THE ALTERNATIVES PROGRAM, CAREGIVER SUPPORT PROGRAM, VETERANS DIRECTED CARE, AND REFUGEE PROGRAM FOR OLDER ADULTS

Request for Applications ("RFA")

1.0. PURPOSE

Salt Lake County Aging & Adult Services ("AAS") is inviting applications for its Supported Aging programs. Through this RFA, providers will directly purchase needed supplies and deliver services in the homes of older adults and adults with disabilities. This RFA will also provide temporary assistance to caregivers of older adults and adults with disabilities. These home-based services will avoid the unnecessary or premature institutionalization of older adults and adults with disabilities.

2.0. BACKGROUND & SCOPE

The Alternatives Program ("TAP"). This program supports older adults or adults with disabilities 18 years of age or older that meet established income and asset eligibility guidelines. TAP client needs are objectively determined through a comprehensive assessment process. Case managers work with clients and their families to develop a care plan that will meet clients' needs. Case managers explore available community support and programs and authorize TAP services when no other funding source is available.

Caregiver Support Program ("CSP"). This program provides temporary assistance to caregivers of older adults or adults with disabilities. Caregivers must be 18 years of age or older. Caregivers are identified and offered services that include information, assistance, counseling, training, support groups, temporary respite, and supplemental services. Respite and supplemental services are objectively identified through an assessment process and are arranged for by a case manager of the CSP. Temporary respite and supplemental services are intermittent and are provided as a means of relieving the caregiver's stress.

Veterans Directed Care ("VDC"). This program is overseen by the Veterans Health Administration. Client referrals are made to AAS by the veteran's VA health care team. AAS will then assist veterans and their family caregivers to develop a care plan that will allow eligible veterans to participate in client self-directed care.

Refugee Program for Older Adults ("RPOA"). This program provides services for older adult refugees in partnership with the Utah Department of Workforce Services-Refugee Services Office ("DWS-RSO"). The Refugee Navigator assists older

adult refugees in accessing existing mainstream services including supportive services, citizenship resources, public assistance benefits, interpretation, and translation services. The Refugee Navigator will also develop opportunities to connect older adult refugees with the community. This community connection will reduce social isolation, integrate them into the community, enhance community connections, and promote health and wellness.

Client eligibility is required for all four programs.

3.0. APPLICATION INFORMATION

Application Documents. Applicants should thoroughly familiarize themselves with the application documents. Should applicants have questions about the RFA or the application documents, they may contact the Supported Aging Contracts and Program Coordinator at 385-468-3232 or by email at jnahas@slco.org.

Applications can be submitted anytime between April 10, 2024, and December 31, 2024. Applications should be submitted electronically to jnahas@slco.org.

Application Package. Application package must include the following documents in this order:

1. Completed General Provider Information – Exhibit 1
2. Completed Service Selection Table – Exhibit 2
3. Current Business License
4. Current Certificate of Insurance based on your service selection in Exhibit 2
5. Current Professional License based on your service selection in Exhibit 2
6. Current Federal Communications Commission Certification based on Exhibit 2
7. Continuity of Operations ("COOP")/Emergency Plan
8. Company Brochure
9. Provider Application Checklist – Exhibit 7

Awards. Contracts will be awarded starting May 1, 2024, upon contract execution. The period of performance of the said agreement shall extend until December 31, 2025. Contracts shall expire on March 31, 2026, unless terminated earlier.

AAS reserves the right to award contracts for selective services from this RFA. The contract awarded shall be non-exclusive. AAS reserves the right to purchase, at its discretion, any product or service covered by the resulting contract from other sources during the term of the contract.

4.0. TRAINING OPPORTUNITIES

Provider Training. Each Provider is required to attend training once the contract has been awarded. The date for the training will be announced. These training sessions will last approximately 2 hours. Providers may also schedule one-on-one appointments for specific contract matters.

Provider Open House. Provider Open Houses may be organized by Supported Aging to bring together providers and case managers. Providers are strongly encouraged to participate to showcase their products and services.

5.0. SERVICE CATEGORIES

The services being sought through this RFA under TAP, CSP, VDC, and RPOA are listed below. Clients will choose providers based upon criteria under Section 22.0 (Client Choice). Referrals cannot be guaranteed by AAS.

Applicants may apply for one or more of these service categories:

1. Home Health Agency (“HHA”)
2. Personal Care Agency (“PCA”)
3. Emergency Response System and Medication Reminder System (“ERS/MRS”)
4. Specialized Medical Equipment, Supplies and Assistive Technology (“SMESAT”)
5. Adult Day Care (“ADC”)
6. Fiscal Intermediary (“FI”)
7. Environmental Adaptation Home Modification (“EAHM”)
8. Assisted Living Facility Services (“ALF”)
9. Nursing Facility Respite Services (“NFR”)

6.0. PURCHASES

No minimum or maximum quantity of purchases under this contract can be specified. Only eligible purchases are reimbursable under a contract resulting from this RFA. To be allowable, the purchase must have occurred during the contract period and within the performance period as authorized by the program case manager. Billings and invoices (original or addendum) submitted more than ninety (90) days past the performance date will not be accepted and will not be reimbursed.

7.0. SERVICE RATES

All four programs under this RFA use a unit cost for the direct provision of services. The unit cost for the purposes of resulting contracts will be referred to as service rates. The service rates stipulated by AAS, and the service rates the provider will specify in Exhibit 2, are the rates allowed for each of the units of service to be delivered. Monthly reimbursement received by all four programs is based on the number of actual units of service provided as authorized by the program case manager.

Providers will not be reimbursed for services rendered without prior authorization from AAS. This requirement is waived for VDC. Verbal authorization is not binding under any circumstances.

