MI CHOICE

Home & Community Based Service Waiver For The Elderly And Disabled

SUBCONTRACTOR AGREEMENT
Senior Services, Inc.
A PREPAID AMBULATORY HEALTH PLAN (PAHP)
MI CHOICE WAIVER PROGRAM
SUBCONTRACTOR AGREEMENT

Overview of the MI Choice Waiver Program

Senior Services, Inc., in contract with the Michigan Department of Health and Human Services (MDHHS), serves as a Prepaid Ambulatory Health Plan (PAHP) to provide the Home and Community Based Services for Elderly and Disabled (HCBS E/D) Waiver Program, more commonly referred to as the MI Choice Waiver Program. This Medicaid program funds a variety of home and community based services to participants aged 18 years and older who, without such services, would require nursing facility level of care. The waiver increases traditional Medicaid services so that people in need of nursing facility care can choose to remain home to receive long term care.

Under a capitated, managed care system, Senior Services, Inc. accesses and manages home and community based care for adults whose needs are at a level of complexity requiring a specialized resource management effort. Senior Services identifies the needs of participants through a comprehensive assessment performed by a nurse and social worker team. Senior Services accesses these services from community vendors, monitoring performance and client condition and adjusts services as necessary.

Direct Service Purchase System

Senior Services, Inc. purchases needed services for participants from an established network of approved community service providers, when other payment options are not available. The Direct Purchase of Services (DPOS) network is established through formal subcontractor agreements with providers that submit completed applications for the services they choose to provide and are approved by Senior Services, Inc. Senior Services is responsible to determine and ensure that service providers meet all program and administrative standards as set by Medicaid (MSA), the Michigan Department of Health and Human Services (MDHHS), and the Center for Medicaid/Medicare Services (CMS). Senior Services is also responsible for authorizing services delivered and establishes the frequency and duration of all services purchased. Services available for selection are described in “Minimum Operating Standards For MI Choice Waiver Program Services” included with this contract document.

Funding Structure

Senior Services, Inc. uses a unit cost reimbursement system to purchase “direct care” services. The Service Agreement form establishes rates for those services provided for under the MI Choice Waiver. Subcontractor providers select the services which they are willing and have capacity to provide. Monthly reimbursement from Senior Services is based on the exact number of service units provided and verified during the month.

Target Population

Client eligibility for all services is determined by Senior Services staff. It is the responsibility of Senior Services to determine appropriate service interventions. Clients who are medically eligible for nursing home level of care, financially eligible for Medicaid under special expanded income guidelines and require at least one waiver service, are qualified to receive services through MI Choice Waiver.
Subcontractor/Provider Eligibility Standards

Eligible Organizations - Eligible providers of waiver services can include, private non-profit or for profit organizations which provide services that meet minimum MI Choice Waiver service standards, certifications and/or licensure requirements (see Attachment F, “Minimum Operating Standards for MI Choice Waiver Program Services” of this document).

Insurance - Service providers shall have sufficient insurance to indemnify loss of federal, state and local resources, due to casualty or fraud. Insurance required for each service provider are: workers compensation; unemployment; property and theft coverage, fidelity bonding (for persons handling cash); Automobile liability (for transportation purposes); General liability and hazard insurance including facilities coverage. Providers shall submit at the beginning of the Agreement and annually thereafter, Certificates of Insurance listing Senior Services, Inc. as the “Additional Insured”. MDHHS recommends several additional types of insurance for agency protection. Please see Attachment F (H), Section 1.F of this document for complete insurance information and requirements.

Confidentiality - All client information shall be maintained to HIPAA standards. Service providers shall have procedures to protect confidential client information. No information will be disclosed without the prior informed consent of an individual or his/her legal representative. Disclosures may be allowed by court order, or for program monitoring by authorized federal, state or local agencies (which are also bound to protect the confidentiality of client information) so long as acting in conformity with the Health Insurance Portability and Accountability Act (HIPAA).

1. APPLICATION PROCESS

Organizations proposing to participate in this system must agree to comply with all required standards and assurances contained in this document and attachments. The Subcontractor Agreement document: “Contracting Forms and Assurances” is structured in the following Attachments:

A. Purchase of Service Agreement Form
This contains services available for bid along with the maximum allowable unit rate as authorized by Senior Services PAHP. Rates for services that do not fall under specific units, such as Environmental Accessibility Adaptations, Specialized Medical Equipment and Supplies, etc. will be determined (TBD) based on the specific services as contained in the service authorization. Service rates listed as BID mean that the bidder will submit a rate for approval from the PAHP. All services must be ordered and authorized by the Senior Services PAHP. When selecting the specific services that you wish to provide, please review the applicable specific minimum service standards (Attachment F(H) of this document).

Applicants please complete this form as follows:

Service Provider Information
Complete all information requested including the contact person(s) for ordering services and for billing inquires.

Service Information Bid Agreement
For each service being applied for, provide information regarding the capacity or number of potential units available for purchase each week and the counties to be served. Add additional pages if more than four services are being bid on.

B. Accessibility Assurances and Service Standards
This includes the Accessibility Assurances and Service Standards Assurance form that includes the Provider’s assurances that the organization and its employees meet the minimum standards developed by the MDHHS and PAHP. Please review all information, fill in the agency name and services applied for.
C. **Home & Community Based Service Waiver For The Elderly & Disabled Subcontractor Enrollment Agreement**  
All providers must complete this form, regardless of current or past participation in Medicaid. Box Numbers 1, 3, 4, 5, 6 and 7 must all be completed with signature and date at bottom of form.

D. **Subcontractor Assurance Agreement.**  
Please review the document which itemizes the various Public Acts.

E. **Provider Agency Agreement.**  
This document contains specific items agreed upon by the subcontractor/provider, the Senior Services PAHP, and both parties. Please review.

F. **Minimum Operating Standards for MI Choice Waiver Program Services (also referenced as Attachment H).**  
This contains all the required standards as established by the Michigan Department of Health and Human Services (MDHHS) which must be met in regard to provider overall operations as well as those specific service(s) provided.

G. **VendorView Enrollment Form**  
Complete only if new or changed from previous year.

H. **Electronic Funds Transfer Form (EFT)**  
Complete only if new or changed from previous year.

I. **W-9 Form**  
Complete only if new or changed from previous year.

2. **REPORTING/PAYMENT SYSTEM**

As of FY 2015-2016 it is required that all vendors use the VendorBilling system to report and submit bills.

Reports cover a one month period - from the first day through the last day of the month. Reports are due to Senior Services no later than the 10th of each month following the month of service (previous month). The reports are verified against Senior Services care plans, with payment issued by the last business day of the month. Payment will be made by electronic transfer or by check. All checks will be mailed. If the information submitted is incomplete or incorrect, payment will be delayed. Faxed reports are accepted. Billings received after 90 days from the date of service will not be honored.

Please note that any previously paid claims will be recouped should it be determined that the Provider did not comply with documentation requirements to verify the claim.

**Selection**

Senior Services, Inc. will select providers on a case-by-case basis, utilizing the following criteria. (Please note that providers must deliver services at levels specified in the client care plans, approved by the participant):

**Client Preference**

Some clients prefer providers they are familiar with. Participant choice is honored.

**Cost**

The cost of services is a factor in selecting a service provider.

**Accessibility**

Practical application involved in selecting a provider include the geographic area of service and ease of service delivery to clients.

**Ability to Provide Quality Services**

The providers past performance in furnishing quality services as authorized in the client care plan is considered.
Quality includes performance, client outcome and accountability as monitored by Senior Services. Therefore, it is required that Critical Incident Reports are reported within 24 hours to the appropriate Supports Coordinator. Vendors are also required to report Private Duty Nursing (PDN) notes on a monthly basis along with their billing.

