REQUEST FOR PROPOSALS

FOR

Medicaid Outreach Program

RFP 07-012

Issued by

THE HAMILTON COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES

222 E. CENTRAL PARKWAY

CINCINNATI, OHIO 45202

(August 3, 2007)

Bidders' Conference: August 16th, 2007 10:00 a.m.

Place: Hamilton County Administration Building

Room 605, 6th Floor

138 East Court Street

Cincinnati, Ohio 45202

Due date for proposal submission: August 27, 2007

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REQUEST FOR PROPOSALS (RFP)
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MISSION STATEMENT

We, the staff of Hamilton County Department of Job and Family Services, provide services for our community today to enhance the quality of living for a better tomorrow.

1.0 REQUIREMENTS & SPECIFICATIONS

1.1 Introduction & Purpose of the Request for Proposal

The Hamilton County Department of Job and Family Services (HCJFS) is seeking proposals to implement a Medicaid Outreach Service Program to increase Medicaid enrollment among eligible individuals and families.

Medicaid is a state and federally funded health program for low-income and medically vulnerable people. It was passed as part of the Social Security Act of 1965 and began in Ohio in 1968. As an entitlement program, people who meet eligibility requirements are guaranteed medical coverage. In Ohio, Medicaid is administered by the Ohio Department of Job and Family Services (ODJFS) through 88 counties. These county offices determine eligibility for Medicaid programs. Some programs require a face-to-face meeting, while others can accept enrollment by mail. Medicaid provides primary and acute care services through fee-for-service system or managed care plans. Both delivery systems provide all services for medically necessary primary, specialty emergency care, preventive services, and will cover transportation to these services.

HCJFS reserves the right to award multiple contracts for this service. Providers must submit a proposal for the term of three (3) years. The purpose of the three (3) year term is to minimize the cost of the process for Providers and the County.

1.2 Scope of Service

Providers will deliver Medicaid Outreach Services, defined as any services which identify individuals potentially eligible for Medicaid, which inform them about the Medicaid program, which assist them in completing any Medicaid application forms, which assist them in gathering and submitting supporting documentation, and which monitor the applications until an eligibility determination is made.

The selected Provider will provide:

1. Deliver culturally sensitive outreach services, including interpreter or translation services as necessary, which would achieve increased enrollment;
2. Obtain HCJFS approval prior to any mass marketing materials;
3. Coordinate with community based Providers to conduct community based outreach (e.g., at hospitals, county schools, churches, clinics, libraries, health departments, nursing homes and community organizations.)
4. Provide a location easily accessible to public transportation;
5. Specify the review of any denied applications with the Legal Aid Society of Southwest Ohio;
6. Providers are expected to actively participate in the Southwest Ohio Covering Kids and Families Coalition and the HCDJFS Medicaid Eligibility Workgroup;
7. Ensure that the following monthly outcome reports are submitted:

    A. The total number of applications submitted, sorted by the type of application submitted (e.g. ODJFS 7103, ODJFS 7200, ODJFS 7216) that month;

B. The total number of applications submitted, sorted by the outreach strategy used to engage the applicant;
C. The total number of applications pending from previous months;
D. The total number of applications approved that month;
E. The number of individuals enrolled that month sorted by type of Medicaid and child v. adult;
F. The total number of applications denied that month;
G. Reasons for denial for applications denied that month;
H. Average number of days from application to eligibility determination for applications approved or denied that month;
I. Other Department of Job and Family Services benefits obtained (e.g. OWF, Food Stamps, and Child Care)

8. Specify availability of free space with two desks with serviceable chairs and adequate lamp or overhead lighting for HCJFS employees;

HCJFS will share eligibility information with selected Providers. This includes access to CRIS-E (Client Registry Information System-Enhanced) and use of HCJFS approved forms (written in English and Spanish). (Attachments G)

All reports are to be submitted to the attention of Performance Improvement Section Chief (or designee), 2nd Floor HCJFS, 222 East Central Parkway, Cincinnati, OH 45202.

1.2.1 Population

The target population includes:

1. Children (up to age 19);
2. Families with children under age 18;
3. Pregnant woman;
4. Adults age 65 and over;

5. Individuals with disabilities;
6. The homeless.

In order to qualify for Ohio Medicaid Services an individual must;

1. Be a U.S. citizen or meet Medicaid citizenship requirements;
2. Be an Ohio resident;
3. Have or obtain a social security number; and
4. Meet certain financial requirements as outlined below.

Who's Covered? Income Guidelines*
(Income guidelines are subject to change)

Who's Covered	Income Guideline
Children (up to 19)	200% FPL
Pregnant Women	150% FPL
Parents	90% FPL
Disabled Persons	~ 64% FPL**
Persons 65 & over	~ 64% FPL**
Medicare Premium Assistance Program Varies	Varies
Institutional Level of Care	Income less than the cost of care
FPL = Federal Poverty Level *Exceptions and calculations will affect final amount counted toward eligibility. Actual determination of eligibility is done at a county job & family services office. Some eligibility categories consider resources other than income.	
** Deductions and exceptions apply; this is an approximate guide. Persons with incomes higher than 64% of the FPL may have medical expenses deducted from income calculations to "spend-down" to this level.	

1.2.2 Service Numbers

An estimated 30,000 eligible residents of Hamilton County, who are not currently enrolled.

2.0 Provider Proposal

To expedite and simplify the process for evaluating proposals, and to assure each proposal receives the same orderly review, it is required that all proposals be submitted in the format as described in this section. Each submission must have one (1) original proposal with eight (8) complete copies, using 12 point Arial font. Providers are encouraged but not required to use double sided copies, where possible, in their proposal.

Proposals must contain all required elements of information ***without exception.*** Proposal sections must be numbered corresponding to the following format:

1. Cover Sheet
2. Service and Business Deliverables
3. Customer References
5. Personnel Qualifications

2.1 Cover Sheet

Each Provider must include the completed cover sheet (Attachment A) in its proposal. The cover sheet must be signed by an authorized representative of the Provider and also include the names of individuals authorized to negotiate with HCJFS. The signature line must indicate the title or position the individual holds in the company. All unsigned proposals will be rejected.

2.2 Services and Business Deliverables

Provider must describe with particularity how their program meets each of the following expectations:

2.2.1 Program Components

A. How will the Provider implement the Scope of Service and how Provider's resources and experiences will support this program? Provider should clearly state its competitive advantage and its ability to meet the terms, conditions, and requirements as defined in this RFP.

B. Provider's vision of Outreach Program's structure and function, including:

    1. Set up
    2. Proposed activities
    3. Staffing
    4. Collaboration with other service Providers

C. Provider's creative use of resources for effective recruitment (Include the use of technology.)

D. How will your organization ensure service from the beginning of the application to final disposition? (Provide a detailed plan).

E. How will your organization coordinate with Hamilton County Job and Family Services to maximize the approved Medicaid application with each other's resources?

F. Approaches your organization will use for marketing, outreach and recruitment of target populations? (Include who will coordinate these functions with service Providers.)

G. Any provider's programmatic and administrative experience including unique or extensive experience with the target population and qualifying Provider to perform the proposed service.

H. Identify your proposed sub-contractors (if any) and the anticipated scope of their services.

I. Describe your capacity and previous experience in utilizing resources to serve the target population's needs.

J. Describe how your proposal will increase the Medicaid enrollment in Hamilton County.

K. Provider will only be compensated for each completed and submitted medical application without regard to denial or approval of assessment decision.

Organizational structure

K. Hours of operation, including off-hours availability.

L. How will you manage, train, and supervise staff and evaluate staff performance?

M. How will you complete required paperwork and reports?

2.2.2 System and Fiscal Administration Components

Please provide the following attached to the original proposal and all copies:

A. **Contact Information**

Provide the address of the agency's/company's headquarters or name of the Provider's local office nearest to the City of Cincinnati, Ohio (if applicable). Include a contact name, address, and phone number.

B. **Agency/Company's History**

Provide a brief history of Provider's organization. Include the Provider's mission statement and philosophy of service.

C. **Subcontracts**

Submit a letter of intent from each subcontractor indicating their commitment, the service(s) to be provided and three (3) references. All subcontractors must be approved by HCJFS and will be held to the same contract standards as the Provider.

D. **Provider's Primary Business**

State the agency's/company's primary line of business, the date established, the number of years of relevant experience, and the number of employees.

E. **Table of Organization**

Clearly distinguish programs, channels of communication and the relationship of the proposed purchase of service to the total company.

F. **Job Descriptions**

For all positions in the program budget.

G. **Program Quality Documents**

Attach documents which describe and support the program evaluation process. For example, procedures and forms, or copies of awards received for excellent program quality.

H. **Agency's/Firm's Brochures**

A copy of the agency's/firm's brochures, which describe the services being proposed.

Please provide the following attached only to the original proposal:

I. **Agency/Company Ownership**

Describe how the agency/company is owned (include the form of business entity -i.e., corporation, partnership or sole proprietorship) and financed.

J. **Annual Report**

A copy of Provider's most recent annual report, the most recent independent annual audit report, and a copy of all management letters related to the most recent independent annual audit report and the most recent Form 990. For a sole proprietor or for profit entities, include copies of the two (2) most recent year's federal income tax returns and the most recent year end balance sheet and income statement. If no audited statements are available, Provider must supply equivalent financial statements certified by Provider to fairly and accurately reflect the Provider's financial status. It is the responsibility of the Provider to redact tax identification numbers from all documents prior to submission to HCJFS.

K. **Articles of Incorporation**

Articles of Incorporation or other applicable organization documentation.

L. **Insurance and Worker's Compensation**

Provide a current certificate of insurance, endorsements, and Worker's Compensation verifications.

2.2.3 Budget and Cost Considerations

A. HCJFS anticipates services will begin no later than September, 2007. Provider must submit a budget for Contract Years 1, 2 and 3. The provider understands the budget will be the basis of calculation of the Unit Rate to be used to

compensate provider for services provided. Provider must warrant and represent the budget is based upon current financial information and programs, and include all costs relating to but not limited by the following:

1. Outreach/Marketing;
2. Insurance;
3. Location; and
4. Other direct service (e.g. translation/interpreter, mileage).

Provider will notify HCJFS, in writing, within five (5) business days when it knows or should have known the information contained in the budget is inaccurate.

All revenue sources available to Provider to serve consumers identified in the Scope of Work shall be listed in the budget, and utilized, where permissible, to reduce the Unit Rate. Specify the cost for the various parts of the program. Cost must be broken down by type of work as well as classifications for staff, i.e. senior program manager vs. lower level position. Total program cost for each year must be listed on the Cover Sheet, Attachment A.

B. Provider must submit a detailed narrative which demonstrates how costs are related to each service presented in the proposal.

C. Provider must take note that “profit” will be a separately negotiated element of price pursuant to OAC 5101:9-4-07, if Provider is a for-profit organization.

D. For the purposes of this RFP, **“unallowable”** program costs include:

1. the cost of equipment or facilities procured under a lease-purchase arrangement unless it is applicable to the cost of ownership such as depreciation, utilities, maintenance and repair;
2. bad debt or losses arising from uncorrectable accounts and other claims and related costs;

3. bonding costs;
4. contributions to a contingency(ies) reserve or any similar provision for unforeseen events;
5. contributions, donations or any outlay of cash with no prospective benefit to the facility or program;
6. entertainment costs for amusements, social activities and related costs for staff only;
7. costs of alcoholic beverages;
8. goods or services for personal use;
9. fines, penalties or mischarging costs resulting from violations of, or failure to comply with, laws and regulations;
10. gains and losses on disposition or impairment of depreciable or capital assets;
11. cost of depreciation on idle facilities, except when necessary to meet Contract demands;
12. costs incurred for interest on borrowed capital or the use of a governmental unit's own funds, except as provided in OAC 5101:2-47-25(n);
13. losses on other contracts';
14. organizational costs such as incorporation, fees to attorneys, accountants and brokers in connection with establishment or reorganization;
15. costs related to legal and other proceedings;
16. goodwill;
17. asset valuations resulting from business combinations;
18. legislative lobbying costs;
19. cost of organized fund raising;
20. cost of investment counsel and staff and similar expenses incurred solely to enhance income from investments;
21. any costs specifically subsidized by federal monies with the exception of federal funds authorized by federal law to be used to match other federal funds;

22. advertising costs with the exception of service-related recruitment needs, procurement of scarce items and disposal of scrap and surplus;
23. cost of insurance on the life of any officer or employee for which the facility is beneficiary;
24. major losses incurred through the lack of available insurance coverage; and
25. cost of prohibited activities from section 501(c)(3) of the Internal Revenue Code.

If there is a dispute regarding whether a certain item of cost is allowable, HCJFS' decision is final.

2.3 Customer References

Provider must list at least three (3) references for which services were provided similar in nature and functionality to those requested by HCJFS. Each reference must be accompanied by:

A. Company name;

B. Address;

C. Phone number & fax number;

D. Contact person;

E. Nature of relationship and service performed; and

F. Time period of contract.

2.4 Personnel Qualifications

For key clinical and business personnel who will be working with the program,

please submit resumes containing the following:

A. Proposed role;
B. Industry certification(s), including any licenses or certifications and, if so, whether such licenses or certifications have been suspended or revoked at any time;
C. Work history; and
D. Personal reference (company name, contact name and phone number, scope and duration of program).

Provider's local program manager must have a minimum of three (3) years experience as a program manager with a similar program.

3.0 PROPOSAL GUIDELINES

3.1 Project Schedule

ACTION ITEM	DELIVERY DATE
RFP Issued	August 3, 2007
RFP Conference	August 16, 2007
Deadline for Receiving Final RFP Questions	August 20, 2007
Deadline for Issuing Final RFP Answers	August 22, 2007
Deadline for Proposals Received by HCJFS Contact Person	August 27, 2007
Proposal Review Completed	August 29, 2007
Commencement of Contract	September , 2007

3.2 HCJFS Contact Person

The RFP, the evaluation of responses, and the award of any resultant contract shall be made in conformance with current County procurement procedures.

HCJFS Contact Person and mailing address for questions about the proposal process, technical issues, the Scope of Service or to send a request for a post-proposal meeting is:

Christy Weber, Contract Services

Hamilton County Department of Job and Family Services

222 East Central Parkway, 3rd floor

Cincinnati, Ohio 45202

3.3 Provider's Conference

A Provider's Conference will take place on August 16, 2007 at 10:00 a.m. EST Hamilton County Administration Building Room 605, 6th Floor 138 East Court Street Cincinnati, Ohio 45202. While attendance is not mandatory, it is highly recommended for each Provider to have a representative attend the Provider's Conference. The purpose of the Provider's Conference is to answer questions related to the RFP.

All interested Providers must fax or e-mail the HCJFS Contact Person prior to the Provider's Conference to register, leaving their name, company name, fax number and phone number. The fax number is (513) 946-2384. The e-mail address is weberc02@jfs.hamilton-co.org. All answers issued in response to Provider questions become part of the RFP and the RFP process. All communications being mailed, faxed or e-mailed are to be sent only to the HCJFS Contact Person listed in Section 3.2.

A. Prior to the Provider's Conference, questions may be faxed or e-mailed regarding the RFP or proposal process to the HCJFS Contract Person. The questions and answers will be distributed at the Provider's Conference.

B. After the Provider's Conference, questions may be faxed or e-mailed regarding the RFP or proposal process to the HCJFS Contact Person. No questions will

be accepted after August 20, 2007. The final responses will be faxed or e-mailed on August 22, 2007 at the close of business.

C. Only Providers who call and register prior to the Provider's Conference or attend and register at the Provider's Conference will receive copies of questions and answers.

3.4 Prohibited Contacts

Neither Provider nor their representatives should communicate with individuals associated with this project during the RFP process. If the Provider attempts any unauthorized communication, HCJFS will reject the Provider's proposal.

The definition of individuals associated with this project is further defined as:

A. Public officials;

B. HCJFS project manager and his/her staff assigned to the project;

C. **HCJFS Contact Person** as listed in **Section 3.2**; and

D. HCJFS staff involved with the RFP development, management and evaluation process.

The integrity of the RFP process is very important to HCJFS in the administration of our business affairs, in our responsibility to the residents of Hamilton County, and to the Providers who participate in the process in good faith. Behavior by Providers that violates or attempts to manipulate the RFP process in any way is taken very seriously.

Examples of unauthorized communications are:

A. Telephone calls;

B. Prior to the award being made, letters and faxes regarding the project or its evaluation made to anyone other than the **HCJFS Contact Person** as listed in **Section 3.2**;

C. Visits in person or through a third party attempting to obtain information regarding the RFP; and

D. E-mail except to the **HCJFS Contact Person** as listed in **Section 3.2.**

3.5 Provider Disclosures

Provider must disclose any pending or threatened court actions and/or claims against the Provider, its parent company or its subsidiaries. This information will not necessarily be cause for rejection of the proposal; however, withholding the information may be for cause rejection of the proposal.

3.6 Provider Examination of the RFP

Providers shall carefully examine the entire RFP and any addenda thereto, all related materials and data referenced in the RFP or otherwise available, and shall become fully aware of the nature of the request and the conditions to be encountered in performing the requested services.

If Providers discover any ambiguity, conflict, discrepancy, omission or other error in this RFP, they shall immediately notify the HCJFS Contact Person of such error in writing and request clarification or modification of the document. Modifications shall be made by addenda issued pursuant to **Section 3.7 Addenda to RFP.** Clarification shall be given by fax or e-mail to all parties who registered without divulging the source of the request for same.

If a Provider fails to notify HCJFS, prior to close of business day **August 23, 2007,** of an error in the RFP known to the Provider, or of an error which reasonably should have been known to the Provider, the Provider shall submit its proposal at the Provider's own risk. If awarded the contract, the Provider shall not be entitled to additional compensation or time by reason of the error or its later correction.

3.7 Addenda to RFP

HCJFS may modify this RFP no later than August 24, 2007 close of business day, by issuance of one or more addenda to all parties who registered for the RFP.

In the event modifications, clarifications, or additions to the RFP become necessary, all Providers who registered for the RFP will be notified and will receive the addenda via fax or e-mail. In the unlikely event emergency addenda by telephone inquiry are necessary, the HCJFS Contact Person, or designee, will be responsible for contacting only those Providers who registered for the RFP as described in Section 3.3 (c) Provider's Conference.

3.8 Availability of Funds

This program is conditioned upon the availability of federal, state, or local funds which are appropriated or allocated for payment of the proposed services. If, during any stage of this RFP process, funds are not allocated and available for the proposed services, the RFP process will be canceled. HCJFS will notify Provider at the earliest possible time if this occurs. HCJFS is under no obligation to compensate Provider for any expenses incurred as a result of the RFP process.

4.0 Submission of Proposal

4.1 Preparation of Proposal

Proposals must provide a straightforward, concise delineation of qualifications, capabilities, and experience to satisfy the requirements of the RFP. Expensive binding, colored displays, promotional materials, etc. are not necessary. Emphasis should be concentrated on conformance to the RFP instructions, responsiveness to the RFP requirements, completeness, and clarity of content. The proposal must include all costs relating to the solutions(s) submitted.

