THIS CONTRACT, between {Enter Name}

(**First Party**)

{Enter Organization Address}

 {Enter Organization City}, KY {Enter Organization Zip}

and {Enter Department Name}

 Health Department

 (**Health Department**)

 {Enter Department Address}

 {Enter Department City}, KY {Enter Department Zip}

is effective Start Date and ends No later than final day of FY.

 **WITNESSETH THAT:**

The Health Department agrees to perform the following services:

{Description of Services Here}

{SCOPE of WORK: Identify all tasks, work elements, and objectives of the contract. (This statement of work should be an accurate, thorough, and measurable description of the essential and technical requirements for the services to be provided.)}

{The description of services should indicate any standards or protocols that must be followed.}

{The description of services to be provided must be sufficiently detailed to clearly describe the specific duties and responsibilities of both parties}

{COMPENSATION/PAYMENT: Describe compensation in terms of hourly rate, number of hours per task, unit pieces, cost per task, cost per deliverable, etc.}

The First Party agrees to abide by the rules and regulations regarding the confidentiality of personal medical records as mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164.

The First Party agrees to comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) and all implementing regulations and executive orders. No person shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination in relation to activities carried out under this contract on the basis of race, color, age, religion, sex, disability or national origin. This includes the provision of language assistance services to individuals of limited English proficiency seeking and/or eligible for services under this contract.

**Section 601 of Title VI of the Civil Rights Act of 1964, (42 U.S.C. 2000d)**, provides that no person shall "on the ground of race, color or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

In 1974 the Supreme Court (Lau v. Nichols, 414 U.S. 563) interpreted regulations promulgated by the former Department of Health, Education and Welfare (HHH's predecessor), 45 CFR 80.3 (b) (2), to hold that Title VI prohibits conduct that has a disproportionate effect on **Limited English Proficient (LEP) persons** because such conduct constitutes national-origin discrimination. On August 11, 2000, **Executive Order 13166** was issued, "Improving Access to Services for Persons with Limited English Proficiency (LEP)."

1. For the services described in this contract, the First Party agrees to pay the Health Department in the following manner, {Enter payment time period.} payable upon receipt of appropriate billing.
2. The total payments made under the terms of this contract shall not exceed ${Enter Contract Value}.
3. The Parties to this contract agree to comply with Section 504 of the Rehabilitation Act of 1973, (P.L. 93-112) and the Kentucky Equal Employment Act of 1978 (H.B. 683) KRS 45.550 to 45.640, and Americans with Disabilities Act, (ADA), (P.L. 101-336).
4. The Health Department certifies that no constitutional, statutory, common law, or regulation adopted by the Cabinet for Health and Family Services pertaining to conflict of interest will be violated by this contract.
5. Either Party shall have the right to terminate this contract at any time upon 30 days written notice to the other Party.

**FIRST PARTY:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ {Enter Date Signed}

(SIGNATURE OF AUTHORIZED AGENT)

{Enter First Party Name}

**HEALTH DEPARTMENT:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ {Enter Date Signed}

(SIGNATURE OF AUTHORIZED AGENT)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PRINT OR TYPE NAME OF AUTHORIZED AGENT)

{Enter Health Department Name}