**Comprehensive Care**
Senior Services, Inc. will make a reasonable effort to minimize the number of agencies involved in providing services to each client. The ability of the provider to provide the different types of services needed by each client is considered.

**3. CERTIFICATION OF AUTHORITY TO SIGN THE AGREEMENT**

The persons signing this Agreement on behalf of the parties hereto certify by said signatures that they are duly authorized to sign the Agreement on behalf of said parties and that this Agreement has been authorized by said parties. This Agreement shall be deemed executed, valid, enforceable, and binding upon the parties once signed and may be delivered by facsimile or electronic transmission.

Senior Services PAHP and Provider agree that this Contract includes all referenced sections, forms, and attachments and are intended to constitute the entire and integrated agreement between them.

**4. AUTHORIZED SIGNATURES**

<table>
<thead>
<tr>
<th>SENIOR SERVICES PAHP AUTHORIZED OFFICIAL</th>
<th>DATE AND TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROVIDER AUTHORIZED OFFICIAL</th>
<th>DATE AND TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Return to:
Senior Services, Inc.
918 Jasper Street
Kalamazoo, MI 49001
Home & Community Based Service
Waiver For The Elderly And Disabled

CONTRACTING FORMS AND ASSURANCES
Home & Community Based Service Waiver For The Elderly And Disabled

ATTACHMENT A
The following services are available for purchase by the Senior Services PAHP at the maximum cost per unit as indicated:

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>To be billed as</th>
<th>Cost per unit Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Health</td>
<td>Units</td>
<td>$3.75</td>
</tr>
<tr>
<td>Chore Services</td>
<td>Units</td>
<td>$5.00</td>
</tr>
<tr>
<td>Community Living Supports Services</td>
<td>Units</td>
<td>$4.25</td>
</tr>
<tr>
<td>Counseling</td>
<td>Per Hour</td>
<td>$65.00</td>
</tr>
<tr>
<td>Environment Accessibility Adaptations</td>
<td>Per Diem</td>
<td>$TBD</td>
</tr>
<tr>
<td>Fiscal Intermediary Services</td>
<td>Per Month</td>
<td>$75.00</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>Per Meal</td>
<td>$BID</td>
</tr>
<tr>
<td>Non-Medical Transportation</td>
<td>Per Mile</td>
<td>$0.48</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>Unit</td>
<td>$10.00</td>
</tr>
<tr>
<td>Personal Emergency Response</td>
<td>Per Month</td>
<td>$TBD</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Unit</td>
<td>$10.00</td>
</tr>
<tr>
<td>Respite In-Home</td>
<td>Unit</td>
<td>$3.75</td>
</tr>
<tr>
<td>Respite Out-of-Home</td>
<td>Per Diem</td>
<td>$TBD</td>
</tr>
<tr>
<td>Specialized Medical Equipment &amp; Supplies</td>
<td>Per Item</td>
<td>$TBD</td>
</tr>
<tr>
<td>Training</td>
<td>Unit</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

*One unit = 15 minutes.

Exceptions to the rate caps will be considered for individual cases that may be deemed to require a higher level or more complex care.

**LENGTH OF AGREEMENT**
Fiscal Year 2016 through 2017. Approved Period: From 10/01/2016 to 09/30/2017
AGENCY: 

SERVICE AND BID INFORMATION

SERVICE #1: 

Number of units you can handle per week: __________________________ Cost (per unit) $ ____________

Counties you will serve (not less than entire county[s]) __________________________________________

SERVICE #2: 

Number of units you can handle per week: __________________________ Cost (per unit) $ ____________

Counties you will serve (not less than entire county[s]) __________________________________________

SERVICE #3: 

Number of units you can handle per week: __________________________ Cost (per unit) $ ____________

Counties you will serve (not less than entire county[s]) __________________________________________

SERVICE #4: 

Number of units you can handle per week: __________________________ Cost (per unit) $ ____________

Counties you will serve (not less than entire county[s]) __________________________________________

SERVICE #5: 

Number of units you can handle per week: __________________________ Cost (per unit) $ ____________

Counties you will serve (not less than entire county[s]) __________________________________________
AGENCY: ________________________________

AUTHORIZED AGENCY REPRESENTATIVE: ________________________________

ADDRESS: _________________________________________________________

ADDRESS: _________________________________________________________

CITY, STATE ZIP: ____________________________________________________

TELEPHONE: ________________________ TOLL FREE ________________________

TELEPHONE: ________________________ TOLL FREE ________________________

FAX: ________________________________ EMAIL ADDRESS: __________________

NPI#: ________________________________ EIN#: ____________________________

AGENCY TYPE: (check one): Public _____ Private “for profit” _____ Private “not for profit” _____

PRIMARY CONTACT: _________________________________________________

TELEPHONE (if different): _____________________________________________

EMAIL ADDRESS: ____________________________________________________

CONTACT PERSON (WHEN ORDERING SERVICES): _________________________

TELEPHONE (if different): _____________________________________________

EMAIL ADDRESS: ____________________________________________________

BILLING CONTACT: __________________________________________________

TELEPHONE (if different): _____________________________________________

EMAIL ADDRESS: ____________________________________________________

STAFFING LOCATIONS, OTHER: _______________________________________

ADDRESS: _________________________________________________________

ADDRESS: _________________________________________________________

CITY, STATE ZIP: ____________________________________________________

(ATTACH ANOTHER SHEET FOR MORE LOCATIONS.)
Home & Community Based Service Waiver For The Elderly And Disabled

ATTACHMENT B
ACCESSIBILITY ASSURANCES AND SERVICE STANDARDS

Any waiver service funded by Senior Services, Inc. must be in full compliance with the Department of Health and Human Services service definitions, unit definitions and, minimum service standards as prescribed. The following signature is evidence of assurance for compliance.

(Enter your company name) ______________________________, (herein after referred to as the Contractor)

THE CONTRACTOR HEREBY ASSURES that personnel involved in implementing this contract have read the attached minimum standards for each and all services for which funds are being requested.

FURTHERMORE, the Contractor assures that it is in compliance with all standards for the following services: (List all services for which you are requesting funding)

SERVICE_____________________________________ SERVICE_____________________________________
SERVICE_____________________________________ SERVICE_____________________________________
SERVICE_____________________________________ SERVICE_____________________________________

FURTHERMORE, the Provider Agency assures that it possesses insurance coverage as required by the Department of Health and Human Services in the Service Standards/Definitions and that a “Certificate of Insurance” indicating Senior Services, Inc. as the “Additional Insured” is included as an appendix to this Agreement. The Provider Agency understands that service purchasing cannot begin until such time as Senior Services has in its possession such a Certificate of Insurance.

This assurance is given in consideration of and for the purpose of obtaining Federal and State funds, contracts, or other financial assistance from Senior Services, Inc. The Contractor recognizes and agrees that any approved financial assistance will be extended based on agreements made in this assurance and that Senior Services, Inc. shall have the right to seek enforcement of this assurance.

The contractor also agrees to offer priority to Senior Services participants for access to non-DSP services available within the Contractor’s regulatory and capacity limitations.

This assurance is binding on the Contractor, its successors, transferees and assignees.
Home & Community Based Service Waiver For The Elderly And Disabled

ATTACHMENT C
HOME & COMMUNITY BASED SERVICES WAIVER FOR THE ELDERLY & DISABLED
SUBCONTRACTOR ENROLLMENT AGREEMENT
Michigan Department of Health and Human Services

This form is to be completed by all providers who wish to receive payment for the Medicaid-enrolled health care delivery system for services provided under the Home & Community Based Services Waiver for the Elderly & Disabled. An original payment agreement must be submitted for each business location and for each eligible person.