Hamilton County may entertain alternative proposals submitted by Provider which may contain responses that differ from the specifications contained in this RFP. All alternative proposals must conform to the RFP instructions and outcomes.

Hamilton County is a governmental agency required to comply with the Ohio Public Records Act as set forth in ORC 149.43. If Hamilton County is required by law to disclose any material or information, Hamilton County will use its best efforts to notify Provider prior to such disclosure. Notwithstanding the above, in the event Provider provides Hamilton County with any material or information which Provider deems to be subject to exemption under the Ohio Public Records Act, Provider shall clearly identify and mark such documents accordingly before submitting them to Hamilton County. If Hamilton County is requested by a third party to disclose those documents which are identified and marked as exempt for disclosure under Ohio law, Hamilton County will notify Provider of that fact. Provider shall promptly notify Hamilton County, in writing, that either a) Hamilton County is permitted to release these documents, or b) Provider intends to take immediate legal action to prevent its release to a third party. A failure of Provider to respond with five (5) business days shall be deemed permission for Hamilton County to release such documents.

4.2 Proposal Cost

The cost of developing proposals is entirely the responsibility of the Provider and shall not be chargeable to HCJFS under any circumstances. Provider must certify the proposal and pricing will remain in effect for a minimum of 180 days after the proposal submission date. All materials submitted in response to the RFP will become the property of HCJFS and may be returned only at HCJFS' option and at the Provider's expense.

4.3 False or Misleading Statements

If, in the opinion of HCJFS, such information was intended to mislead HCJFS, in its evaluation of the proposal, the proposal will be rejected.

4.4 Provider Representative's Signature

The Cover Sheet shall be signed by an individual who is authorized to contractually bind the Provider. The signature must indicate the title or position the individual holds in the agency or firm. Agencies or firms which sign contracts with the name of the agency or firm must provide the name of a corporate officer or executive director for signature validation by HCJFS. All unsigned proposals will be rejected. In submitting a proposal, Provider affirms all statements contained in the proposal are true and accurate.

4.5 Delivery of Proposals

One (1) signed original proposal and (eight) 8 duplicates of the entire written proposal must be received by the **HCJFS Contact Person** at the address listed in **Section 3.2 HCJFS Contact Person** no later than ***11:00 a.m. EST on August 27, 2007***. Proposals received after this date and time will not be considered. Provider shall use certified or registered mail, UPS, or Federal Express with return receipt

requested. A receipt will be issued for all proposals received. No email, telegraphic, facsimile, or telephone proposals will be accepted.

It is absolutely essential that Providers carefully review all elements in their final proposals. Once received, proposals cannot be altered; however, HCJFS reserves the right to request additional information for clarification purposes only.

4.6 Acceptance & Rejection of Proposals

HCJFS reserves the right to:

A. award a proposal received on the basis of individual items, or on the entire list of items'
B. reject any proposal, or any part thereof; and
C. waive any informality in the proposals.

The recommendation of HCJFS staff and the decision by the HCJFS Director shall be final. Waiver of an immaterial defect in the proposal shall in no way modify the RFP documents or excuse the Provider from full compliance with its specifications if Provider is awarded the contract.

4.7 Evaluation & Award of Contract

Preliminary Proposal Review

The review process shall be conducted in four stages:

Stage 1. A preliminary review to ensure the proposal materials adhere to the minimum requirements (and mandatory conditions) specified in the RFP. Proposals which meet Stage 1 requirements described below will be deemed Qualified. Those which do not, shall be deemed Non-Qualified. Non-Qualified proposals will be rejected.

Stage 2. A thorough review of proposals by Review Committee. Qualified proposals will be given a preliminary score, in accordance with the review process.

Stage 3. Review of additional materials, such as references, and, if necessary as determined by Review committee, oral presentations, demonstrations, or written clarification. Modification, as appropriate, of preliminary scores, based on additional information.

Stage 4. Compilation of scores, and determination of winning proposal.

Although it is hoped and expected a Provider will be selected as a result of this process, HCJFS reserves the right to discontinue the procurement process at any time.

1. Stage 1 Preliminary Review

Qualified proposals in response to the RFP must meet the following requirements:

A. Timely Submission – The proposal is received at the address designated in the RFP no later than August 27, 2007 at 11:00 a.m. EST and according to instructions. Proposals mailed but not received at the designated location by the specified date shall be deemed Non-Qualified and shall not be considered.

B. Signed and Completed Cover Sheet

2. Stage 2 Review

All qualified proposals shall be reviewed, evaluated, and rated by the Review Committee. Review Committee shall be comprised of HCJFS staff and other individuals designated by HCJFS.

Review Committee shall evaluate each bidder's proposal and their responses to the questions identified in Section 2, Provider's Proposal, any work samples and additional submitted materials using criteria developed by the HCJFS. Ratings will be compiled using a Review Committee Rating Sheet.

Responses to each question will be evaluated and ranked using the following scale:

Inadequate - Provider did not respond to the questions or the response reflects a lack of understanding of the requirements.

Minimally Acceptable - Provider demonstrates a minimal understanding of the requirements and demonstrates some strengths, but also demonstrates some deficiencies.

Good - Provider's response reflects a solid understanding of the issues and satisfies all the requirements.

Excellent - Provider's response is complete and exceeds all requirements.

At the end of Stage 2, a preliminary ranking of Providers will be conducted, based solely on the scoring from this stage.

3. Stage 3 Additional Materials

Review Committee members will determine what additional or clarifying information is required to complete its review process. HCJFS may also consider provider's history and experience in providing similar services and Provider's financial condition. All information obtained during Stage 3 will be evaluated using the scale set forth in Stage 2 Review. Review Committee may request information from sources other than the written proposal to evaluate provider's programs or clarify Provider's proposal. Other sources of information, may include, but are not limited to, the following:

A. Written responses from Provider to clarify questions posed by Review Committee. Such information requests by Review Committee and Provider's responses must always be in writing;

B. Reference Checks;

C. Oral presentations. If HCJFS determines oral presentations are necessary, the presentations will be focused to ensure all of HCJFS' interests or concerns are adequately addressed. HCJFS reserves the right to video tape the presentations. Provider representatives must include key personnel, who will make the primary presentation.

4. Stage 4 Evaluation

After Stage 2 and 3 are completed, final scoring for each proposal will be calculated. For this RFP, the evaluation percentages assigned to each section are:

A. Program Evaluation and Section 2.2.1 is worth 60% of the total evaluation score.

B. System Evaluation and Section 2.2.2 is worth 20% of the total evaluation score.

C. Fiscal Evaluation, Section 2.2.3 is worth 20% of the total evaluation score.

4.8 Proposal Selection

Proposal selection does not guarantee a contract for services will be awarded. The selection process includes:

1. All proposals will be evaluated in accordance with Section 4.7 Evaluation & Award of Agreement. The proposal is rated based on the criteria in the RFP.

2. Based upon the results of the evaluation, HCJFS will select a provider for the services who it determines to be the most responsive and responsible proposal, with price and other factors considered.

3. HCJFS works with selected provider to finalize details of the Agreement using Attachment B, Contract Sample, to be executed between HCJFS and Provider.

4. If HCJFS and Provider are able to successfully finalize the Agreement, HCJFS will award Provider a contract.

5. If HCJFS and successful Provider are unable to come to terms regarding the Agreement, in a timely manner as determined by HCJFS, HCJFS will terminate the Agreement discussions with provider. In such event, HCJFS reserves the right to select another provider from the RFP process, cancel the RFP or reissue the RFP if it is deemed necessary.

4.9 Post-Proposal Meeting

The post-proposal meeting process may be utilized only by Qualified Providers passing the preliminary Stage 1 Review, who wish to obtain clarifying information regarding their non-selection. If a Provider wishes to discuss the selection process, the request for an informal meeting and the explanation for it must be submitted in writing and must be received by HCJFS within five (5) working days after receipt of notification of the decision. The request shall state the reason(s) for the meeting, citing the law, rule, regulation or RFP procedures on which the request is based. All requests must be signed by an individual authorized to represent the Provider and be addressed to the HCJFS Contact Person at the address listed in Section 3.2 HCJFS Contact Person. Certified or registered mail must be used unless the request is delivered in person, in which case the Provider should obtain a delivery receipt.

A meeting will be scheduled within twenty-one (21) calendar days of receipt of the request and will be for the purpose of discussing a Provider's non-selection. HCJFS has the final decision-making authority. HCJFS is under no obligation to approve a proposal as a result of the solicitation if, in the opinion of HCJFS, the proposal is not responsive to the needs of HCJFS and its consumers. The Provider requesting the meeting will be notified in writing of HCJFS' decision within ninety (90) calendar days of the scheduled meeting. The administrative decision is final.

5.0 Terms & Conditions

The contents of the RFP and the commitments set forth in the selected proposals shall be considered contractual obligations, if a contract ensues. Failure to accept these obligations may result in cancellation of the award.

5.1 Type of Contract

The evaluation of proposals submitted in response to this RFP may result in the issuance of a contract. The contract shall incorporate the terms, conditions and requirements of the RFP, the Provider's proposal, and any other mutually agreed upon terms.

5.2 Order of Precedence

The successful Provider's proposal, this RFP, and other applicable addenda will become part of the final contract. This RFP and all attachments are intended to supplement and compliment each other and shall where permissible be so interpreted. However, if any provision of this RFP or the attachments are in conflict, this RFP takes precedence.

5.3 Contract Period, Funding & Invoicing

A contract will be written for the initial term of one (1) year and two (2) additional one (1) year renewal periods. Provider must submit a budget for the initial term and a budget for each renewal year. For renewal years, any increases in unit rates will be limited to no more than 3%. Provider must submit to HCJFS a budget and narrative description supporting such renewal year unit rate increase no later than 120 days prior to the end of the initial contract term. Contract renewal incorporating any rate increase, up to 3%, will be initiated at the sole discretion of HCJFS. HCJFS decision to renew the contract will be contingent on contract performance and funding availability.

Contract payment is based on unit rates for authorized services already provided. HCJFS will use its best efforts to make payment within thirty (30) days of receipt of timely and accurate invoices and required documentation.

See Attachment B for a sample Provider Contract for minimum contractual requirements of all HCJFS Providers. **HCJFS reserves the right to add or delete contract language to meet program needs.**

5.4 Confidential Information

HCJFS is required to maintain the confidentiality of consumer information. The sharing of consumer information with HCJFS business partners and service providers is governed by numerous laws, regulations, policies and procedures. The governing requirements were developed to ensure that confidentiality is maintained and that appropriate security procedures are implemented and followed to address the exchange of information. Any Provider engaging in any service for HCJFS that requires them to come into contact with confidential HCJFS information will be required to hold confidential such information.

As a means of ensuring the confidentiality of consumer information, all data exchanged by e-mail which is outside of the HCJFS e-mail network will be transmitted as an attached WORD or Excel document which has been encrypted and password protected. The sender and receiver of confidential consumer information are required to initiate the use of new passwords on the first day of each quarter. The passwords will be established by HCJFS and given to the selected Provider(s). Non-encrypted information must be sent to HCJFS via fax, regular mail or on a disk.

5.5 Insurance

Provider agrees to procure and maintain for the duration of this Contract the following insurance: insurance against claims for injuries to persons or damages to property which may arise from or in connection with Provider's products or services as described in this Contract; auto liability; professional liability (errors and omissions) and umbrella/excess insurance. Further, Provider agrees to procure and maintain for the duration of this Contract Workers' Compensation. The cost of all insurance shall be borne by Provider. Insurance shall be purchased from a company licensed to provide insurance in Ohio. Insurance is to be placed with an insurer provided an A.M. Best rating of no less than A; VII. Provider shall purchase the following coverage and minimum limits;

Commercial general liability insurance policy with coverage contained in the most current Insurance Services Office Occurrence Form CG 00 01 or equivalent with limits of at least One Million Dollars ($1,000,000.00) per occurrence and One Million Dollars ($1,000,000.00) in the aggregate and at least One Hundred Thousand Dollars ($100,000.00) coverage in legal liability fire damage. Coverage will include:

Additional insured endorsement;

Product liability;

Blanket contractual liability;

Broad form property damage;

Severability of interests;

Personal injury; and

Joint venture as named insured (if applicable).

Business auto liability insurance of at least One Million Dollars ($1,000,000.00) combined single limit, on all owned, non-owned, leased and hired automobiles. If the Contract contemplates the transportation of the users of Hamilton County services (such as but not limited to HCJFS clients) “Clients” and the Provider provides this service through the use of its employees’ privately owned vehicles “POV”, then the Provider’s Business Auto Liability insurance shall sit excess to the employees POV insurance and provide coverage above its employee’s POV coverage. The Provider agrees the business auto liability policy will be endorsed to provide this coverage.

Professional liability (errors and omission) insurance of at least One Million Dollars ($1,000,000) per claim and in the aggregate.

Umbrella and excess liability insurance policy with limits of at least One Million Dollars ($1,000,000.00) per occurrence and in the aggregate, above the commercial general, professional liability and business auto primary policies and containing the following coverage:

Additional insured endorsement;

Pay on behalf of wording;

Concurrency of effective dates with primary;

Blanket contractual liability;

Punitive damages coverage (where not prohibited by law);

Aggregates: apply where applicable in primary;

Care, custody and control – follow form primary; and

Drop down feature.

Workers' Compensation insurance at the statutory limits required by Ohio Revised Code.

The Provider further agrees with the following provisions:

The insurance endorsement form and the certificate of insurance form will be sent to: Risk Manager, Hamilton County, room 607, 138 East Court Street, Cincinnati, Ohio 45202; and to HCJFS, Contract Services, 3rd floor, 222 East Central Parkway, Cincinnati, Ohio 45202. The forms must state the following: "Board of County Commissioners of Hamilton, County, Ohio and Hamilton County Department of Job & Family Services, and their respective officials, employees, agents, and volunteers are endorsed as additional insured as required by Contract on the commercial general, business auto and umbrella/excess liability policies."

Each policy required by this clause shall be endorsed to state that coverage shall not be canceled or materially changed except after thirty (30) days' prior written notice given to: Risk Manager, Hamilton County, room 607, 138 East Court Street, Cincinnati, Ohio 45202; and to HCJFS, Contract Services, 3rd floor, 222 East Central Parkway, Cincinnati, Ohio 45202.

Provider shall furnish the Hamilton County Risk Manager and HCJFS with original certificates and amendatory endorsements effecting coverage required by this clause. All certificates and endorsements are to be received by Hamilton County before the Contract commences. Hamilton County reserves the right at any time to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications.

Provider shall declare any self-insured retention to Hamilton County pertaining to liability insurance. Provider shall provide a financial guarantee satisfactory to Hamilton County and HCJFS guaranteeing payment of losses and related investigations, claims administration and defense expenses for any self-insured retention.

If Provider provides insurance coverage under a “claims-made” basis, Provider shall provide evidence of either of the following for each type of insurance which is provided on a claims-made basis: unlimited extended reporting period coverage which allows for an unlimited period of time to report claims from incidents that occurred after the policy’s retroactive date and before the end of the policy period (tail coverage), or; continuous coverage from the original retroactive date of coverage. The original retroactive date of coverage means original effective date of the first claim-made policy issued for a similar coverage while Provider was under Contract with the County on behalf of HCJFS.

Provider will require all insurance policies in any way related to the work and secured and maintained by Provider to include endorsements stating each underwriter will waive all rights of recovery, under subrogation or otherwise, against the County and HCJFS. Provider will require of subcontractors, by appropriate written agreements, similar waivers each in favor of all parties enumerated in this section.

Provider, the County, and HCJFS agree to fully cooperate, participate, and comply with all reasonable requirements and recommendations of the insurers and insurance brokers issuing or arranging for issuance of the policies required here, in all areas of safety, insurance program administration, claim reporting and investigating and audit procedures.

Provider’s insurance coverage shall be primary insurance with respect to the County, HCJFS, their officials, and their respective employees, agents, and volunteers. Any insurance maintained by the County or HCJFS shall be in excess of Provider’s insurance and shall not contribute to it.

Maintenance of the proper insurance for the duration of the Contract is a material element of the Contract. Material changes in the required coverage or cancellation of the coverage shall constitute a material breach of the Contract.

If any of the work or services contemplated by this Contract is subcontracted, Provider will ensure that any and all subcontractors comply with all insurance requirements contained herein.

5.6 Declaration of Property Tax Delinquency

As part of the submitted proposal, Provider will include a notarized Declaration of Property Tax Delinquency form (Attachment C) which states the Provider was not charged with any delinquent personal property taxes on the general tax list of personal property for Hamilton County, Ohio or that the Provider was charged with delinquent personal property taxes on said list, in which case the statement shall set forth the amount of such due and unpaid delinquent taxes as well as any due and unpaid penalties and interest thereon. If the form indicates any delinquent taxes, a copy of the notarized form will be transmitted to the county treasurer within thirty (30) days of the date it is submitted. A copy of the notarized form shall also be incorporated into the contract, and no payment shall be made with respect to the contract, unless the notarized form has been incorporated.

5.7 Campaign Contribution Declaration

As part of the submitted proposal, Provider will include the applicable notarized Affidavit in Compliance with Section 3517.13 of the Ohio Revised Code form (Campaign Contribution Declaration – HB694). Amended Substitute House Bill 694 ("HB 694") limits solicitations of and political contributions by owners and certain family members of owners of businesses seeking or awarded public contracts. HB 694 and

The Ohio Legislative Service Commission's Final Analysis of the Bill can be found on the Hamilton County Job & Family Service's (HCJFS) public website located at http://www.hcjfs.hamilton-co.org/, under the Community Providers information tab.

All individuals or entities interested in contracting with Hamilton County, Ohio are required by HB 694 to complete the applicable affidavit certifying compliance with contribution limits set forth by the Bill. The affidavits are included as Attachment H to this RFP. All current and potential vendors should closely review HB 694 or risk loss of their opportunity to obtain or retain Hamilton County contracts. Please seek guidance from your legal counsel if you have questions pertaining to HB 694 as we are unable to provide individual legal advice.

5.8 Terrorist Declaration

As part of the submitted proposal, the applicant will include a completed Ohio Department of Public Safety Form (Attachment D). A purchase order for services rendered will not be issued for payment if this form is not completed and returned with the submitted proposal.

ATTACHMENT A
PROPOSAL COVER SHEET FOR

Medicaid Outreach Program

Bid No: RFP 07-012

Name of Provider serving as Fiscal Agent:_____

Organization Address:_____

Telephone Number: _____ **Fax Number:**_____

Authorized Representative _____

(Please Print or type)

Title: _____ **E-Mail Address:**_____

Authorized Representative Signature:_____

Contact person(s) authorized to negotiate with the:

Name:_____ **Title:** _____

(Please Print)

Phone Number: _____ **Fax Number:**_____

E-mail Address: _____

Name:_____ **Title:** _____

Phone Number: _____ **Fax Number:**_____

E-Mail Address: _____

Total Cost for Initial Term of 12 Months 2007 – 2008	Total Cost for Renewal Year 1 2008 - 2009	Total Cost for Renewal Year 2 2009 - 2010
$_____	$_____	$_____

_____ _____ _____

Signature - Authorized Representative **Title** **Date**

ATTACHMENT B

CONTRACT SAMPLE

Contract #

_____

PURCHASE OF SERVICE CONTRACT

This Contract is entered into on MM/DD/YY between the Board of County Commissioners of Hamilton County through the Hamilton County Department of Job & Family Services (Hereinafter"HCJFS") and **Name of organization**, (Hereinafter "Provider") doing business as **enter only if different name**, with an office at **Name and Street address, Cincinnati, Ohio, 452XX,** whose telephone number is **(513) XXX-XXXX**, for the purchase of **Medicaid Outreach Services.**

TERM

This Contract will be effective from **MM/DD/YYYY** through **MM/DD/YYYY** inclusive, unless otherwise terminated or extended by formal amendment.

