STATE OF HAWAII

Department of Human Services

REQUEST FOR PROPOSAL (RFP)

To provide healthcare services for the State of Hawaii Organ and Tissue Transplant Program (SHOTT)

RFP-MQD–2020-011

APPENDICES

Med-QUEST Division

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Appendix A – Written Questions Format

Appendix A

Written Questions
Format for RFP-MQD-2020-011

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

Appendix B – Notice of Intent

Notice of Intent to Propose

RFP Number and Title: _____
Organization or Individual: _____

Contact Person Information

First Name: _____ Last Name: _____

E-mail Address: _____

Telephone: _____

Fax Number: _____

Mailing Address

Street Address or PO Box _____

City _____ State _____ Zip Code _____

Please provide to the agency contact person listed in the Request for Proposals (RFP).

Appendix C – Proposal Forms

Proposal Application Identification Form
Proposal Letter
Certification for Contracts, Grants, Loans and Cooperative Agreements
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Wage Certification
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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 the State of Hawaii Organ and Tissue Program. 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 unless proposal is withdrawn in accordance with Section 20.770.

Authorized Applicant's Signature/Corporate	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.

Offeror:_____
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 disclosing entity. 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 le asing of any p rope rty; 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 no t limited to agents, managing employees, persons with an ownership or controlling interest in the disclosing entity, a n d t h e i r i m m e d i a t e f a m i l i e s , 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 agreement.

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 applicant's ability to meet Behavioral Health 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 applicant. 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 applicant 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

Provider 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 Provider, 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 to provide healthcare services for the State of Hawaii Organ and Tissue Transplant Program (SHOTT).

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

DISCLOSURE STATEMENT 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	☐ For-Profit
☐ Partnership	☐ Not-For-Profit
☐ Corporation	☐ Other (specify)
☐ Governmental	☐ _____

Appendix C

Annual Disclosure of Ownership (ADO) Instructions

FIELD #	DESCRIPTION
1	Enter name of individual or entity depending on who the ADO is in regards to.
2	Enter current NPI/Medicaid Provider number combination that this ADO is in reference to, if applicable.
3	If there has been a change of ownership or a Federal Tax Identification number, list previous Medicaid provider numbers and effective dates for each, if applicable.
4	Describe relationship or similarities between the provider disclosing information on this form and items "A" through "C". **a. Describe the relationship between the old owner and the new owner. Are they totally different owners or some of the owners the same, etc.?** **b. Describe the relationship between the old board members (under old owner) and the new board members (under the new owner). Are any of the board members under the old ownership also board members under the new ownership structure?** **c. Why is the old owner disenrolling? Essentially, why was there a change in ownership?**
5	Do you plan to have a change in ownership, management company or control within the next year? If so, when?
6	Do you anticipate filing bankruptcy? If so, when?
7	Enter the Federal Tax Identification Number **(if there is an affiliation with a chain)** along with name, address, city, state and zip code.
8	List name, address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. ***Complete question 9 with the officers' and board members' information of the owning entities. If no one owns 5% or more of provider, check box and completed question 9 with the officers' and board members' information.*** If you are enrolled as an individual and do not own a FEIN, please enter **your** name and information. Corporate entities disclosed in this question must disclose every business location.

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.

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:

- Has an ownership interest totaling 5% or more in a disclosing entity;
- Has an indirect ownership interest equal to 5% or more in a disclosing entity;
- Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity;
- Owns an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity;
- Is an officer or director of a disclosing entity that is organized as a corporation; or,
- Is a partner in a disclosing entity that is organized as a partnership?

9	List officers' and board members' information of the owning entities. If no one owns 5% or more and/or the provider is non-profit, the officers' and board members' information must be disclosed.
10	If applicant is related to persons listed in #8 and 9, list the relationship.

11	List name of managing company, if not applicable enter N/A.
12	List names of the disclosing entities in which persons have ownership of other Medicare/Medicaid facilities.

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:

- 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).
- Any Medicare intermediary or carrier.
- 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 or the Act.

13	If entity engages with subcontractors (such as physical therapist, pharmacies, etc.,) which exceeds the lesser of $25,000 or 5% of applicant's operating expense, list subcontractor's name and address.

Significant Business Transaction- means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5% of applicant's operating expense.

14	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period.
15	List name, SSN, address of any immediate family member who is authorized to prescribe drugs, medicine, devices or equipment.
16	List anyone disclosed in question #8 who has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act (SSA) or any criminal offense in this state or any other state. Please also indicate any HI Medicaid provider number(s) associated with individual or organization.
17	List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the SSA or any criminal offense in this state or any other state. Indicate any HI Medicaid provider number(s) associated with individual or organization.

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

18	List the name, title, FEIN/SSN, and business address of all managing employees as defined in 42 CFR 455.101.
19	List name, address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more.

Subcontractor - means 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 an individual, agency or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or lease of real property) to obtain space, supplies, equipment or services provided under the Medicaid agreement.

