STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES REQUEST FOR PROPOSAL Connecticut Home Care Program for Elders	110306_CHCPE_RFP ADDENDUM #2

The State of Connecticut Department of Social Services (DSS) has issued this SECOND ADDENDUM to the Connecticut Home Care Program for Elders (CHCPE) Request for Proposal.

1. This second addendum serves to amend the RFP through the posting of the forty-nine questions from Bidders and the Department's responses. The forty-nine questions and their answers are set forth on pages two through ten of this addendum.

Except for the changes set forth herein, the terms and conditions of the original RFP remain in full force and effect. To the extent that there is a conflict in the provisions of the original RFP and the provisions of this addendum, the terms of this addendum shall prevail.

A complete proposal must include this signature page of the SECOND Addendum.

_____ _____

Authorized Signer Company Name

Date Issued: December 1, 2006

Approved _____

Kathleen M. Brennan
Director, Contract Procurement

(Original Signature on Document in Procurement File)

1. *Section II - C - Bidder's Questions (Page 10): There is no Bidder's Conference scheduled. Will there be an opportunity to submit additional questions after the response to initial questions has been released?*

   RESPONSE: Bidders may submit questions to the Department ONLY if they are prompted by a response provided to the questions presented in this second addendum. The Issuing Office must receive those questions by 3:00 pm on Friday, December 8, 2006. Questions that are not prompted by a response provided in this second addendum and/or are received after 3:00 pm on December 8, 2006 will NOT be answered. Responses to the additional questions will be presented by the Department in an additional addendum to this RFP posted to the State Contracting Portal on or before Friday, December 15, 2006. There will be no additional opportunities for the submission of questions pertaining to this RFP.

2. *Section II - H (Page 12): Please identify specific factors, other than cost, that are utilized in determining that the selected bidder is the most advantageous to manage the contract.*

   RESPONSE: Refer to Section IV, Proposal Evaluation, pages 72-74 for the basis of the Proposal Evaluation.

3. *Section III - C.1 (Page 16): As the official name of the organization must be on each page, is it acceptable to use the organization's name throughout the proposal in all sections?*

   RESPONSE: YES.

4. *Section III - General Proposal Format Requirements (Page 17): Is an Appendices section allowed in Section II? If yes, do these documents count toward the page limitation for this section?*

   RESPONSE: "Section II" of the RFP is the General Proposal Format Requirements. If this question pertains to Part II of a Bidders Proposal, Part II is limited to 50 pages (See RFP Section III C6 Page Limitations). Appendices are NOT allowed within a Bidders response to Part II and the page count is limited to 50 pages.

5. *In Section III, Appendices - Do documents other than resumes and job descriptions count toward the page limitation for this section?*

   RESPONSE: "Section III" of the RFP is the General Proposal Format Requirements. If the question pertains to Part III of the Bidders Proposal, a Bidders' Part III response is limited to 25 pages. Appendices are NOT allowed and only resumes and job descriptions are not considered part of the 25-page

count, all other documents are part of the 25-page limitation. See RFP Section III C 6.

6. *Do the materials placed in an Appendix section need to be formatted in the same manner as listed in Section III - C(7)?*

   RESPONSE: Appendices are NOT allowed. The response format set forth in RFP Section IV Proposal Contents on page 18 of the RFP must be adhered to. Certain of the appendices that have been included in the RFP (I – X) must be included in Part I of the Bidders Proposal.(See RFP Section IV Proposal Contents).

7. *Does the 20-page limitation for Part 4 pertain to one year?*

   RESPONSE: The twenty (20) page limitation to a Bidders Part 4 response pertains to any and all information required to respond to the Part Four Bidder Requirements as set forth on pages 69 through 72 of the RFP except that the requisite audited financial statements or equivalent information for the bidder that must be provided for each of the last two (2) appropriate fiscal years does not count towards the twenty page limit.

8. *Section IV, Part II - 7.2.R (Page 50): It is noted that provider reports are needed for certain non-medical service providers. Are they required for skilled providers?*

   RESPONSE: NO

9. *Section IV, Part III - E (Page 63): Are the Bidders allowed to request references from the Department of Social Services (DSS) staff?*

   RESPONSE: YES, Letters of Reference may be requested from DSS to fulfill the requirements of Section IV, Part III.E. Section IV, Part III.E.1 specifically requires a reference for the Bidder from any state agency that the bidder has been under contract for the past five (5) years. Please note however that DSS staff has been advised that if they are an evaluator for this RFP that they may not provide a reference for any Bidder. DSS staff have been advised to notify bidders if they are asked but unable to provide a reference.

10. *Section VI, Part IV - Bidder Requirement (Page 70): Please provide a projection of the client census by region and program categories for each of the five years in the term of the contract.*

    RESPONSE: Growth rate has been variable, estimate 5-6% per year. Approximately 2/3 of the clients are waiver and 1/3 state funded.

11. *Section IV, Part IV - 4.1. (Page 70): Please provide the maximum allowable rates for each task by contract year.*

    RESPONSE: The current maximum allowable rates are $4.78 per diem for care management, $273.52 for initial assessment, $90.48 for status review and $29.12 for claims processing. Once passed the budget for SFY 08 may impact the maximum allowable rates but that is not known at this time.

12. *Exhibit 22 and Exhibit 23: The town of Willington on Exhibit 22 is shown to be included in ACU Region IV, but Exhibit 23 lists Willington under ACU Region III. Which region is correct?*

    RESPONSE: Willington belongs in Region 3

13. *Exhibit 23: Should the towns of East Hartland, New Preston, Riverton and Winsted be included under ACU Region V?*

    RESPONSE: Yes, all of those towns are parts of the towns included on the map. Winsted is part of Winchester for example.

14. *Can you please provide the current CHCPE caseloads by region?*

    RESPONSE: As of 11/20 Region 1- 1817, Region 2- 3360, Region 3-1144, Region 4-4260, Region 5- 2681.

15. *Are there estimated volume projections for SFY 2008-2012?*

    RESPONSE: See response to Question 10.

16. *<u>RFP Page 60, A. Governance #2 -</u> Please define "responsible director"*

    RESPONSE: "Responsible Director" refers to members of the Board of Directors.

17. *<u>RFP Page 63, Bidder References #1 -</u> If the bidder has during the past five (5) years been under contract with the State of Connecticut, the bidder MUST include a reference from the State of Connecticut. As our multiple, current contracts are all with the Department of Social Services, are there any specific department exclusions for a reference?*

    RESPONSE: If a member of the evaluation team for this procurement is asked to provide a Letter of Reference, they have been instructed to notify the Bidder that they cannot do so. Otherwise, there are no exclusions for the DSS as a provider of a Letter of Reference. Section IV, Part III.E.1. specifically requires a reference for the Bidder from any state agency that the bidder has been under contract for

the past five (5) years).

18. *<u>RFP Page 68, Reporting Requirements and Data Collection -</u> f. Bi-Annual Quantitative Assessment Data. Do we update and submit the Bi-annual Quantitative Assessment Data "quarterly or bi-annually?*

    RESPONSE: Bi-annually

19. *j. Monthly Activity Report - Is the monthly activity report now done quarterly rather than monthly?*

    RESPONSE: No, it is done monthly

20. *<u>RFP Page 69, Financial Information -</u> Can you please provide a schedule with the approved budget line items?*

    RESPONSE: The line item budget schedule is to be determined by the Bidder based on the Bidder's business plan and proposal.

21. *<u>RFP Page 70, Rates -</u> Can you please provide the DSS maximum allowable rates for the four (4) tasks? To calculate the requested 5-year contract term budget, are we allowed to include increases above the current rate?*

    RESPONSE: Refer to the response to Question 11. The Bidders' business (cost) proposal is to propose rates for the services to be provided. The rates proposed will be evaluated through the evaluation process. The selected Bidders' will, during contract negotiations, negotiate the final rates to be paid under the contract. Such negotiations will be based, in part, on the rates proposed and the Department's budget for this program.

22. *p. 27 3.2 - "The Department shall reimburse the Resultant Contractor for Reassessments." And p. 70 4.a - "Annual reassessments shall be included in care management and shall not be considered in the proposed rates as a separate entity." Will you confirm which is accurate, fee for service or included in the CAM rate.*

    RESPONSE: Reassessments are included in the CAM rate, p 70 is correct.

23. *p. 29 Q.4 - "Checklist to Authorize Care Management" - RFP reports this is required to be submitted at the completion of the reassessments. This policy has been revised effective September 2006 no longer requiring the "Checklist to Authorize Care Management" be submitted. Has this procedure been revised since September 2006?*

    RESPONSE: No.

24. *p. 30 3.4 - "Client Status Review"- Second paragraph states status reviews will be reimbursed at 1/3 of the assessment rate – this is not the current percentage utilized (it is currently at 29.62%). Please clarify.*

    RESPONSE: The reimbursement shall not exceed 1/3 of the cost of the assessment.

25. *p. 47 F.1 - "Have been in business at least one (1) year actively performing the service (s) they are contracted to provide:" - Is it permissible to grandfather in current CHCPE providers who will, as of July 1, 2007, not have met the one year of experience criteria?*

    RESPONSE: YES.

26. *p. 51 7.3 F - "The resultant contractor shall not enter into an agreement with a close relative of the client."- Does this refer to the policy that the direct service provider may not assign agency direct care staff to care for close relatives? If so, historically, per an earlier DSS memo, in limited cases, a home health aide can by assigned to a close relative if there is a compelling reason to do so. Does this still apply?*

    RESPONSE: YES.

27. *p. 55 10.A – Bidder Requirements - "Describe how the Resultant Contractor will ensure the Department that persons with the greatest medical, social and economic need receive timely assistance when funds are available." - This implies that the access agency would have completed an assessment first, before placing someone on the waiting list. Is this accurate?*

    RESPONSE: NO. If there is a wait list it will be maintained by the Department. If a slot is available for a new client the Department will turn the client over to the Contractor for an assessment. The Contractor will only conduct the assessment when and if a slot in the program is available.

28. *p. 63 1- "….If the bidder has been under contract with the State of Connecticut the bidder must include a reference from the state of Connecticut." - Is it permissible to ask an Alternate Care Unit Administrator for a reference, since in other sections it is stated that there should be no communication concerning the RFP?*

    RESPONSE: YES. The RFP specifically requires Bidders that have been under contract with the State of Connecticut during the past five (5) years to supply a letter of reference from the State of Connecticut. If the Bidder has contracted with DSS during the past five years they may request the letter of reference from DSS staff. DSS staff have, however, been advised that they cannot provide a

requested letter of reference IF they are an evaluator for this procurement.

29. *p. 64 H.d - "Reimburse any services while an individual is institutionalized, except for: respite care provided in a nursing facility, status reviews in hospitals or nursing facilities, and transition services in accordance with approved procedures;" - Will you define transition services? Additionally, as is the current practice, will initial assessments completed in the hospital or skilled nursing setting, continue to be reimbursed?*

    RESPONSE: Transition services include status reviews that facilitates a client returning to the community from an institutional setting

30. *p. 65 7 - "Submit a 'Magnetic Tape for Billing' .. We currently electronically transmit our files bi-monthly. Is this an acceptable equivalent procedure?*

    RESPONSE: YES.

31. *p. 67 7.2 - "...retained in the provider's record." By "provider", does this refer to Direct Service Provider, i.e. Companion/Homemaker or Home Health Agency? Additionally, by "client case record" does this refer to the record held by the provider agency or the access agency?*

    RESPONSE: YES and YES.

32. *p. 68 b. - Annual Length of Stay Report – "this report is to be prepared by client category with a total page for all categories." - Will you define category?*

    RESPONSE: Refer to pages 7 and 8 of the RFP for the CHCPE categories of service.

33. *General Questions: Will DSS be increasing the maximum allowable case management rates over the life of this contract?*

    RESPONSE: Maximum case management rates may or may not be adjusted. Such action will be dependent upon the SFY 08 budget and negotiations with the successful Bidder(s) (Contractor(s)).

34. *Is it required to separate the budget by state funded and waiver clients as in the quarterly DSS report?*

    RESPONSE: NO.

