/N4 Remove Member Residence Address due to Errata change from Required to Situational • For Tabs: Disenroll, DOB/Gender change, Name/DOB/Gender change, Health plan change, MH Change/Term or Change in Medicare, Other Change, Pregnancy change, Rate code change, COB. • 2330/N3/N4 COB Only - Remove sending TPL address
1.0	Pages 11 4.1.1	• Other Change column: 2000/REF*17-Remove Voucher ID. No payments associated with these actions
1.0	Pages 27-28 4.1.1	• Health Plan change column: Added 2750 loop for Dental plan
1.0	Pages 20 4.1.1	• Add action: Remove 2300/HD loop for Share of Cost/Spend Down. This data will not be sent on an Add.
1.0	Pages 17 4.1.1	• Disenroll: Added 2300/HD loop for end date (correction)
1.0	Pages 18,19 4.1.1 21,22	• COB Only: • 2320/REF#1 - Use '6P' for TPL Insurance type • 2320/REF#2 - Use '60' for TPL Change reason • 2330/NM103 - Concatenated TPL Sequence number and Absent parent indicator to TPL Carrier info
1.0	Pages 11-12 4.1.1	• 2000/Member Supplemental ID/REF02 • Rate code change: Voucher ID is not sent on Rate code changes. They are only on Add, Disenroll and Monthly

1.0	Pages 12	4.1.1	• Name/DOB/Gender Change: • 2100A/NM101 If ACTION-CD = "PN", use "IL"
1.0	Pages 14-15	4.1.1	• Insured/Subscriber; • 2100B/DMG-Added note: Used when Action code when NC, C1, C2, or C4; not used on monthly
1.0	Pages 15-16	4.1.1	• Name/DOB/Gender Change: • 2100G/N3/N4 Removed Med-Payee Address due to Errata change from Required to Situational
1.0	Pages 36-39	4.1.2	• Clean up 820 Examples
1.0	Pages 42-43	4.4.1	• Reformat table for readability
1.1	Page 25	4.1.1	• Renewal Date - New 2700 loop o Add action column o Other change column with note "For 'OC' Other Change Action code only" o Monthly column
1.1	Page 8	4.1.1	• Documentation correction: 005010X220 to 005010X220A1

STAFFING CHANGE NOTIFICATION FORM

Use this form (Notification Form) to notify Med-QUEST Division (MQD) of staffing changes, for which written notification to MQD is a requirement under the Request for Proposal (RFP). The submission to MQD of this Notification Form, will serve as written notification to MQD. Complete a Notification Form for each position affected for which written notification is required. (See sample Notification Form provided.) If this Notification Form is not adequate to describe, or is not applicable to, the staffing change to be reported, please notify MQD using written correspondence that explains the staffing change in detail.

1. Date Notification Form is submitted to MQD:

2. Date Dental TPA has knowledge of the subject staffing change:
(For example: the date of the employee's resignation letter; the date of the decision to terminate an employee; the date an applicant accepts the offer of employment; or the date an employee receives the promotion to a new position.)

3. ☐ DENTAL

4. Dental TPA Position Title and **FTE**:

5. RFP Position Title and **Required FTE** (as listed in the RFP):

6. Name of person *exiting* the above position:

7. Name & contact information of person *entering* the above position and **FTE** this person will serve in the position & program:

(If there is no *entering* person at this time, please provide information for the *Interim Contact Employee* below in item #10.)

Name:
FTE:
Phone:
Email:

8.

- **Does the *entering* person reside in the State of Hawaii?** ☐ Yes ☐ No
- **Does the *entering* person work in the State of Hawaii?** ☐ Yes ☐ No
- ****Submit to MQD, a current RESUME of the *entering* person, along with this Notification Form.** (This resume submission may not apply to the above position. Please refer to the RFP.)