COMPLETION INSTRUCTIONS
PLEASE TYPE OR PRINT CLEARLY

Item #1: Individual providers must enter their last name, first name and middle initial. All other applicants (e.g. a licensed business) must enter the complete business name as licensed/certified.

Item #3: If the applicants are employed/contracted by a business, or in partnership, enter the name of the business you are employed by, affiliated with, contracted with, or in partnership with.

Item #4: Proof of the EIN number (federal tax number) is REQUIRED

Item #5: Providers must attach a copy of the licensure/certification, as applicable.

Item #6: The SSN is required for an individual and is confidential to be used only for the administration of the program.

APPLICATION INFORMATION

1. PROVIDER’S NAME (see instructions)  2. PROFESSIONAL TITLE, IF APPLICABLE

3. EMPLOYER’S NAME (see instructions)  4. EIN NUMBER (see instructions)

5. STATE LICENSE NUMBER (see instructions)  6. APPLICANT’S SOCIAL SECURITY NUMBER (see instructions)

BUSINESS LOCATION

7. MAILING ADDRESS (NO & STREET)  P.O. BOX

CITY  STATE  ZIP  PHONE NUMBER

MEDICAL ASSISTANCE (MEDICAID) PROVIDER PAYMENT AGREEMENT CONDITIONS

1. All information furnished on the payment agreement form is true and complete.

2. I consent that, upon request and at a reasonable time and place, I will permit authorized agents of the State of Michigan or the federal government to inspect, and copy, any records related to my delivery of goods or services to, or on behalf of, a participant under the Medicaid Program.

3. I am not currently suspended, terminated or excluded from any state Medicaid Program or by the U.S. Department of Health and Human Services.

4. I agree to accept the Michigan Medicaid payment as payment in full for the service rendered. Except for patient liability as determined by the Michigan Medicaid Program including applicable co-payments, I will not seek nor accept additional or supplemental payment from the participant, his/her family or representative(s).

5. I may be prosecuted under applicable federal or state criminal and civil law for submitting false claims, concealing material facts, misrepresentation, falsifying date, other acts of misrepresentation, or conspiracy to engage therein.

6. I agree to comply with the MDCHs policies and procedures for the Medical Assistance Program and the Home and Community Based services for the Elderly and Disabled contained in manuals, manual updates, providers bulletins and other program notifications.

As a condition of receiving payment from the Michigan Medicaid Program for services provided to an eligible participant, I certify and/or agree to all of the condition listed above. I certify that the undersigned has the authority to execute this agreement.

IMPORTANT: FAXSIMILE SIGNATURE WILL NOT BE ACCEPTED

APPLICANT’S SIGNATURE  DATE  TITLE

The Michigan Department of Health and Human Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, marital status, political beliefs or disability.

MAIL THIS FORM TO THE MI CHOICE PROVIDER YOU ARE CONTRACTING WITH (FY 2015-2016)
Home & Community Based Service
Waiver For The Elderly And Disabled

ATTACHMENT D
The undersigned recipient of funds from the Michigan Department of Health and Human Services (hereinafter called "recipient") HEREBY AGREES THAT it will comply with section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), all requirements imposed by the applicable HHS regulations (45.C.F.R. Part 84), and all guidelines and interpretations issues pursuant thereto.

Pursuant to 84.5(a) of the regulation (45 C.F.R. 84.5(a) the recipient gives this assurance in consideration of and for the purpose of obtaining any and all grants, loans, contracts and contracts of insurance of guaranty, property, discounts, or other financial assistance extended by the Michigan Department of Health and Human Services after the date of this assurance, including payments or other assistance made after such date on applications for financial assistance that were approved before such date. The recipient recognizes and agrees that such financial assistance will be extended in reliance on the representations and agreements made in this assurance and that the Michigan Department of Health and Human Services will have the right to enforce this assurance through lawful means. This assurance is binding on the recipient, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the recipient.

This assurance obligates the recipient for the period during which Federal financial assistance is extended to it by the Michigan Department of Health and Human Services or, where the assistance is in the form of real or personal property for the period provided for in 84.5(b) of the regulation (45 C.F.R. 84.5(b).


The Subcontractor named below HEREBY AGREES THAT it will comply with Title VI of the Civil Rights Act of 1964 (P.L. 88-352), the Michigan Handicapper’s Civil Rights Act of 1976 (P.A. 220), and the Elliott-Larsen Civil Rights Act of 1976 (P.A. 453, Section 209) and will comply with requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80) issued pursuant to that Title to the end that, in accordance with Title IV of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Subcontractor receives Federal or State financial assistance from Senior Services, Inc. and HEREBY GIVES ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

If any real property or structure thereon is provided or improved with the aid of Federal or State financial assistance extended to the Subcontractor, said property or structure must be used for a purpose for which Federal or State financial assistance is extended. This Assurance further certifies that the applicant agency has no commitments or obligations which are inconsistent with compliance of these and any other pertinent Federal or State regulations and policies, and that any other agency, organization or party which participates in this project shall have no such commitments or obligations, and all activities shall not run counter to the purpose and intent of this agreement.

THIS ASSURANCE is given in consideration for the purpose of obtaining any and all Federal or State grants, loans, contracts, property, discounts, or other Federal or State grants, loans, contracts, property, discounts, or Federal or State financial assistance extended after the date hereof to the Subcontractor by the Contractor, including installment payments after such date on account of applications for Federal or State financial assistance which are approved before such date. The Subcontractor recognizes and agrees that such Federal and State financial assistance will be extended in reliance on the representations and agreements made in the Assurance, that the Contractor or the United States or both shall have the right to seek judicial enforcement of this Assurance. This Assurance is binding on the Subcontractor, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the Subcontractor.
Home & Community Based Service Waiver For The Elderly And Disabled

ATTACHMENT E
PROVIDER AGENCY AGREEMENT

As a result of this Agreement the Provider Agency shall:

1. Accept and serve on a priority basis Waiver clients referred to it by Senior Services. Where openings do not exist in the Provider Agency caseload, the Provider Agency agrees to negotiate alternative arrangements with the Senior Services Waiver staff where possible in order to meet the needs of the client.

2. Accept the comprehensive assessment, available in VendorView, as completed by the Senior Services Waiver staff and refrain from conducting duplicative assessment or re-assessment activities.

3. Provide service delivery as prescribed in the directions (ie. service within VendorView, direct contact with SC) received from the Senior Services Waiver staff during service requisition.

4. Provide the Senior Services staff with the regular, on-going feedback (ie. nursing notes, progress notes, etc), regarding clients referred to it for services.

5. Inform the Senior Services Waiver staff of the appropriate Provider Agency contact person to be notified in care plan development and modification.

6. Enroll at least one representative from your Agency in the VendorView software system by completing and returning the Enrollment form. Use of the Vendor View software system is mandatory.

7. Utilize the VendorView software system to immediately notify the Senior Services Waiver staff if, for any reason, the Provider Agency is unable to provide service to the Senior Services waiver client, as negotiated, or if a service is not provided as agreed to (Non-Service, reduction in hours notification, hospitalization, etc.).

8. Utilize the VendorBilling software system to report and submit all claims and billing.

9. Participate in all required trainings conducted by Senior Services Waiver including, but not limited to: participant health and safety, Critical Incident Reporting, Emergency Reporting, Service interruption reporting, Grievance and Appeals, etc.