35. *Is there a place where we can find the current number of clients by region and by categories of service? Or can that information be released by the Department of Social Services?*

RESPONSE:

REGION	***CATEGORY***	***COUNT***
Bridgeport	*1*	*186*
	2	*219*
	3	*1403*
Bridgeport Total		*1808*
Hartford	*1*	*938*
	2	*708*
	3	*2640*
Hartford Total		*4286*
New Haven	*1*	*370*
	2	*667*
	3	*2336*
New Haven Total		*3373*
Norwich	*1*	*172*
	2	*185*
	3	*782*
Norwich Total		*1139*
Waterbury	*1*	*297*
	2	*585*
	3	*1808*
Waterbury Total		*2690*
TOTAL		***13296***

36. *Given that Request for Proposals changed this week by changing the regions and therefore the ability of an agency to apply or not apply, it is possible to extend the time frame for questions to accommodate this change?*

    RESPONSE: NO, the time frame for the submission of questions will NOT be extended.

37. *Is the State open to a model of service that rests primarily on the use of nurses and nurse practitioners with LPNs and social workers serving a coordinating support function?*

    RESPONSE: The Department will evaluate proposals based upon the RFP requirements. If a Bidder proposes a specific model of service it will be evaluated but must meet the requirements of the RFP.

38. *Does the State want all reporting in the variables listed and in that format, or is the State open to receiving information on clients from grantees with existing proprietary software that, although including those variables, is more expansive?*

    RESPONSE: We expect them to be listed in the format specified.

39. *The RFP states that if a client becomes institutionalized, he or he will not be served until discharge, is the State open to models of service provision where institutionalized individualized clients (or at least a portion of them) could be served by the grantee while institutionalized but under other funding mechanisms in order to test the efficiency of continuity of care from community to institutional and back to community settings?*

    RESPONSE: Institutionalized clients may receive a status review visit done by their care manager.

40. *The RFP alludes to 3 regions in the state, but I could not find this specifically addressed. What and where are they?*

    RESPONSE: The first addendum to this RFP issued by the Department on November 14, 2006 clarified the regional designations.

41. *What is the state' position on an organization sub-contracting some of the functions outlined in the RFPs.*

    RESPONSE: An organization may subcontract the performance of certain functions but the care management functions may NOT be subcontracted.

42. *Will DSS provide a data profile by the five regions, containing clients in each of the three CHCPE eligibility categories, units of service provided under the CHCPE (ex. Adult day care, home health aide) and total expenditures for all categories of service?*

    RESPONSE: NO.

43. *If the answer to the question above is "no", can DSS provide a public data source for the referenced information by region?*

    RESPONSE: Bidders may refer to the CHCPE annual report or the annual reports of the current Access Agencies. Please submit a written request, e-mail is acceptable, for the CHCPE annual report to the Issuing Office Section II A (page 10) of the RFP.

44. *Page 6 Paragraph C – The RFP indicates that the Department administers the CHCPE through contracts with local agencies. Please list the current Access*

Agencies by region. How many clients does each agency serve? How long has each held their contracts?

RESPONSE: Region 1-Southwest Ct. Area Agency on Aging, Region 2-Agency on Aging of Couth Central Ct, Regions 3,4,5- Ct Community Care Inc. See question 14 for client counts. Each of the current contracts have been in effect since July 1, 2001.

45. *Page 9 Paragraph 6 – Please provide information on the number of members that are currently being served by Region. Please include a breakdown by Categories of Service (see Page 7 Paragraph 3).*

    RESPONSE: Refer to question 35.

46. *Page 12 Paragraph 1 – Is it acceptable to provide the electronic copy as a PDF? Do you require a separate electronic copy of the financial proposal?*

    RESPONSE: YES and YES.

47. *Page 16 Paragraph A – Should the electronic copy of the proposal be submitted with the signed original?*

    RESPONSE: YES, one (1) exact electronic copy of the entire proposal, except for those required documents that cannot be converted to electronic format must be submitted with the proposal.

48. *Page 42 Paragraph 4.9 – Section C – Could you please explain the intent of "include a description of how the bidder proposes to remediate and improve compliance if the Department is not the payer of last resort for community-based services."*

    RESPONSE: If an agency discovers that another payment source should have been utilized before the state, describe the process that would be put in place to address that discovery.

49. *Page 50 Paragraph 7.3 – Is a proposed network required with the submission?*

    RESPONSE: NO.

STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES REQUEST FOR PROPOSAL Connecticut Home Care Program for Elders	110306_CHCPE_RFP ADDENDUM #1

The State of Connecticut Department of Social Services (DSS) has issued this FIRST ADDENDUM to the Connecticut Home Care Program for Elders (CHCPE) Request for Proposal.

1. This first addendum serves to amend the RFP through the clarification of service regions. There are five (5) Alternate Care Unit (ACU) regions to be served through the CHCPE. Clarifications made to the RFP have been red-lined and two exhibits (Exhibit 22 and Exhibit 23) have been added to identify the ACU service regions and towns within each region.

Except for the changes set forth herein, the terms and conditions of the original RFP remain in full force and effect. To the extent that there is a conflict in the provisions of the original RFP and the provisions of this addendum, the terms of this addendum shall prevail.

A complete proposal must include this signature page of the FIRST Addendum.

_____ _____
Authorized Signer Company Name

Date Issued: November 14, 2006

Approved _____
Kathleen M. Brennan
Director, Contract Procurement

(Original Signature on Document in Procurement File)

Connecticut Home Care Program for Elders

State of Connecticut
Department of Social Services

REQUEST FOR PROPOSALS

The Department of Social Services is requesting proposals from qualified organizations capable of providing the Department with specific services for the CT Home Care Program for Elders. The CT Home Care Program for Elders is a home health community based program that offers older persons at risk for institutionalization the support needed to remain living at home by conducting assessments; developing plans of care; sub-contracting home health and community-based services; and providing care management services.

Interested bidders may submit a proposal to provide the required services in any of the ~~three~~ five Alternate Care Unit regions of the state. If, however a bidder is interested in providing services in more than one region, they must submit a separate proposal for each region.

Sealed responses must be received no later than 3:00 PM Local Time, January 12, 2007. Any responses received after that date and time might be accepted by the Department as a clerical function but not evaluated. Those submissions that are not evaluated shall be retained for thirty days after the resultant contract is executed, after which time the responses will be destroyed.

This Request for Proposal and all future addendums to this RFP may be obtained by accessing the State Contracting Portal located at http://www.das.state.ct.us/Purchase/Portal/Portal_Home.asp

For further information contact:

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The Department of Social Services is an equal Opportunity/Affirmative Action Employer. Deaf and Hearing Impaired individuals may use a TDY by calling 1-800-842-2524. Questions or requests for information in alternative forms must be directed to the Contract Administration Office at (860) 424-5693.

The Department reserves the right to reject any and all proposals or cancel this procurement at any time if it is deemed in the best interest of the State.

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EXHIBIT 4 "Intra Referral DSS ACU Access Agency/Provider/DMR/ DMH" (W-1547)
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SECTION I. OVERVIEW OF THE DEPARTMENT OF SOCIAL SERVICES AND PROJECT

The following provides a general description of the Department of Social Services and the Connecticut Home Care Program for Elders (CHCPE). Specific details of the operation of the program appear in the work plan requirements beginning on page 20 of this RFP.

A. DEPARTMENT OVERVIEW

The Department of Social Services (the "Department") is a statewide public service agency that provides a broad range of services to the elderly, disabled, families, and individuals who need assistance in maintaining or achieving their full potential for self-direction, self-reliance and independent living. It administers over 90 legislatively authorized programs and one-third of the state budget. By statute, it is the state agency responsible for administering a number of programs under federal legislation, including Food Stamps, Temporary Assistance to Needy Families, and Medicaid.

The Department of Social Services is led by a Commissioner and there are two Deputy Commissioners, one for Programs and one for Administration. There is a regional administrator responsible for each of the Department's three service regions. By statute there is a statewide advisory council for the Commissioner, and each region has a regional advisory board.

Three entities are attached to the Department for administrative purposes only. They are the Commission on Deaf and Hearing Impaired, the Board of Education Services for the Blind, and the Child Day Care Council.

B. ALTERNATE CARE UNIT ADMINISTRATION

The Department's Alternate Care Unit administers the Connecticut Home Care Program for Elders. The mission of the Alternate Care Unit is to develop a dynamic system that includes a flexible array of cost-effective community based services and institutional long care alternatives, which are responsive to the needs and preferences of individuals and families with continuing care needs. There are five (5) Alternate Care Unit Service Regions (refer to Exhibits 22 and 23 for a list of regions and towns within each region).

C. CONNECTICUT HOME CARE PROGRAM FOR ELDERS

The Connecticut Home Care Program for Elders (CHCPE) is a home health community based program that offers individuals at risk for institutionalization the support needed to remain living at home. The CHCPE offers both medical and social services to eligible Connecticut residents including: care management; visiting nurse, physical, occupational and/or speech therapy, home health aide, homemaker, laundry services, personal care assistance (based on labor force available), companion, chore, home delivered meals, emergency response system, adult day health, mental health counseling, transportation, respite care, minor home modification (based on the availability of funds), money management, and assisted living services in approved settings.

The Department administers the CHCPE through contracts with local agencies that have been designated as "Access Agencies". An Access Agency is an organization that complies with all applicable sections of the CHCPE regulations found in the Connecticut Statutes, Regulations of Connecticut State Agencies, Sections 17b-342-1 through 17b-342-5. An Access Agency assists eligible individuals within specified Alternate Care Unit region(s) to receive home and community based services by conducting initial comprehensive assessments of individuals referred to them by

the Department, annual comprehensive assessments, status reviews, and reevaluations as appropriate.

Access Agencies are responsible for providing quality care management services to eligible individuals within specified Alternate Care Unit region(s). Care management includes developing plans of care, subcontracting with direct service providers, effectively and efficiently coordinating the services identified in the plan of care and monitoring the service provider to ensure quality of service and service delivery as stipulated in the individual's plan of care. An Access Agency cannot provide any other direct service to CHCPE eligible individuals or purchase home care services from itself or any related parties.

To be considered responsive, an organization responding to this RFP must currently meet all of the requirements set forth in the applicable sections of the CHCPE regulations found in the Connecticut Statutes, Regulations of Connecticut State Agencies, Sections 17b-342-1 through 17b-342-5 to be designated as an Access Agency or must provide the Department with certain assurances that the responding organization will, by the contract start date, meet all of the requirements set forth in the applicable sections of the CHCPE regulations found in the Connecticut Statutes, Regulations of Connecticut State Agencies, Sections 17b-342-1 through 17b-342-5 to be designated as an Access Agency

1. CHCPE Goals

The goals of the CHCPE are to:

a. Assess whether cost-effective homecare services can be offered to individuals who are at risk of institutionalization;
b. Determine, prior to admission to a nursing facility, whether an individual does or does not need nursing facility services;
c. Authorize Department payment for individuals when nursing facility care or home care is appropriate; and
d. Provide a full range of home care services to eligible individuals who chose to remain in the community, if services are appropriate and cost effective.

2. TYPES OF SERVICE

The CHCPE offers both medical and social services to eligible Connecticut residents including: care management, visiting nurse, physical, occupational and/or speech therapy, home health aide, homemaker, laundry services, personal care assistance (based on labor force availability), companion, chore, home delivered meals, emergency response system, adult day health, mental health counseling, transportation, respite care, minor home modification (based on the availability of funds), money management, and assisted living services in approved settings.

3. CHCPE Categories of Service

The CHCPE has three categories of service, one of which is assigned to all CHCPE eligible individuals. The categories are defined by functional and financial criteria. Individuals can move from one category of service to another. The Department will review an individual's functional and/or financial status as circumstances change and determine if a change in category of service is

appropriate. **"Critical Needs"** as that term is used herein, are bathing, dressing, toileting, eating, transferring, meal preparation, and medication management.
The categories are:

***Category 1*:** This category of service applies to individuals who are at risk of admission to a nursing facility on a short-term or long-term basis if preventive home care services are not provided. Individuals in Category 1 have one (1) or two (2) critical needs and may or may not be financially eligible for Medicaid benefits.