20	Please indicate which number you will be using for reporting monies to you from Medicaid for 1099 purposes. *Example: If you are an individual completing this question, please input your Social Security Number unless you are own a FEIN 100%. An individual provider can bill under his/her individual provider number even If they are working in a group selling. The individual must complete a Map-347 in order to be linked to the group selling under which they are reporting.* ***IRS verification letter or Social Security Card must be attached verifying FEIN/SSN.*
21	Enter your initials if you maintain electronic medical records and are HIPAA compliant. Check the box if you do not keep electronic medical records.
22	Please enter the contact information for OMS to contact should there be any questions regarding this form.
23	Signature: Enter original signature from the individual provider, owner, or officer/board member if the provider does not have an owner. If you are an individual provider, *your* signature is required. Printed Name: The individual signing this form must enter their printed name. Date: Enter the date this disclosure is signed. Title: Must be title of person signing this form. EXAMPLE: individual provider, owner, etc.
24	For Internal Purposes Only: DMS Authorized Signature

Please return form to:

DHS Med-QUEST
Finance Office – TPL
P.O. Box 700190
Kapolei, HI 96709-0190

Annual Disclosure of Ownership (ADO)

THIS FORM IS REQUIRED BY FEDERAL AND STATE LAW AND REGULATION (42 CFR 455.101, 455.104, 455.105 AND 455.106 and HAR §17-1736-19).
Note: See the instructions of this form for definitions of underlined terms according to 42 CFR 455.101, 455.104, 455.105, and HAR §17-1736-19. ***All attachments must be labeled and reference to the question the attachment pertains.***

1	Entity Name that this ADO pertain to:	
2	Enter current NPI/Medicaid Provider number combination that this ADO is in reference to, if applicable. NPI:_____ Provider number:_____ Provider number (Enter only if you aren't required to have a NPI/Taxonomy Code for billing purposes): _____ ☐ *Check here for N/A*	
3	If there has been a change in ownership, change of tax ID number (FEIN), or change in Medicaid Provider Number for a previously enrolled Hawaii Medicaid provider, enter the previous provider number(s) and their effective date(s): ✸ *Check here/or N/A*	
	Previous Medicaid Prov. #: Start Date: End Date:	
4	If you completed #3, describe the relationship between the provider disclosing information on this form, and the following: (a) previous Medicaid owner (b) corporate boards of disclosing provider and previous Medicaid owner; i.e. board members and ownership or control interest (c) disenrollment circumstances. (Attach extra page if necessary.)	
a.		
b.		
c.		
5.	If you anticipate any change of ownership, management company or control within the year, state anticipated date of change and nature of the change. ✸ *Check here for N/A*	
	Date Change	
6.	If you anticipate filing for bankruptcy within the year, enter anticipated date of filing. ☐ *Check here for N/A*	
7.	If this facility is a subsidiary of a parent corporation, enter corporate FEIN#: ☐ *Check here for N/A*	
	Name:	
	Address:	
	City: State: Zip Code:	
8.	List name, date of birth, SSN#/FEIN#, and address of each person or entity that owns 5% or more direct or indirect ownership or controlling interest in the applicant provider. (Attach extra pages if necessary.) *Complete question 9 with the officer's and board members' information of the owning entities.*	

Name/Business Name:	SSN:	
Business Address:	FEIN:	DOB:
City:	State:	Zip

** If a corporate entity is disclosed in question #8 above, all business location(s) of this corporate entity must be disclosed. Please attach a sheet to disclose this information.

9.	List officers' and board members' information of owning entities. However, if no one owns 5% or more direct or indirect ownership, please list the officers' and board member's information. (Attach extra sheet if necessary listing same details below.) ✸ *Check here for N/A*

Name(a)	Title:	
Address:	DOB:	SSN:
City:	State:	Zip:
Name(b)	Title:	
Address:	DOB:	SSN:
City:	State:	Zip:

10.	If any individuals listed in questions 8 and 9 are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships), provide the following information: (Attach extra page if necessary.) ☐ *Check here for N/A*

Name (a):	SSN:
Relationship:	FEIN:
Name (b):	SSN:
Relationship:	FEIN:

11.	If this facility or organization employs a management company, please provide following information: ✸ *Check here for N/A*

Name:		
Address:		
City:	State:	Zip:

12.	List the names of any other disclosing entity in which person(s) listed on this application have ownership of other Medicare/Medicaid facilities. ✸ *Check here for N/A*

Name:	Provider #, if applicable:	
Address:		
City:	State:	Zip:

13.	List the names and addresses of all other Hawaii Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of $25,000 or 5% of your total operating expense. (Attach extra page if necessary.) ✸ *Check here for N/A*

Name:		
Address:		
City:	State:	Zip:

14.	List any significant business transactions between this provider and any wholly owned supplier, or between this provider and any subcontractor, during the previous 5-year period. (Attach extra page if necessary.) ✸ *Check here for N/A*

Name:		
Address:		
City:	State:	Zip:

15.	List the name, SSN, and address of any immediate family member who is authorized under Hawaii Law or any other states' professional boards to prescribe drugs, medicine, medical devices, or medical equipment. ☐ *Check here for N/A*		
Name(a)	Title:		
Address:	DOB:	SSN:	
City:	State:	Zip:	
Name(b)	Title:		
Address:	DOB:	SSN:	
City:	State:	Zip:	
16.	List the name of any individuals or organizations having direct or indirect ownership or controlling interest of 5% or more, who have been convicted of a criminal offense related to the involvement of such persons, or organizations in any program established under Title XVIII (Medicare), or Title XIX (Medicaid), or Title XX (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a HI Medicaid provider number(s), please indicate below. (Attach extra page if necessary.) ☐ *Check here for N/A*		
Name (a)/HI Medicaid Provider Number(s), if applicable:			
Name (b)/HI Medicaid Provider Number(s), if applicable:			
17.	List the name of any agent and/or managing employee of the disclosing entity who has been convicted of a criminal offense related to the involvement in any program established under Title XVIII, XIX, or XX, or XXI of the Social Security Act or any criminal offense in this state or any other state since the inception of those programs. (Attach extra page if necessary.) If individual or organization is associated with a HI Medicaid provider number(s), indicate below. (Attach extra page if necessary.) ✸ *Check here for N/A*		
Name (a)/HI Medicaid Provider Number(s), if applicable:			
Name (b)/HI Medicaid Provider Number(s), if applicable:			
18.	List the name, title, FEIN/SSN, and business address of all managing employees below as defined in 42 CFR 455.101. ✸ *Check here for N/A* (Attach extra page if necessary listing same details below.)		
Name(a)	Title:		
Address:	DOB:	SSN:	
City:	State:	Zip:	
Name(b)	Title:		
Address:	DOB:	SSN:	
City:	State:	Zip:	