10. Comply with all licensing standards as may be prescribed, to assure quality of services delivered to Waiver clients, to comply with all standards and definitions as established by the Michigan Department of Health and Human Services (MDHHS). Private providers must submit copies of current license(s) with this signed agreement, as appropriate.

11. Follow Senior Services screening criteria when referring individuals who may be eligible for Waiver intervention.

12. Indemnity, save and hold harmless Senior Services, Inc. and the Michigan Department of Health and Human Services against expense or liability of any kind arising out of service delivery performed by the Provider Agency, and to immediately notify the Senior Services Waiver staff if the Provider Agency becomes involved in, or is threatened with litigation related to any Senior Services Waiver client.

13. Maintain, in effect at all times during the course of the Agreement, insurance coverage as indicated and required by the Michigan Department of Health and Human Services. Further, Provider shall submit at the beginning of the Agreement and throughout the year, Certificates of Insurance listing Senior Services, Inc. as the “Additional Insured”.

14. Protect client confidentiality and agree to not identify Senior Service Waiver clients by name or otherwise, in any report(s), without prior consent from the client and approval by Senior Services and the MDHHS, and in full compliance of HIPAA.

Legal limitations exist on both the Provider Agency and Senior Services Waiver staff regarding the disclosure of information about a client. The law treats all communication received from the client as confidential, whether oral or written, including records derived from those communications. HOWEVER, the disclosure of information to others does not, by itself abrogate a client’s expectation of privacy as protected by law. Those to whom disclosure is made have a duty to maintain the confidentiality of the disclosure. As such, it is permissible for the Senior Services Waiver staff to share with or request information from a provider for the purpose of better serving the clients based on the general release of information obtained from the client in writing by Senior Services Waiver staff at the time of the initial assessment.

15. Accept from and share any information that may be necessary to better serve the client, that may be viewed as confidential, upon receipt of a copy of the general release of information signed by the client, and avoid requiring the signing of additional release by the client. Providers are also expected to have and utilize their own releases of information forms when sharing/receiving any information in compliance with HIPAA regulations.

16. Conduct and maintain initial and ongoing criminal history screenings of all direct care employees.

17. Maintain a worker service record (in home log), as required in Specific Operating Standards--Attachment F(H), documenting a daily account of services furnished.

16. Accept as payment in full the reimbursement amount from Senior Services PAHP. The Provider may not bill
consumers for the difference between the Provider’s charge and the Senior Services PAHP’s rate for covered services. The Provider shall not seek nor accept additional supplemental payment from the consumer, his/her family, or representative in addition to the amount paid by Senior Services PAHP. The Provider agrees not to maintain any action against a consumer to collect sums that are owed to Provider under the terms of this contract, even in the event Senior Services PAHP fails to pay, becomes insolvent, or otherwise breaches the terms and conditions of this contract. This section shall survive the termination of this contract, regardless of the cause of termination and shall be construed to be for the benefit of the consumer.

For licensed AFCs, HFAs and “Assisted Living Facilities providing Community Living Services the following also apply:

17. Maintain a Community Living Services Tracking Sheet which documents daily services provided and which must be submitted monthly.

18. Request payment for licensed residential services to MI Choice Participants which are only those services that have been authorized and that which exceed what is usual and customary for the licensed residential provider and/or exceeds that which is required and defined under the State of Michigan AFC (MCL) licensing rules.

19. Provider shall refrain from marketing its services in any form or fashion which states, suggests or otherwise infers access to the Senior Services MI Choice Waiver Program. **Failure to comply with this stipulation shall result in immediate suspension of the agreement and the initiation of formal termination of this agreement.**


Senior Services PAHP, MI Choice Waiver program shall:

1. Provide prescreening of all individuals referred for the MI Choice Waiver program.
2. Provide a comprehensive assessment and additional information about a referred participant sufficient for the provider to adequately complete the services to the participant.
3. Provide person centered care plan development in consultation with the participant inclusive of a determination of amount, scope, frequency and duration of all services required under the care plan.
4. Authorize all types, frequencies, and amounts of services as indicated and appropriate.
5. Monitor provider agencies to ensure compliance with all standards, regulations, and requirements.
6. Provide timely payment of services rendered per billing procedures.
7. Provide 24-hour availability for emergency information.
8. Exclusively maintain the ownership and right of control of contract information and keep secure all contract records for a period of not less than six (6) years after the expiration or termination of this Agreement in a location that is readily accessible and preserves contract information.
9. Ensure that the participant is informed of all options available for home and community-based care and will respect and support the choices made by the participant.

Both Parties agree that:

1. The Provider is an independent contractor with respect to Senior Services PAHP and that nothing in this agreement is intended to create an employer/employee relationship, a joint venture relationship, or any other relationship that allows Senior Services PAHP to exercise control or direction over a manner or method by which the Provider furnishes the services covered in this agreement. The services to be performed shall be provided in a manner consistent with all applicable laws, regulations, rules and standards governing such services, the provisions of the master contract with MDHHS, and the provisions of this agreement.
2. Each party shall preserve the privacy and security of confidential participant information except as otherwise permitted or required by law. Where federal and state legal standards respecting disclosure of confidential participant information are in conflict, the stricter standard shall apply. Each party shall have in place and observe policies and
procedures for maintaining the privacy and security of confidential participant information and the prevention of its improper use or disclosure in full compliance with HIPAA. Each party will not use or disclose confidential participant information in a manner that would violate any provision of HIPAA.

3. Senior Services PAHP retains the right to review, approve, and monitor the Provider’s compliance with all rules, regulations, requirements applicable to the MI Choice Waiver program and that the PAHP, MDHHS, and CMS reserve the right as a condition of funding to require the development and implementation of corrective action plans if the Provider demonstrates inadequate performance. Provider shall fully cooperate with any audit from the PAHP, MDHHS, and CMS and provide access to and copies of any required documentation, policies, and procedures as necessary to demonstrate compliance.

4. This contract is effective from 10/01/2016 through 09/30/2017 unless sooner terminated. Provider understands that this contract does not assure or imply continued funding beyond 09/30/2017. If neither party has informed the other in writing that the contract will not be renewed and if the parties have not agreed to a new contract on or before the expiration date, the contract shall automatically be extended on a month-to-month basis until a new contract is reached or the contract is terminated.

5. This contract may be terminated prior to the expiration date by either party by giving sixty (60) days written notice to the other party by certified mail, except for circumstances in which federal, state or local resources for this program are reduced in which case termination of the contract requires thirty (30) days notice. Termination shall not relieve either party of any obligations incurred prior to the effective date of termination. In the event of the termination of this contract, the Provider agrees to promptly submit to Senior Services PAHP all information necessary for the reimbursement of any outstanding Medicaid claims, as requested.

6. This contract may be terminated with twenty-four (24) hours notice based on any of the following actions on the part of the Provider agency or any member of its staff: 1) Charges of gross misconduct of either a professional or personal nature, 2) Suspension, revocation, or restriction of professional license or registration, 3) Conviction of a crime, irrespective of whether such conviction is final, 4) Is included in the Medicare/Medicaid list of providers who are suspended or excluded, 5) Is subject to an adverse action, 6) Is determined to have committed a compliance violation, 7) Fails to perform any services required in accordance with this agreement or standards of quality, or 8) Violates Senior Services PAHP policies and procedures after being given notice of failure to comply.