Category 2: This category of service applies to individuals who, in the absence of the CHCPE, would require admission to a nursing facility on a short-term or long-term basis. Individuals in Category 2 have at least three (3) critical needs and do *not* meet the Medicaid income and/or asset criteria.

Category 3: This category of service applies to individuals who in the absence of the CHCPE would require admission to a nursing facility on a short-term or long-term basis and meet the financial eligibility criteria for Medicaid. Individuals in Category 3 have at least three (3) critical needs.

4. Funding Sources

The CHCPE is funded under a waiver to the Medicaid program and appropriations from the CT General Assembly. Participation in the program is dependent upon eligibility and the availability of funds. CHCPE is organized under a three-tiered category of service structure that enables eligible individuals to receive home care services in levels corresponding to their functional dependence and financial eligibility. The first two (2) categories are funded primarily through a state appropriation. Services to eligible individuals in the third category qualify for reimbursement under the Medicaid program. Therefore, costs for Category 3 are equally distributed between federal and state funds.

5. CHCPE Eligibility

Program eligibility is contingent upon the CHCPE accepting new applicants at the category for which the individual is applying and upon the availability of funds.
To qualify for the CHCPE an individual must:

- Be a Connecticut resident;
- Be age sixty-five (65) years or older;
- Meet the program's functional criteria; and
- Meet the program's income and asset guidelines.

a. Functional Eligibility

An individual must have at least one (1) Critical Need to qualify for the CHCPE program.

b. Financial Eligibility*

An individual may financially qualify for either the state funded component or the Medicaid component of the CHCPE program by meeting the financial eligibility requirements set forth below:

i. <u>State Funded Financial Eligibility</u>

Individual Income	No income limit	
	Assets	$19,020
Couple Income	No income limit	
	Assets	$28,530

ii. <u>Medicaid Eligibility</u>

Individual Income	Income	$1,737
	Assets	$1,600
Couple Income	Income	$1,737
(one (1) receiving services)	Assets	$20,620**
Couple Income	Income	$1,737
(both receiving services)	Assets	$3,200

*Income and asset limits are established annually.
**A higher amount of assets may be allowed with a spousal assessment.

6. CHCPE Target Population

The CHCPE target population is individuals who meet the program's eligibility criteria described above and;

a. Are currently institutionalized or at risk of institutionalization (in danger of hospitalization or nursing facility placement due to medical, functional or cognitive status);
b. In need of one or more community based services offered by the program; and
c. Would be able to remain at home without the creation of an unacceptable risk to the safety of the individual or others if home care services were provided.

7. Public Access to the CHCPE Program

Individuals or their representatives access the program by applying directly to the Department. They may call the program's toll free number (1-800-445-5394) or send a completed Home Care Request form to:

Alternate Care Unit
Department of Social Services
25 Sigourney Street, 11th Floor
Hartford, CT 06106.

Individuals are most often referred to the CHCPE by hospital or nursing home social workers or discharge planners, home health care agencies, advocates and other professionals from a variety of community organizations. Additionally, CHCPE clients and/or their representatives regularly refer individuals to the program.

8. CHCPE Application Process

Individuals and/or their representative(s) are responsible for providing the Department all necessary information for determining CHCPE eligibility and category of service. The application process for participation in the CHCPE includes the following:

a. A preliminary health and financial eligibility screen conducted by the Department to determine if the potential client is likely to be eligible for CHCPE participation;
b. Individuals determined by the Department as "likely to be eligible" are referred to the Access Agency for an initial comprehensive assessment of the prospective client's economic status, health status and home care needs; and
c. Final determination of the potential client's financial eligibility.

SECTION II OVERVIEW OF THE PROCUREMENT PROCESS

A. ISSUING OFFICE AND ADMINISTRATION

The Connecticut Department of Social Services is issuing this Request for Proposals (RFP) through its Office of Contract Administration. This office is the only contact in the State of Connecticut for this competitive bidding process. The address of the issuing office is as follows:

Kathleen M. Brennan
Department of Social Services
25 Sigourney Street
Hartford, CT 06106
Phone: (860) 424-5693 Fax: (860) 424-4953
E-Mail: Kathleen.Brennan@ct.gov

All questions, comments and other communications with the State regarding this RFP must be submitted in writing in sealed envelopes or sealed boxes clearly identifying

"CONNECTICUT HOME CARE PROGRAM FOR ELDERS RFP"

Any material received that does not indicate its RFP-related contents will be opened as general mail.

B. PROCUREMENT SCHEDULE

Milestones	Ending Dates
RFP Released	November 3, 2006
Deadline for Letter of Intent 3:00 PM Local Time	November 17, 2006
Deadline for Questions 3:00 PM Local Time	November 17, 2006
Responses to Questions Released (tentative)	December 1, 2006
Proposals Due by 3:00 PM Local Time	January 12, 2007
Successful Bidder(s) Announced (tentative)	February 9, 2007
Contract Negotiations Begin (tentative)	February 12, 2007
New Program Begins (tentative)	July 1, 2007

C. BIDDERS' QUESTIONS

Interested Bidders' may submit questions regarding this RFP to the Issuing Office (see Section II – A) through fax, e-mail or mail directed to the Issuing Office. To be considered, **questions regarding this RFP must be received by the Issuing Office by 3:00 PM on November 17, 2006. The early submission of questions is encouraged. It is solely the Bidder's responsibility to ensure and verify the Department's receipt of the Bidder's questions.**

The issuing office will respond to only those questions that meet the deadline and criteria listed above. Official responses to all questions will be posted in an amendment to this RFP in the form of an addendum to this RFP, posted on the State Procurement/Contracting Portal www.das.state.ct.us/Purchase/Portal/Portal_home.asp. The tentative posting date for the addendum is December 1, 2006. It is solely the Bidder's responsibility to access the State

Procurement/ Contracting Portal to obtain any and all addendums or official announcements pertaining to this RFP. **A complete response to this RFP must include a signed acknowledgment of the receipt of each the addendums to this RFP that are posted to the State Contracting Portal prior to the Proposal submission date.**

D. LETTER OF INTENT - MANDATORY

Interested Bidders are required to submit a Letter of Intent to the Issuing Office to advise the Department of their intention to present a proposal in response to this RFP. The Letter of Intent **MUST BE** received by the Issuing Office by **3:00 PM Local Time November 17, 2006**. Letters of intent may be sent via mail, e-mail or fax. Submission of a letter of intent by the date and time set forth herein is **required** in order to submit a proposal.

E. EVALUATION AND SELECTION

It is the intent of the Department of Social Services to conduct a comprehensive, fair and impartial evaluation for proposals received in response to this RFP. Only proposals found to be responsive to the requirements of this RFP will be evaluated and scored. A responsive proposal must comply with all instructions listed in this RFP, including but not limited to the general consideration requirements.

F. CONTRACT EXECUTION

The contract developed as a result of this RFP is subject to State contracting procedures for executing a contract which includes approval by the State of Connecticut, Office of the Attorney General. Contracts become executed upon the signature of the Attorney General and no financial commitments can be made unless and until the contract has been approved by the Office of the Attorney General. The Attorney General reviews the contract only after the Commissioner and the Contractor have agreed to the provisions.

G. BIDDER DEBRIEFING

The State will notify all bidders of any award issued as a result of this RFP. Unsuccessful bidders may request a debriefing session. Debriefing sessions will be scheduled following the execution and approval by the Office of the Attorney General of the resultant contract(s). Bidders may request a meeting for debriefing and discussion of their proposal by contacting the Issuing Office in writing at the address listed in Section II-A of this RFP.

NOTE WELL: Debriefing Sessions will not include any comparisons of unsuccessful proposals with other proposals.

H. RIGHTS RESERVED

Upon determination that its best interests would be served, the Department shall have the right to do the following:

- **Cancellation:** Cancel this procurement at any time prior to the contract award.
- **Amend procurement**: Amend this procurement at any time prior to contract award.
- **Refuse to accept:** Refuse to accept, or return accepted proposals that do not comply with procurement requirements.

- **Incomplete proposal:** Reject any proposal in which the any part of the proposal is incomplete or in which there are significant inconsistencies or inaccuracies. The State reserves the right to reject all proposals.
- **Prior contract default:** Reject the proposal of any bidder in default of any prior contract or for the misrepresentation of material presented.
- **Proposals received after due date:** Reject or refuse to evaluate any bidder's response that is received after the stated deadline.
- **Written clarification:** Require bidders, at their own expense, to submit written clarification of proposals in a manner or format that the Department may require.
- **Oral Clarification:** require bidders, at their own expense, to make oral presentations at a time selected and in a place provided by the Department. The Department may invite bidders, but not necessarily all, to make an oral presentation to assist the Department in their determination of award. The Department further reserves the right to limit the number of bidders invited to make such a presentation and the number of attendees per bidder.
- **On-site visits:** Make on-site visits to the operational facilities of bidders to further evaluate the bidder's capacity to perform the duties required in the RFP.
- **No proposal changes:** Except as may be authorized by the Department, allow no additions or changes to the original proposal after the due date specified herein.
- **Property of the State:** Own all proposals submitted in response to this procurement upon receipt by DSS.
- **Separate service negotiation:** Negotiate separately any services in any manner necessary to serve the best interest of the state.
- **All or any portion**: Contract for all or any portion of the scope of work or tasks contained within this RFP.
- **One or more bidders:** Contract with one or more bidders.
- **Proposal most advantageous**: Consider costs and all factors in determining the most advantageous proposal for the Department when awarding a bidder the right to negotiate a contract with the Department. While cost is a factor in determining the bidder to be awarded the right to negotiate a contract with the Department, price alone shall not determine the winning bidder.
- **Technical defects:** Waive technical defects, irregularities and omissions if in its judgment the best interest of the Department will be served.
- **Privileged and confidential information:** Share the contents of any proposal with any of its designees for purpose of evaluating proposals to make an award. The contents of all meetings, including the first, second and any subsequent meetings and all communications in the course of negotiating and arriving at the terms of the Contract shall be privileged and confidential.
- **Best and Final Offers:** Seek Best and Final Offers (BFO) on price from bidders upon review of the scored criteria. In addition, the Department reserves the right to set parameters on any BFOs it receives.
- **Unacceptable proposals:** Reopen the bidding process if the Department determines that all proposals are unacceptable.

I. ELECTRONIC COPY OF PROPOSAL

Bidders shall submit an electronic copy of the complete proposal with the original printed copy of the proposal.

J. PROPOSAL PRESENTATION EXPENSES

The State of Connecticut and the Department assume no liability for payment of expenses incurred by bidders in preparing and submitting proposals in response to this procurement.

K. RESPONSE DATE AND TIME

The issuing office must receive proposals by **3:00 PM Local Time, January 12, 2007**, to consider the proposals for selection. The Department will not consider a postmark date as the basis for meeting any submission deadline. Bidders should not interpret or otherwise construe receipt of a proposal after the closing date and time as stated herein as acceptance of the proposal, since the actual receipt of the document is a clerical function. The Department suggests the Bidder use certified or registered mail to deliver the proposal when the Bidder is not able to deliver the proposals by courier or in person. Bidders that are hand-delivering proposals will not be granted access to the building without a photo id and should allow extra time for security procedures. Bidders must address all RFP communications to the issuing office.

L. ACCEPTANCE OF PROPOSAL CONTENTS

If acquisition action ensues, the contents of this RFP and the proposal of the successful bidder will form the basis of contractual obligations in the final contract.

The resulting contract will be a Purchase of Service (POS) contract between the successful bidder(s) and the Department. The Department's POS contract appears in Appendix I. Part II of the POS contract contains Standard Terms that have been approved by the Office of the Attorney General and the Office of Policy and Management. Part I of the POS contract describes the services to be provided including agreed upon outcomes and measures. Part I is drafted based upon the terms and conditions in this RFP and the successful bidder(s) proposal. The bidder's proposal must include "Signatory Acceptance" (Appendix II), without qualification, of all terms and conditions as stated within this RFP and Part II of the Department's POS contract. A successful bidder may suggest alternate language after having accepted without qualification the mandatory terms and conditions as specified in the Purchase of Service contract. The Department may, after consultation with the Office of the Attorney General and the Office of Policy and Management, agree to incorporate the alternate language in any resultant contract, however, the Department's decision is final. Any proposal that fails to comply in any way with this requirement may be disqualified as non-responsive. The Department is solely responsible for rendering decisions in matters of interpretation on all terms and conditions.