19.	List the name, address, SSN#, FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. (Attach extra page if necessary.) ☐ *Check here for N/A*		
Name:		SSN:	
Address:		FEIN:	
City:	State:	Zip:	
Name:		SSN:	
Address:		FEIN:	
City:	State:	Zip:	

20.	I f y ou keep medical records on an electronic database, you hereby certify by your initials in the space provided that electronic records are confidential and patient privacy is protected. Every health care provider or organization, regardless of size, who creates or maintains individual protected health information in any form (written, oral, or electronic) for the purpose of treatment, payment, or operation is a covered entity and must comply with HIPAA Privacy and Security Rules. Initials _____

21.	Contact Information - This information is used only for questions regarding the information on this form.	
	Contact Name:	Contact Telephone:
	E-mail address:	

22.	I certify that all the Information I have provided on this DHS, Med-QUEST Division Annual Disclosure of Ownership Form is accurate. Failure to provide accurate information could result in termination from the Medicaid program.	
	Signature	Date Signed:
	Printed Name:	
	Title:	

23.	**For Internal Use Only:**		
	Signature		Date Signed:
	Printed Name:		
	Title:		
EPLS/SAM:		OIG/HHS:	SSA Death Master File:

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 applicant'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, Applicant's 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 applicant been suspended or excluded from any federal government programs for any reason?

Yes_____ No_____If yes, please explain:

Financial Planning Form

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

2) Does the applicant 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 applicant 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 applicant's last audit?
      Yes_____ No _____
      If no, provide the name, address, and telephone number of the firm that performed the applicant'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 applicant, by its submission, certifies the letter is unaltered.

If no, the applicant shall provide a comprehensive description of internal control systems. The applicant 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 applicant have an accounting manual?
Yes_____ No _____

If no, the applicant 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 applicant agrees to furnish copies of such written accounting policies and procedures for inspection upon request from the DHS.

6) Does the applicant 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 applicant 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 applicant or its owner(s).

9) Are there any suits, judgments, tax deficiencies, or claims pending against the applicant?
Yes_____ No _____

Briefly describe each item and indicate probable amount.

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

If yes, when? _____

11) Do(es) the applicant'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 applicant 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 applicant intends to provide a bond and/or security to meet established
DHS rules.

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

Yes_____ No _____

If no, the applicant must describe in detail (and attach this description to this form) how it intends to manage, monitor and control IBNR's, The applicant, 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 applicant 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 applicant 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 applicant 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 applicant have a full-time (100%) controller or chief financial officer?

Yes_____ No_____ If yes, enter name: _____

_____

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

a. Medicare reimbursement Yes _____ No ____

_____

b. Other third-party recoveries Yes _____ No ____

_____

If no, explain why.

Controlling Interest Form

The applicant 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 applicant's proposal as unresponsive.

Name	Address	Owner or Controller	Has Controlling Interest? Yes	No

Background Check Information Form

The applicant must provide sufficient information concerning key personnel (i.e. Chief Executive Officer, Medical Director, Financial Officer, Consultants, Accountants, Attorneys, etc.) to enable DHS to conduct background checks. Failure to make full and complete disclosure may result in rejection of your proposal as unresponsive. Attach resumes for all individuals listed below.

Name**	Ever known by another name* Yes	No	Social Security Account #	Date of Birth (Da/Mo/Yr)	Place of birth City/County/State

* If yes, provide all other names. Use a separate sheet if necessary.

** For each person listed:

a. Give addresses for the last ten years
b. Ever suspended from any Federal program for any reason?

Yes_____ No_____ If yes, please explain.

Operational Certification Submission Form

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

By signing below the applicant certifies that it shall at all times during the term of this contract provide and maintain member handbook, 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 applicant warrants that in the event DHS discovers, through an operational review, that the applicant has failed to maintain these operating procedures, the applicant will be subject to a non-refundable, non-waivable sanction in accordance with DHS Rules.

Signature Date

Grievance System Form

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

I hereby certify that _____
Applicant Name

will have in place on the commencement date of this contract a system for reviewing and adjudicating grievances by recipients 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 assure the participation of individuals with authority to require corrective action.

I further understand the applicant must have a grievance policy for recipients and providers which defines their rights regarding any adverse action by the applicant. The grievance 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 procedure 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 Applicant 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 Applicant certifies that it has completed the attached Checklist and:

(Check and complete one)

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

☐ Applicant 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 Applicant is awarded a contract, then Applicant certifies that the foregoing deficiencies will be corrected within five (5) business days after contract award.