7. No assignment or delegation of this agreement or of any right or obligation hereunder shall be valid without specific written prior consent of both parties hereto, except that this agreement may be assigned to any successor entity operating PAHP, which assignment shall forever release Senior Services PAHP hereunder except for any obligations which accrued prior to the date of such assignment. Any attempted assignment or delegation or purported assignment or delegation by the Provider in violation of this section shall be void and of no force and effect and shall not operate to create any liability or performance obligation on the part of Senior Services PAHP to any third party.

**PROVIDER BILLING PROCEDURES REMINDERS**

**BILL RECEIPT:** All billings must be received at Senior Services on or before the 10th of each month, following the month of service (previous month). Any bills received after 90 days, PAYMENT for services will be denied. All billings will be done through the VendorBilling software system.

**SERVICE ORDERS:** **PLEASE FOLLOW YOUR SERVICE ORDERS.** We will make every effort to provide prompt payment after all bills and documentation are complete and verified. The bills are verified against Senior Services Care Plans. If the information is incorrect, payment will be delayed until variances can be corrected.

**NON-SERVICE REPORTING:** Reporting Non-Services is pertinent not only for billing purposes, but for the health and safety of the Client. Reporting of Non-Services should be done using VendorView as they occur and prior to submission of your monthly bill.

**NURSING NOTES:** To avoid delay and/or denial of payments, Client Nursing Notes are to be faxed or mailed in conjunction with monthly billing.
This Agreement will be reviewed annually, and amended if necessary, for the purpose of focusing the provisions herein to more specifically address the agreed upon interactions between the parties.

Periodic review will include amending the Agreement to appropriately reflect pertinent agreements that may be developed between Senior Services and other federal, state and local agencies.
Home & Community Based Service Waiver For The Elderly And Disabled

ATTACHMENT F (H)
Home & Community Based Service
Waiver For The Elderly And Disabled

Reporting Forms

Purchase of Service Monthly Client Billing-Payment Voucher Form

Purchase of Service Monthly Summary Report

Vendor View Enrollment Form

Nursing Notes

Community Living Supports

Direct Deposit Authorization

W-9
### PURCHASE OF SERVICE MONTHLY CLIENT BILLING

**BILLING MONTH:** ____________  **YEAR:** ____________

**SERVICE PROVIDER:** ____________  **PHONE:** ____________

**CLIENT’S NAME:** ____________  **CLIENT’ S PROGRAM ID#:** ____________

**USE ADDITIONAL PAGES AS NECESSARY**

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>INDICATE DATE(S) AND UNITS PER DATE THIS MONTH THAT SERVICE WAS PROVIDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</td>
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<td>4</td>
<td>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31</td>
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</tbody>
</table>

**PROVIDERS - CLIENT SERVICE SUMMARY**

<table>
<thead>
<tr>
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<th>X</th>
<th>UNIT COST</th>
<th>= TOTAL</th>
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<tbody>
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</tbody>
</table>

<table>
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<th>TOTAL UNITS</th>
<th>X</th>
<th>UNIT COST</th>
<th>= TOTAL</th>
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<tr>
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<tr>
<td>4</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**TOTAL DUE:** ____________

**NOTES/COMMENTS:**

The Purchase of Service Monthly Client Billing form(s) will be submitted to Senior Services, Inc. by the 10th of each month following the month in which service was provided. I certify that the expenditures being reported are correct and appropriate. Documentation is available and will be maintained as required.

**SIGNED:** ____________  **DATE:** ____________

FY 2016-2017
# Purchase of Service Monthly Summary Report

**Month:**

**Provider:**

**Phone:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Total Units</th>
<th>Unit Cost</th>
<th>Total</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td></td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>X</td>
<td></td>
<td>=</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>X</td>
<td></td>
<td>=</td>
<td></td>
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<tr>
<td>4.</td>
<td>X</td>
<td></td>
<td>=</td>
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<tr>
<td>7.</td>
<td>X</td>
<td></td>
<td>=</td>
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<tr>
<td>8.</td>
<td>X</td>
<td></td>
<td>=</td>
<td></td>
</tr>
</tbody>
</table>

**Total Due:**

**Notes/comments:** (problems, deviations from ordered services, etc.)

---

The Direct Service Purchase Monthly Service Report Summary form(s) will be submitted to Senior Services, Inc. by the 10th of each month following the month in which the service was provided. I certify that the expenditures being reported are correct and verifiable. Documentation is available and will be maintained as required.

**Signed:**

**Date:**

**Senior Services, Inc. Use Only:**

- **Received:**
- **Entered:**
- **Verified:**
- **Posted:**
- **Paid:**
VENDOR VIEW ENROLLMENT FORM

(PLEASE PRINT)

Vendor Name: ______________________________________________________

VV user with another Agent? Yes_______ No_______

Agent__________________________ Current User ID: ______________

Type of Vendor Connection: Internet_______ Fax_______

Fax#: _________________________

User#1: ___________________________________________________________

Phone Number: ____________________________________________________

User#1 Email Address: ______________________________________________

Send new notice emails: Yes_______ No_______ Billing Access Yes _______ No_______

Temporary Password*: _____________________________________________

User#2: ___________________________________________________________

Phone Number: ____________________________________________________

User#2 Email Address: ______________________________________________

Send new notice emails: Yes_______ No_______ Billing Access Yes _______ No_______

Temporary Password*: _____________________________________________

*Cannot use name, “password”, symbols, or start with a number

PLEASE FAX COMPLETED FORM TO: ATTN WAIVER BILLING, 269-382-3189
Senior Services

918 Jasper St., Kalamazoo, MI 49001
269-382-0515
www.seniorservices1.org

NURSING NOTES
(Please complete in detail and return with your statement for consideration of payment)

PATIENT NAME: ___________________________ DOB: ______________

VITAL SIGNS
RANGE: T_____ P_____ R_____ BP______ BLOOD SUGAR RANGE:________

HOSPITALIZATIONS
WHEN:_________WHERE:____________ WHY:________________________
WHEN:_________WHERE:____________ WHY:________________________

ER ROOM VISITS
WHEN:_________WHERE:____________ WHY:________________________
WHEN:_________WHERE:____________ WHY:________________________

DOCTOR OR SPECIALIST VISITS
WHEN:_________WHERE:____________ WHY:________________________
WHEN:_________WHERE:____________ WHY:________________________

FALLS
DATES:__________________________

CHANGES
SKIN BREAKDOWN:________________________________

MEDICATION CHANGES:

ANY MISSED MEDS:

OVERALL MEDICAL CHANGES:

IS THERE ANYTHING THE SUPPORTS COORDINATOR Needs TO BE AWARE OF?

Please call if any significant changes

PROFESSIONAL SIGNATURE:__________________________ DATE:____________
Electronic Funds Transfer (EFT) Authorization Form
Automatic Payment

Please complete the information listed below for the checking or savings account you are designating for the direct deposit of your monthly MI Choice Waiver payment. PRINT legibly and complete all fields. **Failure to do so may result in the inability to process your request.**

1. Type of account  _____Checking   _____Savings

2. Agency Name:  _____________________________________________________________

3. Send Remittance to : (Email address) ____________________________________________

4. Financial institution name: _____________________________________________________

5. Account number: ____________________________________________________________

6. Routing/Transit number: ______________________________________________________

- I hereby authorize Senior Services of SW Michigan to initiate credit entries to the account indicated above and for the financial institution named above to credit the same to such account. I acknowledge that the origination of ACH (Direct Deposit) transactions must comply with the provisions of U.S. Law.
- Make changes or to cancel this authorization by completing a new form. Allow 2 weeks for processing.
- This authorization is to remain in force and effect until Senior Services of SW Michigan has written notification of its termination in such time and in such manner as to afford Senior Services of SW Michigan a reasonable opportunity to act on it.
- For Question, please contact Lisa Pueblo at (269) 382-0515 x119 or lpueblo@seniorservices1.org.