8.0. SERVICE RATE ESCALATION/DE-ESCALATION

Service rates stipulated in Exhibit 2 will be firm for the initial one (1) year of the resulting contract(s), or until a new contract term begins. Provider may issue a written request for a rate increase at least sixty (60) days prior to the contract anniversary date. The request must include sufficient supporting documentation. The justification for rate increases should be linked to an independent index or indicator not controlled by either AAS or the provider and cannot exceed the cap rate set by AAS. Any service rate increase to the contract must be approved by a written amendment to the contract. Service rate decreases shall also be passed on to AAS immediately and incorporated through a contract amendment.

9.0. LICENSING REQUIREMENTS

Licensing requirements may vary based on the applicant's selected service(s). All applicants must have a current business license issued by the City in which they are located and registered with the Utah Department of Commerce. A professional license issued by the Utah Department of Health and Human Services is also required for services provided by Home Health Agency, Personal Care Agency, Assisted Living Facility and Nursing Facility applicants. Equipment or handset supplied by Emergency Response System and Medication Reminder System provider must have Federal Communications Commission Certification.

All licensing requirements must be maintained throughout the life of the contract. Providers must submit a copy of all required licensure to AAS at the time of application and provide an updated copy to AAS any time there is a change.

10.0. INSURANCE

a. County represents that it is self-insured pursuant to the provisions of Utah Code Ann. § 63G-7-801 (2021).
b. Provider shall, at its sole cost and expense, secure and maintain during the term of this Agreement, including all renewal or additional terms, the following minimum insurance coverage:

    i. GENERAL INSURANCE REQUIREMENTS FOR ALL POLICIES.

        1. Any insurance coverage required herein that is written on a "claims made" form rather than on an "occurrence" form shall (i) provide full prior acts coverage or have a retroactive date effective before the date of this

Agreement, and (ii) be maintained for a period of at least three (3) years following the end of the term of this Agreement or contain a comparable "extended discovery" clause. Evidence of current extended discovery coverage and the purchase options available upon policy termination shall be provided to County.

2. All policies of insurance shall be issued by insurance companies licensed to do business in the State of Utah and either:

   a. Currently rated A- or better by A.M. Best Company:

—OR—

   b. Listed in the United States Treasury Department's current Listing of Approved Sureties (Department Circular 570), as amended.

3. Provider shall furnish certificates of insurance, acceptable to County, verifying the foregoing matters concurrent with the execution hereof and thereafter as required.

4. In the event any work is subcontracted, Provider shall require its subcontractor, at no cost to County, to secure and maintain all minimum insurance coverages required of the Provider hereunder.

5. In the event that governmental immunity limits are subsequently altered by legislation or judicial opinion, Provider shall provide a new certificate of insurance within thirty (30) days after being notified thereof in writing by County, certifying coverage in compliance with the modified limits or, if no new limits are specified, in an amount acceptable to County.

6. All required certificates and policies shall provide that coverage thereunder shall not be canceled or modified without providing thirty (30) days prior written notice to County in a manner approved by the County District Attorney.

7. In the event Provider fails to maintain and keep in force any insurance policies as required herein, County shall have the right at its sole discretion to obtain such coverage and reduce payments to Provider for the costs of said insurance.

ii. REQUIRED INSURANCE POLICIES. Provider agrees to secure and maintain the following required policies of insurance in accordance with the general insurance requirements set forth in the preceding subsection:

1. Workers' compensation and employer's liability insurance as required by the State of Utah, unless a waiver of coverage is allowed and acquired pursuant to Utah law. This requirement includes Providers who are doing business as an individual and/or as a sole proprietor as well as corporations, limited liability companies, joint ventures, and partnerships. No owner or officer may be excluded. In the event any work is subcontracted, Provider shall require its subcontractor(s) similarly to provide workers' compensation insurance for all of the latter's employees, unless a waiver of coverage is allowed and acquired pursuant to Utah law.

2. Commercial general liability insurance in the minimum amount of Two Million Dollars ($2,000,000.00) per occurrence with a Three Million Dollars ($3,000,000.00) general policy aggregate and a Two Million Dollars ($2,000,000.00) products completed operations policy aggregate.

   a. Sexual abuse and molestation endorsement with a required minimum amount of Twenty-Five Thousand Dollars ($25,000.00) and a recommended amount of One Million Dollars ($1,000,000.00).

   OR

   b. Provider providing Emergency Response Systems ("ERS") whom shall not be visiting or entering any client's home under this Agreement specifically agrees to the following conditions:

      i. Provider shall not visit or enter any client's home in connection with any services rendered under this Agreement. Inasmuch as Provider agrees not to visit or enter any client's home in connection with services rendered under this Agreement, County shall not require Provider to provide a sexual abuse and molestation endorsement. Provider agrees to indemnify and hold County harmless for any claims, actions, demands, lawsuits (hereinafter collectively referred to as "Claims"), resulting from any and all sexual abuse and molestation Claims and Provider's failure to carry insurance against such Claims.

3. Professional liability insurance with a minimum policy limit of One Million Dollars ($1,000,000.00). County is not to be an additional insured for professional liability insurance.

    a. Professional liability insurance is required for the following services only: Registered Nurse ("RN"); Licensed Practical Nurse ("LPN"); Personal Budget Assistance ("PBA"); and Fiscal Intermediary ("FI") services, including all Personal Attendant Services (PAS1, PAS2, and VA PAS).

4. Commercial automobile liability insurance that provides coverage for owned, hired, and non-owned automobiles, with County as an additional insured, in the minimum amount of One Million Dollars ($1,000,000.00) per person, Two Million Dollars ($2,000,000.00) per accident, Five Hundred Thousand Dollars ($500,000.00) per occurrence for property damage, or single combined limit of Two Million Dollars ($2,000,000.00).