_____
Name of Applicant

_____ _____
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:

a) *"THE STATE OF HAWAII IS AN ADDITIONAL INSURED WITH RESPECT TO OPERATIONS PERFORMED FOR THE STATE OF HAWAII."*
b) *"ANY INSURANCE MAINTAINED BY THE STATE OF HAWAII SHALL APPLY IN EXCESS OF, AND NOT CONTRIBUTE WITH, INSURANCE PROVIDED BY THIS POLICY."*

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.

Applicant: _
Signature: _
Title: _
Date: _

CONTRACTNO. _____

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]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 – Organ and Tissue Transplant Guidelines

ORGAN AND TISSUE TRANSPLANT GUIDELINES

General Guidelines

1. Covered transplants must be non-experimental, non-investigational for the specific organ/tissue and specific medical condition.

    a. There must be conclusive evidence from published peer-review literature that the specific transplant has a positive effect on health outcomes. This evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results and with positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale.

    b. Published peer-review medical literature must demonstrate that over time the transplant leads to improvement in health outcomes and that beneficial effects outweigh any harmful effects.

    c. Published peer-review medical literature must demonstrate that the transplant must, in the least, be as effective in improving health outcomes as other established treatments.

    d. Published peer-review medical literature must exist that shows improvement in health outcomes is possible in standard conditions of medical practice, outside clinical investigatory settings.

2. Solid organ transplants must be performed in facilities certified by Medicare for the specific transplant involved.

3. Based upon a comprehensive evaluation of the patient and sound medical judgment, the transplant is expected to improve the patient's quality of life and chances for long term survival and:

    a. Evaluation for transplant must take into account any involvement of other organ systems as well as any systemic diseases such as malignancies.

    b. There are no significant impairments or conditions that would affect negatively the transplant surgery or supportive medical services and the post-transplantation (outpatient and inpatient) management of the patient. In cases where the patient has a history of current or past

alcohol or substance abuse, the patient shall be monitored with alcohol and/or drug screening as part of the compliance evaluation.

c. There is strong clinical indication that the patient can survive the transplantation procedure and related medical therapy (chemotherapy, immunosuppression).

d. Peer reviewed medical literature recommends transplantation as the best chance of long term survival for the specific condition, Including non-transplant treatment options.

e. The patient has sufficient social support to assure the patient's adherence to pre-transplant requirements by the transplant facility, immunosuppressive therapy and other post-transplant requirements.

f. The patient and/or their social support system is able and willing to comply with a lifelong disciplined medical regime (requiring multiple drugs several times a day and close supervision by physicians with the likelihood of serious consequences in the event of non-compliance).

g. The patient has a primary caregiver identified to assist prior, during and after the transplant process.

Organ Transplant Guidelines

The transplant insurer has contracted with the State of Hawaii to cover organ/tissue transplants specifically cited below. Coverage of transplants for adults will only be made for those recipients who meet the applicable Medicare criteria, are diagnosed as having a Medicare approved clinical condition for transplantation and transplanted in a CMS/Medicare approved facility for the specific transplant.

LIVER

Conditions for which liver transplantation can be considered but are not limited to include:

1. Alcoholic Cirrhosis

2. Chronic Hepatitis including Hepatitis B and/or C

3. Auto immune Hepatitis which can be due to a variety of etiologies including SLE, RA, sjogrens, scleroderma among others

4. Bile Duct Disorders including primary biliary cirrhosis and primary sclerosing cholangitis

5. Post neurotic cirrhosis

6. Inherited Metabolic Liver disease including hereditary hemochromatosis, Wilson's disease and alpha-1 antitrypsin disease

7. Toxic Reactions

8. Trauma

9. Other medical conditions leading to cirrhosis or liver failure

10. Pediatric liver transplant reviewed on case by case basis

Potential contraindications include:

1. Other end stage disease not attributable to liver disease.

2. Known current malignancy or recent malignancy with high risk recurrence.

3. Evidence of medical non-compliance

4. Contra-indications to immunosuppression

5. A history of behavior pattern or psychiatric illness considered likely to interfere significantly with a disciplined medical regimen.

Coverage of liver transplants in adults will only be made for those beneficiaries who meet the applicable Medicare criteria. Guidelines for patient selections are:

1. The criteria must be based upon both a critical medical need for a transplantation and a maximum likelihood of successful clinical outcome.

2. The patient must have end-stage liver disease with a limited life expectancy due to liver dysfunction.

3. In the case of alcoholic cirrhosis, the selection of a patient who needs a liver transplant should include evidence of sufficient social support to assure assistance in alcohol rehabilitation and in immunosuppressive therapy following the operation. Although the center should require abstinence at the time of the operation, Medicare does not specify how long the patient should be abstinent prior to the operation. The hospital and the transplant team should establish such guidelines. Facilities will be required to submit the period of time they require for abstinence in a patient with end-stage liver disease due to alcoholic cirrhosis.

Other Considerations:

Plans for long-term adherence to a disciplined medical regime must be feasible and realistic for the individual patient.

HEART

Conditions for which heart transplantation can be considered but are not limited to include:

1. Ischemic myocardial disease. Cardiomyopathy (Non-ischemic, Ischemic, Idiopathic)

2. Idiopathic cardiomyopathy

3. Severe Valvular heart disease.

4. Congenital cardiac disease.

5. Severe Myocardial disease (e.g. sarcoidosis and amyloidosis).

6. Other conditions leading to severe hemodynamic compromise due to heart failure or severe ischemia consistently limiting routine activity not amenable to bypass surgery, or recurrent symptomatic ventricular arrhythmias refractory to accepted therapeutic modalities.