M. BIDDER ASSURANCES

1. **Independent Price Determination:** By submission of a proposal and through assurances given in its Transmittal Letter, the bidder certifies that in connection with this procurement the following requirements have been met:

   - Costs: The costs proposed have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such process with any other organization or with any competitor.
   - Disclosure: Unless otherwise required by law, the costs quoted have not been knowingly disclosed by the bidder on a prior basis directly or indirectly to any other organization or to any competitor.

- Competition: No attempt has been made or will be made by the bidder to induce any person or firm to submit or not submit a proposal for the purpose of restricting competition.
- Prior Knowledge: The bidder has no prior knowledge of the RFP contents prior to actual receipt of the RFP and had no part in the RFP development.
- Offer of Gratuities: The bidder certifies that no elected or appointed official or employee of the State of Connecticut has or will benefit financially or materially from this procurement. Any contract arising from this procurement may be terminated by the State if it is determined that gratuities of any kind were either offered to or received by any of the aforementioned officials or employees from the contractor, the contractor's agent or the contactor's employee(s).

2. **Valid and Binding Offer**: The proposal represents a valid and binding offer to provide services in accordance with the terms and provisions described in this RFP and any amendments or attachments hereto.

3. **Press Releases:** The bidder agrees to obtain prior written consent and approval from the Department for press releases that relate in any manner to this RFP or any resulting contract.

4. **Restrictions on communications with DSS staff:** The bidder agrees that from the date of release of this RFP until the Department makes an award, that it shall not communicate with the Department's staff on matters relating to this RFP except as provided herein through the Issuing Office. Any other communication concerning this RFP with any of the Department's staff may, at the decision of the Department, result in disqualification of that bidder's proposal.

5. **HIPAA Compliance:** By submission of a proposal and through assurances given in its transmittal letter, the Bidder certifies that in connection with this procurement the bidder is compliant or will be compliant as a business associate by with the following parts of HIPAA pursuant to CFR 45 Part 160 and 164.

   a. Privacy
   b. Transaction Code Sets

N. FREEDOM OF INFORMATION

Due regard will be given to the protection of proprietary information contained in all proposals received, however, bidders should be aware that all materials associated with this procurement are subject to the terms of the Freedom of Information Act, the Privacy Act and all rules, regulations and interpretations resulting there from. Bidder must provide convincing explanation and rationale to justify each exception from release consistent with Section 1-210 of the Connecticut General Statutes to claim proprietary exemption.

It will not be sufficient for bidders to merely state generally that the proposal is proprietary in nature and therefore not subject to release to third parties to claim an exemption. Price and cost alone do not meet exemption requirements. The particular pages or sections of the proposal that a bidder believes are proprietary must be specifically identified as such. The rationale and explanation must be stated in terms of the prospective harm to the competitive position of the bidder that would result if the identified material were to be released and the reasons why the materials are legally exempt from release pursuant to the above-cited statute.

In any case, the narrative portion of the proposal may not be exempt from release. Between the bidder and the State, the final administrative authority to release or exempt any or all material so identified rests with the State.

O. SET ASIDE AFFIRMATIVE ACTION

Section 4a-60g of the Connecticut General Statutes sets forth the requirements of each executive branch agency relative to the Connecticut Supplier Diversity Program. Pursuant to that statute, twenty-five (25%) of the average total of all contracts let for each of the three previous years must be set aside.

The State requires that the resultant contractor make a "good-faith effort" to set aside a portion of this contract for a small, minority or women's business enterprise as a subcontractor. Such subcontractors may supply goods or services. Prospective bidders may obtain a list of firms certified to participate in the Supplier Diversity program by contacting the Department of Administrative Services at (860) 713-5236 or through e-mail at Supplier.Diversity@ct.gov or access the DAS website.
http://www.das.state.ct.us/Purchase/SetAside/OSD_Search_Vendors.asp

SECTION III GENERAL PROPOSAL FORMAT REQUIREMENTS

Bidders must submit proposals that follow the requirements of this RFP including the requirements of form and format that have been established in order to facilitate the Department's evaluation process. The proposal format requirements are listed in this section below and the proposal content requirements are listed in Section IV of this RFP.

A DELIVERY CONDITION - Copies Necessary

The original (clearly marked) and five (5) exact, legible copies of the proposal must be submitted in properly marked **"CT Home Care Program for Elders RFP"** sealed boxes by the deadline. In addition, one (1) exact electronic copy of the entire proposal, except for those required documents that cannot be converted to electronic format.

B. STRUCTURE

All bidders must observe the separate binding and sealed delivery requirements when they submit their proposals. A proposal from any bidder that fails to observe the sealed delivery and separate binding requirements will be considered non-responsive and will result in disqualification from the bidding process.

1. Parts One, Two and Three Separately Sealed from Part Four - The original and five (5) copies of Part Four, the business and cost component, must be sealed in separate cartons or envelopes from the original and five (5) copies of Parts One, Two and Three.

2. Shipping Container Labeling - The cartons or envelopes that contain the separate parts may be incorporated into one or more shipping containers. The shipping containers must be labeled with the following information: the name of the bidding organization, the name of the RFP (CT Home Care Program for Elders RFP") and the contents of the shipping container – i.e. Part One, Part Two and Part Three; Part Four.

C. CONSTRUCTION REQUIREMENTS

1. Binding of Proposal

Bidders must submit proposals that coincide with the RFP Table of Contents in loose leaf or spiral bound notebooks. The official name of the organization must appear on the outside front cover of each binder and on each page of the proposal.

2. Tab Sheet Dividers

A tab sheet keyed to the Table of Contents must separate major sections of each part of the proposal. The title of each major section must appear on the tab sheet.

3. Table of Contents

Each proposal must incorporate a Table of Contents. It is through this Table of Contents that the Department will evaluate conformance to uniform proposal content and format.

4. Cross-Referencing RFP and Proposal

All responses must correspond to the specific assigned task number in the RFP and shall follow the sequence order found in the RFP.

Each section of the proposal must cross-reference the appropriate section of the RFP that is being addressed. Proposal responses to specific task requirements must reference the RFP request citation. This will allow the Department to determine uniform compliance with specific RFP requirements.

5. Page Numbers

Each page of each part of the proposal must be numbered consecutively in Arabic numerals from the beginning of the proposal to the last page.

6. Page Limitation

Part 1 has no page limitation. All forms shown as Appendices in this RFP and submitted in Part I of the proposal are not subject to page limitations. Part 2 is limited to not more than fifty (50) pages. Part 3 is limited to twenty-five (25) pages, not including Resumes or job descriptions. Part 4 is limited to twenty (20) pages not including audit information.

7. Page Format

The standard format to be used throughout the proposal is as follows:

a. Text shall be on 8 ½" x 11" paper in the "portrait" orientation.
b. Text shall be single-spaced.
c. Font shall be a minimum of twelve (12) point in Arial (not Arial narrow) or Times New Roman (not Times New Roman Condensed) font as used in Microsoft® Word.
d. The binding edge margin of all pages shall be a minimum of one and one half inches (1 ½"); all other margins shall be 1".
e. Graphics may have a "landscape" orientation, bound along the top (11") side. If oversize, graphics may have a maximum of one (1) fold.
f. Graphics may have a smaller text spacing, pitch, and font size.
g. Resumes are considered text not graphics.

SECTION IV PROPOSAL CONTENTS

Bidders must submit proposals that follow the requirements of this RFP in order to facilitate the Department's evaluation process. The proposal content requirements are listed below.

1. **RFP Section IV -Bidders Proposal Part One** must contain the transmittal requirements
2. **RFP Section IV – Bidder's Proposal Part Two** must contain the response to the Scope of Work requirements for the resultant contractor in the specific responses to the bidder requirements. The bidder's response should demonstrate the bidder's understanding of and ability to perform the resultant contractor's performance requirement. The bidder's proposal must present the bidder's understanding of the project, including how the bidder proposes to perform the tasks, identify problems and solve them without a mere re-writing of the RFP requirements. A responsive proposal shall address each task requirement separately.
3. **RFP Section IV – Bidder's Proposal Part Three** This section must contain the bidder's organizational information as it relates to the bidder's ability to perform the activities as presented in the RFP. It must describe the background and experience of the bidder's organization and subcontractors (if any) and include details regarding its size and resources, its experience relevant to the functions to be performed under this contract or recent contracts for similar services.
4. **RFP Section IV – Bidder's Proposal Part Four** (separately bound from Part One, Two and Three) must contain the bidder's cost and price information.

Bidders that intend to submit proposals for more than one region must submit separate versions of Part 4 for each region considered. The requirements in this RFP require only one submission for Parts 1, 2 and 3 when multiple regions are considered. The Department will evaluate each proposal Part separately in sequence.

PART ONE OF BIDDER'S PROPOSAL
TRANSMITTAL COMMUNICATION, FORMS AND ACCEPTANCES

Part One of the Bidder's proposal must be presented in the order specified below:

A. Addendum Acknowledgement

The bidder must include the signed acknowledgement of their receipt of any and all Addendums issued for this RFP.

B. Transmittal Letter:

The original proposal and all copies must include a Transmittal Letter of no more than two (2) pages that includes:

1. The following information:

   a. Full Legal name of the corporation
   b. Federal Taxpayer Identification Number
   c. Name, title, telephone number, fax number and e-mail address of the individual with the authority to bind the bidder to sign a contract with the Department

d. Name, title, and e-mail address of the bidder's principal contact to receive addendums to the RFP and requests for clarification.
e. The region or regions covered by the proposal.

2. The assurance of independent price determination. (RFP Section II - M)

3. The identification of any proprietary information. (RFP Section II - N)

C. Table of Contents

The original proposal and all copies must include a Table of Contents for the entire proposal beginning with the Executive Summary

D. Executive Summary

The original proposal and all copies must include an Executive Summary limited to two (2) pages

E. Procurement Agreements – Signatory Acceptance (Appendix II)

The bidder must provide a signed Acceptance Statement, without qualification, of all mandatory terms and conditions in the Standard POS contract (Appendix I)

F. Workforce Analysis Form (Appendix III)

Bidders with Connecticut Work sites must complete this form

G. Notification to Bidders Form (Appendix IV)

The bidder must provide a signed Notification to Bidders Form. The bidders must address in writing the following five factors as appropriate to the bidder's particular situation.

1. Affirmative Action Plan: The bidder's success in implementing an Affirmative Action Plan.
2. Development of an Affirmative Action Plan: The bidder promises to develop and implement an Affirmative Action Plan if no successful Affirmative Action Plan is in place.
3. Apprenticeship Program: The bidder's success in developing an apprenticeship program complying with Sections 46a-68-1 to 46a-68-17 of the Connecticut General Statutes, inclusive.
4. EEO-1 Data: The bidder's submission of EEO-1 data indicating that the composition of its work force is at or near parity when compared to the racial and sexual composition of the work force in the relevant labor market area.
5. Set-Aside for Minority Business: The bidder's promise to set-aside a portion of the contract for legitimate minority business enterprises and to provide the Department Set-Aside reports in a format required by the Department.

H. Smoking Policy (Appendix V)

If the bidder is an employer subject to the provisions of Section 31-40q (Appendix V) of the Connecticut General Statutes, the bidder agrees to provide the Department a copy of its written rules concerning smoking. The Department must receive the rules or a statement that the bidder is

not subject to the provision of Section 31-40q of the Connecticut General Statutes prior to contract approval.