____________________________________  _________________________________________
Signature (Vendor agrees to terms above)  Print Name

__________________________________________
Date

Verification of Account Number Required:

**For Deposit to Checking Account:** Attach copy of VOIDED check or Direct Deposit Authorization form from your financial institution (no checking account deposit slips, please).

**For Deposit to Savings Account:** Attach copy of Direct Deposit Authorization form from your financial institution.

**Return to:** Senior Services of SW Michigan
ATTN: Accounts Payable
918 Jasper St.
Kalamazoo, MI 49001
COMMUNITY LIVING SUPPORT SERVICES TRACKING SHEET

This sheet is **required** to be completed daily to track residential services provided to your MI Choice Medicaid Waiver resident. This sheet **must** be returned with your monthly billing sheets each month for Waiver to process your payment.

Name of AFC/HFA: _______________________  Month: ___________  Year: ___________

Recipient name: _______________________  Telephone: _______________________

PLEASE INDICATE THE AMOUNT OF TIME SPENT BY YOUR STAFF EACH DAY MEETING THE NEEDS OF THIS RESIDENT:

| Day of the Month | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|------------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| Services provided: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Bathing |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Dressing |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Hygiene |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Grooming |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Toileting |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Incontinence care |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Eating |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Mobility assistance |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Transfers |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Addition needs: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Communication |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Cognition |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Wandering |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Elopement |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Aggressiveness |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Resistance to care |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Additional Comments:
________________________________________________________________________
________________________________________________________________________

Signature of AFC/HFA responsible party __________________________ Date ___________
W-9

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box:  □ Individual/Sole proprietor  □ Corporation  □ Partnership
□ Limited liability company. Enter the tax classification (Q=disregarded entity, C=corporation, P=partnership) □ □ Exempt payee

Address (number, street, and apt. or suite no.)
City, state, and ZIP code

Requested's name and address (optional)

List account number(s) here (optional)

Part I  Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II  Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification Instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here

Signature of U.S. person ▶

Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,
The U.S. grantor or other owner of a grantor trust and not the trust, and
The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:
1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under the treaty, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exemption (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

Penalties
Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions
Name
If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as" (DBA) name on the "Business name" line.

Limited liability company (LLC). Check the "Limited liability company" box only and enter the appropriate code for the tax classification. "C" for disregarded entity, "C" for corporation, "P" for partnership in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee
If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.
Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note.** If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2).
2. The United States or any of its agencies or instrumentalities.
3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities.
4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,
7. A foreign central bank of issue,
8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
9. A futures commission merchant registered with the Commodity Futures Trading Commission,
10. A real estate investment trust,
11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
12. A common trust fund operated by a bank under section 584(a),
13. A financial institution,
14. A middleman known in the investment community as a nominee or custodian,
15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

<table>
<thead>
<tr>
<th>IF the payment is for . . .</th>
<th>THEN the payment is exempt for . . .</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest and dividend payments</td>
<td>All exempt payees except for 9</td>
</tr>
<tr>
<td>Broker transactions</td>
<td>Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker</td>
</tr>
<tr>
<td>Barter exchange transactions and patronage dividends</td>
<td>Exempt payees 1 through 5</td>
</tr>
<tr>
<td>Payments over $600 required to be reported and direct sales over $5,000¹</td>
<td>Generally, exempt payees 1 through 7</td>
</tr>
</tbody>
</table>

¹See Form 1099-MISC, Miscellaneous Income, and its instructions.

**Part I. Taxpayer Identification Number (TIN)**

**Enter your TIN in the appropriate box.** If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see How to get a TIN below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see Limited liability company (LLC) on page 2), enter the owner’s SSN (or EIN, if the owner has one). Do not enter the disregarded entity’s EIN. If the LLC is classified as a corporation or partnership, enter the entity’s EIN.

**Note.** See the chart on page 4 for further clarification of name and TIN combinations.

**How to get a TIN.** If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5. Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting www.irs.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write “Applied For” in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

**Note.** Entering “Applied For” means that you have already applied for a TIN or that you intend to apply for one soon.

**Caution:** A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

**Part II. Certification**

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

**For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see Exempt Payee on page 2.**

**Signature requirements.** Complete the certification as indicated in 1 through 5 below:

1. **Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983.** You must give your correct TIN, but you do not have to sign the certification.

2. **Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983.** You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.
3. Real estate transactions. You must sign the certification. You may cross out Item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requestor’s trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

### What Name and Number To Give the Requester

<table>
<thead>
<tr>
<th>For this type of account:</th>
<th>Give name and SSN of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Individual</td>
<td>The individual</td>
</tr>
<tr>
<td>2. Two or more individuals (joint account)</td>
<td>The actual owner of the account or, if combined funds, the first individual on the account</td>
</tr>
<tr>
<td>3. Custodian account of a minor (Uniform Gift to Minor Act)</td>
<td>The minor ¹</td>
</tr>
<tr>
<td>4. a. The usual revocable savings trust (grantor is also trustee)</td>
<td>The grantor-trustee ¹</td>
</tr>
<tr>
<td>b. So-called trust account that is not a legal or valid trust under state law</td>
<td>The actual owner ¹</td>
</tr>
<tr>
<td>5. Sole proprietorship or disregarded entity owned by an individual</td>
<td>The owner ²</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For this type of account:</th>
<th>Give name and EIN of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Disregarded entity not owned by an individual</td>
<td>The owner</td>
</tr>
<tr>
<td>7. A valid trust, estate, or pension trust</td>
<td>Legal entity ²</td>
</tr>
<tr>
<td>8. Corporate or LLC electing corporate status on Form 8832</td>
<td>The corporation</td>
</tr>
<tr>
<td>9. Association, club, religious, charitable, educational, or other tax-exempt organization</td>
<td>The organization</td>
</tr>
<tr>
<td>10. Partnership or multi-member LLC</td>
<td>The partnership</td>
</tr>
<tr>
<td>11. A broker or registered nominee</td>
<td>The broker or nominee</td>
</tr>
<tr>
<td>12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or privity that receives agricultural program payments)</td>
<td>The public entity</td>
</tr>
</tbody>
</table>

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person’s number must be furnished.

² Circle the minor’s name and furnish the minor’s SSN.

³ You must show your individual name and you may also enter your business or "EIN" name on the second name line. You may use either your SSN or EIN if you have one, but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see Social security for partnerships on page 1.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

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### Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:
- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

**Protect yourself from suspicious emails or phishing schemes.** Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.consumer.gov/idtheft or 1-877-IDTHEFT(438-4338).

Visit the IRS website at www.irs.gov to learn more about identity theft and how to reduce your risk.

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### Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to other federal, state, District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.
To Whom It May Concern,

As you may be aware, the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) require Senior Services, Inc., a "Covered Entity" under the Act, to obtain Business Associate Agreements from those non-covered organizations that, through contract, business arrangement, or relationship, perform certain services for Senior Services, Inc.

I am requesting that you review and sign the enclosed Business Associate Agreement regarding protecting the privacy of any health information that your organization may have access to in the course of providing prescribed services for Senior Services, Inc. Once signed, please return a signed copy of the agreement to Senior Services, Inc.

If your organization is, in fact, a "Covered Entity" under HIPAA, please review and sign the enclosed verification form and return to Senior Services, Inc. along with your current "Notice of Privacy Practices" statement.