7. Drug inducted myocardial destruction.

8. Pediatric cardiac transplants reviewed on case by case basis.

Potential contraindications include:

1. Severe pulmonary hypertension.

2. Severe renal or hepatic dysfunction not explained by the underlying heart failure and not deemed reversible (because of the nephrotoxicity and hepatotoxicity of cyclosporine).

3. Severe peripheral or cerebral vascular disease (because of accelerated progression in some patients after cardiac transplantation and on chronic corticosteroid treatment).

4. Severe lung disease including COPD.

5. Active systemic infection (because of the likelihood of exacerbation with initiation of immunosuppression).

6. Recent and unresolved pulmonary infarction, pulmonary roentgenographic evidence of infection, or other signs of active pulmonary infection.

Presence of other non-cardiac medical conditions likely to limit or preclude survival and rehabilitation after transplantation.

7. The use of a donor heart, that may have had its effectiveness compromised by such factors as the use of substantial vasopressors prior to its removal from the donor, its prolonged or compromised maintenance between the time of its removal from the donor and its implantation into the patient, or preexisting disease.

8. Other end stage disease not attributable to heart disease.

9. Known current malignancy or recent malignancy with high risk recurrence.

10. Evidence of medical non-compliance

11. Contraindications to immunosuppression

12. A history of behavior pattern or psychiatric illness considered likely to interfere significantly with a disciplined medical regimen.

Other considerations:

Plans for a long-term adherence to a disciplined medical regimen must be feasible and realistic for the individual patient.

LUNG

Lung transplantation may be considered medical necessary for carefully selected patients with irreversible, progressively disabling, end-stage pulmonary disease unresponsive to maximum medical therapy, including but not limited to one of the conditions below.

Conditions for which lung transplantation can be considered but are not limited to include:

1. Alpha-1 antitrypsin deficiency.

2. Primary pulmonary hypertension.

3. Pulmonary fibrosis Idiopathic/interstitial pulmonary fibrosis, post inflammatory pulmonary fibrosis).

4. Bilateral bronchiectasis

5. Cystic fibrosis

6. Bronchopulmonary dysphagia

7. Eisenmenger's syndrome.

8. Sarcoidosis lung involvement

9. Scleroderma

10. Lymphangiomyomatosis

11. Emphysema.

12. Eosinophililc granuloma

13. Chronic obstructive pulmonary disease

14. Pulmonary hypertension due to cardiac disease

15. Idiopathic fibrosing alveolitis

16. Respiratory failure

17. Recurrent pulmonary emboli

Selection Criteria is based on CMS' National Policy and criteria for the NHLBI of the National Institutes of Health:

a. A patient is selected based upon both a critical medical need for transplantation and a strong likelihood of successful clinical outcome.

b. A patient who is selected has irreversible, progressively disabling, end-state pulmonary disease (or, in some instances, end-state cardiopulmonary disease).

c. The facility has tried or considered all other medically appropriate medical and surgical therapies that might be expected to yield both short and long-term survival comparable to that of transplantation.

d. Plans for long term adherence to a disciplined medical regimen are feasible and realistic for the individual patient.

Potential contraindications include:

1. Other end stage disease not attributable to lung disease.

2, Known current malignancy or recent malignancy with high risk recurrence.

3. Evidence of medical non-compliance.

4. Contraindications to immunosuppression.

5. A history of behavior pattern or psychiatric illness considered likely to interfere significantly with a disciplined medical regimen.

Each of the criteria should be addressed with consideration of these procedures, although rational argument may be presented to override single criteria exclusions (e.g., age limitations).

Other adverse factors that should be considered in lung transplant evaluation:

1. Continued cigarette smoking or failure to have abstained for long enough to indicate low likelihood of recidivism.

2. Coronary artery disease not amenable to percutaneous intervention or bypass grafting, or associated with significant impairment of left ventricular function

3. Colonization with highly resistant or highly vivulent bacteria, fungi, or mycobacteria.

HEART-LUNG

The heart-lung transplantation is highly complex and involves a coordinated triple operative procedure consisting of procurement of donor heart-lung block, excision of the heart and lungs of the recipient, and implantation of the heart and lung(s) from a single cadaver donor. Heart-lung transplants are rare procedures with 23 individuals undergoing procedure in the United States in 2013. If a heart-lung transplant is needed, patient will require transport to a medicare approved facility for further evaluation and management.
Conditions for which heart-lung transplantation can be considered but are not limited to include:

1. Idiopathic pulmonary artery hypertension with heart failure.

2. Non-specific severe pulmonary fibrosis, with severe heart failure

3. Eisenmenger syndrome.

4. Cystic fibrosis with severe heart failure.

5. Emphysema with severe heart failure.

6. COPD with severe heart failure.

7. Pulmonary fibrosis with uncontrollable pulmonary hypertension or heart failure.

Candidates for heart-lung transplant must meet criteria under both heart transplant and lung transplant.

Potential contraindications include

1. Other end stage disease not attributable to heart or lung disease.

2. Known current malignancy or recent malignancy with high risk recurrence.

3. Evidence of medical non-compliance

4. Contraindications to immunosuppression

5. A history of behavior pattern or psychiatric illness considered likely to interfere significantly with a disciplined medical regimen.

Other Considerations:

Plans for long-term adherence to a disciplined medical regime must be feasible and realistic for the individual patient. Potential contraindications include contraindications listed under the heart transplant and lung transplant sections.