I. Lobbying Restrictions (Appendix VI)

The bidder must include a signed statement to the effect that no funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member or Congress, an officer or employee of Congress or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

J. Contract Affidavits/Certifications (Appendices VII, VIII and IX)

Connecticut General Statutes Section 4-250 through 4-252 require that State contracts with a value of $50,000.00 or more be accompanied by a Gift Certification and a Consulting Agreement Affidavit. In addition, pursuant to paragraph 8 of Governor M. Jodi Rell's Executive Order No. 1, bids or proposals for Large State Contracts (having a total cost to the State of more than $500,000.00) must include a Campaign Contribution Affidavit. A responsive proposal must include a completed Gift Certification (Appendix VII) a completed Campaign Contribution Affidavit (Appendix VIII) and a Consulting Agreement Affidavit (Appendix IX).

K. Prohibition on Campaign Contributions by Prospective State Contractors (Appendix X)

Pursuant to Public Act 05-05 of the October 25 Special Session as amended by Public Act 06-137, effective on December 31, 2006, "principals" of state contractors and prospective state contractors are prohibited from donating and soliciting certain campaign contributions. A responsive proposal must include a completed State Contractor Principals Collection Form (Form SEEC - SC 1 (Rev. 7/2006) (Appendix X)

L. Confidentiality

The bidder must include a statement that it shall comply with all applicable state and federal laws and regulations pertaining to the confidentiality of all Medicaid applicant/client records and other materials that are maintained in accordance with the CT Home Care Program for Elders contract, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

PART TWO OF BIDDER'S PROPOSAL
GUIDELINES AND WORK PLAN REQUIREMENTS

A. GUIDELINES TO REPONDING TO WORK PLAN REQUIREMENTS

1. Understanding the CHCPE and Performance Requirements

Part Two of the Bidder's Proposal shall present the bidder's understanding of the CHCPE and performance requirements of the CHCPE. The Resultant Contractor selected as a result of this procurement shall provide services in accordance with the performance requirements described in

this document. The Department may, at its discretion, issue future directives that may modify or change the requirements.

2. No Rewrites

The Department does not want a "rewrite" of the RFP requirements. In each task, the RFP requires the bidder to respond to specific requests. The bidder must respond to each statement beginning with "Bidder Requirements: A responsive proposal shall."

3. Project Timetable

The bidder must project a timetable by submitting a PERT, Gantt, or Bar Chart, that clearly outlines the timetable for the regional planning and implementation of the CHCPE from beginning to end. The chart must display key dates and events relative to the project.

4. Department Support

The bidder must specify the type of support the bidder requires from the Department to carry out the project. Support includes, but is not limited to, Department staff time, Departmental reports or information required, or any other resources the Contractor expects the Department to provide.

In addition to the specific negotiated provisions of an awarded contract as the result of this RFP, the Department shall:

a. Monitor the Contractor's performance and request updates as appropriate;
b. Respond to written requests for policy interpretations
c. Provide technical assistance to the Contractor as necessary to accomplish the expected outcomes
d. Provide a project leader
e. Schedule and hold regular project meetings for the Contractor
f. Provide a process for and facilitate open discussions with staff and personnel to gather information regarding recommendations and suggestions for improvement
g. Make staff available to assist with training about the CHCPE policies and procedures and to provide ongoing technical assistance in all aspects of the CHCPE;
h. Provide both an application and a provider participation agreement that must be completed, signed, and filed with the Department prior to enrollment as a Medical Service Provider; and
i. Provide billing instructions and be available to provide assistance with the billing process including completion of claim forms and corrections.

B. WORK PLAN REQUIREMENTS

1. DESIGNATION AND ROLE OF AN "ACCESS AGENCY" AND MEDICAL ASSISTANCE PROGRAM PROVIDER ENROLLMENT

The Department administers the CHCPE through contracts with "Access Agencies". An Access Agency is an organization that assists individuals in receiving home and community based services by conducting initial comprehensive assessments for those individuals referred to them by the Department, annual comprehensive reassessments, status reviews, and reevaluations as appropriate. To be considered an Access Agency an organization MUST comply with all applicable sections of the CHCPE regulations found in the Connecticut Statutes, Regulations of Connecticut

State Agencies, Sections 17b-342-1 through 17b-342-5. Once determined to be an Access Agency, the Access Agency must be enrolled with the Department as a Medical Assistance Program Provider. Enrollment is required for the Access Agency to be reimbursed for services.

Access Agencies are also responsible for providing quality care management services to CHCPE clients. Care management includes developing plans of care, subcontracting with direct service providers, effectively and efficiently coordinating the services identified in the plan of care and monitoring the service provider to ensure the quality of services and service delivery as stipulated in the client's plan of care and this RFP. An access agency must not provide any other direct service to program clients or purchase home care services from itself or any related parties.

NOTE WELL: Throughout the remainder if this RFP the information preceded by the term "Resultant Contractor Requirements" refers to contract requirements that the resultant contractor(s) shall be contractually obligated to comply with. The information preceded by the term "Bidder Requirements" refers to information that a bidder must address or include in their proposal to be considered responsive.

Resultant Contractor Requirements

A. The Resultant Contractor must be comply with all applicable sections of the CHCPE regulations found in the Connecticut Statutes, Regulations of Connecticut State Agencies, Sections 17b-342-1 through 17b-342-5 to be designated as an Access Agency

B. The Resultant Contractor once designated as an Access Agency must enroll with the Department as a Medical Assistance Program Provider. Enrollment is required for the Resultant Contractor to be reimbursed for services. To enroll, the Resultant Contractor must meet the conditions and specifications in the following documents:

    1. DSS Medicaid Provider Enrollment Agreement (Exhibit 1);
    2. DSS "Provider Agreement Guidelines" (Exhibit 2); and
    3. This RFP and any resulting contract.

C. The Resultant Contractor must adhere to all applicable State and Federal Regulations as well as make available, at the Department's request all applicable licenses, certificates, or permits.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe the bidder's compliance with or timeline to be in compliance with the all applicable sections of the CHCPE regulations found in the Connecticut Statutes, Regulations of Connecticut State Agencies, Sections 17b-342-1 through 17b-342-5 to be designated as an Access Agency.

B. Describe the bidder's current status or timeline to be granted status as a Medical Assistance Program Provider.

C. Include evidence of the bidder's registration if the bidder is currently registered with the Department as a Medical Assistance Program Provider; or

D. Describe how the bidder will meet the Department's requirements to become a Medical Assistance Program Provider if the bidder is not currently registered.

2. CHCPE APPLICANTS AND CLIENTS WITH SPECIAL NEEDS

The CHCPE has applicants and individual program participants (hereinafter Clients) with special needs including but not limited to individuals whose primary language is not English and individuals who are hearing and/or visually impaired.

Resultant Contractor Requirements

A. The Resultant Contractor shall employ staff or implement and facilitate an effective strategy that will provide the Department with the assurances necessary to ensure that the Resultant Contractor has the ability to serve CHCPE applicants and clients with special needs, including but not limited to individuals whose primary language is not English, who are hearing and/or visually impaired or who have other special needs;

Bidder Requirements: A responsive proposal shall:

A. Describe the bidder's staffing plan and/or strategy to ensure the Department that the bidder has the ability to provide services for CHCPE applicants and clients who have special needs.

3. CLIENT ASSESSMENTS

3.1. Initial Assessment

Initial Assessment is a process by which a CHCPE applicant is evaluated for functional and financial eligibility. The initial assessment involves a comprehensive written evaluation of an individual's medical, psychosocial and economic status, degree of functional impairment, related service needs and identification of the appropriate category of service. The initial assessment process also includes conducting all CHCPE administrative requirements associated with the CHCPE application process. The CHCPE applicant or applicant's representative is educated about all relevant aspects of the CHCPE and a plan of care is developed and implemented.

The Department shall reimburse the Resultant Contractor for Initial Assessments. The Department's payment for an initial assessment includes:

a. All costs for visiting the CHCPE applicant;
b. Completing the "Modified Community Care Assessment" tool;
c. Obtaining all required applicant signatures on appropriate DSS' forms;
d. Assisting applicant completion and submittal of DSS' "Special Eligibility Determination Document" (Exhibit 9)";
e. Contacting providers or other caregivers in conjunction with the assessment;
f. Developing the plan of care; and
g. Making initial arrangements to start services.

Resultant Contractor Requirements

The Resultant Contractor shall conduct initial assessments adhering to specific requirements. The Resultant Contractor shall:

A. Require a registered nurse or social worker conduct the initial assessments;

B. Contact the CHCPE applicant or the applicant's representative within one (1) working day of receiving the referral from the Department to schedule a face-to-face interview with the applicant;

C. Inform the CHCPE applicant or the applicant's representative at the time the applicant contact is made that clients who require nursing facility care have the right to decide whether or not to live in the community or an institution. (Nursing facility care is defined as in need of assistance with three (3) or more critical needs);

D. Prior to the initial assessment:

1. Provide the CHCPE applicant or the applicant's representative with a copy of DSS' "CHCPE – Your Rights and Responsibilities" (Exhibit 3);
2. Ensure and document in the client record the CHCPE applicant and/or applicant's representative receives and understands the document; and
3. Provide, ensure and document in the client record the applicant and/or applicant's representative receives and understands any written policies the Resultant Contractor may have regarding client rights and responsibilities;

E. Provide the CHCPE applicant or applicant's representative with the Resultant Contractor's grievance procedures assuring and documenting that the CHCPE applicant and/or the applicant's representative receives and understands the document;

F. Obtain all required applicant or applicant's representative dated signatures on DSS' forms including the:

1. "CHCPE Informed Consent" form signed by the CHCPE applicant or the applicant's representative prior to conducting the initial assessment:
   i. The signed consent form authorizes the care manager to conduct the assessment, provide services and obtain information regarding the applicant from other providers and agencies;
   ii. The signed consent form is required to authorize the Department to pay the Resultant Contractor for the assessment; and
   iii. A CHCPE applicant's refusal to sign a "CHCPE Informed Consent" requires written confirmation forwarded to the Department, preferably from the applicant. If a written confirmation cannot be obtained, the care manager is to send notification to the Department utilizing DSS' "Intra Referral DSS ACU Access Agency/ Provider/ DMR/ DMH" (Exhibit 4);
2. "Uniform Client Care Plan" (Exhibit 5);
3. "Client Applied Income Contribution Agreement" (Exhibit 6) if applicable;
4. "Notice of Liability To Applicant or Recipient of Care or Support or Legally Liable Relative" form (Exhibit 17) if applicable.
   i. Used by the Department to determine the cost liability (if any) of the client's spouse;
   ii. The Resultant Contractor shall inform the applicant and/or applicant's representative prior to the acceptance of services that the applicant's spouse may be considered a legally liable relative and may be required to contribute to the cost of care when his or her income exceeds the allowed amount;
   iii. The Resultant Contractor shall obtain and submit a DSS '"Notice of Liability To the CHCPE Applicant or Recipient of Care or Support or Legally Liable

Relative" form (Exhibit 17) form signed and dated by the applicant or applicant's representative; and

iv. The Resultant Contractor shall inform the applicant of the determination.

5. "Special Eligibility Determination Document" (Exhibit 9)

i. Used by the Department to determine CHCPE applicant financial eligibility for program participation and Medicaid eligibility.

G. Verify and document the cognitive and functional status and category of service determination by utilizing and completing all sections of the Department's "Modified Community Care Assessment" tool and "CHCPE Assessment/Revaluation/Status Review Outcome Form";

H. Complete the "Modified Community Care Assessment" tool during a face-to-face interview conducted in the CHCPE applicant's home, or at the hospital or nursing facility if the applicant is institutionalized. If the applicant is institutionalized, the initial assessment shall:

1. confirm the applicant's discharge date;
2. inform appropriate hospital staff of the development of a plan of care;
3. provide all reasonable and necessary measures to implement the plan of care at the time of discharge;
4. include a follow-up home visit to the applicant within five (5) working days of discharge; and
5. document the required activities listed above in the client record.

I. Identify the applicant's service needs;

J. Request a change of category of service when appropriate adhering to the CHCPE "Paper Work for Changes in Category Levels";

K. Develop an individual plan of care adhering to the Department's requirements for plans of care.

L. Provide the applicant with a copy of the signed and completed plan of care;

M. Examine and document the risks associated with the provision of community based services to the applicant and establish that a cost-effective plan of care can be offered without the creation of an unacceptable risk to the applicant or others;

1. Unacceptable risk is defined as a situation which places an individual's life or health in immediate jeopardy. In determining whether an unacceptable risk exists, the Department shall take into account the provider's professional standards, the applicant's needs and the applicant's informed viewpoint with regard to the potential risk.