9. Describe the staffing change:

(For example: "Jane Doe is retiring and will no longer be the ***QI Member Services Director*** as of 11/1/20. Effective 11/1/20, Bob Sox will be the ***QI Member Services Director***. Bob Sox accepted the promotion to the ***QI Member Services Director*** (Officer, Medicaid Member Services) position, from his position as the *QI Member Grievance Coordinator*. A separate Notification Form will be submitted for the *QI Member Grievance Coordinator* position that Bob Sox will be vacating.") (Complete separate Notification Forms for each position affected that requires a written notification.)

10. *Interim Contact Employee* (if applicable):

Name:
Position Title:
Phone:
Email:

11. Name, position title, and contact information of the person who completed this Notification Form:

STAFFING CHANGE NOTIFICATION FORM (10/20)

INSTRUCTIONS

PURPOSE:

The purpose of this form (Notification Form) is to notify Med-QUEST Division (MQD) of staffing changes, for which written notification to MQD is a requirement under the Request for Proposal (RFP). The submission to MQD of this Notification Form, will serve as written notification to MQD. Complete a Notification Form for each position affected for which written notification is required. (See SAMPLE Notification Form provided.) If this Notification Form is not adequate to describe, or is not applicable to, the staffing change to be reported, please notify MQD using written correspondence that explains the staffing change in detail.

FORM INSTRUCTIONS:

1. Date Notification Form is submitted to MQD

Enter the date that this Notification Form is submitted to MQD.

2. Date Dental TPA has knowledge of the subject staffing change

Enter the date that the Health Plan is informed of, or decides upon, the staffing change being reported. Health Plans must notify MQD in writing within seven (7) days of learning of a change in the status of particular positions.

3. ☐ DENTAL

Check the box next to the program to which the staffing change being reported applies. Only one box shall be checked. If "Other" is checked, provide the name of the applicable program in the space provided.

4. Dental TPA Position Title and **FTE**

If more than one position is affected by the staffing change, select one to be the "subject position" for this Notification Form, and complete separate Notification Forms for each position affected that requires written notification. Enter the official name of the subject position given by the Health Plan. Also, enter the full-time equivalent (FTE) assignment from the Health Plan for the subject position. The FTE indicates the extent to which an individual serving in the subject position is required by the Health Plan to dedicate work to that position as it relates to the program specified above (QI, CCS, or Other). For example, a 1.0 FTE assignment by a Health Plan regarding QI, indicates that its employee serving in the subject position is specifically designated and assigned to perform only the work of the position as it relates to QI, in an amount equal to a full-time schedule. Likewise, a 0.6 FTE assignment by a Health Plan regarding QI, of a full-time employee indicates that the full-time employee serving in the subject position, may perform other work not pertaining to the QI program or QI position, in an amount equal to 40% of a full-time schedule.

5. RFP Position Title and **Required FTE** (as listed in the RFP)

Enter the name of the position listed in the RFP (as it is listed in the RFP) to which the subject position of this Notification Form corresponds. Also, enter the FTE requirement (if any) for this position as stated in the RFP.

6. Name of person *exiting* the above position

Enter the name of the person leaving the subject position.

7. Name & contact information of person *entering* the above position and **FTE** this person will serve in the position & program

Enter the name, phone number, and email address of the person hired or promoted to officially fill the subject position. Also, enter the FTE this person is required by the Health Plan to dedicate toward this position and program. If no one has yet been hired or promoted to fill the subject position, provide information for the *Interim Contact Employee* in item #10.)

8.

- **Does the *entering* person reside in the State of Hawaii?** ☐ Yes ☐ No
- **Does the *entering* person work in the State of Hawaii?** ☐ Yes ☐ No

Check one box for each question. For some positions, the RFP requires that the employee reside and work in the State of Hawaii.

- ****Submit to MQD, a current RESUME of the *entering* person, along with this Notification Form**

Submit to MQD along with this Notification Form, an updated resume of the person officially hired or promoted to fill the subject position. Most positions for which a staffing change notification is required, also require the submission of a resume. If a resume for the person officially hired or promoted to fill the subject position has already been submitted to MQD within the past year, and there are no updates for the resume, then state so below in the space provided for "Describe the staffing change", and re-submission of the same resume is not necessary.