    - OR (APPLICABLE ONLY TO PROVIDERS PROVIDING EMERGENCY RESPONSE SYSTEMS) IF THERE WILL NOT BE ANY VEHICLE OPERATION -

    Provider shall not operate a vehicle in connection with any services rendered under its contract resulting from this RFA. Inasmuch as Provider agrees not to operate a vehicle in connection with services rendered under said contract, County shall not require Provider to provide commercial automobile liability insurance.

11.0. GENERAL REQUIREMENTS FOR PROVIDERS

11.1. Provider will comply with all specifications and terms of this RFA, the Provider's response to this RFA (Provider's complete application package), and the resulting contract. Provider will further assure that services shall be defined and provided in accordance with applicable Salt Lake County, State, and Federal laws within the United States.

11.2. Provider certifies with respect to this agreement that all eligible clients can be served and Provider will abide by the provisions of Title VI and Title VII of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; the Americans with Disabilities Act (P.L. 101-336, 28 CFR Part 36); the Fair Labor Standards Act, the Hatch Act, the Age Discrimination Act of 1975; and will comply with the Immigration and Naturalization requirement to maintain a signed copy of the U.S. Citizenship and Immigration Services 1-9 form for each employee. Provider will maintain a drug-free workplace in compliance with the

requirement of 45 CFR, Part 76. Provider agrees to abide by Utah Executive Order dated June 30, 1989, which prohibits sexual harassment in the workplace. Provider shall comply with the provisions of Utah Indoor Clean Air Act Section 26-38-1 et. Seq., Utah Code Annotated, 1953, as amended, relative to smoking in public and other places. Provider agrees to abide by 13-7-1 through 4, UCA, prohibiting discrimination on the basis of race, color, sex, religion, ancestry, national origin, or sexual orientation.

11.3. Provider assures that standards of service provision, licensure, and codes of behavior are established to protect eligible clients from unsafe or unhealthful conditions and/or unprofessional conduct. Provider agrees to follow and enforce the State of Utah Department of Human Services Licensing DHS Code of Conduct and Client Rights (Exhibit 5 or Exhibit 6). Provider must maintain a signed and dated DHS Code of Conduct and Client Rights (Exhibit 5 or Exhibit 6) for each volunteer, direct service worker, and administrative staff member.

11.4. Provider will comply with the program administrative procedures for eligibility, reimbursement, reporting, auditing, and monitoring according to Federal, State, Salt Lake County rules and regulations.

11.5. Provider shall not conduct research involving direct service workers or clients under this agreement until such research and methodology has been approved by the Utah State Department of Health and Human Services, Institutional Review Board.

11.6. Provider shall ensure that all direct service workers assigned under this agreement will receive appropriate orientation and training, exhibit sufficient skill and capability to meet the needs of the individual clients to whom they are assigned, and that all applicable licensure and training of direct service workers is documented under procedures established by the State of Utah Nurse Practice Act and Medical Practices Act, the Utah State Division of Aging and Adult Services, and AAS rules and regulations, and other Federal, State, Salt Lake County or City licensing and regulatory agencies.

11.7. Provider will educate its direct service workers, agents, and subcontractors about:

11.7.1. The False Claims Act, 31 United States Code §§3729-3733.

11.7.2. Administrative Remedies for False Claims and Statements, 31 United States Code §§3801-3812.

11.7.3. The Utah False Claims Act, Utah Code § 26-20-1, et seq.

11.7.4. The Utah Protection of Public Employees Act, Utah Code §67-21-1, et seq. (if applicable).

11.7.5. Policies and procedures for detecting and preventing fraud, waste, and abuse.

11.7.6. How to report suspected fraud, waste, and abuse of Medicaid funds.

11.7.7. The whistleblower protections afforded employees that report suspected fraud, waste, and abuse of Medicaid funds in good faith.

11.7.8. The penalties for filing false or fraudulent claims for Medicaid payment.

11.8. Upon request by AAS, Provider shall produce the following required training documentation for each direct service worker and administrative staff member:

11.8.1. Signed State of Utah Department of Health and Human Services Licensing DHS Code of Conduct and Client Rights (Exhibit 5 or Exhibit 6);

11.8.2. Signed I-9; and

11.8.3. COOP/Emergency Plan training documentation, which must include but is not limited to the dates of training, sign-in sheets, attendee names, training topics, name of instructor, etc.

11.9. Provider will notify program case manager as to whether a client can be accepted for services within twenty-four (24) hours or one (1) working day. Once a client has been accepted for services, provider agrees to process the intake and initiate approved services within seven (7) days of the start date found on the service authorization. Delays in starting approved services must be documented in the client's file, as well as any communication efforts made to resolve the delay.

11.10. Provider will notify the program case manager of needed adjustments in authorized services and levels of service within one (1) working day. The program case managers will make the final decision on authorized changes. No changes will be made without a new service authorization generated and provided by the program case manager.

11.11. Provider shall notify program case manager within twenty-four (24) hours of any changes in clients' medical, psychosocial, or service needs including but not limited to, hospitalization, institutionalization, living environment, formal and informal support systems, and death.

11.12. Provider shall not impose any fees upon the client for services given under this agreement except as authorized by the program case manager. Provider understands that only upon the program case manager's authorization may other services be eligible as billable services.

11.13. Provider will maintain client files which shall contain a current AAS service authorization and current AAS care plan. Provider will also maintain records of all service delivery provided under the contract resulting from the RFA. Provider shall retain such records for a period of six (6) years after the last payment has been made on said contract, or until all reviews initiated within six (6) years have been completed.

11.14. Upon request by AAS, Provider shall make available all client file documentation, as well as any other records related to service delivery under the contract resulting from the RFA, including but not limited to:
   11.14.1. Time records;
   11.14.2. Client's progress notes documenting daily work accomplished;
   11.14.3. Problems or concerns and description;
   11.14.4. Dates and duration of actual services provided;
   11.14.5. Copies/duplicates of receipts for any shopping provided on behalf of the client;
   11.14.6. Statistical and fiscal data;
   11.14.7. Copies of audits; and
   11.14.8. All other records necessary for reporting and accountability required by AAS.