The total amount of the Contract can not exceed **$000,000.00** over the life of this Contract.

SCOPE OF SERVICE

Subject to terms and conditions set forth in this Contract, Provider agrees to provide the services defined in EXHIBIT I, request for Proposal, and Exhibit II, Providers Proposal.

EXHIBITS

Subject to terms and conditions set forth in this Contract and the attached exhibits (such exhibits are deemed to be a part of this Contract as fully as if set forth herein), Provider agrees to perform the Medicaid Outreach services to increase Medicaid enrollment among eligible individuals and families. This population will include; children(up to age 19) families (with children up to age 18), pregnant women, Adults age 65 and over; individuals with disabilities, and the homeless as more particularly described in Exhibit I, Request for Proposal, Section 1.2, Scope of Service.

1. Exhibit I – The Request for Proposal;
2. Exhibit II – Providers Proposal; and
3. Exhibit III – Budget

ORDER OF PRECEDENCE

This Contract is based upon Exhibits I through III as defined in 2.A. EXHIBITS above. This Contract and all exhibits are intended to supplement and compliment each other and shall, where possible, be so interpreted. However, if any provisions of this Contract irreconcilably conflict with an exhibit, this Contract takes precedence over the exhibits. In the event there is an inconsistency between the exhibits, the inconsistency will be resolved in the following order:

1. Exhibit I – The Request for Proposal;
2. Exhibit II – Provider's Proposal
3. Exhibit III- Budget

BILLING AND PAYMENT

A. Rates of Payment – HCJFS agrees to compensate Provider in the amount of $00.00 per each eligible consumer with a completed and submitted Medicaid Application.

B. Billing and Payment – Original invoices, signed by Provider, will be sent each month to HCJFS within thirty (30) days of the end of the service month. Each monthly invoice submitted for payment must include a copy of every individual Medicaid application submitted in that service month. Provider shall make all reasonable efforts to include all service provided during the service month on the invoice.

   HCJFS reserves the right to withhold payment until such time as requested and/or required reports are received.

   1. HCJFS will not make payment for any service, either an initial invoice or a supplemental invoice, which is submitted to HCJFS more than ninety (90) calendar days from the end of the service month. The HCJFS Fiscal Department has the final authority in determining if an invoice is received timely and accurately. For invoices which are received timely but are not accurate, there will be no extension of the time limitations.

   2. For accurate invoices which are received timely, HCJFS will make payment within thirty (30) calendar days after receipt of the invoice for all invoices received in accordance with the terms of this Contract. HCJFS will only pay for those services authorized and referred.

3. The monthly Contract program financial report shall be submitted to the HCJFS Contract Services Section no later than forty-five (45) days after the end of the service month. HCJFS reserves the right to withhold payment until such time as the report is received.

C. Provider will indicate the purchase order, authorization number and vendor number on all invoices submitted for payment.

D. Provider warrants that the following unallowable costs were not included in determining the rate of payment and that these costs will not be included in any invoice submitted for payment. For this project, unallowable costs are:

1. bad debt or losses arising from uncollectible accounts and other claims and related costs;
2. bonding costs;
3. contributions to a contingency(ies) reserve or any similar provision for unforeseen events;
4. contributions, donations or any outlay of cash with no prospective benefit to the facility or program;
5. entertainment costs for amusements, social activities and related costs;
6. costs of alcoholic beverages;
7. goods or services for personal use;
8. fines, penalties or mischarging costs resulting from violations of, or failure to comply with, laws and regulations;
9. gains and losses on disposition or impairment of depreciable or capital assets;
10. cost of depreciation on idle facilities, except when necessary to meet Contract demands;
11. costs incurred for interest on borrowed capital or the use of a governmental unit's own funds, except as provided in rule 5101:2-47-26.2 of the Administrative Code;
12. losses on other contracts;
13. organizational costs such as incorporation, fees to attorneys, accountants and brokers in connection with establishment or reorganization;
14. costs related to legal and other proceedings;

15. goodwill;
16. asset valuations resulting from business combinations;
17. legislative lobbying costs;
18. cost of organized fund raising;
19. cost of investment counsel and staff and similar expenses incurred solely to enhance income from investments;
20. any costs specifically subsidized by federal monies with the exception of federal funds authorized by federal law to be used to match other federal funds;
21. advertising costs with the exception of service-related recruitment needs, procurement of scarce items and disposal of scrap and surplus;
22. cost of insurance on the life of any officer or employee for which the facility is beneficiary;
23. major losses incurred through the lack of available insurance coverage; and
24. cost of prohibited activities from section 501(C)(3) of the Internal Revenue Code.

E. Provider warrants that a separate General Ledger account has been established and will be maintained for the revenue and expenses of this contracted program.

F. Provider warrants that claims made to HCJFS for payment for services provided shall be for actual services rendered to eligible individuals and do not duplicate claims made by the Provider to other sources of public funds for the same service.

ELIGIBILITY FOR SERVICES

Service is to be provided only for Consumers who are part of the Target Population and meet the additional criteria and income guidelines as described below:

The target population includes:

7. Children (up to age 19);
8. Families with children under age 18;
9. Pregnant woman;
10. Adults age 65 and over;
11. Individuals with disabilities;
12. The homeless.

In order to qualify for Ohio Medicaid Services an individual must;

5. Be a U.S. citizen or meet Medicaid citizenship requirements;
6. Be an Ohio resident;
7. Have or obtain a social security number; and
8. Meet certain financial requirements as outlined below.

Who's Covered? Income Guidelines*
(Income guidelines are subject to change)

Who's Covered	Income Guideline
Children (up to 19)	200% FPL
Pregnant Women	150% FPL
Parents	90% FPL
Disabled Persons	~ 64% FPL**
Persons 65 & over	~ 64% FPL**
Medicare Premium Assistance Program Varies	Varies
Institutional Level of Care	Income less than the cost of care
FPL = Federal Poverty Level *Exceptions and calculations will affect final amount counted toward eligibility. Actual determination of eligibility is done at a county job & family services office. Some eligibility categories consider resources other than income.	
** Deductions and exceptions apply; this is an approximate guide. Persons with incomes higher than 64% of the FPL may have medical expenses deducted from income calculations to "spend-down" to this level.	

AVAILABILITY AND RETENTION OF RECORDS

a. Provider agrees that all records, documents, writing or other information, including but not limited to, financial records, census records, client records and documentation of compliance with Ohio Administrative Code rules, produced by Provider under this Contract, and all records, documents, writings or other information, including but not limited to financial, census and client records used by Provider in the performance of this Contract are treated according to the following terms:

    1. All records relating to costs, work performed and supporting documentation for invoices submitted to HCJFS by Provider, along

with copies of all deliverables submitted to HCJFS pursuant to this Contract, will be retained and made available by the Provider for inspection and audit by HCJFS, or other relevant governmental entities including, but not limited to the Hamilton County Prosecuting Attorney, Ohio Department of Job and Family Services (ODJFS), the Auditor of the State of Ohio, the Inspector General of Ohio or any duly appointed law enforcement officials and the United States Department of Health and Human Services for a minimum of three (3) years after reimbursement for services rendered under this Contract. If an audit, litigation or other action is initiated during the time period of the Contract, the Provider shall retain such records until the action is concluded and all issues resolved or the three (3) years have expired, whichever is later.

b. Provider agrees that it will not use any information, systems or records made available to it for any purpose other than to fulfill the contractual duties specified herein, without permission of HCJFS. Provider further agrees to maintain the confidentiality of all clients and families served. No information on clients served will be released for research or other publication without the express written consent of the HCJFS Director.

c. Provider agrees to keep all financial records in a manner consistent with generally accepted accounting principles.

d. Provider agrees that each financial transaction shall be fully supported by appropriate documentation. Provider further agrees that such documentation shall be available for examination.

NO ASSURANCES

Provider acknowledges that, by entering into this Contract, HCJFS is not making any guarantees or other assurances as to the extent, if any, that HCJFS will utilize Provider's services or purchase its goods. In this same regard, this Contract in no way precludes, prevents, or restricts Provider from obtaining and working under additional contractual arrangement(s) with other parties, assuming the contractual work in no way impedes Provider's ability to perform the services required under this Contract. Provider warrants that at the time of entering into this Contract, it has no interest in nor shall it acquire any

interest, direct or indirect, in any contract that will impede its ability to provide the goods or perform the services under this Contract.

NON-EXCLUSIVE

This is a non-exclusive Contract, and HCJFS may purchase the same or similar item(s) from other Providers at any time during the term of this Contract.

CONFLICT OF INTEREST

This Contract in no way precludes, prevents, or restricts Provider from obtaining and working under an additional contractual arrangement(s) with other parties aside from HCJFS, assuming that the contractual work in no way impedes Provider's ability to perform the services required under this Contract. Provider warrants that at the time of entering into this Contract, it has no interest in nor shall it acquire any interest, direct or indirect, in any contract that will impede its ability to perform the services under this Contract.

Provider further agrees that there is no financial interest involved on the part of any HCJFS officers, Board of County Commissioners or employees of the county involved in the development of the specifications or the negotiation of this Contract. Provider has no knowledge of any situation that would be a conflict of interest. It is understood that a conflict of interest occurs when a HCJFS employee will gain financially or receive personal favors as a result of the signing or implementation of this Contract. Provider will report the discovery of any potential conflict of interest to HCJFS. If a conflict of interest is discovered during the term of this Contract, HCJFS may exercise any right under the Contract including termination of the Contract.

Provider further agrees to comply with Ohio ethics laws as listed in the Ohio Revised Code Chapters 102 and 2921, and the Ohio Administrative Code Chapter 5101. By signing this Contract, Provider certifies to be in compliance with these provisions.

ASSIGNMENT AND SUBCONTRACTING

The parties expressly agree that this Contract shall not be assigned by the Provider without the prior written approval of HCJFS. Provider may not subcontract any of the services agreed to in this Contract without the express written consent of the HCJFS. At the time of Contract signing, Provider warrants that Provider has a signed Contract with all approved subcontractors or will execute a signed Contract with all approved subcontractors within

thirty (30) days of execution of Provider's Contract with HCJFS. All subcontracts are subject to the same terms, conditions, and covenants contained within this Contract, including the insurance requirement in which Hamilton County, the BOCC, HCJFS and the Provider are listed as additional insured. Provider agrees it will remain primarily liable for the provision of all deliverables under this Contract and it will monitor any approved subcontractors to assure all requirements under this Contract are being met. HCJFS acknowledges and agrees that the following subcontractors may perform services in relation to this Contract:

Not withstanding any other provisions of this Contract that would afford Provider an opportunity to cure a breach, Provider agrees the assignment of any portion of this Contract or use of any subcontractor, without HCJFS prior written consent, is grounds for HCJFS to terminate this Contract with one (1) day prior written notice. Provider must notify HCJFS within one (1) business day when Provider knows or should have known that the subcontractor is out of compliance or unable to meet Contract requirements. Should this occur, Provider will immediately implement a process whereby subcontractor is immediately brought into compliance or the subcontractor's Contract with Provider is terminated. Provider shall provide HCJFS with written documentation regarding how compliance will be achieved. Under such circumstances, Provider shall notify HCJFS of subcontractor's termination and shall make recommendations to HCJFS of a replacement subcontractor. All replacement subcontractors are subject to the prior written consent of HCJFS. Provider is responsible for making direct payment to all subcontractors for any and all services provided by such contractor.

GOVERNING LAW

This Contract and any modifications, amendments, or alterations, shall be governed, construed, and enforced under the laws of Ohio.

INTEGRATION AND MODIFICATION

This instrument embodies the entire Contract of the parties. There are no promises, terms, conditions or obligations other than those contained herein; and this Contract shall supersede all previous communications, representations or contracts, either written or oral, between the parties to this Contract. This Contract shall not be modified in any manner except by an instrument, in writing, executed by the parties to this Contract.

Provider acknowledges and agrees that only staff from the Contract Services Section of

HCJFS may implement contract changes. In no event will an oral agreement with HCJFS be recognized as a legal and binding change to the Contract.

SEVERABILITY

If any term or provision of this Contract or the application thereof to any person or circumstance shall, to any extent be held invalid or unenforceable, the remainder of this Contract or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby and each term and provision of this Contract shall be valid and enforced to the fullest extent permitted by law.

TERMINATION

This Contract may be terminated by either party upon notice, in writing, delivered upon the other party prior to the effective date of termination. Should Provider wish to terminate this Contract, Provider must deliver the notice of termination one hundred and twenty (120) days prior to the effective date of termination. Based on substantiated allegations of inappropriate activities, behaviors and/or actions including, but not limited to, loss of required license, abuse or neglect of a consumer or unethical or business violations, HCJFS reserves the right to terminate immediately upon delivery of the termination notice. The parties further agree that should Provider become unable to provide the services agreed to in this Contract for any reason or otherwise materially breach this Contract, such service as Provider has provided upon the date of its inability to continue the terms of this Contract shall be eligible to be billed and paid according to the provisions of **Section 3 – BILLING AND PAYMENT.** HCJFS shall receive credit for reimbursement already made when determining the amount owed to Provider.

Provider, upon receipt of notice of terminations, agrees that it will cease work on the terminated activities under this Contract, terminate all subcontracts relating to such terminated activities, take all necessary or appropriate steps to limit disbursements and minimize costs and furnish a report as of the date of receipt of notice of termination describing the status of all work under this Contract, including without limitations, results accomplished, conclusion resulting there from and such other matters as HCJFS may require.

The parties further agree that should Provider become unable to complete the work requested in this Contract for any reason, such work as Provider has completed upon the

date of its inability to continue the terms of this Contract shall become the property of HCJFS. HCJFS shall not be liable to tender and/or pay to Provider any further compensation after the date of Provider's inability to complete the terms hereof, which date shall be the date of termination, unless extended upon request by HCJFS.

Notwithstanding the above, Provider shall not be relieved of liability to the HCJFS for damages sustained by HCJFS by virtue of any breach of the Contract by Provider and HCJFS may withhold any compensation to Provider for the purpose of off-set until such time as the amount of damages due HCJFS from Provider is agreed upon or otherwise determined.

COMPLIANCE

Provider certifies that Provider and all subcontractors who provide direct or indirect services under this Contract will comply with all requirements of federal laws and regulations, applicable Code of Federal Regulations cites including, but not limited to 2CFR Part 215 (OMB A-110), 2CFR Part 225 (OMB A-87), 2CFR Part 230 (OMB A-122), and 2CFR Part 220 (OMB A-21), state statutes and Ohio Administrative Code rules in the conduct of work hereunder. The Provider accepts full responsibility for payment of any and all unemployment compensation premiums, all income tax deductions, pension deductions, and any and all other taxes or payroll deductions required for the performance of the work by the Provider's employees.

NON-DISCRIMINATION

Provider certifies it is an equal opportunity employer and shall remain in compliance with state and federal civil rights and nondiscrimination laws and regulations including, but not limited to Title VI, and Title VII of the Civil Rights Act of 1964 as amended, the Rehabilitation Act of 1973, the Americans with Disabilities Act, the Age Discrimination Act of 1975, the Age Discrimination in Employment Act, as amended, and the Ohio Civil Rights Law.

During the performance of this Contract, Provider will not discriminate against any employee, contract worker, or applicant for employment because of race, color, religion, sex, national origin, ancestry, disability, Vietnam-era veteran status, age, political belief or place of birth. Provider will take affirmative action to ensure that during employment, all employees are treated without regard to race, color, religion, sex, national origin, ancestry, disability, Vietnam-era veteran status, age, political belief or place of birth. These provisions apply also to contract workers. Such action shall include, but is not limited to,

the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising, layoff, or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices stating the Provider complies with all applicable federal and state non-discrimination laws.

Provider, or any person claiming through the Provider, agrees not to establish or knowingly permit any such practice or practices of discrimination or segregation in reference to anything relating to this Contract, or in reference to any contractors or subcontractors of said Provider.

PROVIDER SOLICITATION OF HCJFS EMPLOYEES

Provider warrants that for one (1) calendar year from the beginning date of this Contract with HCJFS, Provider will not solicit HCJFS employees to work for Provider. The term "Provider" includes all Provider staff.

RELATIONSHIP

Nothing in this Contract is intended to, or shall be deemed to constitute a partnership, association or joint venture with Provider in the conduct of the provisions of this Contract. Provider shall at all times have the status of an independent contractor without the right or authority to impose tort, contractual or any other liability on HCJFS or its Board of County Commissioners.

DISCLOSURE

Provider hereby covenants that it has disclosed any information that it possesses about any business relationship or financial interest that said Provider has with a county employee, employee's business, or any business relationship or financial interest that a county employee has with Provider or in Provider's business.

WAIVER

Any waiver by either party of any provision or condition of this Contract shall not be construed or deemed to be a waiver of any other provision or condition of this Contract, nor a waiver of a subsequent breach of the same provision or condition.

NO ADDITIONAL WAIVER IMPLIED

If HCJFS or Provider fails to perform any obligations under this Contract and thereafter

such failure is waived by the other party, such waiver shall be limited to the particular matter waived and shall not be deemed to waive any other failure hereunder. Waivers shall not be effective unless in writing.

CONFIDENTIALITY

Provider agrees to comply with all federal and state laws applicable to HCJFS and/or consumers of HCJFS concerning the confidentiality of HCJFS' consumers. Provider understands that any access to the identities of any HCJFS consumers shall only be as necessary for the purpose of performing its responsibilities under this Contract. Provider agrees that the use or disclosure of information concerning HCJFS consumers for any purpose not directly related to the administration of this Contract is prohibited. Provider will ensure that all consumer documentation is protected and maintained in a secure and safe manner whether located in Provider's office or taken out of Provider's office.

AUDIT RESPONSIBILITY

A. Provider agrees to accept responsibility for receiving, replying to and/or complying with any audit exception by appropriate federal, state or local audit directly related to the provision of this Contract.

Audits will be conducted using a "sampling" method. Depending on the type of audit conducted, the areas to be reviewed using the sampling method may include but are not limited to months, expenses, total units, and billable units. If errors are found, the error rate of the sample period will be applied to the entire audit period.

