Contract Section Number (Lead) **FY** **HID** **MO** **ID**  Third-Party Billing is responsibility of contractor Y/N

THIS CONTRACT, between {Enter Department Name}

Health Department

(**Health Department**)

{Enter Department Address}

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

and {Enter Contractor's Name}

(**Contractor**)

{Enter Contractor's Address}

{Enter Contractor's City}, {Enter Contractor's State} {Enter Zip}

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

**WITNESSETH THAT:**

WHEREAS, the Health Department, in the exercise of its lawful duties has determined that {Enter Service Type}

services are essential to the operation of the Health Department in fulfilling its legal responsibilities;

WHEREAS, the Contractor, is available, willing, and qualified to perform these services.

NOW, THEREFORE, the Contractor agrees to perform the following described services, which are

Hereinafter described in detail as follows:

{ENTER THE CONTRACT DESCRIPTION}

{PROVIDER CREDENTIALS: Enter Contractor qualifications/credentials.}

{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}

{The terms of the contract must indicate if the contractor may bill the patient or other third-party payer for any part of the services provided under this contract.} {State that: Procedures and supply items that are incidental and integral to procedures are included in a base payment rate and shall not be billed separately.}

{Indicate on each contract section if the health department is authorized to bill third parties for all services included in the contract section.} {Attach Medicaid Statement of Authorization (CH-55) for each medical provider under a contract that is billable to Medicaid.}

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

{BILLING PROCEDURES: Describe how invoices are to be submitted by the Contractor and payment terms for the Health Department.}

Contract Section Number (Lead) **FY HID MO ID**

Third-Party Billing is responsibility of contractor. Y/N

{Use this page to add a different section number for this contract}

{Enter all the information pertinent to this section of the contract as if it were a separate contract.}

{If there is no other section to this contract, this page may be deleted.}

{If there are more sections to be added to this contract, copy the lines that show the section number and third-party billing information to a new page.}The Contractor 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. Any subcontract entered by the Contractor as the result of this agreement shall mandate that the subcontractor is required to abide by the same statutes and regulations regarding confidentiality of personal medical records as is the Contractor.

The Contractor 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)."

All referred statutes, regulations, and policies are adopted and incorporated by reference as part of this contract. The parties to this contract acknowledge inclusion of those statutes, regulations, and policies and each party is responsible to review, be aware of, and comply with the referred statutes, regulations, and policies.

The Contractor is responsible to maintain its own liability insurance and/or professional liability insurance; workers’ compensation insurance; and wage/salary and benefits program for the Contractor’s employees that is compliant with all Federal and State laws. Proof of insurances is to be provided to the Health Department.

1. This Payment made under the terms of each section of this contract shall not exceed:

**Contract Section #** **Amount** **Contract Section #** **Amount**

|  |  |  |  |
| --- | --- | --- | --- |
| {Section Number} | {Section Value} | {Section Number} | {Section Value} |

|  |  |  |  |
| --- | --- | --- | --- |
| {Section Number} | {Section Value} | {Section Number} | {Section Value} |

|  |  |  |  |
| --- | --- | --- | --- |
| {Section Number} | {Section Value} | {Section Number} | {Section Value} |

1. For the services described in this contract, the Health Department agrees to pay the Contractor in the following manner, {Enter payment time period.} payable upon receipt of appropriate billing.

3) The total payments made under the terms of this contract shall not exceed ${Enter Contract Value}.

4) 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).

5) The Contractor is an independent contractor. There is no intention by the parties to the contract to form or create an employer-employee relationship, and it is agreed that an employer-employee relationship does not exist. The Health Department is not responsible for withholding of any taxes or FICA, providing workers’ compensation insurance, liability insurance, or any other form of benefits for or to the Contractor.

6) The Contractor certifies that no officer, stockholder, partner or owner is a member of the governing board of health of the Health Department nor an employee of the Health Department and 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.

7) Either Party shall have the right to terminate this contract at any time upon 30 days written notice to the other Party.

**HEALTH DEPARTMENT:**

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

(SIGNATURE OF AUTHORIZED AGENT)

{Enter Health Department Name}

**CONTRACTOR:**

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

(SIGNATURE OF AUTHORIZED AGENT)

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

(PRINT OR TYPE NAME OF AUTHORIZED AGENT)

{Enter Vendor Name}

I hereby declare that I, {Enter Contractor Name}

a duly licensed {Enter Type of License}

have entered into a

contractual agreement {Enter Contract Number}

with {Enter Health Department Name}

{Enter Department Address}

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

to provide professional services.

I authorize payment to

{Enter Health Department Name}

from the Kentucky Medical Assistance Program for all services provided by me under the terms of our contract. I understand that I, personally, cannot bill the Kentucky Medical Assistance Program for any service that is reimbursed to

{Enter Health Department Name}

as part of our contractual agreement.

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

(Signature of Professional) (Date Signed)

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

(License and/or Certificate #) (Specialty)