SMALL BOWEL WITH OR WITHOUT LIVER

Generally, small bowel and combined small bowel and liver transplants have been done in children and not adults. Patients may be covered through the month of their 21st birthday. A small bowel transplant may be considered medically necessary in patients with intestinal failure who have developed a long-term dependency on total parenteral nutrition (TPN) and are established developing or have developed severe complications due to TPN.
Intestinal failure results from surgical resections, congenital defect, or disease-associated loss of absorption and is characterized by the inability to maintain protein-energy, fluid electrolyte, or micronutrient balance.

Potential contraindications include

1. Other end stage disease not attributable to small bowel disease.

2. Known current malignancy or recent malignancy with high risk recurrence.

3. Evidence of medical non-compliance.

4. Contraindications to immunosuppression.

5. A history of behavior pattern or psychiatric illness considered likely to interfere significantly with a disciplined medical regimen.

KIDNEY or KIDNEY-PANCREAS

Kidney transplantation, as a therapy for end stage renal disease (ESRD), can improve both patient survival and quality of life as compared to dialysis. In addition, preemptive transplantation prior to dialysis is considered optimal treatment, particularly for children and adolescents. Patients with advanced chronic kidney disease (CKD) or ESRD may be good candidates for renal transplantation.

Medicaid recipients who have medicaid as the primary coverage for renal transplant may apply for SHOTT. Medicaid recipients who do not have medicaid as the primary coverage for renal transplant will remain on the managed care plan. However, patients under the age of 21 who have medicaid secondary may apply for SHOTT and considered on a case by case basis.

There are a multitude of diagnosis and medical conditions that can result in CKD. Patients with advanced CKD or ESRD may be candidates for SHOTT regardless of the underlying etiology. There is no inclusion list of diagnosis other than advanced CKD or ESRD.

Kidney-Pancreas transplantation must also meet the requirements for kidney transplantation. In addition, the facility must be medicare approved for kidney-pancreas transplantation and the patient must meet clinical requirements for pancreas transplantation.

Potential contraindications for renal transplant include but are not limited to:

1. Other irreversible end-stage disease not attributable to advanced CKD or ESRD

2. Known current malignancy or recent malignancy with high risk of recurrence

3. Evidence of medical non-compliance

4. Contraindications to immunosuppression

5. A history of behavior pattern or psychiatric illness considered likely to interfere significantly with a disciplined medical regimen.

STEM CELL TRANSPLANT: Autologous and Allogeneic

Stem cell transplantation (SCT) is a process in which stem cells are harvested from either the patient being treated (autologous) or from a donor source (allogeneic) such as bone marrow, peripheral blood, or cord blood. Hematopoietic stem cells are multi-potent stem cells that can give rise to a variety of cell types including red blood cells, white cells, and platelets in a process described as engraftment. SCT can be used to restore function in recipients who no longer produce enough stem cells by an inherited or acquired deficiency or defect. For example, chemotherapy used to treat malignancies can be very myelotoxic causing decreased production of stem cells. SCT may also be considered for the treatment of selected severe immunodeficiencies such has severe combined immunodeficiency (SCID) or aplastic anemia. National Comprehensive Cancer Network (NCCN) national guidelines are used as a guide when considering patients for stem cell transplant.

The SHOTT contractor shall also determine if the patient is enrolled in any clinical trial. A clinical trial may vary in scope from being a relative small part of one treatment arm to the other extreme of affecting the type of stem cell transplant. If a clinical trial is being conducted, the contractor will request a “coverage analysis” that differentiates routine costs which are paid by the health plan vs non-routine costs, which are billed to the sponsor of the clinical trial.

Clinical Trial Guidance

Clinical Trial

There are two main types of clinical studies: Clinical trials (also called interventional studies) and observational studies. A clinical trial, as defined by the National Institutes of Health (NIH), is a research study in which human subjects are prospectively assigned to interventions to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes. In a clinical trial, participants receive specific interventions according to the research plan or protocol designed by the investigators. Clinical trials may compare a new medical approach to a standard one that is already available, to a placebo that contains no active ingredients, or to no intervention. Some clinical trials compare interventions that are already available to each other.

Qualifying Clinical Trial

A qualifying clinical trial (QCT) is a trial that meets the requirement set forth in Clinical Trial Policy (Refer to Attachment NCD 310.1) by the Center for Medicare and Medicaid Services (CMS). This policy delineates the requirements that a trial must meet to be designated as a QCT.

A QCT means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, diagnosis, treatment, palliative care or supportive care of cancer and is described in any of the following clauses:

1. Trials reviewed and approved by one or more of the following:
    a. The National Institutes of Health (NIH), including National Cancer Institute (NCI)-designated Cancer Centers with an approved Scientific Review Committee
    b. The Centers for Disease Control and Prevention (CDC)
    c. The Agency for Healthcare Research and Quality (AHRQ)
    d. The Centers for Medicare and Medicaid Services (CMS)
    e. The Department of Defense (DOD)
    f. The Department of Veterans Affairs (VA)
2. Trials supported by centers or cooperative groups that are funded by the NIH, CDC, AHRQ, CMS, DOD, and VA; and
3. Trials conducted under an investigational new drug application (IND) reviewed by the Food and Drug Administration (FDA).

Routine Costs

Medicaid covers the routine costs of QCT's, as such costs are defined below, as well as medically necessary items and services used to diagnose and treat complications arising from participation in all clinical trials. All other Medicaid rules apply. The QCT must use in-network providers and be located in the state of Hawaii. Out-of-state clinical trials may be considered on a case by case basis.