Provider agrees to repay HCJFS the full amount of payment received for duplicate billings, erroneous billings, or false or deceptive claims. Provider recognizes and agrees that HCJFS may withhold any money due and recover through any appropriate method any money erroneously paid under this Contract if evidence exists of less than full compliance with this Contract. When an overpayment is identified and the overpayment cannot be repaid in one month, Provider will be asked to sign a REPAYMENT OF FUNDS AGREEMENT (the "Repayment Agreement"). If payments are not made according to the agreed upon terms, future checks may be held until the repayment of funds is current. Checks held more than sixty (60) days will be cancelled and will not be re-issued. HCJFS also reserves the right to not increase the rate(s) of payment or the overall Contract amount for services purchased under this Contract if there is any outstanding or unresolved

issue related to an audit finding.

HCJFS may allow a change in the terms of the Repayment Agreement. Any change will require a formal amendment to the Repayment Agreement that will be signed by all parties. An amendment to the Repayment Agreement may also be processed if any additional changes or issues develop or need to be addressed.

B. Provider shall cause to be conducted an annual independent audit report. Within fifteen (15) days of receipt, Provider agrees to give HCJFS a copy of Provider's most recent annual report, most recent annual independent audit report and any report associated management letters.

C. HCJFS reserves the right to evaluate programs of contracted providers. Evaluation activities may include, but are not limited to reviewing records, observing programs, and interviewing program employees and consumers. Such evaluations will be deemed at Provider's own time and expense.

D. To the extent applicable, Provider will cause a single or program-specific audit to be conducted in accordance with OMB Circular A-133. Provider should submit a copy of the completed audit report to HCJFS within forty-five (45) days after receipt from the accounting firm performing such audit.

WARRANTY

Provider warrants and represents that its services shall be performed in a professional and work like manner in accordance with applicable professional standards.

Provider warrants and represents that all other sources of revenue have been actively pursued prior to billing HCJFS for Services, including but not limited to, third party insurance, Medicaid, and any other source of local, state or federal revenue.

Provider warrants that separate books and records, including, but not limited to the general ledger account journals and profit/loss statements have been established and will be maintained for the revenue and expenses of this program.

AVAILABILITY OF FUNDS

This Contract is conditioned upon the availability of federal, state, or local funds that are appropriated or allocated for payment of this Contract. If funds are not allocated and

available for the continuance of the function performed by the Provider hereunder, the products or services directly involved in the performance of that function might be terminated by HCJFS at the end of the period for which funds are available.

HCJFS will notify the Provider at the earliest possible time of any products or services that will or may be affected by a shortage of funds. No penalty shall accrue to HCJFS in the event this provision is exercised, and HCJFS shall not be obligated or liable for any future payments due or for any damages as a result of termination under this section.

FORCE MAJEURE

If by reason of force majeure, the parties are unable in whole or in part to act in accordance with this Contract, the parties shall not be deemed in default during the continuance of such inability provided, however, that Provider shall only be entitled to the benefit of this paragraph for fourteen (14) days if the event of force majeure does not affect HCJFS' property or employees which are necessary to Provider's ability to perform.

The term "Force Majeure" as used herein shall mean without limitation: acts of God; strikes or lockout; acts of public enemies; insurrections; riots; epidemics; lightning; earthquakes; fire; storms; flood; washouts; droughts; arrests; restraint of government and people; civil disturbances; and explosions.

Provider shall, however, remedy with all reasonable dispatch any such cause to the extent within its reasonable control, which prevents Provider from carrying out its obligations contained herein.

COORDINATION

Provider will advise HCJFS of any significant fund raising campaigns contemplated by the Provider within Cincinnati and Hamilton County for supplementary operating or capital funds during the term of this Contract so that the same may be coordinated with any planned promotion of public or private funds by HCJFS for the benefit of this and other agencies within the community.

LEGAL ACTION

Any legal action brought pursuant to the Contract will be filed in the courts located in Hamilton County, Ohio and Ohio law will apply.

PUBLIC RECORDS

This Contract is a matter of public record under the laws of the State of Ohio. Provider agrees to make copies of this Contract promptly available to any requesting party. Upon request made pursuant to Ohio law, HCJFS shall make available the Contract and all public records generated as a result of this Contract.

By entering into this Contract, Provider acknowledges and understands that records maintained by Provider pursuant to this Contract may be deemed public record and subject to disclosure under Ohio law. Provider shall comply with the Ohio public records law.

DRUG-FREE WORKPLACE

Provider certifies and affirms that Provider will comply with all applicable state and federal laws regarding a drug-free workplace as outlined in 45 CFR Part 76, Subpart F. Provider will make a good faith effort to ensure that all employees performing duties or responsibilities under this Contract, while working on state, county or private property, will not purchase, transfer, use or possess illegal drugs or alcohol, or abuse prescription drugs in any way.

PUBLIC ASSISTANCE WORK PROGRAM PARTICIPANTS

Pursuant to Chapter 5107 of the Ohio Revised Code and Prevention, Retention, and Contingency Program established under Chapter 5108 of the Revised Code, Provider agrees to not discriminate in hiring and promoting against applicants for and participants for the Ohio Works Program. Provider also agrees to include such provision in any such contract, subcontract, grant or procedure with any other party which will be providing services, whether directly or indirectly, to HCJFS consumers.

MEDIA RELATIONS, PUBLIC INFORMATION, AND OUTREACH

Although information about and generated under this Contract may fall within the public domain, Provider will not release information about or related to this Contract to the general public or media verbally, in writing, or by any electronic means without prior approval from the HCJFS Communications Director, unless Provider is required to release requested information by law. HCJFS reserves the right to announce to the general public and media: award of the Contract, Contract terms and conditions, scope of work under the Contract, deliverables and results obtained under the Contract, impact of Contract activities, and assessment of Provider's performance under the Contract. Except where

HCJFS approval has been granted in advance, the Provider will not seek to publicize and will not respond to unsolicited media queries requesting: announcement of Contract award, Contract terms and conditions, Contract scope of work, government-furnished documents HCJFS may provide to Provider to fulfill the Contract scope of work, deliverables required under the Contract, results obtained under the Contract, and impact of Contract activities.

If contacted by the media about this Contract, Provider agrees to notify the HCJFS Communications Director in lieu of responding immediately to media queries. Nothing in this section is meant to restrict Provider from using contract information and results to market to specific clients or prospects.

AMENDMENTS

This writing constitutes the entire agreement between Provider and HCJFS with respect to all matters herein. This Contract may be amended only in writing and signed by Provider and HCJFS; however, it is agreed by Provider and HCJFS that any amendments to laws or regulations cited herein will result in the correlative modification of this Contract, without the necessity for executing written amendments. The impact of any applicable law, statute, or regulation not cited herein and enacted after the date of execution of this Contract will be incorporated into this Contract by written amendment signed by Provider and HCJFS and effective as of the date of enactment of the law, statute, or regulation. Any other written amendment to this Contract is prospective in nature.

INSURANCE

Provider agrees to procure and maintain for the duration of this Contract the following insurance: insurance against claims for injuries to persons or damages to property which may arise from or in connection with Provider's products or services as described in this Contract; auto liability; professional liability (errors and omissions) and umbrella/excess insurance. Further, Provider agrees to procure and maintain for the duration of this Contract Workers' Compensation. The cost of all insurance shall be borne by Provider. Insurance shall be purchased from a company licensed to provide insurance in Ohio. Insurance is to be placed with an insurer provided an A.M. Best rating of no less than A; VII. Provider shall purchase the following coverage and minimum limits;

A. Commercial general liability insurance policy with coverage contained in the most current Insurance Services Office Occurrence Form CG 00 01 or equivalent with limits of at least One Million Dollars ($1,000,000.00) per occurrence and One

Million Dollars ($1,000,000.00) in the aggregate and at least One Hundred Thousand Dollars ($100,000.00) coverage in legal liability fire damage. Coverage will include:

1. Additional insured endorsement;
2. Product liability;
3. Blanket contractual liability;
4. Broad form property damage;
5. Severability of interests;
6. Personal injury; and
7. Joint venture as named insured (if applicable).

Endorsements for physical abuse claims and for sexual molestation claims must be a minimum of Three Hundred Thousand Dollars ($300,000.00) per occurrence and Three Hundred Thousand Dollars ($300,000.00) in the aggregate.

Business auto liability insurance of at least One Million Dollars ($1,000,000.00), combined single limit, on all owned, non-owned, leased and hired automobiles. If the Contract contemplates the transportation of the users of Hamilton County services (such as but not limited to HCJFS' clients) "Clients" and the Provider provides this service through the use of its employees' privately owned vehicles "POV", then the Provider's Business Auto Liability insurance shall sit excess to the employees POV insurance and provide coverage above its employee's POV coverage. The Provider agrees the business auto liability policy will be endorsed to provide this coverage.

B. Professional liability (errors and omission) insurance of at least One Million Dollars ($1,000,000) per claim and in the aggregate.

C. Umbrella and excess liability insurance policy with limits of at least One Million Dollars ($1,000,000.00) per occurrence and in the aggregate, above the commercial general, professional liability and business auto primary policies and containing the following coverage:

1. Additional insured endorsement;
2. Pay on behalf of wording;
3. Concurrency of effective dates with primary;

4. Blanket contractual liability;
5. Punitive damages coverage (where not prohibited by law);
6. Aggregates: apply where applicable in primary;
7. Care, custody and control – follow form primary; and
8. Drop down feature.

D. Workers' Compensation insurance at the statutory limits required by Ohio Revised Code.

E. The Provider further agrees with the following provisions:

1. The insurance endorsement form and the certificate of insurance form will be sent to: Risk Manager, Hamilton County, room 607, 138 East Court Street, Cincinnati, Ohio 45202; and to HCJFS, Contract Services, 3rd floor, 222 East Central Parkway, Cincinnati, Ohio 45202. The forms must state the following: "Board of County Commissioners of Hamilton, County, Ohio and Hamilton County Department of Job & Family Services, and their respective officials, employees, agents, and volunteers are endorsed as additional insured as required by Contract on the commercial general, business auto and umbrella/excess liability policies."

2. Each policy required by this clause shall be endorsed to state that coverage shall not be canceled or materially changed except after thirty (30) days' prior written notice given to: Risk Manager, Hamilton County, room 607, 138 East Court Street, Cincinnati, Ohio 45202; and to HCJFS, Contract Services, 3rd floor, 222 East Central Parkway, Cincinnati, Ohio 45202.

3. Provider shall furnish the Hamilton County Risk Manager and HCJFS with original certificates and amendatory endorsements effecting coverage required by this clause. All certificates and endorsements are to be received by Hamilton County before the Contract commences. Hamilton County reserves the right at any time to require complete, certified copies of all required insurance policies, including endorsements affecting the coverage required by these specifications.

4. Provider shall declare any self-insured retention to Hamilton County pertaining to liability insurance. Provider shall provide a financial guarantee satisfactory to Hamilton County and HCJFS guaranteeing payment of losses and related investigations, claims administration and defense expenses for any self-insured retention.

5. If Provider provides insurance coverage under a "claims-made" basis, Provider shall provide evidence of either of the following for each type of insurance which is provided on a claims-made basis: unlimited extended reporting period coverage which allows for an unlimited period of time to report claims from incidents that occurred after the policy's retroactive date and before the end of the policy period (tail coverage), or; continuous coverage from the original retroactive date of coverage. The original retroactive date of coverage means original effective date of the first claim-made policy issued for a similar coverage while Provider was under Contract with the County on behalf of HCJFS.

6. Provider will require all insurance policies in any way related to the work and secured and maintained by Provider to include endorsements stating each underwriter will waive all rights of recovery, under subrogation or otherwise, against the County and HCJFS. Provider will require of subcontractors, by appropriate written agreements, similar waivers each in favor of all parties enumerated in this section.

7. Provider, the County, and HCJFS agree to fully cooperate, participate, and comply with all reasonable requirements and recommendations of the insurers and insurance brokers issuing or arranging for issuance of the policies required here, in all areas of safety, insurance program administration, claim reporting and investigating and audit procedures.

8. Provider's insurance coverage shall be primary insurance with respect to the County, HCJFS, their officials, and their respective employees, agents, and volunteers. Any insurance maintained by the County or

HCJFS shall be in excess of Provider's insurance and shall not contribute to it.

9. Maintenance of the proper insurance for the duration of the Contract is a material element of the Contract. Material changes in the required coverage or cancellation of the coverage shall constitute a material breach of the Contract.

10. If any of the work or services contemplated by this Contract is subcontracted, Provider will ensure that any and all subcontractors comply with all insurance requirements contained herein.

INDEMNIFICATION & HOLD HARMLESS

To the fullest extent permitted by and in compliance with applicable law, Provider agrees to protect, defend, indemnify and hold harmless the County in behalf of HCJFS and their respective members, officials, employees, agents, and volunteers (the Indemnified Parties) from and against all damages, liability, losses, claims, suits, actions, administrative proceedings, regulatory proceedings/hearings, judgments and expenses, subrogation's (of any party involved in the subject of this Contract), attorneys' fees, court costs, defense costs or other injury or damage (collectively "Damages"), whether actual, alleged or threatened, resulting from injury or damages of any kind whatsoever to any business, entity or person (including death), or damage to property (including destruction, loss of, loss of use of resulting without injury damage or destruction) of whatsoever nature, arising out of or incident to in any way, performance of the terms of this Contract including, without limitation, by Provider, its subcontractor(s), Provider's or its subcontractor's (s') employees and agents, assigns, and those designated by Provider to perform the work or services encompassed by the Contract. Provider agrees to pay all damages, costs and expenses of the Indemnified Parties in defending any action arising out of the aforementioned acts or omissions.

SCREENING AND SELECTION

A. Criminal Record Check:

Provider will complete criminal record checks on all individuals assigned to work with or transport Consumers. Provider will obtain a nationwide conviction record check through the Bureau of Criminal Identification and Investigation (the"BCII") and obtain a the criminal record transcript from the Cincinnati Police Department, the Hamilton County Sheriff's Office and any law enforcement or police department necessary to conduct a complete criminal record check of each individual providing Services.

Provider shall not assign any individual to work with or transport Consumers until a BCII report and a criminal record transcript has been obtained. A BCII report must be dated within six (6) months of the date an employee or volunteer is hired.

Provider shall not utilize any individual who has been convicted or plead guilty to any violations contained in ORC 5153.111(B)(1) or ORC 2919.24.

Provider warrants and represents that it will comply with Ohio Revised Code, Section 2151.86.

LOBBYING

During the life of the Contract, Provider warrants that Provider has not and will not use Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any Federal agency, a member of Congress, office or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C.1352. Provider further warrants that Provider shall disclose any lobbying with any non-Federal funds that takes place in connection with obtaining any Federal award. Upon receipt of notice, HCJFS will issue a termination notice in accordance with the terms of this Contract. If Provider fails to notify HCJFS, HCJFS reserves the right to immediately suspend payment and terminate the Contract.

MAINTENANCE OF SERVICE

Provider certifies the services being reimbursed are not available from the Provider on a non-reimbursable basis or for less than the unit cost and that the level of service existing prior to the Contract shall be maintained.

Provider further certifies that Federal funds will not be used to supplant non-federal funds for the same service.

GRIEVANCE PROCESS

Provider will notify HCJFS in writing on a monthly basis of all grievances initiated by participants that involve the services provided through this Contract. Provider shall submit any and all facts pertaining to the grievance and the resolution of the grievance. The monthly report will be submitted to the assigned Contract Manager.

Provider will post the grievance policy and procedure in a public or common area at each contracted site so all participants are aware of the process.

PROPERTY OF HAMILTON COUNTY

Any item produced under this Contract or with funds provided under this Contract, including any documents, data, photographs and negatives, electronic reports/records, or other media, are the property of Hamilton County, which has an unrestricted right to reproduce, distribute, modify, maintain, and use the deliverables. Provider will not obtain copyright, patent, or other proprietary protection for the deliverables. Provider will not include in any deliverable any copyrighted matter in the manner provided in this Contract. Provider agrees the deliverables will be made freely available to the general public unless HCJFS determines, pursuant to state or federal law, that such materials are confidential.

DEBARMENT AND SUSPENSION

OAC 5101:9-4-07(J)(7) Debarment and suspension

County family services agency and workforce development agency procedures must include requirements to ensure that no contracts are entered into with or purchases made from a person or entity which is debarred or suspended or is otherwise ineligible for participation in federal assistance programs under Executive Order 12549, debarment and suspension, and other applicable regulations and statutes, including 7 C.F.R. Part 3017, 29 C.F.R. Part 97, and 45 C.F.R. Part 76. Provider will, upon notification by any federal, state, or local government agency, immediately notify HCJFS of any debarment or suspension of the Provider being imposed or contemplated by the federal, state or local government agency. Provider will immediately notify HCJFS if it is currently under debarment or suspension by any federal, state, or local government agency.

DEBT CHECK PROVISION

Ohio Revised Code Section 9.24 prohibits public agencies from awarding a contract for goods, services, or construction, paid for in whole or in part from state funds, to a person or

entity against who a finding for recovery has been issued by the Ohio Auditor of State, if the finding for recovery is unresolved. By entering into this Contract, Provider warrants that a finding for recovery has not been issued to Provider by the Ohio Auditor of State. Provider further warrants and represents that Provider shall notify HCJFS within one (1) business day should a finding for recovery occur during the Contract term.

FAITH BASED ORGANIZATIONS

Provider agrees that it will perform the duties under this Contract in compliance with section 104 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and in a manner that will ensure that the religious freedom of program participants is not diminished and that it will not discriminate against any Consumer based on religion, religious belief, or refusal to participate in a religious activity. No funds provided under this Contract will be used to promote the religious character and activities of Provider. If any Consumer objects to the religious character of the organization, Provider will immediately refer the individual back to HCJFS for an alternative Provider.

CHILD SUPPORT ENFORCEMENT

Provider agrees to cooperate with HCJFS, ODJFS and any other Child Support Enforcement Agency in ensuring that Provider's employees meet child support obligations established under state law. Further, by executing this Contract, Provider certifies present and future compliance with any order for the withholding of support that is issued pursuant to sections 3113.21 and 3113.214 of the Ohio Revised Code.

DEFAULT BY PROVIDER

In the event of a Material Breach of this Contract by Provider, HCJFS may terminate this Contract, upon thirty (30) day prior written notice to Provider specifying the nature of the breach; provided that Provider shall have the opportunity to cure such breach within the thirty (30) day notice period. HCJFS reserves the right to invoke immediate termination as defined in Section 14, Termination.

MATERIAL BREACH shall mean an act or omission by a party which violates or contravenes an obligation required of the party under this Contract and which, by itself or together with one or more other breach(es), has a substantial negative effect on, or thwarts, the purpose of this Contract. Material Breach shall not include an act or omission which is merely a technical or immaterial variation from the form of the Contract, or which has a trivial or negligible effect on quality, quantity, or delivery of the goods or services to be

provided under this Contract, to the extent that in the opinion on the non-breaching party such technical or non-material variation does not rise to the level of a Material Breach when viewed in light of the breaching party's overall conduct under this Contract.

Any extension of time to cure any breach given to Provider by HCJFS shall be in writing and will not operate to preclude the future exercise of any rights HCJFS may have under this Contract.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT(HIPPA)

Provider agrees to comply with all Health Insurance Portability and Accessibility Act ("HIPPA") requirements and meet all HIPPA compliance dates.