Please feel free to call me should you have any questions or concerns.

Sincerely,

Lori A Ellmer, R.S.S.T.
MSW Candidate
Quality Assurance/Risk Management Coordinator
MI Choice Waiver Program
This Business Associate Agreement ("Agreement") is made effective October 1, 2016 by and between
________________________________________________________ (the "Business Associate")
and Senior Services, Inc. (the "Covered Entity").

RECITALS

A. The purpose of this Agreement is to comply with the Health Insurance Portability and
   Accountability Act of 1996 ("HIPAA") which sets forth the standards for protecting the
   privacy of certain Protected Health Information (PHI).
B. The Covered Entity has contracted the Business Associate to provide certain products
   and/or Services (collectively, the "Services") pursuant to an existing contract, business
   arrangement, or relationship (collectively, the "Underlying Contract").
C. The Business Associate regularly receives PHI in its performance of the Services
   pursuant to the Underlying Contract.
D. The Covered Entity has requested the Business Associate to perform the Services
   pursuant to the requirements set forth in the HIPAA Regulations.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants contained in this
Agreement, parties agree as follows:

1. Definitions. The following terms used in this Agreement have the following meanings:

   Business Associate. “Business Associate” shall generally have the same meaning as the term
   “business associate” at 45 CFR 160.103, and in reference to the party to this agreement, shall
   mean the Business Associate as named above.

   Covered Entity. “Covered Entity” shall generally have the same meaning as the term
   “covered entity” at 45 CFR 160.103, and in reference to the party to this agreement, shall
   mean Senior Services, Inc.

   HIPAA Rules. “HIPAA Rules” shall mean the Privacy, Security, Breach Notification, and

   Protected Health Information"(PHI) means any information, kept or maintained in any
   format or medium by the Covered Entity, which identifies an individual or be used to identify
   an individual and relates to any of the following: (a) the past, present, or future physical or
   mental health condition of an individual; (b) the provision of services to an individual; or (c)
the past, present, or future payment for the provision of services to an individual.

Notice of Privacy Practices means the Covered Entity's Notice of Privacy Practices attached hereto and incorporated herein, and as amended from time to time by the Covered Entity.

2. Obligations and Activities of Business Associate. With regard to the use and/or disclosure of PHI the Business Associate agrees that all uses and disclosures will be in accordance with the Notice of Privacy Practices and applicable federal, state, and local law. The Business Associate will not use or disclose any PHI in violation of HIPAA. In all instances where the use or disclosure of PHI is necessary, the Business Associate will use or disclose only the minimum necessary to achieve the intended purpose for such use or disclosure. Business Associate agrees that it will de-identify all PHI prior to its use or disclosure, to the extent possible. Business Associate further agrees to:

(a) Not use or further disclose PHI other than as permitted or required by this Agreement or as required by law.
(b) Use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement.
(c) Mitigate, to the extent practicable, any harmful effect that is known to Business Associate from a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.
(d) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;
(e) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;
(f) Ensure that any agent, including a subcontractor, to whom it provides PHI, agrees to the same restrictions and conditions that apply through this Agreement to the Business Associate with respect to such information.
(g) Provide access, at the request of Covered Entity, and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set (if applicable), to Covered Entity or, as directed by Covered Entity, to an Individual.
(g) Make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.
(h) Make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by Business Associate on Behalf of Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the HIPAA Regulations.

(i) Document such disclosures of PHI and information related to such disclosures as is required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with HIPAA.

(j) Provide to Covered Entity or an Individual in a time and manner designated by Covered Entity, information collected in accordance with Section (i) above, in order to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with HIPAA.

3. Permitted Uses and Disclosures by Business Associate.

(a) General Use and Disclosure Provisions: Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI on behalf of, or to provide the Services to, Covered Entity, for the purposes described in the Underlying Contract, if such use or disclosure of PHI would not violate the requirements of HIPAA if done by Covered Entity.

(b) Specific Use and Disclosure Provisions

   (i) Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided such uses do not violate the requirements of HIPAA.

   (ii) Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

   (iii) Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by HIPAA.

   (iv) The Business Associate is not authorized to use protected health information to de-identify the information in accordance with 45 CFR 164.514(a)-(c).
4. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions

(a) Covered entity shall provide Business Associate with the notice of privacy practices (the "Notice") that Covered Entity produces in accordance with HIPAA. Covered Entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR 164.520, to the extent that such limitation may affect business associate’s use or disclosure of protected health information.

(b) Covered Entity shall notify Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect Business Associate’s use or disclosure of protected health information.

(c) Covered Entity shall notify Business Associate of any restriction on the use or disclosure of protected health information that Covered Entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect Business Associate’s use or disclosure of protected health information.

5. Term and Termination.

(a) **Term.** The Term of this Agreement shall be effective as of the date first above written and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is not feasible to return or destroy the PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

(b) **Termination for Cause.** Irrespective of any provision in the Underlying Contract, Covered Entity may terminate the Underlying Contract in its sole discretion and without compensation of any kind to Business Associate if it reasonably suspects or determines that Business Associate has improperly used or disclosed PHI in violation of HIPAA, the Regulations, other statutes or laws, or in violation of the terms of this Agreement. Covered Entity may in lieu of termination, in its sole discretion, provide notification to Business Associate of an opportunity to cure the improper use or disclosure within a specific cure period.

(c) **Effect of Termination.**

   (i). Except as provided below in paragraph ii. of this subsection, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies,
summaries or excerpts of the PHI. Business Associate shall certify in writing within thirty (30) days from the date of termination or expiration of this Agreement or the Underlying Contract that all PHI has been returned or disposed of as provided and the PHI has not been retained in any form.

(ii). In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of PHI is infeasible; Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

6. Miscellaneous:

(a) **Waiver and Severability.** The waiver by either party of a violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provisions hereof. If any provision of this Agreement or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this Agreement shall not be affected thereby, and each provision of this Agreement shall be valid and enforceable to the fullest extent permitted by law.

(b) **Assignment.** Neither party shall assign or transfer or permit the assignment or transfer of this Agreement without the prior written consent of the other.

(c) **Applicable Law.** This Agreement shall be governed by the laws of the State of Michigan.

(d) **Binding Effect and Third Party Rights.** This Agreement shall be binding upon and inure to the benefit of the parties hereto and their permitted successors and assigns; and is not entered into for the benefit of, and shall not be construed to confer any benefit upon, any other party or entity.

(e) **Notices.** Notices, statements and other communications to be given under the terms of this Agreement shall be in writing and delivered by hand, or sent by certified or registered mail or by Federal Express or other similar overnight mail service, return receipt requested to such address as from time to time is designated by the party receiving the notice. Notice shall be deemed effective upon receipt.

(f) **Entire Agreement and Amendment.** This Agreement, together with the other documents signed by the parties expressly stated to be supplementing hereto and together with any instruments to be executed and delivered pursuant to this Agreement, constitutes the entire Agreement between the parties and supersedes all prior understandings and writings, and may
be changed only by a written statement signed by the parties hereto. This Agreement will automatically amend to comply with any final regulation or amendment to a final regulation adopted by the Department of Health and Human Services concerning the subject matter of this Agreement upon the effective date of the final regulation or amendment.

(g) **Counterparts and Facsimiles.** This Agreement may be executed and delivered in any number of counterparts, all of which when executed and delivered shall have the force and effect of an original. Facsimile copies hereof shall be deemed to be originals.

(h) **Survival of Rights and Obligations.** Business Associate's duties and obligations of confidentiality and compliance with applicable law shall survive the expiration or termination of this Agreement.