11.15. Provider shall include the cost of travel, time, mileage, record keeping, nursing assessment (if applicable), and supervision time in the unit rates. Provider understands that these services are not separate billable services.

11.16. Provider shall accept all responsibility and liability for subcontracted services provided under this agreement.

11.17. Provider shall make all reasonable efforts to attend annual provider training conducted by AAS.

11.18. Provider shall complete an updated General Provider Information
   11.18.1. Client service or direct service worker contacts.
   11.18.2. Billing contacts.
   11.18.3. Administrative contacts.
   11.18.4. Address (physical or billing).
   11.18.5. Ownership.
   11.18.6. Tax ID information; and/or
   11.18.7. Enrollment status.

11.19. Provider shall attend special individual case staffing as deemed necessary by the program case managers.

11.20. Provider shall designate at least one administrative contact, one case management contact, and one billing contact who can answer contractual questions or concerns. Provider must communicate changes in any of these contacts with AAS to ensure timely correspondence regarding billing, case manager referrals, insurance, licensing, and other requirements. Failing to update this information could result in a decrease in new client referrals and late or no payment.

11.21. Provider shall not contact the client once AAS services have been closed. Any additional concerns should be directed to the client's program case manager.

11.22. Provider shall not contact the client to solicit business or to inquire about increasing or changing services. All inquiries shall be directed to the program case manager.
11.23. Provider shall ensure adequate supervision is provided for all direct service workers. Supervision will include service delivery, monitoring, and documentation of services in the type and amount authorized by the program case manager.
11.24. Provider shall respond to direct service worker issues within three (3) working days.
11.25. Provider shall maintain the flexibility to serve clients with special needs, including but not limited to medical, social, emotional, environmental, and mental health issues.
11.26. Provider shall ensure services are available seven (7) days a week, including holidays, for a minimum of one (1) full hour of service up to the maximum authorized by the program case managers. Provider will make every effort to ensure continuity of care for clients by providing services as normally scheduled even if a normally scheduled visit falls on a holiday. Provider may ask the client if they would be comfortable with a schedule change to accommodate holiday scheduling. If the client chooses not to have their schedule altered, or if doing so would cause undue hardship upon the client, services must still be performed as scheduled. Additionally, if services are normally rendered seven (7) days per week, the provider must still perform client care seven (7) days per week. Provider may not impose rates upon the client nor AAS above the rates stipulated in Exhibit 2 for services performed under any circumstance including nights, weekends, and/or holidays.
11.27. Provider shall ensure that direct service workers will not conduct other business while providing service to the client.
11.28. Provider shall deliver services in compliance with the program case manager's authorized care plan. The direct service worker will perform and document the tasks or services specified in the client's approved care plan.
11.29. Provider shall ensure that routine assessment and supervision visits are included in the approved rate.
11.30. Provider shall have procedures in place to protect the confidentiality of clients' information. No information will be disclosed without the prior informed written consent of an individual. Client files and records related to this agreement shall be made available to AAS and/or the State of Utah upon request.
11.31. Provider shall use the program funds as a "last resort" and will work with program case manager to access other available resources needed to meet client's in-home product and service needs.

12.0. GENERAL REQUIREMENTS FOR SALT LAKE COUNTY

12.1. AAS shall be responsible for auditing, monitoring, and evaluating the delivery of services to ensure compliance with the provisions of this agreement and other applicable Federal, State, or Salt Lake County laws or regulations. Reviews will be scheduled annually but are not limited to once per year. A written evaluation will be forwarded to the Provider upon review completion.

12.2. AAS shall provide training and technical assistance upon request to enable the Provider to meet the requirements of this agreement. All requests for technical assistance and training shall be responded to in a timely manner and no longer than thirty (30) days following the request.

12.3. AAS shall provide a copy of the client care plan upon referral and at least annually thereafter.

12.4. AAS shall document all telephone conversations and written communication between the Provider and program case manager.

13.0. ADDITIONAL REQUIREMENTS FOR HOME HEALTH AGENCY (HHA) AND PERSONAL CARE AGENCY (PCA) SERVICES

13.1. Provider's supervisors must observe the direct service worker on-the-job and determine client satisfaction within ninety (90) days after the initial assessment and at least every six (6) months thereafter unless an earlier visit is necessary. A written copy of supervisory review notes will be kept by the Provider in the clients' files and submitted to AAS upon request.

13.2. Provider shall not allow nonemployees of the agency to accompany the direct service worker during home visits. This includes the direct service workers children, family members, or other visitors.

13.3. Regardless of what services are provided, Provider will ensure that every client's garbage is taken out, and every client's bathroom and kitchen are clean or cleaned during each visit.

13.4. Non-Medical Transportation services are billed on a per unit basis, with a one (1) way trip equaling one (1) billable unit. A one-way trip is considered transportation out or in, regardless of how many stops are made on the way out and/or on the way in. Non-Medical Transportation will be within ten (10) miles of the client's residence.

13.5. Medical Transportation services are billed on a per unit basis, with a one (1) way trip equaling one (1) billable unit. A one-way trip is considered transportation to medical appointments and from medical appointments, regardless of how many stops are made on the way and/or on the way in. Medical Transportation services will be within ten (10) miles of the client's residence. Any Medical Transportation beyond the ten (10) miles will be considered an additional unit per every ten (10) miles.

14.0. ADDITIONAL REQUIREMENTS FOR EMERGENCY RESPONSE SYSTEM (ERS) AND MEDICATION REMINDER SYSTEM (MRS)

14.1. Provider must have the service authorization from the program case manager prior to the installation or removal of any equipment.

14.2. Provider assures that it will provide training to the client on the operation and use of the emergency response equipment and/or medication reminder systems.