HCJFS CONTACT INFORMATION

NAME	PHONE #	DEPARTMENT	RESPONSIBILITY
John Doe	987-1234	Contract Services	Contract changes, contract language
Jane Doe	987-4321	Contract Services	Contract budget, audits
TBD	946-	Fiscal	billing and payment
TBD	946-	Medicaid Services	scope of service, client authorization, service eligibility

CLEAN AIR AND FEDERAL WATER POLLUTION CONTROL ACT

Provider agrees to comply with all applicable standards, orders or regulations issued pursuant to section 306 of the Clean Air Act (42 U.S.C. 7401), section 508 of the Clean Water Act (33 U.S.C. 1386), Executive Order 11738, and environmental protection agency regulation (40 C.F.R. Part 30). Provider understands that violations of all applicable standards, orders or regulations issued pursuant to section 306 of the Clean Air Act (42 U.S.C.7401), section 508 of the Clean Water Act (33 U.S.C. 1386), Executive Order 11738, and environmental protection agency regulation (40 C.F.R. Part 30) must be reported to the Federal awarding agency and the Regional Office of Environmental Protection Agency (EPA).

ENERGY POLICY AND CONSERVATION ACT

Provider agrees to comply with all applicable standards; orders or regulations issued

relating to energy efficiency which is contained in the state energy conservation plan issued in compliance with the Energy Policy and Conservation Act (Pub. L. 94-163, 89 Stat. 871).

CONTRACT CLOSEOUT

At the discretion of HCJFS, a Contract Closeout may occur within ninety (90) days after the completion of all contractual terms and conditions. The purpose of the Contract Closeout is to verify there are no outstanding claims or disputes and to ensure all required forms; reports and deliverables were submitted to and accepted by HCJFS in accordance with contract requirements.

CAMPAIGN CONTRIBUTION DECLARATION

Provider shall provide the applicable notarized Affidavit in Compliance with Section 3517.13 of the Ohio Revised Code (Campaign Contribution Declaration – HB694). Amended Substitute House Bill 694 ("HB 694") limits solicitations of and political contributions by owners and certain family members of owners of businesses seeking or has been awarded public contracts. Provider further warrants Provider shall notify HCJFS within one (1) business day should the status of the HB 694 change during the Contract term. HB 694 and The Ohio Legislative Service Commission's Final Analysis of the Bill can be found on the Hamilton County Job & Family Service's (HCJFS) public website located at http://www.hcjfs.hamilton-co.org/, under the Community Providers information tab.

The terms of this contract are hereby agreed to by both parties, as shown by the signatures of representatives of each.

SIGNATURES

In witness whereof, the parties have hereunto set their hands on this _____day of _____, 2007.

Provider or Authorized Representative -
:_____
_____

Title:
_____Date:_____
_____ _____

By: _____ Date: _____
Hamilton County, Ohio

Recommended By:

_____ Date: _____
Moira Weir, Director
Hamilton County Department of Job & Family Services

Approved as to form:

By:_____Date:_____
_____
Prosecutor's Office
Hamilton County, Ohio

Prepared By: _____
Checked By: _____
Approved By: _____

Revised 3/1/06

ATTACHMENT C

Declaration of Property Tax Delinquency

(ORC 5719.042)

I, _____, hereby affirm that the Proposing Organization

herein, _____, is ____ / is not ____ **(check**

one) charged at the time of submitting this proposal with any delinquent property taxes on

the general tax list of personal property of the County of Hamilton.

If the Proposing Organization is delinquent in the payment of property tax, the amount of

such due and unpaid delinquent tax and any due and unpaid interest is

$_____.

State of Ohio

County of Hamilton

Before me, a notary public in and for said County, personally appeared

_____, authorized signatory for the Proposing Organization,

who acknowledges that he/she has read the foregoing and that the information provided

therein is true to the best of his/her knowledge and belief.

IN TESTIMONY WHEREOF, I have affixed my hand and seal of my office at _____, Ohio this _____ day of _____ 20____.

_____

Notary Public

ATTACHMENT D
Ohio Department of Public Safety

Division of Homeland Security

http://www.homelandsecurity.ohio.gov

GOVERNMENT BUSINESS AND FUNDING CONTRACTS

In accordance with section 2909.33 of the Ohio Revised Code

DECLARATION REGARDING MATERIAL ASSISTANCE/NONASSISTANCE TO A TERRORIST ORGANIZATION

This form serves as a declaration of the provision of material assistance to a terrorist organization or organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List (see the Ohio Homeland Security Division website for a reference copy of the Terrorist Exclusion List).

Any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided. Failure to disclose the provision of material assistance to such an organization or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree.

For the purposes of this declaration, "material support or resources" means currency, payment instruments, other financial securities, funds, transfer of funds, and financial services that are in excess of one hundred dollars, as well as communications, lodging, training, safe houses, false documentation or identification, communications equipment, facilities, weapons, lethal substances, explosives, personnel, transportation, and other physical assets, except medicine or religious materials.

LAST NAME	FIRST NAME	MIDDLE INITIAL
HOME ADDRESS		
CITY	STATE	ZIP	COUNTY
HOME PHONE	WORK PHONE	

COMPLETE THIS SECTION ONLY IF YOU ARE A COMPANY, BUSINESS OR ORGANIZATION

BUSINESS/ORGANIZATION NAME			
BUSINESS ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE NUMBER			

DECLARATION

In accordance with division (A)(2)(b) of section 2909.32 of the Ohio Revised Code

For each question, indicate either "yes" or "no" in the space provided. Responses must be truthful to the best of your knowledge.

1. Are you a member of an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ YES ☐ NO
2. Have you used any position of prominence you have with any country to persuade others to support an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ YES ☐ NO
3. Have you knowingly solicited funds or other things of value for an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ YES ☐ NO
4. Have you solicited any individual for membership in an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ YES ☐ NO
5. Have you committed an act that you know, or reasonably should have known, affords "material support or resources" to an organization on the U.S. Department of State Terrorist Exclusion List?
   ☐ YES ☐ NO
6. Have you hired or compensated a person you knew to be a member of an organization on the U.S. Department of State Terrorist Exclusion List, or a person you knew to be engaged in planning, assisting, or carrying out an act of terrorism?
   ☐ YES ☐ NO

In the event of a denial of a government contract or government funding due to a positive indication that material assistance has been provided to a terrorist organization, or an organization that supports terrorism as identified by the U.S. Department of State Terrorist Exclusion List, a review of the denial may be requested. The request must be sent to the Ohio Department of Public Safety's Division of Homeland Security. The request forms and instructions for filing can be found on the Ohio Homeland Security Division website.

CERTIFICATION

I hereby certify that the answers I have made to all of the questions on this declaration are true to the best of my knowledge. I understand that if this declaration is not completed in its entirety, it will not be processed and I will be automatically disqualified. I understand that I am responsible for the correctness of this declaration. I understand that failure to disclose the provision of material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List, or knowingly making false statements regarding material assistance to such an organization is a felony of the fifth degree. I understand that any answer of "yes" to any question, or the failure to answer "no" to any question on this declaration shall serve as a disclosure that material assistance to an organization identified on the U.S. Department of State Terrorist Exclusion List has been provided by myself or my organization. If I am signing this on behalf of a company, business or organization, I hereby acknowledge that I have the authority to make this certification on behalf of the company, business or organization referenced on page 1 of this declaration.

X _____ _____

Signature Date

ATTACHMENT E

HCJFS CONTRACT BUDGET USER GUIDE

When contracting with the Hamilton County Department of Job & Family Services (HCJFS), it is required that a budget be completed for each program being proposed. In order to facilitate the process, we request that the attached budget be used. This budget consists of two parts: the User Guide to assist in the completion of the budget, and the budget itself.

This guide is designed to assist the user in completing the budget. In some instances field definitions and other information will be given. If possible, examples will be provided. Definitions and examples will occasionally not be provided. Should you have a question regarding that particular area, contract the HCJFS Contract Services Section.

Page 1 is a summary of expenses. It should be completed after all other budget pages are finalized. The totals from the information supplied on pages 2 through 9 are used to complete this page. Information at the bottom of the page should be completed regarding the total units and the cost of the service. Pages 2 through 9 should be prepared itemizing each line item.

There are three columns without a column header or title. These columns have been purposely left blank in order for each Provider to enter the type of service being proposed. When completing the budget, it will be important to provide a header for each column being used. These columns are to be used to record the direct costs for the contracted program(s). If the program offers supportive services such as transportation, those costs should be broken out and entered in one of the other Contract Program columns. Costs for all other direct services of the agency should be combined and entered in the column titled “Other Direct Services”.

Management, administrative, and indirect costs should be entered in the column entitled "MGMT/Indirect". Indirect costs are those costs incurred for a common or joint purpose benefiting more than one service area or cost

center. Allowable indirect costs for the indirect cost column include, but are not limited to, the accounting and budgeting functions, disbursing services, personnel & procurement functions, and other agency administration.

INSTRUCTIONS FOR SUMMARY PAGE – PAGE 1

Page 1 of the budget is a summary of expenses. It should be completed after all other budget pages are finalized. Information at the bottom of the page should be completed regarding the total units and the cost of the service.

AGENCY NAME: The legal, and if applicable, incorporated name of the Provider agency.

NAME OF CONTRACT PROGRAM: The name of the program being purchased.

BUDGET PERIOD: The specific time period for the budget completed.

ACTUAL BUDGET AREA: A total of all the figures carried over from the previous pages. This gives an overview of the budget for which the proposal is being submitted, as well as, an overall picture of the agency costs. The total figures given for each of these areas should match the same figures indicated in each of the appropriate sections.

For a more detailed explanation of each of the areas, use the instructions in each specific section. Once all totals have been carried to this section be sure to double check the figures to make sure all columns and rows balance.

EXPENSES BY SERVICES COLUMN: Each column header from pages 2 through 9 are listed in this column so that the totals for each of these items can be listed in each of the specific columns.

EXPENSES BY PROGRAM SERVICES: The horizontal row is used to define the column header. "MGMT Indirect, Other Direct Ser and TOTAL Expense" fields are already defined. The first three column headers have been purposely left blank in order to indicate the name of the program being purchased.

If a proposal includes more than one service within the program, then an additional column would be completed for the additional service. For example, the proposal being submitted is for employment development. The services included in this proposal are skill training, and employment retention. In this instance, one column would be completed for skill training and the other for employment retention.

If for example, a proposal is being submitted for an offender program, the header for that column would be titled "Offender Program". In this instance, the other two column headers would be left blank.

If a proposal is being submitted is for workforce development and transportation and case management are two components of the program, then the first column header would indicate "Transportation" and the second column would indicate "Case Management". In this instance, the third column would be left blank.

MGMT INDIRECT: The totals entered per line item for each item on the other pages.

CONTRACT PROGRAM: The totals entered per line for each item on the other pages.

OTHER DIRECT SERVICES: The figures entered here should represent the total calculations based on the figures and percentages entered for each item on the other pages.

TOTAL EXPENSES: The totals for all figures entered on this page. They are also the totals of all of the three previous fields (MGMT Indirect, Contract Program and Other Direct Services) as well as the programs being purchased.

TOTAL UNITS: The number of units that the program being purchased is planning to provide. Depending on the contract, a unit could be considered an hour, a session, a trip, etc...

UNIT COST: The total expenses divided by the total units.

UNIT =: Indicate whether the unit is an hour, trip, session, etc.

INSTRUCTIONS FOR BUDGET SECTION A - PAGE 2; STAFF POSITIONS

This section is used to list all positions that are included in the contracted program. This page will also capture the financial information needed on the rest of the agency. If a proposal is being submitted for one service being offered within a program, one column would be completed for the contracted program, one for the management indirect services and one for other direct services. Should a proposal being submitted include more than one service within the program, an additional column would be completed for the additional service. For example, the proposal being submitted is for employment development. The services included in this proposal are skill training, and employment retention. In this instance one column would be completed for skill training and another for employment retention.

SALARIES: List all position titles of staff who work for the Agency. If Provider agency is extremely large, Provider may list salary amounts for staff in other direct service programs by program total or by one total for all other programs. However, in order to complete the budget in this manner, Provider must obtain permission from a Contract Services Supervisor or Section Chief. All staff who work in any capacity in the program or programs to be contracted, plus all management and administrative staff, must be listed separately with the specific amounts paid to each. In the second column, indicate the number of staff who have the same job title, i.e. teachers, and who earn the same annual wage. Indicate the number of staff and the annual cost - this is the amount paid annually to each of the teachers. If some teachers work more or less hours, and/or earn more, then a second, separate listing should be made. If the program has quite a number of staff then Provider may want to copy the Salaries page, to be able to list all the variations. Total all Salaries at the bottom of each column. Make sure this page "balances" - each column adds across and down, to the sum listed in the total sections.

POSITION TITLE: Indicate the titles of the individuals **presently** working in the program being contracted. If the Provider has an individual that has a percentage of time dedicated to the contracted program & another percentage dedicated to other areas, list this individual separately as well.

For EXAMPLE: The agency has three social workers. In this instance, two of those employees are dedicated full time to the program being contracted however; the other only spends 60% of their time on this project and 40% of their time on another project. Given this example, then all three social workers would be listed and the actual weekly number of hours worked in the program area would be entered in the HRS Week field.

The "other" field represents all staff employed by the agency that do not work in the contracted program.

For EXAMPLE: There is the Director and three social workers for the contracted program, then another four social workers that report to the same director but work in another program area. In this instance, the Director and the three social workers are listed as program personnel and the four social workers are then listed as "Others" because they work for the same agency but do not have anything to do with the program being contracted.

 # STAFF: This field must indicate the number of staff that hold the title listed in the "Position Title" field. However, in the "other: field, this number will be the total number of individuals employed by Provider company that do not have anything to do with the contracted program. Remember, if an employee works in the contracted program for any percentage of time then that person would be counted separately.

HRS WEEK: Indicate the number of hours worked each week in the contracted program area, for each employee.

ANNUAL COST: This is the annual salary for each individual listed in the contracted program area. The first block will contain the total of all the salaries

for those individuals counted as “Others”.

For example: There is the Director and three social workers for the contracted program, then another four social workers that report to the same director but work in another program area. In this instance, the Director and the three social workers are listed as program personnel and the four social workers are then listed as “Others” because they work for the same agency but do not have anything to do with the program being contracted.

CONTRACT PROGRAM: Enter the salary for the amount of time spent in the contracted program. There are three columns to indicate amounts for each program in which a proposal is being written. For vacant positions that will be filled during the contract year, prorate the salary to reflect the anticipated start date.

MGT INDIRECT: This field should only be completed if the position title of an individual is in a management position. Duties performed that would be included in the ”Percent to Mgt. Indirect” would include evaluations, writing checks, dealing with personnel issues, building management or other non-program issues.

OTHER DIRECT SERVICES: Enter the total salaries for each of the staff employed by the agency that is not related to the program being contracted.

TOTAL EXPENSES: This is the total of the Contracted Programs, Management Indirect, and any Other Direct Services.

INSTRUCTIONS FOR BUDGET SECTION B - PAGE 3; PAYROLL RELATED EXPENSES

PAYROLL TAXES: Enter the percentage used in calculating the amount withheld in each of the categories listed. The amounts figured using this percentage should be listed on the appropriate line under the "Expenses by Program Services" column.

UNEMPLOYMENT %: When computing unemployment taxes, the percentage of time the staff devotes to the contracted program should be used to calculate the amount of unemployment taxes attributed to the contracted program for that staff person up to the first $9,000.00 per employee wages, per year.

BENEFITS: The amounts charged to each column should be based on the staff and salaries shown in that column on page 2. Enter the totals in the spaces provided. The percentage used to calculate the retirement should be entered on the line indicated. The "OTHER" section should list all other deductions that are taken, listing each one separately.

TOTAL EMPLOYEE BENEFITS & PAYROLL TAXES: Indicate the total for the amounts indicated above.

INSTRUCTIONS FOR BUDGET SECTION C - PAGE 3; PROFESSIONAL FEES & CONTRACTED SERVICES

PROFESSIONAL FEES & CONTRACTED SERVICES: Contracted services are items such as janitorial, pest control, security, etc. Professional fees are when Provider pay for auditors, accountants, payroll processors, program consultants, etc. These costs are used to pay for services from a company or individual who is not an employee of the agency, but who performs a service for which he/she is paid. Show the amounts related to each column heading.

Each service that has been purchased (contract or professional) should be listed in this field, individually. For example, if the Provider has a contract with Terminix to provide bug control then that would be one item. The accountant would be another item.

TOTAL PROFESSIONAL FEES AND CONTRACTED SERVICES:

Indicate the totals for the amounts entered above.

INSTRUCTIONS FOR SECTION D - PAGE 4; CONSUMABLE SUPPLIES

CONSUMABLE SUPPLIES: Enter amounts for items used or consumed by the respective programs per the column heading. Generally supplies are items such as stationary, paper, pens, file folders, and envelopes. Other types of supplies are items such as cleaning supplies, toilet paper, mops, brooms, paper towels and floor cleaner. Program and other supplies would also be included in this section such as printed pamphlets, text books and/or computer software. These items must be used or consumed within one year or less. List each item under "OTHER" separately and be specific.

INSTRUCTIONS FOR SECTION E - PAGE 4; OCCUPANCY COSTS

OCCUPANCY COSTS: Enter amounts in the proper column based on a proration of space used by the programs under the column headings. It may be necessary to actually measure the space used by the various programs to achieve a proper proration of these costs. Some Provider's choose to put building and other occupancy costs in their Management and Indirect Costs column, and allocate them along with other "shared" types of costs. Telephone costs should be allocated or prorated based on actual usage, that is the number of phones used by Contract Program, and amount of long distance calls, rather than combined with other occupancy costs.

The occupancy cost includes a usage allowance that is similar to depreciation when the building is owned. In order to calculate the cost, the historical cost of the building must be used. The Provider must calculate the percentage that is to be used by the contracted program. Once both figures are obtained, the cost of the building is multiplied by the percentage of space used to determine the dollar amount to be charged to the program. For example, the actual cost of the building was $150,000.00. The building is 3 stories and each story is 1000 square feet. The third floor is the management, the second floor is another

program and the first floor is the contracted program. In this case, the first floor or 1000 square feet would be changed to the program or 33%. Therefore, $150,000.00 divided by the 37.5 year life (life span per the IRS) of the building times 33% (program utilization) = $1,320.00 per year. This amount can be charged to the program.

RENTAL @ PER SQ. FT.: Indicate the unit amount per square foot. For example, the rent is $1000.00 per month for 100 square feet; however the unit amount is $10.00. Indicate the total dollar amount in the block for the budget period. For example, the rent is $1000.00 per month. The contract is for 10 months. The total dollar amount entered should be $10,000.00.

HEAT & ELECTRICITY: If taking a straight line percentage of the total electric for the agency, identify the percentage used on the line indicated. If this is included in the rent, write the word "included" on this line.

WATER: If taking a straight line percentage of the total water for the agency, identify the percentage used on the line indicated. If this is included in the rent, write the word "included" on this line.