N. Assist the applicant in selecting the most appropriate services to meet the individual's needs;

O. Provide assistance with the completion of DSS' " Special Eligibility Determination Document" (Exhibit 9) if needed;

P. Educate the CHCPE applicant and/or the applicant's representative that the CHCPE will complement, but not replace services being provided by other funding sources or the CHCPE applicant's family or friends;

Q. Complete the assessment process within seven (7) working days of receiving the referral; and

R. Request additional time from the Department when more than seven (7) work days are needed to complete the assessment process, including the development of the plan of care, by submitting to the Department in advance:

1. A completed "CHCPE Notification of Delay of Assessment" form (Exhibit 8);
2. An advanced notification and request for an extension on a newly completed "CHCPE Notification of Delay of Assessment" (Exhibit 8) when the delay will extend past the anticipated date noted on the previous "Notification of Delay of Assessment" form (Exhibit 8);
3. An "Intra Referral DSS ACU Access Agency/Provider/DMR/DMH", (Exhibit 4) with a recommendation for action consistent with existing Department policies and procedures when an extension of a delay is not appropriate; and
4. Provide any additional information the Department requires to act on the delay request.

S. Arrange to have actual service delivery ready to begin when the CHCPE applicant has been determined to be eligible for CHCPE participation and has accepted community based services; and

T. Provide advanced notice to the Department when services cannot start within seven (7) days of the Resultant Contractor's submission of the assessment outcome and plan of care using the "CHCPE Notification of Delay of Assessment" (Exhibit 8). The Resultant Contractor shall:

1. Submit a completed "CHCPE Notification of Delay of Assessment" (Exhibit 8); and
2. Notify the Department within thirty (30) days that a resolution has been achieved; and
3. report the individual's current status on an "Intra Referral DSS ACU Access Agency/Provider/ DMR/DMH" (Exhibit 4) signed and dated by the care manager.

U. Upon completion of the initial assessment, forward to the Department a completed:

1. "CHCPE Assessment/Revaluation/Status Review Outcome Form";
2. "Uniform Client Care Plan" (Exhibit 5);
3. "CHCPE Care Plan Cost Worksheet" (Exhibit 7);
4. "CHCPE Applied Income Worksheet" (Exhibit 10);
5. "Client Applied Income Contribution Agreement" if applicable (Exhibit 6);
6. "Notice of Liability To Applicant or Recipient of Care or Support or Legally Liable Relative" (Exhibit 17);
7. "Checklist to Authorize Care Management" (Exhibit 11); and
8. A request for a change in service category when the category of service determined at assessment differs from the category of service on the "CHCPE Referral Form" (Exhibit 13).

V. Obtain and provide any information the Department requires to process the individual's application to the CHCPE;

W. Obtain the Department's authorization for all home care services prior to the delivery of services.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe how the bidder will ensure adherence to each of the Resultant Contractor Requirements for initial assessments. Include:

   1. A description of how the bidder will evaluate client risk associated with the provision of CHCPE services and document the factors and rationale that determine an acceptable level of risk.

   2. A description of how the bidder will monitor for adherence to required timeframes for initial assessments. Describe the methods that will be used to remediate and improve adherence to required timeframes for conducting initial assessments and submitting required paperwork if timeframes are not adhered to.

B. Describe how the bidder will monitor for accuracy level of care determinations. Include the methods that will be used to remediate and improve the accuracy of level of care determinations if inaccuracies occur.

C. Describe how the bidder will ensure that the CHCPE applicant and/or the applicant's representative understands client rights and responsibilities and understands any Department form the CHCPE applicant is required to sign to participate in the CHCPE.

D. Submit a procedure for documenting in the client record that the applicant and/or applicant's representative received and understood DSS "Client Rights and Responsibilities" and any written policies the bidder has regarding client rights and responsibilities.

E. Describe how the bidder will monitor compliance with the requirements for clients' rights and responsibilities as described in the Resultant Contractor Requirements. Include a method to remediate and improve compliance if noncompliance occurs.

3.2. Client Reassessment

The client reassessment is very similar to the initial assessment except that it involves a comprehensive written reexamination of a client's medical, psychosocial, and economic status, degree of functional impairment, related service needs, and category of service. The reassessment identifies whether or not circumstances have changed that affect the client's program eligibility or service needs. The reassessment also serves to identify changes in the availability of services that would affect the client's plan of care or program participation status. Revision to the plan of care is made when appropriate and the plan of care resulting from the reassessment is implemented.

The Department shall reimburse the Resultant Contractor for Client Reassessments.

Resultant Contractor Requirements

The Resultant Contractor shall conduct reassessments adhering to specific requirements: The Resultant Contractor shall:

A. Require a registered nurse or social worker conduct the reassessments;

B. Conduct reassessments annually during the month of the anniversary date of the completion of the initial assessment;

C. Verify and document the cognitive and functional status and category of service determination by utilizing the Department's "Modified Community Care Assessment" tool and the "CHCPE Assessment/ Revaluation/Status Review Outcome Form";

D. Request a change of category of service, when appropriate, adhering to the CHCPE's "Paper Work Required For Changes in Category Levels". Upon Department approval of the category change, the Resultant Contractor's care manager shall:

1. Ensure that the client has a plan of care reflecting any changes in services;
2. Adhere to the CHCPE "Paper Work for Changes in Category Levels".

E. Provide a face-to-face interview conducted in the client's home, hospital or nursing facility if the client is institutionalized at the time of the reassessment;

F. If the client is institutionalized, begin the reassessment process no later than the same month of the client's initial assessment date. The resultant contractor shall:

1. Confirm the client's discharge date;
2. Inform appropriate hospital or nursing home staff of the development of a plan of care;
3. Take all reasonable and necessary measures to implement the plan of care at the time of discharge; and
4. Conduct a follow-up home visit to the client within seven (7) working days of discharge.

G. If the client is out of state, begin the reassessment process no later than the same month of the client's initial assessment date. The reassessment shall include:

1. Written documentation confirming that the reassessment process began with either written or verbal communication that includes;
   i. Confirmation the client is maintaining his/her status as a Connecticut resident;
   ii. Confirmation that the client is maintaining his/her Medicaid active status, if appropriate;
   iii. Notation of reported significant changes in the client's health functional or financial status; and
   iv. Anticipated date of client's return to Connecticut;

2. Reasonable and necessary measures to restart services upon the client's return to Connecticut; and

3. A completed reassessment process including a home visit within seven (7) days of the client's return to Connecticut.

H. Assist the client or the client's representative with the completion of all required forms;

I. Assist the client to or the client's representative to the greatest extent possible with the completion and submittal of the Department's "Special Eligibility Determination Document" (Exhibit 9) to promote the client's timely re-determination of financial eligibility;

J. Identify all service needs;

K. Develop and implement an updated individual plan of care. New plan of care forms are to be used that reflect all requirements as detailed in Section IV, Part Two on page 37 of this RFP. The client's and Resultant Contractor's care manager's dated signature must be on the current plan of care and a copy given to the client;

L. Establish whether the client can be offered a cost-effective plan of care without the creation of an unacceptable risk to the client or others;

M. Re-educate the client about the full range of services available under the program, their rights and responsibilities under the program, and any fees or other required contributions toward the cost of care;

N. Obtain all required client/client representative dated signature(s) on all appropriate Department forms including on the updated plan of care;

O. Update the amount that the client must contribute to the cost of care by completing the Department's "CHCPE Applied Income Worksheet" (Exhibit 10) form according to Department's guidelines and obtain the client's signature on a new "Client Applied Income Contribution Agreement" (Exhibit 6) if the applied income amount has changed due to the client's program status change;

P. Provide sufficient documentation to the Department that the client continues to meet all eligibility criteria;

Q. Upon completion of the reassessment, forward to the Department a completed:

1. DSS' "Special Eligibility Determination Document" for State-funded clients (Exhibit 9);
2. "Client Applied Income Contribution Agreement" (Exhibit 6) if applicable;
3. A request for a change in service category when appropriate; and
4. "Checklist to Authorize Care Management" (Exhibit 11).

R. Ensure service delivery in accordance with the updated plan of care; and

S. Obtain and provide any information the Department requires regarding the client's continued participation.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe how the bidder will ensure the Department that the bidder shall be able to satisfactorily adhere to the Resultant Contractor's requirements for reassessments. Include a method to remediate and improve compliance if noncompliance occurs.

B. Describe how the bidder will monitor for accuracy level of care determinations. Include the methods that will be used to remediate and improve the accuracy of level of care determinations if inaccuracies occur.

C. Propose a procedure of how the bidder will assist and monitor CHCPE clients with their annual Medicaid redetermination process. The proposal shall contain a procedure with timeframes that will contribute toward a client's timely completion and submittal of the DSS "Special Eligibility Determination Document" (Exhibit 9).

D. Include a procedure for communicating to the Department when a CHCPE client's Medicaid eligibility is in jeopardy.

3.3. Client Reevaluation

Client reevaluation means a reexamination of the functional and cognitive status of a program applicant, whose initial assessment had been completed within the last sixty (60) days, but the application process was not completed or the applicant had not yet received care management

services. Reevaluations may also be requested when the Department requires a client status update to facilitate a fair hearing. The Department does not reimburse for reevaluations.

Resultant Contractor Requirements

The Resultant Contractor shall conduct reevaluations adhering to specific requirements. The Resultant Contractor shall:

A. Utilize a registered nurse or social worker to conduct reevaluations;

B. Include a reexamination of the client's functional and cognitive status;

C. Include a reevaluation of the appropriateness of the plan of care, including an evaluation for the need of a back-up plan, and making any necessary revisions;

D. Request a change of category of service adhering to the requirements as presented in **"**Paper Work for Changes in Category Levels"**;** and

E. Submit to the Department:

1. An "CHCPE Assessment/ Revaluation/Status Review Outcome Form" for clients who will not be participating in the CHCPE program; or

2. All documentation required to be submitted for an initial assessment for clients who will be participating in the CHCPE program.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe how the bidder will ensure the Department that the bidder shall be able to satisfactorily adhere to the Resultant Contractor's requirements for revaluations. Include a description of how the bidder will monitor for adherence to contractor requirements for reevaluations. Describe the methods that will be used to remediate and improve adherence if the requirements for reevaluations are not adhered to.

3.4. Client Status Review

Client Status review means a review of the functional and cognitive status of a client based on a face-to-face interview. The status review is conducted when a lapse of time has occurred between the assessment and initiating care management services or when a lapse of time has taken place since the client has received care management services.

The Department shall reimburse the Resultant Contractor for Status Reviews. Status Reviews will be reimbursed at one-third (1/3) of the assessment rate.

Resultant Contractor Requirements

The Resultant Contractor shall conduct status reviews that adhere to specific requirements: The Resultant Contractor shall:

A. Utilize a registered nurse or social worker to conduct status reviews;

B. Conduct status reviews during an individual's hospital or nursing facility stay according to the following:

1. no more than one time during a hospital stay which is less than or equal to forty-five (45) days;

2. no more than one (1) time during a nursing facility stay which is less than or equal to forty-five (45) days; and

3. upon obtaining prior authorization from the Department for status reviews conducted more than forty-five (45) days during an individual's hospital or nursing facility stay.