14.3. Provider is responsible at no extra cost for replacement (including one (1) lost ERS pendant up to a value of one hundred fifty dollars ($150.00), required repairs, and removal of equipment. Such replacement and/or repair must occur within three (3) working days of notification of malfunction. Additional replacements for lost equipment will be the responsibility of the client. AAS may be able to assist with additional replacement costs on a case-by-case basis. Requests for reimbursement of additional replacement costs must be made through the client's program case manager. Unmonitored personal alert systems are exempt from the responsibility of equipment removal. Provider shall present the client with written instructions on how to request replacement or repair of equipment.

14.4. Provider will install and remove equipment within ten (10) calendar days of the start/end date found on the service authorization supplied by the program case manager.

14.5. Provider understands that AAS will not provide reimbursement for the purchase, installation, or routine monthly charges of a telephone line.

14.6. Provider must include the cost of travel, replacement, repair, or removal of equipment, client training and documentation, and supervision time in the monthly unit rate. Provider understands and agrees that these are not separate billable services.

15.0. ADDITIONAL REQUIREMENTS FOR SPECIALIZED MEDICAL EQUIPMENT, SUPPLIES, AND ASSISTIVE TECHNOLOGY (SMESAT)

15.1. Provider shall complete orders using the most cost-effective method and materials to meet the need unless otherwise specified by the program case manager.

15.2. Once all approvals are in place, provider will either be contacted by the client directly to schedule a date for delivery, or the program case manager will coordinate a date for delivery. Provider will not be responsible for contacting the client initially to schedule delivery.

16.0. ADDITIONAL REQUIREMENTS FOR FISCAL INTERMEDIARY ("FI")

16.1. Provider will ensure that TAP, CSP, VDC, and RFOA approved clients will be assisted in managing domestic personal attendance services ("PAS") direct service workers with payroll related issues. Provider will represent the approved client and will assume all their payroll duties.

16.2. Provider will ensure that all PAS direct service workers are paid completely for all hours worked and reported as authorized by the program case manager. The hours submitted each payroll period under TAP, CSP, and RFOA are confirmed by the program case manager before being sent to the Fiscal Intermediary for payment. Only hours that have been authorized by the program case manager will be paid.

16.3. Under the VDC program, Provider is expected to pay for all hours submitted. If hours submitted are more than the hours authorized by the program case manager, Provider will notify the program case manager in writing within twenty-four (24) hours.

16.4. Provider will ensure that PAS direct service workers will be paid directly, and Provider will be reimbursed by AAS after invoices are submitted and approved by program case manager.

16.5. Provider is responsible for paying the wages of PAS direct service workers twice monthly.

16.6. Provider will notify program case managers as to whether a client can be accepted for services within twenty-four (24) hours or one (1) working day. Once an approved criminal background check from the Bureau of Criminal Investigation ("BCI") is in place, Provider will notify the program case manager within seven (7) days of said approval that the client has been accepted for services.

16.7. Provider shall ensure that all required employment forms are complete for each PAS direct service worker before receiving payment.

16.8. Provider will visit client homes to complete required employment forms when requested by the program case manager.

16.9. Provider is responsible for withholding, filing and depositing FICA, FUTA, and SUTA on behalf of the client. Any federal and/or state penalties assessed for failure to withhold the correct amount and/or for untimely filing and depositing of required forms will be paid by the Fiscal Intermediary.

16.10. Provider shall abide by the U.S. Internal Revenue Service "Agent Employment Tax Liability" under Section 3504 of the Internal Revenue Code.

16.11. Provider will be subject to the following reporting and payment instructions for FI:

  16.11.1. TAP, CSP, and RPOA PAS direct service workers submit timesheets directly to AAS twice per month (every two (2) weeks, 1st through the 15th, and 16th through the end of the month). Timesheets include the

name of the client, PAS direct service worker name, and representative name. Timesheet processing is not accepted through web portal or other online tools. AAS will email approved timesheets to the FI only after they have been reviewed and approved by the program case manager; the FI pays the client's PAS direct service worker for that pay period.

16.11.2. VDC PAS direct service workers submit timesheets directly to the FI; the FI pays the client's PAS direct service worker for that pay period. AAS will send the FI a billing statement for each pay period via email, which includes the name of client, number of hours authorized, and the gross monthly salary. FI shall complete the statement by indicating the number of hours paid, the cost of taxes, the cost of worker's compensation, and the administrative fee for the total cost for each client. The statement must be returned by FI to the program case manager by the billing deadline described below. AAS will reimburse the FI for authorized services in accordance with the veteran's spending plan and payment schedule semi-monthly. If Provider rendered services for clients who are not on the billing statement prepared by the program case manager, or whose services were provided in previous months, provider must submit a billing addendum. Billings and invoices (original and addendum) submitted more than ninety (90) days past the performance date will not be accepted and will not be reimbursed.

16.11.3. Billing statements for the previous month's pay periods (first through last day of the month), administrative fees for clients served, and any needed billing addendum are due to AAS on the 17th or next business day of the following month. For example, January 1-31 billing statements are due by February 17th or the next business day.

16.11.4. Year-end billing information will be sent by AAS to the FI approximately three (3) months before the end of the fiscal year.

16.11.5. TAP, CSP, VDC, and RFOA will use a unit cost that encompasses gross hourly salary, employee paid taxes, and worker's compensation. In addition, a flat reimbursement rate will be charged for administrative fees.

16.11.6. An administrative fee may not be charged if the following two (2) conditions are met:

16.11.6.1. The client and designated PAS direct service worker(s) have not submitted time for any part of the month; and

16.11.6.2. The program case manager has communicated with the FI in writing that client services are anticipated to be on hold for an extended period.

16.12. Provider shall also comply with the following for VDC clients:

16.12.1. Provider shall obtain a federal employer identification number (EIN) for each employer (veteran or their representative, as applicable) it represents.