(i) **Interpretation.** Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Privacy Rule.

(j) **Indemnification.** Business Associate agrees to defend, indemnify and hold Covered Entity harmless from and against any and all claims, liabilities, judgments, fines, assessments, penalties, awards or other expenses of any kind or nature whatsoever, including without limitation, attorney's fees, expert witness fees, costs of investigation, costs of litigation or dispute resolution relating to or arising out of any breach or alleged breach of this Agreement by Business Associate.

(k) **Insurance.** At the sole discretion of Covered Entity, Business Associate shall obtain and maintain insurance coverage with such limits and with such companies as Covered Entity shall direct naming Covered Entity as an additional insured against the improper uses and disclosures of PHI by Business Associate.

(l) **Disclaimer.** Business Associate is responsible for its own HIPAA compliance. Covered Entity is not responsible or liable to Business Associate for its failure to comply with HIPAA or the Regulations. Further, Covered Entity will not be liable to Business Associate for any claim, loss or damage relating to unauthorized use or disclosure of any information received by Business Associate from Covered Entity or from any other source.

(m) **Headings and Terms.** Headings, in this Agreement, are provided solely for the convenience of the parties and shall not be used to interpret or construe its provisions. Nouns and pronouns will be deemed to refer to the masculine, feminine, neuter, singular and plural, as the identity of the person or persons, firm or corporation may in the context require.

(n) **Arbitration.** The sole and exclusive method for resolving any dispute arising out of the interpretation or application of this Agreement (or relating to the Services provided hereunder or any termination of the Services) shall be arbitrated in accordance with this paragraph. The Commercial Rules of Arbitration of the American Arbitration Association (AAA) shall
govern arbitration. A party wishing to obtain arbitration of an issue must deliver the written demand for arbitration to the AAA, including a description of the issue to be arbitrated no later than one hundred eighty (180) days after the alleged breach occurred or the occurrence of the act or event upon which the dispute is based. The party filing the demand shall be solely responsible for any filing fee required by the AAA. A neutral arbitrator shall be selected pursuant to the rules of the AAA. The Arbitrator shall hold a hearing at a mutually acceptable location in Kalamazoo, Michigan within ninety (90) days after the appointment. The Arbitrator shall have the power to issue subpoenas directing either party to disclose information to the other party prior to the hearing, and to direct the appearance of witnesses at the hearing. The fees and expenses of the arbitrator shall be paid one-half by each party. Both the Business Associate and the Covered Entity may be represented by counsel and may present testimony and other evidence at the hearing. Within thirty (30) days after the commencement of the hearing, the arbitrator will issue a written decision. The decision of the arbitrator will be final and binding on the parties and shall be enforceable in accordance with law. Judgment may be entered on the arbitrator's award in any court having jurisdiction. Either party shall be entitled to specific performance of such party's rights under or connected with this Agreement. The arbitrator shall award costs and expenses, including reasonable attorney fees, to the prevailing party; if neither party prevails on all issues, the arbitrator shall allocate costs and expenses, in the arbitrator's discretion based on the extent to which each party has prevailed.

IN WITNESS WHEREOF, each of the parties has executed this Agreement as of the date first above written.

COVERED ENTITY
Senior Services, Inc.

By: _______________________
Its: _______________________

BUSINESS ASSOCIATE

{Enter Name of Entity)

By: _______________________
Its: _______________________
VERIFICATION AS A COVERED ENTITY

By signing below, I verify and confirm that __________________________is considered a "Covered Entity" pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Enclosed with this statement is our most current "Notice of Privacy Practices".

___________________________________                                   ________________
Signature                                                                   Date

___________________________________
Title

Please Sign and Return with Notice of Privacy Practices to:

Senior Services
918 Jasper Street
Kalamazoo, MI 49001

(269) 382-0515
Complaints and Communications to Us
You may write to:
Privacy Officer
Senior Services, Inc.
918 Jasper Street
Kalamazoo, MI 49001
Phone: 269-382-0515
Fax: 269-382-3189
Email: RLittke@seniorservices1.org

Complaints to the Federal Government
You may write to:
Office of Civil Rights
Dept. of Health and Human Services
200 Independence Ave, S. W.
Washington, DC 20201
Phone: 866-927-7748
TTY: 886-788-4989
Email: ocprivacy@hhs.gov

Copies of this notice
You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call or write to us to request a copy. This notice is available in other languages and alternate formats that meet the guidelines for the Health Insurance Portability and Accountability Act (HIPAA).

Esta notificacion esta disponible en otras lenguas y formatos diferentes que satisfacen las normas del Health Insurance Portability and Accountability Act (HIPAA).

Notice of Privacy Practices
Effective April 14, 2003

This notice describes how personal and health information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Our Privacy Commitment to You
We care about your privacy. The information we collect about you is private. We are required to give you a notice of our privacy practices. Only people who have both the need and legal right may see your information. Unless you give us permission in writing, we will only disclose your information for purposes of treatment/services, payment business operations or when we are required by law to do so. If there is ever any breach of unsecured Personal Health Information you will be notified by Senior Services immediately.

Understanding the Type of Information We Have
We get information about you when you receive services through any programs of Senior Services, Inc. It includes your date of birth, sex, ID number and other personal information. We also get bills, reports from your home health service provider, and other data about your services through us.

How We Use and Disclose Your Personal Information
• Treatment/Services- We may disclose information about you to coordinate your services. For example, we give information to a provider in order for you to receive the services that you have agreed to through your Person-Centered Plan.
• Payment-We may use and disclose information so the care you get can be properly billed and paid for. For example, we may ask your case manager for details before we pay the bill for your care.

• Business Operations- We may need to use and disclose information for our business operations. For example, we may use information to review the quality of the services you get. We may use or disclose only your demographic information, as Necessary, in order to contact you for fundraising activities supported by our agency.

• Exceptions- For certain kinds of records, your permission may be needed even for release for treatment, payment, and business operations.

• As Required By Law- We will release information when we are required by law to do so. Examples of such release would be for law enforcement or national security purposes, subpoenas or other court orders, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety, or in other kinds of emergencies.

• With Your Permission- If you give permission in writing, we may use and disclose your personal information. If you give permission, you have the right to change your mind and revoke it. This must be in writing, too. We cannot take back any uses or disclosures already made with your permission.

Your Privacy Rights
You have the following rights regarding the personal information that we have about you.

• Your Right to Inspect and Copy- In most cases, you have the right to look at or get copies of your records. You may be charged a fee for the cost of copying records.

• Your Right to Amend- You may ask us to change your records if you feel that there is a mistake. We can deny your request for certain reasons, but we must give you a written reason for our denial.

• Your Right to a List of Disclosures- You have the right to ask for a list of disclosures made after April 14, 2003. This list will not include the times that information was disclosed for treatment, payment or business operations. This list will not include information provided directly to you or your family, or information that was sent with your authorization.

• Your Right to Request Restrictions On Our Use Or Disclosure Of Information-You have the right to ask for limits on how your information is used or disclosed. We are not required to agree to such requests.

• Your Right to Request Confidential Communications- You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address. You do not have to explain the basis for your request.

Changes to this notice
We reserve the right to revise this notice. A revised notice will be effective for information we already had about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. Any changes to our notice will be published on www.seniorservices1.org. If the changes are material, a new notice will be mailed to you before it takes effect.

How to Use Your Rights Under this Notice
If you have questions or would like more information, you may contact our Privacy Officer at 269-382-0515

If you believe your privacy rights have been violated, you can file a complaint with Senior Services, Inc. or the Federal Government. You will not be penalized for filing a complaint.