C. Conduct status reviews when a program applicant's initial assessment was completed within the time period of sixty (60) days and six (6) months. Prior authorization from the Department is required;

D. Conduct status reviews when the initial assessment was conducted and a plan of care was developed within the time period of six (6) months to one (1) year, but the client did not receive care management services;

E. Conduct status reviews when a program participant has not received care management services from the Resultant Contractor for more than two (2) months. Prior authorization from the Department is required;

F. Conduct status reviews no more than one (1) time every twelve (12) months for annual reassessment of a person not receiving care management from an access agency;

G. Include an evaluation of the appropriateness of the plan of care, including an evaluation for the need of a back-up plan, and making any necessary revisions;

H. Request a change of category of service adhering to the requirements as presented in **"**Paper Work for Changes in Category Levels";

I. Include confirmation that the individual does not present an unacceptable risk to themselves or others; and

J. Submit to the Department:

1. An "CHCPE Assessment/ Revaluation/Status Review Outcome Form" for clients who will not be participating in the program; or
2. All documentation required to be submitted for an initial assessment and the following:
   i. Updated DSS' "Special Eligibility Determination Document" for State-funded clients (Exhibit 9);
   ii. Updated "Client Applied Income Contribution Agreement" (Exhibit 6) if applicable; and
   iii. A request for a change in service category when appropriate.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe how the bidder will ensure the Department that the bidder shall be able to satisfactorily adhere to the Resultant Contractor's requirements for status reviews. Include a description of how the bidder will monitor for adherence to contractor requirements and describe the methods that will be used to remediate and improve adherence if the requirements are not adhered to.

3.5. Cost Liability

The Resultant Contractor shall identify changed circumstances that affect eligibility or service needs, or changes in the availability of services and would affect the plan-of-care or program participation status.

Resultant Contractor Requirements

The Resultant Contractor shall be held liable for costs that are incurred due to improper procedures including the following:

A. Improper documentation of the level of care;

B. Inaccurate determination of the cost of the plan-of-care;

C. Inaccurate notification and acknowledgment of client rights, responsibilities and choices in relation to the CHCPE; and

D. Failure to comply with established DSS procedures for client contributions.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe the bidder's plan to:

1. Implement, document, coordinate and monitor care management;
2. Ensure the Department of the continued presence of necessary safeguards to protect the health and welfare of clients; and
3. Ensure the Department that the care providers meet established standards of provider participation and quality.

4. CARE MANAGEMENT

Care management services include those activities that involve the implementation, coordination, monitoring and reassessment of a community- based plan of care. Care management is a consumer-centered service that respects consumer rights, values and preferences. Care management services assist the client in meeting their home health care needs, monitors service delivery and the quality of services provided, monitors client satisfaction, and uses available resources effectively and efficiently. Individuals who conduct care management activities are referred to as "Care Managers".

4.1. CHCPE Care Manager and Care Manager Supervisor

The Resultant Contractor will need to employ qualified care managers to conduct care management services to CHCPE clients, and care manager supervisors to ensure high quality care management services and strict adherence to the Department's policies and procedures. The Resultant Contractor is responsible for employing care managers sufficient to meet the needs of the clients and estimated caseloads of the service area.

Qualifications of Care Managers and Care Manager Supervisors

The Resultant Contractor shall employ care managers and care manager supervisors that meet or exceed the following requirements:

A. A care manager shall be either a registered nurse licensed in the State of Connecticut or a social service worker who is a graduate of a four (4) year college or university;

B. A care manager shall have a minimum of two (2) years of experience in health care or human services. A bachelor's degree in nursing, health, social work, gerontology or a related field may be substituted for one (1) year of experience;

C. A care manager shall have the following additional qualifications:

1. Demonstrated interviewing skills which include the professional judgment to probe as necessary to uncover underlying concerns of the applicant;
2. Demonstrated ability to establish and maintain compassionate and supportive relationships;
3. Experience conducting social and health assessments;
4. Knowledge of human behavior, family/caregiver dynamics, human development and disability;

5. Awareness of community resources and services;
6. The ability to understand and apply complex service reimbursement issues; and
7. The ability to evaluate, negotiate and plan for the costs of care options.

D. A care manager supervisor shall meet all of the qualifications of a care manager plus have demonstrated supervisory ability and at least one (1) year of specific experience in conducting assessments, developing care plans and monitoring home and community based services.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Provide the current number of care managers employed by the bidder and describe the bidder's strategy to obtain and employ throughout the term of the contract an adequate numbers of care managers to conduct the client assessments and care management activities as described in this RFP.

B. Propose a care manager to client ratio, identify the number of qualified staff currently employed, the number of qualified staff the bidder will need to recruit, the anticipated turnover rate and the strategy(s) to recruit and maintain qualified care managers and care manager supervisors throughout the term of the contract.

C. Describe the process by which the bidder will select care managers/ care manager supervisors including the steps that the bidder will take to confirm an applicant meets the requirements.

4.2. Orientation, Training and Supervision

The Resultant Contractor shall be responsible for providing adequate orientation and training to new employees, appropriate and ongoing in-service programs for existing staff and adequate supervision of staff to ensure adherence to CHCPE's policies and procedures.

Resultant Contractor Requirements

The Resultant Contractor shall:

A. Ensure that care managers and other appropriate staff are appropriately trained and supervised:
   1. Provide or arrange for orientation, initial and ongoing training for care managers, care management supervisors and other appropriate staff;
      i. Care managers and care manager supervisors orientation and training should, at a minimum, encompass CHCPE policy and procedures including the correct completion and submittal of program forms and use of the assessment tool;
   2. Provide for adequate and appropriate supervision and clinical consultation;
      i. Care managers with a social service background shall have nursing staff available for consultation during normal business hours; and
      ii. Care managers with a nursing background shall have social service staff available for consultation during normal business hours.
   3. Employ care manager supervisors to oversee care mangers adherence to CHCPE policies, procedures and overall quality of care management services.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Propose an orientation and training program for newly hired staff with special attention given to the orientation and training of care managers and care manager supervisors.

B. Describe the bidder's plan to implement and maintain an ongoing in-service program for professional staff to ensure that staff understands the CHCPE purposes and that CHCPE policies and procedures are implemented.

C. Propose a care manager supervisor to care manager ratio and provide a rationale for the proposed ratio. Describe the specific responsibilities of the care manager supervisor.

4.3. Care Management Services

Resultant Contractor Requirements

The Resultant Contractor shall employ care managers who conduct quality care management services that meet or exceed the following specified requirements. The Resultant Contractor's care managers shall:

A. be the primary contact with the client and their family unless other arrangements are specified in the plan of care;

B. cooperate with the client's legal representatives or other individuals for which consent has been given by the client or client's representative;

C. provide client advocacy, crisis intervention, and referral services to the client and the client's family;

D. provide program information that explains the options under the program and answers client questions;

E. direct efforts to maximize the potential of the informal support system and encourage better community independent living capability;

F. conduct initial assessments, reassessments, reevaluations and status reviews;

G. assist the client with the completion and submittal of any required forms including DSS' Special Eligibility Determination Document (Exhibit 9);

H. conduct care management activities only after the completion of the initial comprehensive assessment and development of the plan of care;

I. authorize the start of service delivery for subcontracted service providers;

J. Ensure the timely discontinuance of a service(s) when appropriate;

K. Collaborate with and involve all providers that serve a particular client at all points of the care management process;

L. Coordinate the delivery of all services on the plan of care regardless of the provider or source of reimbursement, if any, to avoid duplication and overlapping services, to monitor service quality and quantity, and to maintain the informal network;

M. Develop working relationships with nursing facilities and/or hospitals to develop policy and procedures in order to access necessary information (such as facility or hospital records) as allowed under federal regulation (e.g. HIPPA);

N. Document care management on the plan of care and all activities in the client's record;

O. Provide care management only to people who are not living in an institutional setting such as a hospital or nursing facility unless they are institutionalized for respite care;

P. Ensure that community based services are not continued during a period of institutionalization unless transition services are subsequently authorized;

Q. Ensure care management is not provided to people living in an institutional setting unless they are there for respite care;

R. Provide information and service referral or access to appropriate resources on a 24 hour per day basis, including responding to emergencies;

S. Work collaboratively with the Department's Protective Services for the Elderly Program (PSE) to report suspected abuse, neglect, exploitation and/or abandonment of CHCPE program participants;

T. The Resultant Contractor shall adhere to all requirements set forth in DSS' "Guidelines for Coordination Between the Protective Services for the Elderly Program (PSE), the Connecticut Home Care Program for Elders (CHCPE), the Alternate Care Unit (ACU), the Contracted Access Agencies (AAs), and the Contracted Assisted Living Service Agencies (ALSAs)" (Exhibit 14).

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe how the bidder will satisfactorily ensure adherence to each of the resultant contractor's requirements for conducting the care management services listed above. Include a description of how the bidder will remediate and improve adherence to the resultant contractor requirements if the resultant contractor requirements are not met.

4.4. Clinical Client Record

Resultant Contractor Requirements

The Resultant Contractor shall maintain a written or electronic clinical client record for each care managed client adhering to the following requirements:

A. All care management activities shall be documented in the client record. The client record shall include the following documents completed with all requested information;

1. DSS' Record Face Sheet;
2. Initial "Modified Community Care Assessment" tool and a copy of the associated "CHCPE Assessment/ Revaluation/Status Review Outcome Form";
3. "Modified Community Care Assessment" tool for each reassessment and the associated "CHCPE Assessment/ Revaluation/Status Review Outcome Form";
4. "Client Goals Worksheet";
   i. Goals shall be client centered;
   ii. Goals shall specifically address all activities of daily living and independent activities of daily living needs identified by the most recent "Modified Community Care Assessment" tool and/or changes in the client's status; and
   iii. Goals shall be measurable.
5. Assessment Profile or Problem List;
   i. List that presents an inventory of all of the client's functional and cognitive impairment(s) as identified in the most recent "Modified Assessment Tool".

6. "Alternate Care Unit Progress Notes" (Exhibit 16);
7. Signed "CHCPE Informed Consent";
8. "Special Eligibility Determination Document" (Exhibit 9) for state funded clients only;
9. "Uniform Client Care Plan" (Exhibit 5);
10. "CHCPE Care Plan Cost Worksheet" (Exhibit 7);
11. Provider Service Orders;
12. "Checklist to Authorize Care Management" (Exhibit 11);
13. Social Service Provider Reports for homemaker, companion, and adult day care services;
14. Prior Authorizations (if applicable);
15. Current "CHCPE Applied Income Worksheet" (Exhibit 10);
16. Any communication documents relevant to the client;
17. Current and signed "Client Applied Income Contribution Agreement" (Exhibit 6) if applicable;
18. Signed "Notice of Liability To Applicant or Recipient of Care or Support or Legally Liable Relative" form (Exhibit 17) if applicable;
19. "CHCPE Notification of Delay of Assessment" (Exhibit 8) if applicable; and
20. Any other forms or documentation required by the Department.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe the process through which the bidder will ensure that throughout the term of the contract, a written or electronic clinical client record for each care managed client will be maintained containing all required documentation as specified in this RFP.

4.5. Confidentiality and Safeguarding of Client Information

The Resultant Contractor shall be responsible for protecting CHCPE client confidentiality and implementing client information safeguards.

Resultant Contractor Requirements

The Resultant Contractor shall

A. Maintain the confidentiality of all client case records;
B. Implement a confidentiality policy;
C. Provide the Department, its designees and/or the Federal Government access to client case records;
D. Require written consent by the client to release medical information to other providers;
E. Develop a standard release form;
F. Obtain the Department's written approval in advance for all other CHCPE case records releases; and
G. Conduct all other release activity in accordance with written policy on the protection and release of information as specified in the Federal and State Regulations (e.g. HIPPA).

BIDDER REQUIREMENTS: A responsive proposal shall

A. Include a proposed confidentiality policy.

B. Include a proposed release form.

C. Describe how the bidder will monitor adherence to each of the resultant contractor's requirements for confidentiality and safeguarding of client information described above. Include a description of how the bidder will remediate and improve adherence to the resultant contractor requirements if the resultant contractor requirements are not met.

4.6. Client Monitoring

The Resultant Contractor shall conduct care management services that include conducting and adequately documenting in the client record, monitoring activities for each care managed client. Monitoring activities involve the ongoing oversight of all aspects of a client's participation in the CHCPE.