16.12.2. Provider shall maintain copies of the employer's FEIN, IRS FEIN notification, and a copy of the filed Form SS-4, Request for FEIN in the employer's file.

16.12.3. Provider shall retire employers' FEINs when they are no longer employers and the employer requests this in writing.

16.12.4. Provider shall prepare and submit a signed IRS Form 2678 (Employer Appointment of Agent and a Request for IRS Approval Letter) to the IRS for each employer it represents. When the employer is no longer represented by the Provider, the Provider shall revoke the IRS Form 2678 in accordance with IRS requirements. Provider shall maintain a copy of these documents in each employer's file.

16.12.5. Provider shall receive written authorization from the IRS to be the employer agent for each employer it represents and shall maintain a copy of the written authorization in each PAS employer file.

16.12.6. Provider shall file a signed IRS Form 8821 (Tax Information Authorization) with the IRS for each employer it represents to communicate with the IRS as appropriate on the employer's behalf regarding federal tax filing and payment matters. Providers shall maintain copies of the form in each PAS employer file.

16.12.7. Provider shall file all applicable forms required by the State and Federal government for purposes of withholding, paying, and reporting income tax, unemployment tax or both for each employer it represents using each employer's state unemployment registration number and per state requirements.

16.12.8. Provider shall collect, process, and maintain the following forms for each PAS direct service worker for whom payroll is processed:

16.12.8.1. USCIS Form I-9

16.12.8.2. IRS Form W-4

16.12.9. Provider shall collect, process, and maintain the following forms for each employer for whom payroll is processed.

16.12.9.1. Authorization Form (provider-specific)

16.12.9.2. Employer/Fiscal Intermediary Agreement Form (provider-specific)

16.12.9.3. IRS Form SS-4

16.12.9.4. IRS Form 2678

16.12.9.5. IRS Form 8821

16.12.10. Provider shall pay PAS direct service workers in compliance with Federal and State Department of Labor wage and hours rules.
16.12.11. Provider shall maintain information required to complete employment verifications, Social Security earnings verifications, and other ancillary requests.
16.12.12. Provider shall report new hires per State requirements.
16.12.13. Provider shall register individuals as an employer and obtain the appropriate state employer registration number for Utah State unemployment tax filing and payment purposes for all employers it represents.
16.12.14. Provider shall withhold federal unemployment taxes (FUTA) and file an IRS Form 940 in the aggregate using the separate FEIN for all employers it represents annually.
16.12.15. Provider shall pay FUTA in the aggregate using the Vendor Fiscal/Employer Agent's separate FEIN for all employers it represents per IRS depositing rules.
16.12.16. Provider shall pay State Unemployment Taxes individually for all employers it represents using each employer's state unemployment registration number and per state requirements.
16.12.17. Provider shall pay Federal Insurance Contributions Act (FICA) and federal income tax withholding in the aggregate using the Vendor Fiscal/Employer Agent's separate FEIN for all employers it represents, in accordance with IRS depositing rules.
16.12.18. Provider shall process payments according to all FICA, FUTA, and State Unemployment Tax Authority (SUTA) exemptions.
16.12.19. Provider shall withhold, file, and pay State income tax in the aggregate for all employers' direct service workers using the Vendor Fiscal/Employer Agent's state income tax registration number and per state requirements.
16.12.20. Provider shall withhold and file State Unemployment Insurance tax individually for all employers it represents using each employer's state unemployment registration number and per state requirements.
16.12.21. Provider shall manage the application of all garnishments, levies, and liens on direct service workers' payroll checks in an accurate and timely manner and maintain the relevant documentation in the individual's file.
16.12.22. Provider shall pay PAS direct service workers within the time period required by the Utah State Department of Labor via either direct deposit or pay card.

16.12.23. Provider shall prepare, file, and distribute IRS Forms W-2, and Wage and Tax Statement for employers' direct service workers per IRS instructions to include completing all year-end tax filings/reporting.

16.12.24. Provider shall deliver monthly reports to both the employer and program case manager. The report shall include:

16.12.24.1. The name of the veteran (employer) with which the payment was associated;

16.12.24.2. The name of the direct service worker who was paid;

16.12.24.3. Beginning and ending balance for the veteran's account;

16.12.24.4. The amount of any payments made from the veteran's account; and

16.12.24.5. Applicable payment service code(s).

16.12.25. Provider shall establish a secured and encrypted method for document sharing and data transfer.

16.12.26. Provider shall document billing fees separate from the payroll/payment pass through that is associated with the veteran's budget; fees will be billed monthly in arrears.

16.12.27. Provider shall make payments on behalf of the veteran only in accordance with their care plan and only for approved goods, services, and applicable employer related taxes and worker's compensation premiums associated with said payments. VDC may not place restrictions upon the payment of overtime; Provider shall contact the case manager for further information on overtime guidelines.

16.12.28. Provider assures that it shall adhere to all Provider-specific stop payment policies.

16.13. AAS shall ensure the following FI services for VDC clients:

16.13.1. AAS will ensure at least one case management staff will be responsible to coordinate intake/eligibility and will develop the veteran's individual cost plan and approved services.

16.13.2. AAS shall provide all the necessary funding authorizations to Provider.

16.13.3. AAS shall process other necessary documentation of the PAS direct service worker after obtaining VA approval and criminal background check completion. These must be completed prior to giving program approval to Provider.

16.13.4. AAS shall notify Provider once the veteran is no longer active in the VDC Program.

17.0. ADDITIONAL REQUIREMENTS FOR ADULT DAY CARE ("ADC")

17.1. Provider must ensure services are available a minimum of five (5) days a week, for at least four (4) to a maximum of eight (8) hours of service per day.

17.2. Provider shall notify the program case manager if a client consistently stays at the facility for less than four (4) hours per authorized eight (8) hour day.