"Routine patient care costs" include all items and services that are a benefit under a health plan that would be covered if the covered person were not involved in a clinical trial. Trials of therapeutic interventions must enroll patients with diagnosed disease rather than healthy volunteers. Trials of diagnostic interventions may enroll healthy patients in order to have a proper control group.

“Routine patient care costs” include:

a. Items or services that are typically provided absent a clinical trial;
b. Items or services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications;
c. Items or services needed for medically necessary care arising from the provision of an investigational item or service, in particular, for the diagnosis or treatment of complications.

“Routine patient care costs” does not include:

a. The investigational item or service, itself unless otherwise covered outside of the clinical trial;
b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management of the patient;
c. Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial;
d. Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the enrollee’s health plan;
e. Items or services that are excluded from Medicaid coverage; and
f. Items or services for a clinical trial that does not have therapeutic intent. These are trials that are designed exclusively to test toxicity or pathophysiology without therapeutic intent.

For most QCT's, it is best practice to have a formal coverage analysis that provides guidance regarding the designation of items or services as routine care vs. non-routine care. This coverage analysis may have been generated at the national level by the sponsor (i.e. National Cancer Institute or Industry sponsor) or at the local level. If desired, a copy of the coverage analysis may be requested from the local billing or trial coordinating entity.

Clinical trials allow for the advancement of medicine while improving the quality of care for patients. Our intent is to assure that our Medicaid beneficiaries have the same access to clinical trials and treatment options as would the non-Medicaid beneficiaries.

ALLOGENEIC STEM CELL TRANSPLANTATION

Patients who are candidates for allogenic transplantation should have an identified donor source prior to coming onto SHOTT program.
Conditions for which allogeneic SCT can be considered but are not limited to include:

1. Leukemia, leukemia in remission, or aplastic anemia when reasonable and medically necessary. Conditions would include but not limited to acute myelocytic leukemia (AML), chronic myelocytic leukemia (CML), acute lymphocytic leukemia (ALL), chronic lymphocytic leukemia (CLL). Requires sufficient medical evidence that SCT prolongs survival and decreases mortality in patients who have received SCT for the type of leukemia in question.

2. Severe combined immunodeficiency disease (SCID)

3. Homozygous beta-thalassemia (Thalassemia major)

4. Wiskott-Aldrich syndrome

5. Myelodysplastic syndromes on selected basis

6. Non-Hodgkin's lymphoma

7. Aplastic Anemia

8. Other rare medical conditions can be considered for SCT based on medical evidence and medical necessity.

AUTOLOGUS STEM CELL TRANSPLANT

Conditions for which autologous SCT can be considered but are not limited to include:

1. Neuroblastoma, State III or Stage IV, in patients over 12 months of age.

2. Testicular Germ Cell tumors at initial or subsequent relapse or that is refractory to standard dose chemotherapy with an FDA approved platinum compound. Refractory cases include:

    a. Patients with advanced disease who fail to achieve a complete response to second-line therapy; or

b. Patients with moderate or minimal extent disease who fail to achieve a complete response to third-line therapy for Testicular Germ Cell tumors that meet the above criteria. Standard protocol involves tandem transplant. Germ cell tumor stage is to be determined using the Indiana University/Einhorn classification or Follicular Non-Hodgkin's lymphoma in patients who have failed primary therapy without histologic transformation.

3. Acute leukemia in remission in patients with a high probability or relapse and who have no HLA matched donor. The leukemia type must meet the general conditions (sensitive to chemotherapy/radiation and incurable with conventional chemotherapy/radiation).

Resistant non-Hodgkin's lymphomas or those presenting with poor prognostic features following an initial response.

4. Non-Hodgkin's lymphoma, follicular, in patients who have failed primary therapy without histologic transformation.

5. Hodgkin's Lymphoma, relapse or refractory disease* who have failed conventional therapy and have no HLA-matched donor.

6. Multiple myeloma ONLY after receipt of a high dose chemotherapy regime.

The above strict conditions are approved for autologous bone marrow transplantation under Medicare.

This is not an all-inclusive list. Other conditions may apply based on the discretion of the MQD.

Organ transplant guidelines as outlined in Appendix D for both solid organ and stem cell transplant are subject to further updates and changes as needed.

Appendix E – Transplant Evaluation Form

APPENDIX E - TRANSPLANT EVALUATION FORM

INFORMATION NEEDED FOR TRANSPLANT EVALUATION

Patient Information				
Medicaid ID #	Name (Last, First, M.I) *(please print)*	Date of Birth	Phone#	Address (Number, Street, Apt, Zip Code)

Primary Care Giver (PCG) Contact			
PCG Name *(please print)*	Relationship	Phone # of PCG (*Indicate cell, home, or work)*	Address of PCG if different from above

Physician Information		QUEST Integration Plan Information		
Physician Name *(please print)*	Phone#	Plan Name	Contact Name *(please print)*	Phone#

Transplant Type				List all pertinent diagnoses	List current medications
	Kidney		Lung		
	Kidney / Pancreas		Small Bowel without Liver		
	Liver		Small Bowel with Liver		
	Heart-Lung		Allogeneic Stem Cell/Bone Marrow		Pharmacy
	Heart		Autologous Stem Cell/Bone Marrow		

The following are required to be submitted with the completed 1144 Request for Medical Authorization.