TELEPHONE: If taking a straight line percentage of the total phone cost for the agency, identify the percentage used on the line indicated.

OTHER: List all other deductions for occupancy costs separately and be specific.

INSTRUCTIONS FOR SECTION F - PAGE 5; TRAVEL COSTS

TRAVEL COSTS: The costs entered into each column should be based on a review of actual travel costs incurred by the respective programs. A study of past years records should be completed before this section of the budget is prepared. Enter the figure used to calculate the reimbursement rate on the line provided.

TOTAL TRAVEL COSTS: Enter the amount for each column on this line. Be sure the totals balance for all columns.

INSTRUCTIONS FOR SECTION G - PAGE 5; INSURANCE COSTS

INSURANCE: Some agencies allocate all insurance costs to the Management and Indirect column of their budgets, and then allocate them along with all the other shared type of costs. If one program operated by the agency has disproportionate insurance costs (either higher or lower) than the other agency programs, then a more appropriate method would be to show that program's insurance costs in the column for that program.

INSTRUCTIONS FOR SECTION H - PAGES 6 & 7; EQUIPMENT COSTS

EQUIPMENT COSTS: There are some directions listed on the budget pages for completing the four areas of this section. Any individual equipment item costing less than $5,000 should be included as equipment cost. The exception to the "individual equipment cost" is for computer components which are purchased as a group, i.e. hard drive, monitor, keyboard, printer, etc. While these components may individually cost less than $5,000, the entire group is to be depreciated if the purchase price is $5,000 or greater. For equipment items used for more than one program, show the percentage of time the contract program expects to use them and compute the amount based on that percentage. The large equipment items used by the Management and Indirect activities of the agency should also be listed, with the percentage used by both programs, i.e. the Contract Program and MGT/Indirect, computed.

INSTRUCTIONS FOR SECTION I - PAGE 8; MISCELLANEOUS COSTS

MISCELLANEOUS COSTS: Enter any expense items, and the amount which

Provider expects to spend for them, that Provider has not entered elsewhere in this document. Examples of miscellaneous costs are printing, advertising, and postage.

TOTAL MISCELLANEOUS COSTS: Enter the total of all miscellaneous costs in this section in the appropriate columns.

PROFIT MARGIN: For profit entities only - Enter the amount of profit being charged to the contract program.

TOTAL OF ALL EXPENSES: The total of all expenses should be calculated from the sub-totals of sections D through I.

EXPLANATION: Be sure to pay special attention to this section. It is important to note the rationale or basis for the figures used in the proration of MGT/INDIRECT costs. Specific instructions have been included on the budget to be followed.

INSTRUCTIONS FOR SECTION G - PAGE 9; INSTRUCTIONS FOR REVENUES BY PROGRAM SERVICES SECTION

Revenues of the Agency should also be completed for the same time period for which the budget expenses are detailed. Please use the "Explanation" section and attach extra pages if needed. Be specific and list each funding separately. Government contracts, including the revenues expected to be received from the contract with HCJFS, should be listed separately (i.e., Hamilton County $nnn,nnn.nn, Butler County $nnn,nnn.nn). Donations from individual benefactors need not be listed separately unless they represent a significant proportion or amount of donated funds. Fees from clients do not mean fees paid by third parties (insurance, Medicaid, contracts), and should only represent monies gained directly from clients.

FINAL REVIEW

1. Before submitting the budget, make a final check that each column of each page is correctly added, and that all figures are legible.

2. Review the Revenue page and make sure all revenue sources are listed. The total revenues shown MUST equal or exceed the total expenses shown in pages 1-8.

3. Please review Equipment section to make sure that all equipment purchases have been listed in proper section.

ATTACHMENT E1

HCJFS CONTRACT BUDGET

(Check for 4-month suppression of Unit Rate Alerts for new budgets)

AGENCY _____ **BUDGET PREPARED FOR PERIOD**

NAME OF CONTRACT PROGRAM Medicaid Outreach 2007 TO 2008

INDICATE NAME OF SERVICE IN APPROPRIATE COLUMN BELOW

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
A. STAFF SALARIES						
B. EMPLOYEE PAYROLL TAXES & BENEFITS						
C. PROFESSIONAL & CONTRACTED SERVICES						
D. CONSUMABLE SUPPLIES						
E. OCCUPANCY						
F. TRAVEL						
G. INSURANCE						
H. EQUIPMENT						
I. MISCELLANEOUS						
J. PROFIT MARGIN						
SUB-TOTAL OF EACH COLUMN						
ALLOCATION OF MGT/INDIRECT COSTS						
TOTAL PROGRAM EXPENSES						

ESTIMATED TOTAL UNITS OF SERVICE TO BE PROVIDED: _____ _____ _____ UNIT=_____

TOTAL PROGRAM COST/TOTAL UNITS OF SERVICE = UNIT COST: $_____ $_____ $_____

EXHIBIT II

A. STAFF SALARIES – Attach Extra Pages for Staff, if needed

POSITION TITLE	# STAFF	HRS WEEK	ANNUAL COST	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERVICE	TOTAL EXPENSE
TOTAL SALARIES									

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERVICES	TOTAL EXPENSE
B. PAYROLL TAXES						
FICA _____ %						
WORKER'S COMP. _____%						
UNEMPLOYMENT _____ %						
BENEFITS						
RETIREMENT _____ %						
HOSPITAL CARE						
OTHER (SPECIFY)						
TOTAL EMPLOYEE PAYROLL TAXES & BENEFITS						

C. PROFESSIONAL FEES & CONTRACTED SERVICES (Indicate type, function performed, and estimate of use (hours, days, etc.)	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERVICES	TOTAL EXPENSE
TOTAL PROFESSIONAL FEES & CONTRACTED SERVICES						

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERVICES	TOTAL EXPENSE
D.CONSUMABLE SUPPLIES						
OFFICE						
CLEANING						
PROGRAM						
OTHER (SPECIFY)						
TOTAL CONSUMABLE SUPPLIES						
E. OCCUPANCY COSTS						
RENTAL @ ___ PER SQ.FT.						
USAGE ALLOWANCE OF BLDG.OWNED @2% OF ORIG.ACQUISTION COST						
MAINTENANCE & REPAIRS						
UTILITIES (MAY BE INCLUDED IN RENT) HEAT & ELECTRIC _____ WATER _____						
TELEPHONE						
OTHER (SPECIFY)						
TOTAL OCCUPANCY COSTS						

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
F. TRAVEL COSTS						
GASOLINE & OIL						
VEHICLE REPAIR						
VEHICLE LICENSE						
VEHICLE INSURANCE						
OTHER						
MILEAGE REIMBURSE.@ ___ PER MILE						
CONFERENCES & MEETINGS, ETC.						
PURCHASED TRANSPORTATION						
TOTAL TRAVEL COSTS						
G. INSURANCE COSTS						
LIABILITY						
PROPERTY						
ACCIDENT						
OTHER						
TOTAL INSURANCE COSTS						

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERV	TOTAL EXPENSE
H. EQUIPMENT COSTS						
SMALL EQUIPMENT (items costing under $5,000.00, which are to be purchased during budget period should be listed)						
TOTAL SMALL EQUIPMENT COSTS						
EQUIPMENT MAINTENANCE & REPAIR (DETAIL)						
TOTAL EQUIPMENT & REPAIR						
EQUIPMENT LEASE COSTS (DETAIL)						
TOTAL LEASE COSTS						
TOTAL COST DEPRECIATION OF LARGE EQUIPMENT ITEMS (detail on page 7)						
TOTAL EQUIPMENT COSTS						

EXHIBIT II

LARGE EQUIPMENT DEPRECIATION COSTS

Any individual equipment item costing $5,000 or more at time of purchase may be included in the budget and must be depreciated. The exception to the "individual equipment item" is for computer components which are purchased as a group, i.e. hard drive, monitor, keyboard, printer, etc. If the total cost for all the components is $5,000 or greater, the equipment must be depreciated. Any item which was fully depreciated on the agency's books prior to the beginning date of the contract may not be used as a basis for determining costs of the program proposed for a contract, even though that item of equipment is used by the program. Any items of equipment used by the Management and Indirect activities of the Agency for which costs are included in this budget must also be itemized on this sheet. If needed, extra copies may be made and numbered 7A, 7B, & 7C, etc.

ITEM(S) TO BE DEPRECIATED	NEW OR USED	DATE OF PURCHASE	TOTAL ACTUAL COST	SALVAGE VALUE	TOTAL TO DEPRECIATE	USEFUL LIFE	CHARGEABLE ANNUAL DEPRECIATION	PERCENT USED BY CONTRACT PROGRAM	AMOUNT CHARGED TO CONTRACT PROGRAM	WHICH CONTRACTED PROGRAM

EXHIBIT II

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
I. MISCELLANEOUS COSTS						
TOTAL MISCELLANEOUS COSTS						
J. PROFIT MARGIN (For profit entities only- indicate the amount)						
TOTAL PROGRAM EXPENSES						

A rationale or basis for the proration of MGT/INDIRECT Cost must be included which details how the amount charged to this program was determined. Some agencies allocate these types of costs on staff salaries, total personnel costs, total direct program costs, and/or time studies. HCJFS staff are available to discuss the most appropriate basis for the program for which the budget is being prepared, if agency staff are unfamiliar with this process.

EXPLANATION: _____

_____

_____

REVENUES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SER	TOTAL REVENUES
A. GOVERNMENTAL AGENCY FUNDING (specify agency & type)						
B. OTHER FUNDING						
FEES FROM CLIENTS						
CONTRIBUTIONS – (identify all contributions which exceed $1000.00 by donor and amount)						
AWARDS & GRANTS						
OTHER (specify)						
TOTAL REVENUE						

EXPLANATION OF ANY ITEMS ABOVE: _____

_____

_____

_____

HCJFS CONTRACT BUDGET

(Check for 4-month suppression of Unit Rate Alerts for new budgets)

AGENCY _____ **BUDGET PREPARED FOR PERIOD**

NAME OF CONTRACT PROGRAM Medicaid Outreach 2008 TO 2009

INDICATE NAME OF SERVICE IN APPROPRIATE COLUMN BELOW

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
A. STAFF SALARIES						
B. EMPLOYEE PAYROLL TAXES & BENEFITS						
C. PROFESSIONAL & CONTRACTED SERVICES						
D. CONSUMABLE SUPPLIES						
E. OCCUPANCY						
F. TRAVEL						
G. INSURANCE						
H. EQUIPMENT						
I. MISCELLANEOUS						
J. PROFIT MARGIN						
SUB-TOTAL OF EACH COLUMN						
ALLOCATION OF MGT/INDIRECT COSTS						
TOTAL PROGRAM EXPENSES						

ESTIMATED TOTAL UNITS OF SERVICE TO BE PROVIDED: _____ _____ _____ UNIT=_____

TOTAL PROGRAM COST/TOTAL UNITS OF SERVICE = UNIT COST: $_____ $_____ $_____

EXHIBIT II

A. STAFF SALARIES – Attach Extra Pages for Staff, if needed

POSITION TITLE	# STAFF	HRS WEEK	ANNUAL COST	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERVICE	TOTAL EXPENSE
TOTAL SALARIES									

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERVICES	TOTAL EXPENSE
B. PAYROLL TAXES						
FICA _____ %						
WORKER'S COMP. _____%						
UNEMPLOYMENT _____ %						
BENEFITS						
RETIREMENT _____ %						
HOSPITAL CARE						
OTHER (SPECIFY)						
TOTAL EMPLOYEE PAYROLL TAXES & BENEFITS						

C. PROFESSIONAL FEES & CONTRACTED SERVICES (Indicate type, function performed, and estimate of use (hours, days, etc.)	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERVICES	TOTAL EXPENSE
TOTAL PROFESSIONAL FEES & CONTRACTED SERVICES						

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERVICES	TOTAL EXPENSE
D.CONSUMABLE SUPPLIES						
OFFICE						
CLEANING						
PROGRAM						
OTHER (SPECIFY)						
TOTAL CONSUMABLE SUPPLIES						
E. OCCUPANCY COSTS						
RENTAL @ ___ PER SQ.FT.						
USAGE ALLOWANCE OF BLDG.OWNED @2% OF ORIG.ACQUISTION COST						
MAINTENANCE & REPAIRS						
UTILITIES (MAY BE INCLUDED IN RENT) HEAT & ELECTRIC _____ WATER _____						
TELEPHONE						
OTHER (SPECIFY)						
TOTAL OCCUPANCY COSTS						

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
F. TRAVEL COSTS						
GASOLINE & OIL						
VEHICLE REPAIR						
VEHICLE LICENSE						
VEHICLE INSURANCE						
OTHER						
MILEAGE REIMBURSE.@ ___ PER MILE						
CONFERENCES & MEETINGS, ETC.						
PURCHASED TRANSPORTATION						
TOTAL TRAVEL COSTS						
G. INSURANCE COSTS						
LIABILITY						
PROPERTY						
ACCIDENT						
OTHER						
TOTAL INSURANCE COSTS						

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERV	TOTAL EXPENSE
H. EQUIPMENT COSTS						
SMALL EQUIPMENT (items costing under $5,000.00, which are to be purchased during budget period should be listed)						
TOTAL SMALL EQUIPMENT COSTS						
EQUIPMENT MAINTENANCE & REPAIR (DETAIL)						
TOTAL EQUIPMENT & REPAIR						
EQUIPMENT LEASE COSTS (DETAIL)						
TOTAL LEASE COSTS						
TOTAL COST DEPRECIATION OF LARGE EQUIPMENT ITEMS (detail on page 7)						
TOTAL EQUIPMENT COSTS						

EXHIBIT II

LARGE EQUIPMENT DEPRECIATION COSTS

Any individual equipment item costing $5,000 or more at time of purchase may be included in the budget and must be depreciated. The exception to the "individual equipment item" is for computer components which are purchased as a group, i.e. hard drive, monitor, keyboard, printer, etc. If the total cost for all the components is $5,000 or greater, the equipment must be depreciated. Any item which was fully depreciated on the agency's books prior to the beginning date of the contract may not be used as a basis for determining costs of the program proposed for a contract, even though that item of equipment is used by the program. Any items of equipment used by the Management and Indirect activities of the Agency for which costs are included in this budget must also be itemized on this sheet. If needed, extra copies may be made and numbered 7A, 7B, & 7C, etc.

ITEM(S) TO BE DEPRECIATED	NEW OR USED	DATE OF PURCHASE	TOTAL ACTUAL COST	SALVAGE VALUE	TOTAL TO DEPRECIATE	USEFUL LIFE	CHARGEABLE ANNUAL DEPRECIATION	PERCENT USED BY CONTRACT PROGRAM	AMOUNT CHARGED TO CONTRACT PROGRAM	WHICH CONTRACTED PROGRAM

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
I. MISCELLANEOUS COSTS						
TOTAL MISCELLANEOUS COSTS						
J. PROFIT MARGIN (For profit entities only- indicate the amount)						
TOTAL PROGRAM EXPENSES						

A rationale or basis for the proration of MGT/INDIRECT Cost must be included which details how the amount charged to this program was determined. Some agencies allocate these types of costs on staff salaries, total personnel costs, total direct program costs, and/or time studies. HCJFS staff are available to discuss the most appropriate basis for the program for which the budget is being prepared, if agency staff are unfamiliar with this process.

EXPLANATION: _____

_____

_____

REVENUES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SER	TOTAL REVENUES
A. GOVERNMENTAL AGENCY FUNDING (specify agency & type)						
B. OTHER FUNDING						
FEES FROM CLIENTS						
CONTRIBUTIONS – (identify all contributions which exceed $1000.00 by donor and amount)						
AWARDS & GRANTS						
OTHER (specify)						
TOTAL REVENUE						

EXPLANATION OF ANY ITEMS ABOVE: _____

_____

_____

_____

HCJFS CONTRACT BUDGET

(Check for 4-month suppression of Unit Rate Alerts for new budgets)

AGENCY _____ **BUDGET PREPARED FOR PERIOD**

NAME OF CONTRACT PROGRAM Medicaid Outreach **2009 TO 2010**

INDICATE NAME OF SERVICE IN APPROPRIATE COLUMN BELOW

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
A. STAFF SALARIES						
B. EMPLOYEE PAYROLL TAXES & BENEFITS						
C. PROFESSIONAL & CONTRACTED SERVICES						
D. CONSUMABLE SUPPLIES						
E. OCCUPANCY						
F. TRAVEL						
G. INSURANCE						
H. EQUIPMENT						
I. MISCELLANEOUS						
J. PROFIT MARGIN						
SUB-TOTAL OF EACH COLUMN						
ALLOCATION OF MGT/INDIRECT COSTS						
TOTAL PROGRAM EXPENSES						

ESTIMATED TOTAL UNITS OF SERVICE TO BE PROVIDED: _____ _____ _____ **UNIT=** _____

TOTAL PROGRAM COST/TOTAL UNITS OF SERVICE = UNIT COST: $_____ $_____ $_____

EXHIBIT II

A. STAFF SALARIES – Attach Extra Pages for Staff, if needed

POSITION TITLE	# STAFF	HRS WEEK	ANNUAL COST	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERVICE	TOTAL EXPENSE
TOTAL SALARIES									

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERVICES	TOTAL EXPENSE
B. PAYROLL TAXES						
FICA _____ %						
WORKER'S COMP. _____%						
UNEMPLOYMENT _____ %						
BENEFITS						
RETIREMENT _____ %						
HOSPITAL CARE						
OTHER (SPECIFY)						
TOTAL EMPLOYEE PAYROLL TAXES & BENEFITS						

C. PROFESSIONAL FEES & CONTRACTED SERVICES (Indicate type, function performed, and estimate of use (hours, days, etc.)	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERVICES	TOTAL EXPENSE
TOTAL PROFESSIONAL FEES & CONTRACTED SERVICES						

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERVICES	TOTAL EXPENSE
D.CONSUMABLE SUPPLIES						
OFFICE						
CLEANING						
PROGRAM						
OTHER (SPECIFY)						
TOTAL CONSUMABLE SUPPLIES						
E. OCCUPANCY COSTS						
RENTAL @ ___ PER SQ.FT.						
USAGE ALLOWANCE OF BLDG.OWNED @2% OF ORIG.ACQUISTION COST						
MAINTENANCE & REPAIRS						
UTILITIES (MAY BE INCLUDED IN RENT) HEAT & ELECTRIC _____ WATER _____						
TELEPHONE						
OTHER (SPECIFY)						
TOTAL OCCUPANCY COSTS						

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
F. TRAVEL COSTS						
GASOLINE & OIL						
VEHICLE REPAIR						
VEHICLE LICENSE						
VEHICLE INSURANCE						
OTHER						
MILEAGE REIMBURSE.@ ___ PER MILE						
CONFERENCES & MEETINGS, ETC.						
PURCHASED TRANSPORTATION						
TOTAL TRAVEL COSTS						
G. INSURANCE COSTS						
LIABILITY						
PROPERTY						
ACCIDENT						
OTHER						
TOTAL INSURANCE COSTS						

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SERV	TOTAL EXPENSE
H. EQUIPMENT COSTS						
SMALL EQUIPMENT (items costing under $5,000.00, which are to be purchased during budget period should be listed)						
TOTAL SMALL EQUIPMENT COSTS						
EQUIPMENT MAINTENANCE & REPAIR (DETAIL)						
TOTAL EQUIPMENT & REPAIR						
EQUIPMENT LEASE COSTS (DETAIL)						
TOTAL LEASE COSTS						
TOTAL COST DEPRECIATION OF LARGE EQUIPMENT ITEMS (detail on page 7)						
TOTAL EQUIPMENT COSTS						

EXHIBIT II

LARGE EQUIPMENT DEPRECIATION COSTS

Any individual equipment item costing $5,000 or more at time of purchase may be included in the budget and must be depreciated. The exception to the "individual equipment item" is for computer components which are purchased as a group, i.e. hard drive, monitor, keyboard, printer, etc. If the total cost for all the components is $5,000 or greater, the equipment must be depreciated. Any item which was fully depreciated on the agency's books prior to the beginning date of the contract may not be used as a basis for determining costs of the program proposed for a contract, even though that item of equipment is used by the program. Any items of equipment used by the Management and Indirect activities of the Agency for which costs are included in this budget must also be itemized on this sheet. If needed, extra copies may be made and numbered 7A, 7B, & 7C, etc.