9. Describe the staffing change

In the space provided, briefly describe the staffing change.

For example: "Jane Doe is retiring and will no longer be the ***QI Member Services Director*** as of 11/1/20. Effective 11/1/20, Bob Sox will be the ***QI Member Services Director***. Bob Sox accepted the promotion to the ***QI Member Services Director*** (Officer, Medicaid Member Services) position, from his position as the *QI Member Grievance Coordinator*. A separate Notification Form will be submitted for the *QI Member Grievance Coordinator* position that Bob Sox will be vacating."

(Note: Complete separate Notification Forms for each position affected that requires a written notification.)

10. *Interim Contact Employee* (if applicable)

Complete this section only if the subject position has not been officially filled. Enter the name, position title, phone number, and email address of the person designated as the Interim Contact for the subject position while the subject position remains vacant.

11. Name, position title, and contact information of the person who completed this Notification Form

Enter the name, position title, phone number, and email address of the person who filled-out this form.

SAMPLESTAFFING CHANGE NOTIFICATION FORM**SAMPLE**

Use this form (Notification Form) to notify Med-QUEST Division (MQD) of staffing changes, for which written notification to MQD is a requirement under the Request for Proposal (RFP). The submission to MQD of this Notification Form, will serve as written notification to MQD. Complete a Notification Form for each position affected for which written notification is required. (See sample Notification Form provided.) If this Notification Form is not adequate to describe, or is not applicable to, the staffing change to be reported, please notify MQD using written correspondence that explains the staffing change in detail.

1. Date Notification Form is submitted to MQD: 10/18/20

2. Date Dental TPA has knowledge of the subject staffing change: 10/14/20

(For example: the date of the employee's resignation letter; the date of the decision to terminate an employee; the date an applicant accepts the offer of employment; or the date an employee receives the promotion to a new position.)

3. ☒ DENTAL

4. Health Plan Position Title and **FTE**: Officer, Medicaid Member Services (1.0 FTE)

5. RFP Position Title and **Required FTE** (as listed in the RFP): Member Services Director (1.0 FTE)

6. Name of person *exiting* the above position: Jane Doe

7. Name & contact information of person *entering* the above position and **FTE** this person will serve in the position & program:

(If there is no *entering* person at this time, please provide information for the *Interim Contact Employee* below in item #10.)

Name: Bob Sox
FTE: 1.0 FTE
Phone: 808-123-4567
Email: B.sox@healthplan.org

8.

- **Does the *entering* person reside in the State of Hawaii?** ☒ Yes ☐ No
- **Does the *entering* person work in the State of Hawaii?** ☒ Yes ☐ No
- ****Submit to MQD, a current RESUME of the *entering* person, along with this Notification Form.** (This resume submission may not apply to the above position. Please refer to the RFP.)

9. Describe the staffing change:

Jane Doe is retiring and will no longer be the ***QI Member Services Director*** as of 11/1/20. Effective 11/1/20, Bob Sox will be the ***QI Member Services Director***. Bob Sox accepted the promotion to the ***QI Member Services Director*** (Officer, Medicaid Member Services) position, from his position as the *QI Member Grievance Coordinator*. A separate Notification Form will be submitted for the *QI Member Grievance Coordinator* position that Bob Sox will be vacating. (Complete separate Notification Forms for each position affected that requires a written notification.)

10. *Interim Contact Employee* (if applicable):

Name: N/A
Position Title: N/A
Phone: N/A
Email: N/A

11. Name, position title, and contact information of the person who completed this Notification Form:

Charles Brown QI Compliance Officer 808-222-5555 C.brown@healthplan.org

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]

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[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).

[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)

4. STATE'S OBLIGATIONS.

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

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

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 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.

BUSINESS ASSOCIATE:

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

STATE:

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: _____

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