	REQUIRED DOCUMENTS FOR TRANSPLANT EVALUATION	
	Requirements	**Comments**
	Pertinent diagnostic testing (imaging—ultrasounds, x-rays, MRIs, PET scans, biopsies, catheterizations, etc.)	
	Physician clinic/office notes for the last 3 months	
	Adults-Results of any psychosocial evaluations—include identified PCG	
	ADDITIONAL REQUIREMENTS FOR STEM CELL TRANSPLANT	
	For allogenic stem cell transplant, confirmation of donor	
	If diabetic, Hemoglobin A1C level	
	MQD OFFICE USE ONLY	
	TPL-HPMMIS:	
	TPL-KOLEA:	
	MEDICARE:	

Revised 12/18/2019

Appendix F – General Terms and Conditions

CONTRACT NO. _____

GENERAL CONDITIONS FOR HEALTH & HUMAN SERVICES CONTRACTS
TABLE OF CONTENTS

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 Responsibilites. 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

5.3 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.

5.4 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:

- Social Security number;
- Driver's license number or Hawaii identification card number; or
- 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:

- The personal information collected, used, or maintained by the PROVIDER will be treated as confidential;
- Access to the personal information will be allowed only as necessary to perform the Contract; and
- 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.

Appendix G – Business Associate Agreement

BUSINESS ASSOCIATE AGREEMENT

The State of Hawaii Department of Human Services (STATE) has determined that it 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/PROVIDER (BUSINESS ASSOCIATE), under the CONTRACT will provide to STATE certain services described in the CONTRACT to which this Exhibit I 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:

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]

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]

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).

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:

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

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

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]

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

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]

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]

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).

As applicable only to the PHI 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]

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

[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)
[13] 45 CFR §§164.314(a)(2), 164.410(a), 164.504(e)(2)(ii)(C)

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]

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]

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.

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

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;

[14] 45 CFR §164.410(a)(2)
[15] 45 CFR §§164.308(a)(6)(ii); 164.530(f)
[16] 45 CFR §§164.404(c)(1), 164.408, 164.410(c)(1) and (2)

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.

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]

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 any provisions of these special conditions, which may include termination of employment.[18]

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.[19]

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.[20]

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

[17] 45 CFR §§164.314(a)(2), 164,410
[18] 45 CFR §§164.308(a), 164.530(b) and (e)
[19] 45 CFR §164.504(e)(2)(ii)(I)
[20] 45 CFR §164.522

obligations to provide an Individual with access to their PHI under 45 CFR §164.524, in the time and manner designated by the STATE.[21]

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.

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.[22]

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.

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 if done by the STATE or violate the Minimum Necessary requirements applicable to the STATE.[23]

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. [24]

[21] 45 CFR §§164.504(e)(2)(ii)(E), 164.524
[22] 45 CFR §§164.504(e)(2)(ii)(G) and (H), 164.528; HAR ch. 2-71, subch. 2.
[23] 45 CFR §§164.502(a) and (b), 164.504(e)(2)(i)
[24] 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)

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, or BUSINESS ASSOCIATE obtains reasonable assurances from the person to whom PHI is disclosed that it will remain confidential and used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person, and the person notifies BUSINESS ASSOCIATE of any instances of which it is aware in which the confidentiality of PHI has been breached. [25]

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.[26]

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).

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

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.

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.

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:

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

[25] 45 CFR §164.504(e)(4)(ii)
[26] 45 CFR §164.502(b)

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

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

Immediately terminate this Agreement if BUSINESS ASSOCIATE has breached a material term of this Agreement and sufficient mitigation is not possible.[27]

Effect of Termination.[28]

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

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.

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, and 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.

[27] 45 CFR §164.504(e)(2)(iii)
[28] 45 CFR §164.504(e)(2)(ii)(J)

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.

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.

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.

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,[29] and the cost of mitigating any harmful effect of the Breach.[30]

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.

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.

[29] 45 CFR Part 164, Subpart D
[30] 45 CFR §164.530(f)

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

STATE:

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

BUSINESS ASSOCIATE:

_____
_____
_____
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

Appendix H – Business Proposal

APPENDIX H - BUSINESS PROPOSAL

I, (Name of Official authorized to commit Firm, copy attached) hereby enter the official proposal prices indicated below on behalf of (Name of Firm entering proposal) and warrant that all terms and conditions of the RFP for the Care Coordination/Case Management Services for the State of Hawaii Organ and Tissue Transplant Program are met.

Potential Transplant Volume	Monthly Administrative Fee
0-60	
61-80	
81-100	

Claims Processed per month	Claims Processing Fee
HCFA-1500/1835 claims or 4216 claim lines	
UB-92/311 claims or 4981 claim lines	
Pharmacy/57 claims or 146 claim lines	
Others/475 claims or 786 claim lines	

All fees listed shall be inclusive of all fees and taxes.

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

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

ORGANIZATION - WIDE BUDGET BY PROGRAMS

(Period_____to_____)

Applicant/Provider _____

RFP No. : _____

Contract No. (As Applicable): _____

BUDGET CATEGORIES	(a) Contract/RFP#: Program:	(b) Contract/RFP#: Program:	(c) Contract/RFP#: Program:	(d) Contract/RFP#: 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 Date	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: 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:

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-206D

BUDGET JUSTIFICATION
CONTRACTUAL SERVICES - ADMINISTRATIVE

Applicant/Provider: _____

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

Contract No.

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

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

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

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

JUSTIFICATION/COMMENTS:

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

APPENDIX H

Summary of Budget Sheets

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