ITEM(S) TO BE DEPRECIATED	NEW OR USED	DATE OF PURCHASE	TOTAL ACTUAL COST	SALVAGE VALUE	TOTAL TO DEPRECIATE	USEFUL LIFE	CHARGEABLE ANNUAL DEPRECIATION	PERCENT USED BY CONTRACT PROGRAM	AMOUNT CHARGED TO CONTRACT PROGRAM	WHICH CONTRACTED PROGRAM

EXPENSES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SER	TOTAL EXPENSE
I. MISCELLANEOUS COSTS						
TOTAL MISCELLANEOUS COSTS						
J. PROFIT MARGIN (For profit entities only- indicate the amount)						
TOTAL PROGRAM EXPENSES						

A rationale or basis for the proration of MGT/INDIRECT Cost must be included which details how the amount charged to this program was determined. Some agencies allocate these types of costs on staff salaries, total personnel costs, total direct program costs, and/or time studies. HCJFS staff are available to discuss the most appropriate basis for the program for which the budget is being prepared, if agency staff are unfamiliar with this process.

EXPLANATION: _____

_____

_____

REVENUES BY PROGRAM SERVICES	PROGRAM 1	PROGRAM 2	PROGRAM 3	MGMT INDIRECT	OTHER DIRECT SER	TOTAL REVENUES
A. GOVERNMENTAL AGENCY FUNDING (specify agency & type)						
B. OTHER FUNDING						
FEES FROM CLIENTS						
CONTRIBUTIONS – (identify all contributions which exceed $1000.00 by donor and amount)						
AWARDS & GRANTS						
OTHER (specify)						
TOTAL REVENUE						

EXPLANATION OF ANY ITEMS ABOVE: _____

ATTACHMENT F

AFFIDAVIT IN COMPLIANCE WITH

SECTION 3517.13 OF THE OHIO REVISED CODE

(Corporation or Business Trust)

(*R.C. 3517.13(J)(3)*)

STATE OF OHIO

COUNTY OF _____ SS:

I, the undersigned, after being first duly cautioned and sworn, state the following with respect to Section 3517.13 of the Ohio Revised Code:

1. I am _____ and I am employed as _____
[*Name*] [*Title*]
for _____.
[*Name of Corporation/Business Trust*]

2. In my position as _____, I have the authority to make the
[*Title*]
certifications contained herein on behalf of _____.
[*Name of Corporation/Business Trust*]

3. On behalf of _____, I do hereby certify that all of
[*Name of Corporation/Business Trust*]
the following persons, if applicable, are in compliance with division (J)(1) of Section 3517.13 of the Ohio Revised Code:
   (a) Each owner of more than twenty per cent of the corporation or business trust;
   (b) Each spouse of an owner of more than twenty per cent of the corporation or business trust;
   (c) Each child seven years of age to seventeen years of age of an owner of more than twenty per cent of the corporation or business trust;
   (d) Any political action committee affiliated with the corporation or business trust;
   (e) Any combination of persons identified in (a) through (d) of this section.

4. I further certify that if _____ is awarded a

[*Name of Corporation/Business Trust*]

contract, the following persons shall, beginning on the date the contract is awarded and extending until one year following the conclusion of that contract, maintain compliance with division (J)(2) of Section 3517.13 of the Ohio Revised Code:

(a) An owner of more than twenty per cent of the corporation or business trust;

(b) A spouse of an owner of more than twenty per cent of the corporation or business trust;

(c) A child seven years of age through seventeen years of age of an owner of more than twenty per cent of the corporation or business trust;

(d) Any political action committee affiliated with the corporation or business trust;

(e) Any combination of persons identified in (a) through (d) of this section.

5. I do hereby acknowledge that to knowingly make any false statement herein may subject me and/or _____ to the penalties set forth in Section

[*Name of Corporation/Business Trust*]

3517.992 of the Ohio Revised Code.

Further, Affiant sayeth naught.

_____

[*Signature*]

_____

[*Title*]

Sworn to before me, and subscribed in my presence, this _____ day of _____, 200_.

_____

Notary Public - State of _____

My Commission Expires: _____

ATTACHMENT F1

AFFIDAVIT IN COMPLIANCE WITH

SECTION 3517.13 OF THE OHIO REVISED CODE

(Individuals or Non-Corporate Entities)

(*R.C. 3517.13(I)(3)*)

STATE OF OHIO

COUNTY OF _____ SS:

I, the undersigned, after being first duly cautioned and sworn, state the following with respect to Section 3517.13 of the Ohio Revised Code:

1. I am _____ and I am employed as _____
[*Name*] [*Title*]

for _____.
[*Name of Entity*]

3. In my position as _____, I have the authority to make the
[*Title*]
certifications contained herein on behalf of _____.
[*Name of Entity*]

5. On behalf of _____, I do hereby certify that the
[*Name of Entity*]
following persons, if applicable, are in compliance with division (I)(1) of Section 3517.13 of the Ohio Revised Code:

(a) The individual;
(b) Each partner or owner of the partnership or other unincorporated business;
(c) Each shareholder of the association;
(d) Each administrator of the estate;

(e) Each executor of the estate;

(f) Each trustee of the trust;

(g) Each spouse of any person identified in (a) through (f) of this section;

(h) Each child seven years of age to seventeen years of age of any person identified in (a) through (f) of this section;

(i) Any political action committee affiliated with the partnership or other unincorporated business, association, estate, or trust.

(j) Any combination of persons identified in (a) through (i) of this section.

6. I further certify that if _____ is awarded a contract,

[*Name of Entity*]

the following persons shall, beginning on the date the contract is awarded and extending until one year following the conclusion of that contract, maintain compliance with division (I)(2) of Section 3517.13 of the Ohio Revised Code:

(a) The individual;

(b) Each partner or owner of the partnership or other unincorporated business;

(c) Each shareholder of the association;

(d) Each administrator of the estate;

(e) Each executor of the estate;

(f) Each trustee of the trust;

(g) Each spouse of any person identified in (a) through (f) of this section;

(h) Each child seven years of age to seventeen years of age of any person identified in (a) through (f) of this section;

(i) Any political action committee affiliated with the partnership or other unincorporated business, association, estate, or trust.

(j) Any combination of persons identified in (a) through (i) of this section.

5. I do hereby acknowledge that to knowingly make any false statement herein may subject me and/or _____ to the penalties set forth in Section

[Name of Entity]

3517.992 of the Ohio Revised Code.

Further, Affiant sayeth naught.

_____

[*Signature*]

_____

[*Title*]

Sworn to before me, and subscribed in my presence, this _____ day of _____, 200_.

_____

Notary Public - State of _____

My Commission Expires: _____

PART I: To be completed by the Hamilton County Department of Job and Family Services

Consumer's Name:	Case Number:	Date Sent:	
Tenant's Name: *(if different)*	Caseworker's Name:	District:	Phone: 946-

Part III of this form should be completed by:
- ☐ Landlord/Caretaker (if receiving Food Stamps)
- ☐ Person aware of consumer's situation, but ***NOT*** related to the consumer and ***NOT*** living in the same household

PART II: Release of information to be completed by the Consumer

My signature below means that I give the person indicated below permission to furnish all information about me that is requested on this form. I understand this information will be used to establish my eligibility for public assistance. I also give the Department of Job and Family Services permission to contact this person to obtain or clarify any information contained on this form.

Consumer's Signature:	Phone:	Date:

PART III: To be completed by Landlord/Caretaker or Disinterested Third Party

I verify that the person listed below: ☐ ***is*** living at the address listed; ☐ ***will be*** living at the address listed

Consumer's Name: *(First and Last)*

Street Address:	Apt. # or Floor:	City:	State:	Zip:

List all others who live at this address: *(including children)* Use the back of this form if additional space is required.

First Name	Last Name	Relationship to Consumer	Source of Income	Date (s)he began living at above address

Utilities

Check which utilities tenant is responsible for:
☐ None; ☐ Gas Heat; ☐ Cooking Gas; ☐ Garbage; ☐ Water;
☐ Electric; ☐ Other: (specify) _____

Are utilities subsidized? ..... ☐ No; ☐ Yes
If yes, what is the monthly subsidy amount? $
Is tenant responsible for air conditioning charges? ☐ No; ☐ Yes

CMHA only below:
Has any of the utility subsidy been applied toward the rent? ..... ☐ No; ☐ Yes
If yes, how much? ..... $

CMHA – enter only tenant's owed amount in the rent section.
Is this account eligible for a utility reimbursement check? ..... ☐ No; ☐ Yes
If yes, how much? ..... $

Rent

What is tenant's out-of-pocket monthly cost for rent? ..... $
Is heat included in the rent? ..... ☐ No; ☐ Yes
Is rent subsidized? ..... ☐ No; ☐ Yes
If yes, what is the amount of subsidy? *(if any)* ..... $
List the name of the person/entity who subsidizes the rent here: _____

Are there any additional, **mandatory** charges (i.e., air conditioning, appliances, pets, etc.) for the rental of this unit? ..... ☐ No; ☐ Yes
If yes, the amount is: ..... $

My signature below indicates that I completed this form and it is accurate to the best of my knowledge.

Signature of person completing form:	*Address:*	*Phone:*	*Date:*

Are you the landlord/caretaker? ☐ No; ☐ Yes
Are you related to the tenant? ☐ No; ☐ Yes — *If yes, specify relationship:* _____

Do Not Write Below This Line (Agency Use Only)

This statement is acceptable for eligibility: ☐ Yes; ☐ No — *If not, Indicate reason this form is unacceptable:*

Employee's Signature:	*District:*	*Date:*

HCJFS 3390 (REV. 5-06)

9. Signature of person who completed this application

By signing this application:

- I understand the questions on this form and certify, under penalty of perjury, that all my answers are correct and complete to the best of my knowledge, including information about the citizenship or alien status of each household member applying for assistance.
- I state under penalty of perjury I have disclosed all annuities and other similar financial devices in which I and/or my spouse have any interest.
- I understand and agree to provide documents to prove what I have said.
- I understand and agree that the CDJFS may contact other persons or organizations to obtain the necessary proof of my eligibility and level of assistance.
- I understand that by signing this application and receiving OWF, I am assigning to the State of Ohio any rights to all support owed to me and the minor children in the assistance group.
- I understand that in some instances, I may be asked to give consent to the CDJFS to make whatever contacts are necessary to determine my eligibility.

Signature of Applicant or Authorized Representative	If Authorized Representative, Relationship to Applicant	Date

10. What to do when you complete this application

OHIO Job & Family SERVICES

Return this application to your local County Department of Job and Family Services office.

Your civil rights

Federal law and the policies of the U.S. Department of Agriculture (USDA), the U.S. Department of Health and Human Services (HHS), the Ohio Department of Job and Family Services (ODJFS) and the local County Department of Job & Family Services (CDJFS) say that we must not discriminate on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a discrimination complaint, write or call USDA, HHS, or ODJFS.

Write or Call:	Write or Call:	Write or Call:
USDA Director, Office of Civil Rights Room 326-W, Whitten Building 1400 Independence Avenue, S.W. Washington, D.C. 20250-9410 (202) 720-5964 (voice and TDD)	**HHS** Region V, Office of Civil Rights 233 N. Michigan Ave., Suite 240 Chicago, Illinois 60601 (312)886-2359 (voice) (312) 353-5693 (TDD) (312)886-1807 (fax)	**ODJFS** Bureau of Civil Rights 150 E. Gay Street, 18th Floor Columbus, OH 43215 (614) 644-2703 (voice) 1-866-227-6353 (toll free) (614) 752-6381 (fax) 1-866-221-6700 (TTY)

USDA, HHS, and ODJFS are equal opportunity providers and employers.

Application/Reapplication Verification Request Checklist

Assistance Group Name:		Program(s) applied for: ☐ **OWF** (Ohio Works First); ☐ **FS** (Food Stamps); ☐ **Medicaid;** ☐ **PRC;** ☐ Other:	Application Date:
Case Number:	SSN:		Interview Date:
Return all verifications no later than this date: K			

As discussed in your interview, there are certain eligibility factors which must be verified before the County Department of Job & Family Services can determine your eligibility for the program(s) checked above. Checked below are the documents you said you would provide.

PERSONAL IDENTIFICATION
- ☐ Birth Certificate
- ☐ Death Certificate
- ☐ Divorce papers
- ☐ Identity (proof of)
- ☐ Marriage certificate
- ☐ Pregnancy verification (including number of fetuses)
- ☐ Social security cards (or numbers) for:

RESOURCES
- ☐ Bank statements (savings, checking, etc.)
- ☐ Insurance policies
- ☐ Title to motor vehicles
- ☐ Trust fund verification

INCOME-RELATED
- ☐ Child care expenses (verification completed by person caring for child/ren).
- ☐ Income verification
  - ☐ Court support order
  - ☐ Employment verification (employment form, pay stubs, self-employment records)
  - ☐ Social security award letter
  - ☐ Unemployment compensation verification
  - ☐ Veterans benefits awards letter
  - ☐ Worker's compensation letter
  - ☐ Other income: _____
- ☐ Medical expenses (proof of)
- ☐ School attendance verification

WORK-RELATED
- ☐ Medical form completed by doctor for:
  ☐ self; ☐ other family member living in your home who is ill
  Name of family member:
- ☐ Work registration form

HOUSING-RELATED
- ☐ Proof of residency: You must provide one of the following items checked below:
  - ☐ Rent receipts with your name, address, amount paid, and landlord's name and phone number; or
  - ☐ Mortgage book; or
  - ☐ Third Party Statement - letter with your name, address, amount paid, from management, mortgage company, or person providing you with shelter; or
  - ☐ Household Verification ((*This form, HCJFS 3390, is attached and provided for your convenience.)*
- ☐ Property deed and/or property taxes verification
- ☐ Utility receipts

OTHER: *(specify)*

IF YOU FAIL TO PROVIDE DOCUMENTS - It is important that you provide all verifications checked above to prevent your application from being denied/assistance being stopped/a sanction from being placed on your Food Stamps, cash or medical benefits.

IF YOU ARE UNABLE TO PROVIDE DOCUMENTS - If you are unable to obtain any requested verification, the County Department of Job & Family Services can assist you. **Contact me immediately if you have any difficulty in securing the verification.** It is important that you complete all requirements as soon as possible. Assistance cannot begin until this information is received to determine your eligibility. The County Department of Job & Family Services must determine your eligibility by _____.

IF YOU ARE PREGNANT - If you are pregnant and are in immediate need of health care and your income is at or below the Healthy Start standard for your family size, the CDJFS can determine your eligibility for Expedited Medicaid with proof of pregnancy. All Medicaid covered services, with the exception of inpatient hospital care, will be covered under the expedited card.

Signature of Caseworker:	Date:	District:	Phone Number: (513) 946-

JFS 07105 (REV. 11/2000)
ODJFS 07105-A (REV. 3-03)

Hamilton County Department of Job & Family Services (HCJFS)

Authorization for the Release or Use of Protected Health Information (PHI)

SECTION A:

(Last Name)	(First Name)	(Middle Name)	(Maiden Name)	Date of birth:	Sex: ☐ M ☐ F	Phone:
Street Address:				Social Security Number: *(Optional--see pg. 2)*		
City:		State: **OH**	Zip:	Billing Number:		

Reason for Requesting the Release of Medical Information: To establish initial or continued incapacity or disability, we must develop detailed medical findings about your impairment by obtaining current medical evidence. The execution of this release is voluntary with the understanding that the information requested will be kept confidential and will be used in connection with a disability or medication dependent determination in seeking eligibility for public assistance benefits and/or SSI. **Re-disclosure of this information requires separate written authorization.**

This authorization is valid for the purpose, information, agencies, and persons cited in this release. This information release has been prepared in accordance with the authority specified in Title 42 of the Code of Federal Regulations at section 2.31, part 2, subpart C, as revised October 1, 1985 and in accordance with 3701.243 of the Ohio Revised Code.

Consumer's Understanding and Authorization for Release: I release the Hamilton County Department of Job & Family Services and the physician, hospital or institution supplying medical information from all legal responsibility and liability that may arise from the action I am authorizing.

My signature in Section D. below indicates that:

- I authorize and request *(Hospital, or Agency Name)* _____ to release the following protected health information from my own medical records or the medical records of my *(relationship)* _____ to the Hamilton County Department of Job & Family Services. This authorization includes release of information concerning treatment, hospitalization, and/or outpatient care for any medical condition, including psychological or psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) and or tests for antibodies to the Human Immunodeficiency Virus (HIV).
- I have read and fully understand the above statements as they apply to me.
- I consent to the disclosure of the treatment records to the purpose and extent stated here:
- I agree that the following information may be released or reviewed as well as any specific information listed in Section B below:

☐ Discharge Summary ☐ Reports or tests and x-rays ☐ Complications and operative procedures
☐ History and Physical ☐ Immunization (shot) records ☐ Outpatient clinic notes: (Specify clinic)
☐ Consultation report(s) ☐ Face sheet with final diagnosis ☐ Other:
☐ Emergency treatment(s) ☐ Operative report(s) and findings

Mail requested information to:	Person or Entity:				Is this information being released for an insurance claim? ☐ No ☐ Yes – (See Section II on reverse side.)
	Street:	City: Cincinnati	State:	Zip:	

SECTION B:

List the specific protected health information to be released:	List the applicable date (or date range) for the released information: ☐ Specific date _____ ; or ☐ Date range: begin _____ and end _____

SECTION C: By signing below, I understand that:

1. This authorization shall expire within one year on _____, or upon completion of the "event" on _____, or when revoked by me in writing, whichever comes first.
2. I have the right to revoke or cancel this authorization at any time by providing notice in writing to:
   Hamilton County Department of Job & Family Services
   Attn: Consumer Services Office
   222 E. Central Parkway
   Cincinnati, OH 45202
3. If I revoke or cancel this authorization, it is not effective for the use or for the disclosure of my protected health information that has already occurred.
4. Any information used or disclosed by this specific authorization may be re-disclosed by the person or entity receiving the information. In such a situation, it may no longer be protected by federal or state law.
5. I am not required to sign this authorization. If I refuse to sign this form, it will not affect my Medicaid eligibility, my eligibility for other programs such as Disability Assistance Medical, Refugee Medical, or Healthy Start Healthy Families or my application for such programs.
6. I have a right to inspect or copy the protected health information that will be used or disclosed as per this authorization.
7. If, by law, we cannot send the protected health information to the entity listed above, initial in the following space if you want a copy of the information sent to you directly:_____.