17.3. Provider shall include the cost of client meals in full-day and six (6) hour day services, all social activities available to other clients, staff time, personal client assistance, documentation, and supervision time in the unit rates. Provider must also include the cost of incontinence care including toileting every two (2) hours as needed and changing incontinence pads. Provider understands and agrees that these are not separate billable services.

17.4. Provider must allow the program case manager to authorize the provision of personal care assistance (including bathing and grooming, if needed) at the facility using an outside home health agency.

18.0. ADDITIONAL REQUIREMENTS FOR ENVIRONMENTAL ADAPTATION HOME MODIFICATION ("EAHM")

18.1. Provider shall respond to the program case manager via email with an estimate by the date indicated on the "Estimate/Request Bid for Environmental Adaptation" (Exhibit 3). The due date for the requested estimate must be within two (2) weeks of the initial request. If drawings are required by Provider, or if there is a two-step process that is required and Provider cannot comply with the two-week rule, Provider will notify the program case manager of the expected date for receipt of the bid via email.

18.2. Provider will prepare an estimate for the work and send any draft plans for the work directly to the program case manager for approval prior to sending the information to the client. The program case manager and program managers will either approve or deny the work before the client becomes involved in the process.

18.3. Provider's estimate shall only include the specific work ordered by the program case manager.

18.4. Once approved, Provider shall complete the work ordered using the most cost-effective method and materials to meet the need.

18.5. Once approved, Provider shall respond to the service request within three (3) business days of receiving approval from the program case manager.

18.6. Once approved, the program case manager will have the client contact Provider directly to schedule a date for work to begin. Provider will not be responsible for contacting clients initially to set up scheduling.

18.7. Provider shall notify the program case manager within one (1) business day when any unexpected delay in completion of the work occurs, and the program case manager will notify the client.

18.8. When all work has been completed, Provider shall notify the program case manager within three (3) business days so that the program case manager may contact the client for verification and conduct an on-site inspection of the work.

18.9. AAS must verify all completed work for quality and full completion prior to paying associated invoices. Invoices that are received prior to said verification will not be paid until the program case manager has verified that the work is complete.

18.10. Provider shall guarantee parts and labor. Replacement and repairs shall be guaranteed at no additional cost to AAS for ninety (90) days after the date of completion.

18.11. AAS will ensure the following for Providers of EAHM services:

18.11.1. The program case manager shall obtain written authorization from the section manager or program manager for EAHM that exceeds two hundred fifty dollars ($250.00).

18.11.2. When EAHM is needed, the program case manager will submit an "Estimate/Request for Environmental Adaptation" Form (Exhibit 3) to Provider via email that contains all relevant information, including a detailed list of the work to be done and any financial limitations that may exist.

18.11.3. When multiple Providers are available to complete the work, the program case manager will obtain at least two (2) bids on large, costly projects such as ramps, extensive handrail/stair rail installations, home modifications such as doorway widening, etc. These bids will be reviewed by the program case manager, section manager, and program manager.

18.11.4. The program case manager is not required to obtain multiple bids on small projects such as grab bar installations, shower head installations, etc.

18.11.5. Upon approval of the estimate, the program case manager will send an "Estimate Approval of Submitted Bill for Environmental Adaptation Services" form (Exhibit 4) back to Provider via email. This form will include the agreed upon price, the client information, and the date by which the work must be completed.

18.11.6. Once the program case manager has verified the work for quality and full completion and has confirmed that the client is satisfied with the work, the program case manager will notify Provider to submit an invoice for payment.

19.0. ADDITIONAL REQUIREMENTS FOR ASSISTED LIVING FACILITY ("ALF") AND NURSING FACILITY RESPITE ("NFR")

19.1. Provider shall have written policies and procedures regarding the respite care of clients which meet the guidelines established by DHHS and shall provide AAS with copies upon request.

19.1.1. Written policies and procedures must include medication administration, notification of a responsible party in case of emergency, service agreement and admission criteria, behavior management interventions, philosophy of respite services, post service summary, training for employees, and handling of client's personal funds. Provider shall make copies of these policies and procedures available to AAS upon request.

19.2. Provider shall deliver a copy of the State of Utah Resident Rights document to clients referred to under this contract.

20.0. REPORTING, BILLING, AND PAYMENT INSTRUCTIONS

20.1. By the sixth (6th) working day of each month, Providers must submit individualized invoices for each client served the previous month in an approved format. Invoices must be itemized by service. The invoices must include:

20.1.1. Business Name;
20.1.2. Business Address;
20.1.3. Business Phone Number;
20.1.4. Invoice Number;
20.1.5. Service Dates (Range);
20.1.6. Name of Client;
20.1.7. Name of authorizing AAS Case Manager;
20.1.8. Program under which the services were authorized, e.g., TAP, CSP, VDC, RPOA;
20.1.9. Unit cost;
20.1.10. Total cost;
20.1.11. Amount of service provided; and
20.1.12. Description of service performed (must match AAS service authorization).

20.2. Invoices must be submitted electronically to: CCTPBilling@slco.org. Invoices should be batched by program. Providers must calculate units based on the exact time spent providing direct client care. Partially provided units must be rounded to the closest fifteen (15)-minute unit, rounding down when equal to or less than seven (7) and rounding up when equal to or more than eight (8). Upon audit, time sheets must accurately match AAS service authorization.

20.3. Non-Medical Transportation services are billed on a per unit basis, with a one-way trip equaling one (1) billable unit. A one-way trip is considered

transportation out or in, regardless of how many stops are made on the way out and/or on the way in.

20.4. Medical Transportation services are billed on a per unit basis, with a one-way trip equaling one (1) billable unit. A one-way trip is considered transportation to medical appointments and from medical appointments, regardless of how many stops are made on the way out and/or on the way in. Medical Transportation (one-way trip) is limited to a ten (10) miles radius. Any medical transportation beyond ten (10) miles will be considered an additional unit per every ten (10) miles.