SECTION D:

Signature of Individual or Authorized Representative	Print name of individual	Today's Date:
Representative's legal authority to individual	Print name of Authorized Representative	Today's Date:
If patient is unable to sign, it is because: ☐ (s)he is an unemancipated minor (Patient's age _____); or ☐ of the reason listed in the space at right →		
Signature of closest relative or legal guardian		Today's Date:
Signature of Witness (when appropriate)		Today's Date:

HCJFS 3607 (REV. 6-03) Page 1 of 2 Important information and both completion and distribution instructions for this form are on page 2.

Important Information and Completion Instructions for the
Authorization for the Release or Use of Protected Health Information (PHI)

I. The Hamilton County Department of Job and Family Services may obtain and/or release information pursuant to this signed authorization only if the form is completed thoroughly and all conditions listed on the completed form are met. Furthermore, Information concerning the receipt of medical assistance under Chapter 5111, Chapter 5115, Section 5101.49 of the Revised Code and sections 5101.50 through 5101.5110 of the Revised Code may be released ***only if both of the following apply:***

A. The release of information is for purposes directly connected to the administration of programs created under Chapter 5111, Chapter 5115, section 5101.49 of the Revised Code and sections 5101.50 through 5101.5110 of the Revised Code or services provided under programs created under these chapters;

B. The information is released to persons or government entities that are subject to standards of confidentiality and safeguarding information substantially comparable to those established for programs created under Chapter 5111, Chapter 5115, Section 5101.49 of the Revised Code and sections 5101.50 through 5101.5110 of the Revised Code.

II. If the information being released is for an insurance claim, per Ohio Administrative Code (OAC) rule 5101:3-1-08(D), the Ohio Department of Job and Family Services has subrogation rights pursuant to section 5101.58 of the Revised Code (Medicaid, or any federal or state funded public health program) against the liability of a third party for the cost of medical services paid by the department, or billable to the department for payment at a later date.

III. Instructions

Section A:

1) "Name," "Address," and "Billing Number" of the individual whose protected health information (PHI) is being released. If the form is being completed by an authorized representative or other legal authority, enter the name and address of the authorized representative or legal authority and enter the billing number of the individual whose PHI is being released. If the billing number is not known, enter the "Social Security Number" of the individual whose PHI is being released.

2) "Name of individual" is the individual whose PHI is being released.

3) "Who will receive the information?" is the person or organization who will obtain the PHI when it is released.

4) If the PHI being released is being released for an insurance claim, see the important information in section II above regarding Ohio Administrative Code (OAC) rule 5101:3-1-08.

5) Explain why the PHI is being released to a third party.

6) Be sure to provide a complete address for the entity you want to receive the information.

Section B:

Thoroughly specify what PHI is being released and the time frame. Federal regulations (45 CFR 164.502) require that only the MINIMUM NECESSARY information needed to accomplish the intended purpose may be released.

Section C:

The signed authorization is valid until the completion of the "event" or until it is revoked in writing by the individual who signed it, whichever comes first. "Event" may be defined as the reason the signed authorization is needed. For example, if the signed authorization is needed for an insurance claim to be processed and paid, the signed authorization is only valid until that occurs. It is recommended that the length of an authorization not exceed one year. In some situations the law may not allow us to release information to the entity you specified. If in such a situation you want us to instead mail copies of the protected health information directly to you, write your initials in the space provided.

Section D:

The individual whose PHI is being released should sign and date the form. However, if the individual is unable to sign the form, the individual's authorized representative should sign and date it. If the form is signed by an authorized representative, the representative's "legal authority" to act on the part of the individual must be indicated. Legal authority includes (but is not limited to) a parent who signs the form for a minor child or an individual who has power of attorney over the affairs of the individual whose PHI is being released.

IV. **Definition of Protected Health Information (PHI):** Protected Health Information (PHI) under HIPAA is information that is received from, or created or received on behalf of the Hamilton County Department of Job and Family Services and is information about an individual which 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 there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased. The following components of a patient's information also are considered PHI:

a) names;
b) street address, city, county, precinct, zip code;
c) dates directly related to a patient, including birth date, admission date, discharge date, and date of death;
d) telephone numbers, fax numbers and electronic mail addresses;
e) Social Security numbers;
f) medical record numbers;
g) health plan beneficiary numbers;
h) account numbers;
i) certificate/license numbers;
j) vehicle identifiers and serial numbers, including license plate numbers;
k) device identifiers and serial numbers;
l) Web Universal Resource Locators (URLs);
m) biometric identifiers, including finger and voice prints;
n) full face photographic images and any comparable images; and
o) any other unique identifying number, characteristic or code.

DISTRIBUTION:

Original: **Send completed original to the source from which information is being requested.**
NOTE: If information is being requested from HCJFS, send the form to:
Hamilton County Department of Job & Family Services
ATTN: Consumer Services Office
222 E. Central Parkway
Cincinnati, OH 45202

Copies to: **Individual and individual's authorized representative**

HCJFS 3607 (REV. 6-03) Page 2 of 2

Employment Verification Form

To Be Completed by Employer Only!

Employee Name:		SSN:	
Date Sent:		Client Number:	
Return to:	Dist. #	Phone:	Fax:

Authorization for Release of Information

I agree that the employer named below may release my employment information to the Hamilton County Department of Job & Family Services, the Cincinnati Metropolitan Housing Authority, or Hamilton County Section 8.

This information will be used to determine eligibility for: ~ OWF; ~ Medicaid; ~ Food Stamps; ~ Other program, specify: _____.

I am aware of my responsibilities to report completely and fully all facts which bear upon my eligibility for assistance. I realize if the requested information reveals I have improperly reported my situation, the information may be given to the prosecuting attorney for possible civil action or criminal prosecution.

Signature of Applicant/Recipient: _____ **Date:** _____

Dear Employer: Please complete the areas checked below.

~ **Work Schedule Information:**

Date started _____
Rate per hour $_____
Does this employee receive tip income? ~ Yes ~ No

Number of hours hired to work per week_____
If work hours vary: From_____ to _____
If yes, average weekly amount of tips: $ _____

Date of FIRST pay *(Actual)* _____
Payroll ends on _____
~ Daily; ~ Wkly. on _____; ~ Bi-Wkly. on_____; ~ Monthly on _____; ~ Semi-Monthly on _____

Workdays: (please circle) S M T W TH F SA
Pay schedule: (please check & note day or date below)

~ **Pay Information:** (Last six gross amounts and pay dates - please include tip income, if applicable)

Date received:	Gross $
1.	$
2.	$
3.	$

Date received:	Gross $
4.	$
5.	$
6.	$

~ **Employment Information:** *(Please complete all that apply.)*

~ Currently employed
~ Between Assignments as of _____
~ Laid-off on _____
~ On leave of absence since _____

~ Child Support is being withheld at the amount of $_____per pay.

~ No longer employed, eff. _____
Reason: _____

~ Date & amount of final pay: _____

~ Employee has health insurance, for self only _____or, for _____, at a monthly cost of $_____, via (company) _____

~ **Additional Pay Information: If checked, please provide the additional pay information noted on the reverse side of this form.**

~ **Employer Information:**

Company Name/Employer: _____ Phone: _____
Parent Company Name, if applicable: _____ Federal ID#: _____
Address: _____ Fax: _____

My signature below indicates that the information provided is correct:
Signature: _____ Date: _____
Title: _____ Phone: _____

~ **HCJFS**
222 E. Central Parkway
Cincinnati, OH 45202

~ **Cincinnati Metro Housing Authority**
1635 Western Avenue
Cincinnati, OH 45214

~ **Hamilton County Section 8**
630 Main St.
Cincinnati, OH 45202

Additional pay information needed for the period of _____ thru _____.

No.	Date Received	Gross Amount	No.	Date Received	Gross Amount
1			11		
2			12		
3			13		
4			14		
5			15		
6			16		
7			17		
8			18		
9			19		
10			20		

Additional comments:

Request for Cash, Food Stamp, and Medical Assistance

Ohio Department of Job and Family Services

Office Use Only - You will be given an appointment date and time after you complete the following application.

Appointment Date: _____ **Appointment Time:** _____

How do I apply for assistance?

You will need to:

1. Complete this application.
2. Submit this application to your local County Department of Job and Family Services (CDJFS).
3. Complete a face-to-face interview, unless we tell you that you don't need to.
4. Provide verification for the programs for which you are applying. Verification is explained on the next page.

Do you need help completing this application?

1. **If English is not your primary language:** The CDFJS will provide someone who can help you understand the questions on this application at the interview.
2. **If you have a disability, are hearing-impaired or visually-impaired:** We will help you complete this application and the interview
3. **We will also help you at other times, such as:** When you report changes, or when you have questions about your case.

How do I complete this application?

1. **Fill out this application:** Answer as many questions as you can on the application. You have the right to apply for assistance the day you contact your local CDJFS.
2. **If you cannot fill out this application today:** Fill out page one of the application with your name, address, and signature and turn it in to your local CDJFS office so that we can provide assistance from today if you are eligible. You can fill out the rest of the application at home and return it to your CDJFS office.
3. **Applying for someone else:** You can choose someone to apply for assistance for you. This person is called an authorized representative. If you are applying for someone else, answer the questions as they relate to that person.

Where do I turn in this application?

1. **Turn in the application to your local CDJFS office:** Our offices offer evening and/or weekend hours. This will start the application process for all assistance programs.

How do I complete the face-to-face interview?

1. **Come in for your interview:** During this interview, we will complete the rest of the application process. We will also tell you what assistance you may get.
2. **If you cannot come in for your interview:** You must contact your local CDJFS and reschedule your interview. If you do not contact us within 30 days from the date you file this application, we may deny your assistance and you will have to reapply. You may not have to come in for an interview if we determine you meet a hardship condition such as illness or lack of transportation.

-- Please keep this page for your records. --

JFS 07200 (Rev. 10/2006)

What type of verification do I need?

The table below lists the items required for each program you are applying for. Contact your local CDJFS for examples of the documents you can use as proof. If you can't bring everything, come to the interview anyway and we will help you.

- If you are not a U.S. citizen and are only applying for alien emergency medical assistance, you do not have to verify your citizenship status or immigration status, or provide a social security number.
- Your food stamp amount may increase if you also bring proof of the following costs: child/dependent care, child support paid for children not living with you, housing, utilities, medical costs for people with disabilities or for people who are over age 60 (including prescriptions).

	Cash Assistance	Food Stamp Assistance	Medical Assistance Families and children	Medical Assistance Aged, blind or disabled
Proof you have applied for a Social Security Number (if you don't already have one)	✓	✓	✓	✓
Permanent Resident Card ("green card") or other INS documentation if not a U.S. citizen	✓	✓	✓	✓
Proof of U.S. citizenship if a U.S. citizen	✓		✓	✓
Proof of income or any other money coming into your household (such as pay stubs, tax records, award letters, child support)	✓	✓	✓	✓
Most recent statements for any bank accounts (such as checking, credit union, savings)	✓			✓
Proof of ownership of vehicles (such as car, truck, motorcycles, boats, RVs)				✓
Proof of current value of stocks/bonds, certificates of deposit, life insurance, trusts, annuities	✓		✓	✓
Proof of identity	✓	✓		
Proof of any child/dependent care costs	✓	✓	✓	
Proof of any child support paid for children not living with you	✓	✓	✓	
Proof of any housing and utility costs		✓		
Proof of any medical costs for people with disabilities or for people who are over age 60 (including prescriptions)		✓		✓
Proof of any health insurance			✓	✓

When will I receive assistance?

Cash and food stamp assistance: We base eligibility for the cash and/or food stamp programs on the date we get your signed and dated application. Your eligibility for these programs is determined within 30 days from the date we receive your signed and dated application.

Medical assistance: We base eligibility for medical assistance on the date we get a signed and dated application. Your eligibility should be determined within 30 days unless you are claiming a disability. If you are claiming a disability, your eligibility should be determined within 90 days. We will also explore medical assistance for the 3 months before the month we get your application.

What if I need food right away?

If you need food stamp assistance right away, and are not currently receiving it: Answer the questions on pages one and two of the application. You may qualify to get food stamp assistance as quickly as 24 hours to 7 days.

Do I have to be a Citizen?

No. Please do not let fear of the U.S. Citizenship and Immigration Services (USCIS) keep you from seeking needed assistance for your family. Many immigrants can receive cash, food stamp, and medical assistance. Also, alien emergency medical assistance is available without regard to your immigration status.

What other services are available?

You may be eligible to receive other services such as: Child care assistance, prenatal care, housing costs, work skills, and help getting a job. These services may require a separate application. Ask your caseworker about these services. If you need help with child care costs, contact your local CDJFS for a child care application.

-- Please keep this page for your records. --

JFS 07200 (Rev. 10/2006)

Request for Cash, Food Stamp, and Medical Assistance

Ohio Department of Job and Family Services

1. Tell us about you (the applicant)

Complete this section for you or for the person for whom you are applying.

First Name, Middle Initial

Last Name

Are you:
- ❑ Visually Impaired
- ❑ Hearing Impaired

Do you need any of the following services?
- ❑ Interpreter
- ❑ Sign Language
- ❑ Other: _____

Office Use Only

Date Received: _____

Application Number: _____

Case Number: _____

Expedited Food Stamps: ❑ Yes ❑ No

PRC Requested: ❑ Yes ❑ No

Child Care Requested ❑ Yes ❑ No

Have you, or anyone living with you, ever received cash, food stamp, or medical assistance? ❑ Yes ❑ No

If yes, who: _____ Where (City/County/State): _____

2. Tell us how to reach you

Complete this section for you or for the person for whom you are applying.

Street Address ❑ Check here if you are homeless

City	County	State	Zip Code

Phone Number	Additional Phone Number	E-mail Address
( )	( )	

Mailing Address (if different):

Street Address

City	County	State	Zip Code

3. Tell us if you are an authorized representative

An authorized representative is someone who assists the applicant by completing the application process. If you are filling out this form as an authorized representative, please fill out the following.

First Name, Middle Initial Last Name

Street Address

City	County	State	Zip Code

Phone Number	Additional Phone Number	E-mail Address
( )	( )	

4. Sign Here

Signature of Applicant or Authorized Representative	Print Name	Date

5. Tell us if you need food stamp assistance right away

These questions will help us decide if you qualify to get food stamp assistance within 24 hours to 7 days.

How many people live with you and buy, fix, and eat meals with you? _____

Answer the following questions for only the people who buy, fix and eat meals with you.

Is your total gross income before taxes for the current month less than $150?	❑ Yes ❑ No
Is your total net income after taxes and paying for such things as housing costs, child/ dependent care costs, or child support payments for the current month zero?	❑ Yes ❑ No
Are your total resources in cash, checking, and savings accounts less than $100?	❑ Yes ❑ No
Are your monthly rent or mortgage and utilities (such as gas, electric, water, and phone) more than your total monthly gross income before taxes?	❑ Yes ❑ No
Are you a migrant or seasonal farm worker?	❑ Yes ❑ No

6. Tell us about the people in your home

You must list everyone who lives with you even if they are not applying. Please be sure to list your name first. If you need more space, attach a separate piece of paper.

- **Social Security Number:** You only have to list a social security number for someone who is applying for cash, food stamp, or medical assistance. You do not have to provide a social security number for someone applying for alien emergency medical assistance.
- **U.S. Citizen:** You only have to indicate if someone is a U.S. citizen if they are applying for cash, food stamp, or medical assistance.
- **Sex (gender):** If your household is only applying for food stamp assistance, you do not have to complete the sex (gender) question.
- **Race/Ethnicity:** Title VI of the Civil Rights Act of 1964 allows us to ask for racial/ethnic (Hispanic or Latino) information. If you do not want to give us this information, it will have no effect on your case. If you do not give us this information, the worker will enter an answer.

Name (First, Last)	Relationship to You (spouse, son, friend, etc.)	Social Security Number	Date of Birth	Sex Write M or F	U.S. Citizen Write Y or N	Race	Hispanic or Latino Write Y or N
	Self						

Are you married? ❑ Yes ❑ No Spouse's name_____

Are you, or anyone you are applying for, pregnant? Only answer if applying for cash or medical assistance.
❑ Yes ❑ No If yes, who? _____

Do you, or anyone you are applying for, need nursing home / in-home care?
❑ Yes ❑ No If yes, who? _____

What is your preferred language? Spoken _____ Written _____

6. Tell us about the people in your home (continued)

Is anyone 60 years of age or older? ❑ Yes ❑ No

If yes, answer the questions in this section. If no, please skip to question 7.

Is this person(s) receiving disability benefits? ❑ Yes ❑ No

If yes, from what source? _____

Is this person(s) unable to prepare meals due to a disability? ❑ Yes ❑ No

If you answered "Yes" to the last three questions, does this person(s) wish to receive food stamp assistance separately from the other people you live with? ❑ Yes ❑ No

7. Tell us about your finances

Will you or the people in your home receive income this month? ❑ Yes ❑ No

Income refers to all the money that you and the people in your home receive such as earnings from employment, child/spousal support, disability benefits, retirement benefits, Workers' Compensation, Social Security, SSI, Veterans Benefits, etc.

If yes, please complete the table below.

Name	Type of Income	Amount of Income (before taxes)	How Often Received (weekly, bi-weekly, etc)	Date Last Received

How much do you and the people in your home have in cash, checking, or savings (such as bank accounts, annuities, stocks, or bonds)?

Give your best estimate of the total: $ _____

Did anyone in your home leave a job or lose a job within the last 60 days? ❑ Yes ❑ No

If yes, who? _____ When? _____ For what reason? _____

Is anyone in your home on strike from a job? ❑ Yes ❑ No

If yes, who? _____

8. Tell us about your expenses

Which expenses do you and the people in your home pay? Check all that apply. List the amount for each expense.

❑ **Day care costs for a child or other dependent(s)**

Estimated amount paid per month: $ _____

If you need help with child care costs, contact your local CDJFS for a child care application.

❑ **Child support payments**

Estimated amount paid per month: $ _____

❑ **Medical expenses for anyone who is disabled or age 60 or older**

These include expenses such as medical bills, prescriptions, health insurance premiums, or other medical services.

Estimated amount paid per month: $ _____

❑ **Rent / Mortgage payments**

Estimated amount paid per month: $ _____

Utilities –Provide an estimated amount paid per month for each utility.

Do you pay for heating and/or air conditioning?
❑ Yes ❑ No

❑ Gas $_____
❑ Telephone $_____
❑ Garbage $_____
❑ Electricity $_____
❑ Water $_____
❑ Sewer $_____
❑ Other $_____