20.5. Providers should receive payment from AAS monthly if bills are submitted within required time frames. Payments will be denied for invoices (original and addendum) submitted more than ninety (90) days past the performance date. Billing will be verified by the program case manager for compliance with authorized services and service levels. If the information submitted is incomplete or incorrect, payment for incorrect portions of the bill will be delayed until the necessary corrections are submitted and approved for payment. Providers will be required to receive payment via direct deposit.

21.0. ERRORS IN PAYMENTS AND INVOICING

21.1. Providers will receive payment only for expenditures eligible for reimbursement under the terms and conditions of this agreement, and all eligible expenditures must be adequately documented. Provider agrees that if it is determined through audit or financial review that payments to Provider for services provided under this agreement were incorrectly billed, incorrectly paid, or inadequately documented, AAS may adjust the Provider's payment for the remainder of the contract period or any renewal period. Upon written request, any excess payments are immediately due and payable to AAS within thirty (30) days. Provider further agrees that AAS shall have the right to withhold any or all subsequent payments under this or other contracts with Provider until recovery of overpayment is complete.

21.2. All billing information should be addressed to:

Fiscal Manager
Salt Lake County Aging & Adult Services
Supported Aging
2001 South State Street, Suite S1-600
Salt Lake City, Utah 84190

22.0. CLIENT CHOICE

TAP, CSP, VDC, and RFOA all operate under a client choice model and clients are allowed to choose their service providers from the list of approved providers, organized alphabetically on a Provider Choice List. If the client does not have a preference, the program case manager will educate clients on all possible choices.

23.0. CONTINUITY OF OPERATIONS ("COOP")/EMERGENCY PLAN

Providers must maintain and include with application submission a Continuity of Operations Plan ("COOP") or Emergency Plan. The COOP/Emergency Plan ("Plan") must have policies and procedures in place to ensure essential functions are performed and that continuity of care for Supported Aging clients is sustained in the event of a disaster or emergency. Providers must offer annual training on the Plan and must update the Plan when applicable. A copy of all updated Plans will be provided to AAS with modifications clearly indicated. Essential elements of a COOP/Emergency Plan include policies and procedures to:

23.1. Reduce/mitigate disruption to operations;
23.2. Ensure continued performance of essential functions;
23.3. Reduce loss of life/minimize damage;
23.4. Ensure for the recovery and maintenance of client records;
23.5. Provide full operational capability for essential functions not later than twelve (12) hours after COOP/Emergency Plan activation;
23.6. Be capable of sustaining operations for up to thirty (30) days; and
23.7. Ensure communications with AAS, other appropriate government agencies, clients, and client families will be maintained.

24.0. AUDIT AND QUALITY ASSURANCE REVIEW

24.1. AAS will perform annual Quality Assurance ("QA") Reviews with all Providers. Providers will be given thirty (30) days' notice with a list of quality assurance tools to be reviewed.

24.2. Upon request, Provider agrees to make available to AAS all service and billing records for services provided under the resulting contract, at no additional cost. Provider must maintain sufficient documentation to verify that the services provided have been accurately authorized and billed. AAS may review direct service workers' time sheets, customer records, and billings during regular business hours. Billing records should be clear and easy to read for QA Review. Records must clearly show:

24.2.1. Client's name;
24.2.2. Name of direct service worker performing services;
24.2.3. What services were provided;
24.2.4. Categories of service and the specific tasks performed within each category must be clearly documented (For example, time spent on

homemaking tasks should be clearly distinguishable from time spent on home health tasks);

24.2.5. Dates of services performed (including month, day, and year);

24.2.6. Separate documentation of individual funding streams when more than one payer source is being utilized.

24.3. If areas of contract non-compliance are found during the audit or QA Review, a plan of correction will be required. Generally, this includes a request for staff training, payback and/or best practice recommendations. If there is an egregious violation, a possible suspension of contract could be issued and a report to the State authorities such as Medicaid, Adult Protective Services, etc., will be made. This could be a cause for contract termination.

25.0. CLIENT ON HOLD/MISSED APPOINTMENTS

25.1. Clients will be put on hold in the case of hospitalization, nursing home placement, or other change in residence, whether temporary or permanent. Provider shall immediately stop providing services to the client when the program case manager notifies the provider that the client is put on hold. Services may resume only after the provider has been instructed by the program case manager.

25.2. Provider will communicate with the program case manager if there is a client who frequently misses appointments. Should a missed visit occur, Provider will document why and shall maintain missed visit documentation in the client's file.

25.3. AAS will pay providers for missed appointments when a client is not home without advance notice, up to two (2) times per client. AAS will not pay for missed appointments if the case manager has notified Provider in advance that the client will not be home. Although clients have a responsibility to let Provider know if they are not going to be home for a scheduled visit, it is best practice for Provider to call in advance to ensure the client will be home.

26.0. GRIEVANCE PROCEDURES

26.1. The program case manager will document client complaints.

26.2. The program case manager will make reasonable efforts to resolve the issue with Provider. If the complaint is not resolved, the program case manager will file a complaint with the program manager of Supported Aging.

26.3. A report by the program case manager will be reviewed by Supported Aging to determine if all issues have been discussed with Provider and sufficient efforts have been made to come to a resolution.

26.4. If sufficient efforts have been made and a resolution to the issue has not been implemented, Supported Aging may make an on-site visit to review the issues.

26.5. If issues are not resolved sufficiently, a full contract review/audit may take place.

27.0. CERTIFICATION

By signing the RFA application, Provider certifies that all applicable licensing and standards required by Federal or State of Utah laws or regulations and ordinances of Salt Lake County and the city in which the services are provided, including all application information and forms is complete and correct.