Resultant Contractor Requirements

When conducting care manager monitoring activities the Resultant Contractor shall:

A. Conduct and document monthly contacts with the client, client's representative or provider by telephone or by a home visit, depending upon the client's needs. Monthly contacts shall:

1. Verify that services specified in the plan of care meet current needs of the client;
2. Verify that services are being provided as specified in the plan of care;
3. Verify that the plan of care remains within the CHCPE cost limits;
4. Verify client/family satisfaction with services;
5. Verify that client goals remain appropriate and revise client goals if appropriate;
6. Identify the existence of potential problem(s) relating to the client's health, safety and/or any aspect of their participation in the CHCPE and implement corrective action(s) if warranted;
7. Verify that the corrective action for an identified problem(s) is effective; and
8. Verify that the informal support system remains active and provides the assistance noted on the plan of care.

B. Conduct and document client face-to-face home visits six (6) months from the month of assessment or last reassessment to determine the appropriateness of the service plan and to assess changes in the client's condition. The six (6) month home visit shall, at a minimum:

1. Verify that the services specified in the plan of care are appropriate and meet current needs of the client;
2. Verify that services are being provided as specified in the plan of care;
3. Verify the plan of care remains within the CHCPE cost limits;
4. Verify client satisfaction with services;
5. Verify that client goals are appropriate, document the status of the progress toward those goals, and revise client goals if appropriate;
6. Identify the existence of potential problem(s) relating to the client's health, safety and/or any aspect of their participation in the CHCPE and implement corrective action(s) if warranted;

7. Verify that corrective action for an identified problem(s) is effective;
8. Verify that the informal support system remains active and provides the assistance noted on the plan of care;
9. Complete and maintain in the client record an updated **"**Checklist to Authorize Care Management" (Exhibit 11) for the first home visit following the initial assessment; and
10. Respond to changes in client needs as they occur by making appropriate changes in the type, frequency, cost or provider of services needed for the client to remain safely in the community within the limitations of service availability.

C. Request a change of category, when appropriate, adhering to the CHCPE "Paper Work For Changes In Category Levels" when appropriate. Upon Department approval of the category change, the care manager shall:

1. Ensure that the client has a plan of care reflecting any changes in services;
2. Ensure that the client's and care manager's signature is on the current plan of care;
3. Ensure that the client's signature is on a new "Client Applied Income Contribution Agreement" (Exhibit 6) if the applied income amount has changed due to the client's program status change; and
4. Adhere to the CHCPE "Paper Work for Changes in Category Levels"

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe how the bidder shall conduct and document client monitoring activities that satisfactorily comply with the Resultant Contractor's requirements as described in this RFP. Include a description of how the bidder will remediate and improve adherence to the resultant contractor requirements if the resultant contractor requirements are not met.

4.7. Client Discontinuance From CHCPE Services

Discontinuance from the CHCPE is the sole responsibility of the Department. The Resultant Contractor cannot discharge a CHCPE client prior to written approval from the Department.

Resultant Contractor Requirements

The Resultant Contractor shall:

A. Conduct and document client discontinuance activities in accordance with established Department procedure.

B. Recommend to the Department CHCPE discontinuance of services when appropriate. Circumstances upon which discontinuation of services may been recommended include, but are not limited to:

1. The client voluntarily chooses not to participate;
2. The client is no longer a resident of the State of Connecticut;
3. The client is no longer functionally eligible;
4. The client is no longer financially eligible;
5. The client is institutionalized for more than ninety (90) days;
6. The client enters a nursing home and does not intend to return to the community;
7. The lack of available services to meet the client's needs;

8. The plan of care exceeds the Department's established cost limits;
9. The client cannot safely remain in the community and his or her needs can best be met in a nursing facility;
10. The client does not comply with the mandatory fee agreement;
11. The client fails to comply with the mandatory Medicaid requirement; and/or
12. The death of a client.

C. Initiate the Department's approval process for the discontinuance of services by completing and submitting to the ACU Clinical Staff DSS' "Discontinuance Recommendation" form (Exhibit 18) within one (1) working day of obtaining information that there is a Department recognized reason to discontinue a client;

D. Complete and maintain in the client record the DSS "Potential Discharge Recommendation Due to Non-Payment of Client Contribution" form (Exhibit 19);

E. When services are being discontinued due to the client's or client representative's request, obtain the request for discontinuance in writing from the client or client representative. If the client or client representative refuses to provide the request in writing, the Resultant Contractor shall document in the client record the date the verbal request was made;

F. Document in the client record that the client and/or client representative is informed of the plan to discontinue services, the reasons for the discontinuance, and the client's right to appeal;

G. Provide pre-discontinuance planning to the client, provide agencies and all other sources of service; and

H. Upon receiving Department approval for a client's discontinuance from the CHCPE, make sure that all subcontracted providers are notified in a timely manner that services are to be discontinued.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe the bidder's process to conduct and document client discontinuances from the CHCPE. The process must satisfactorily comply with the Resultant Contractor's requirements as described in this RFP. Include a description of how the bidder will remediate and improve adherence to the resultant contractor requirements if the resultant contractor requirements are not met.

4.8. Plan of Care

A plan of care is a written individualized plan of home care services. The plan of care specifies the type and frequency of all services required to maintain the individual in the community. The plan of care names each service provider and the associated cost of the service regardless of the payment source or whether or not there is an actual charge for the service. A back-up plan is included on the plan of care when a client's health and/or safety is jeopardized if a disruption in services occurs.

The Resultant Contractor's care managers are responsible for the development and monitoring of clients' plans of care. The Department shall review all initial plans of care and care plan cost worksheets to determine the appropriateness of services and to assure that the plan of care is complete and within Department plan of care cost limits.

Resultant Contractor Requirements

The Resultant Contractor shall develop and monitor individualized plans of care adhering to the following requirements:

A. Plan of Care Format and Content

1. Use the DSS "Uniform Client Care Plan" (Exhibit 5) format and content as the standard design for individual plans of care;
2. Plans of care must have at least one (1) CHCPE covered service as listed in Section 1, C 2 on page 7 of this RFP;
3. Care plans shall be complete, dated, and signed by the care manager and the client or the client representative at initial assessment, at each reassessment and any time there is a significant revision to the plan of care;
4. Use new care plan forms for care plans developed at reassessments and any time significant changes have been made to the care plan;
5. Document all formal and informal home care services regardless of the provider, source of reimbursement or whether the services are compensated or uncompensated;
6. Specify the frequency, type of service(s), and monthly cost of service. (Services expressed in weeks on the plan of care are multiplied by 4.3 to ascertain the monthly units. The monthly units multiplied by the rate per unit equals the monthly cost of the service.);
7. Reflect all client need(s) identified and documented on the most recent DSS' "Modified Community Care Assessment" tool; and
8. Document care management on the plan of care.

B. Development of Plan of Care

1. Confirm that a cost effective plan of care that meets the individual's home care needs can be developed;
2. When the client agrees, utilize the least costly provider when a choice of providers of the same community based service and the same quality of service is available;
3. Assist the client in selecting the most appropriate services to meet the individual's needs;
4. Plan services in close cooperation with the family and other involved members of the informal support system. The program applicant shall have the opportunity to be involved in and informed about the process, concerns and decisions throughout his/her program participation and be involved, to the extent possible, in the entire process;
5. Document the factors and rationale that allow an acceptable level of risk; and
6. Establish and ensure an appropriate, non-duplicative or overlapping service mix:
7. Plans of care shall not unnecessarily provide similar services at the same time, such as the overlapping of companion and homemaker services; and
8. Collaborate with other health care professionals providing services to the client to avoid duplication and to obtain input regarding the development of the plan of care.
9. Review the plan of care and determine whether or not there is the need for a back-up plan for each service listed on the plan of care. A back-up plan is required for all CHCPE clients whose day and/or time of service(s) are necessary to ensure the client's health and/or safety;

i. Evaluate each service on the plan of care to determine if the schedule may vary without risk to the client;

ii. Review for the need of a back-up plan:

iii. At the time of assessment;

iv. At the time of reassessment;

v. At any time the client's status changes to the extent that a back-up plan becomes necessary or is no longer necessary;

vi. Document on the plan of care the review for the need of a back-up plan and the results of that review;

vii. Note the back-up plan on the plan of care and include:

1. The specificity of day and/or time needed to ensure the client's health and safety;
2. The identification of a specific individual as the back-up and their contact information; and
3. Notify the provider(s) when a client's health and/or safety are jeopardized if services are either not delivered or not delivered at the day and/or time indicated on the plan of care.

10. Submit to the Department a copy of the initial plan of care and upon request any subsequent plans of care;
11. Ensure that the client is given a copy of the and most current care plan signed and dated by both the client and care manager;
12. Establish and monitor that the plan of care does not exceed the cost limits established by the Department for each category of service. (See Section 20.2.5, "CHCPE Categories of Service" for category of service definitions.); and
13. Obtain the Department's authorization for all home care services for elders under the CHCPE prior to the delivery of the service(s).

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe how the bidder will implement a quality assurance procedure to ensure that clients' plans of care will adhere to the requirements listed above.

B. Describe how the bidder will determine if a cost effective plan of care that meets the individual's home care needs can be developed;

C. Describe how the bidder will afford the client and the client's family the opportunity to be involved in the decisions regarding the client's participation on the CHCPE.

D. Propose a procedure that will result in a thorough exploration and utilization of all available services and funding sources resulting in the Department being the payer for community based services of last resort.

E. Describe the bidder's plan to document price comparisons,

F. Describe how the bidder will ensure plans of care are non-duplicative and do not provide an overlapping service mix:

G. Describe how the bidder will ensure review of the client's plan of care for the need of a back-up plan, how the bidder will ensure that the required information for back-up plans are documented

on the plan of care and how they will work with performing providers to ensure the implementation of the back-up plan when necessary.

H. Describe how the bidder will monitor compliance with the resultant contractor requirements and include a description of how the bidder will remediate and improve adherence to the resultant contractor requirements if the resultant contractor requirements are not met.

4.9. Exploration of Resources – Department as Payer of Last Resort

The Resultant Contractor shall be responsible for ensuring that there is no other existing resource available to pay for a service on a CHCPE client's plan of care. The Department is always the payer of last resort for all services listed on the plan of care. The Resultant Contractor must conduct a thorough exploration of all available services and funding sources. Potential alternative resources include, but are not limited to, Medicare, other third party payers, nonprofit organizations and foundations.

Resultant Contractor Requirements

The Resultant Contractor shall:

A. Ensure that the Department is always the payer of last resort by:
   1. Exploring and utilizing all alternative sources of community support that are available through local and statewide organizations, client's family and neighborhood;
   2. Informing and referring clients to all appropriate and available sources of assistance including Medicare and other third party payers;
   3. Providing client assistance with accessing alternative resources by obtaining and completing applications;
   4. Approaching local and state government agencies for available services and funding only after the Resultant Contractor has accessed all available alternative sources of support; and
   5. Providing the Department with information on alternative supports explored and utilized that resulted in the Department being the payer of last resort.

Bidder Requirement A responsive proposal shall:

A. Describe how the bidder will identify alternative supports and funding sources other than DSS resources.

B. Propose a method to monitor care managers' effectiveness in identifying and securing alternative supports and funding sources when developing plans of care.

C. Include a description of how the bidder proposes to remediate and improve compliance if the Department is not the payer of last resort for community-based services.

4.10. Cost Limits on Individual Plans of Care by Category of Service

Plans of care costs must be within the limits related to the applicant or program participant's category of service. All state administered costs for home care services shall be counted, including Medicaid, state funds, Older American's Act Funds (Title III funds) and Social Service Block Grants services funded by Medicare (Title 18), an individual's private third party insurance (e.g. Anthem/ Blue Cross), and/or services the client pays for that are beyond the client's required contribution, if applicable, are not included when determining the care plan cost.

The cost limits on individual plans of care by category are:

- Category 1 Services may be authorized for up to twenty-five percent (25%) of the weighted average nursing home facility cost for individuals;
- Category 2 Services may be authorized for up to fifty percent (50%) of the weighted average nursing home facility cost for individuals; and
- Category 3 Services, in order to ensure cost effectiveness, cannot exceed one hundred percent (100%) of the weighted average Medicaid cost of a nursing facility.

The cost of non-medical or social services shall not exceed sixty percent (60%) of the weighted average Medicaid rate for of a nursing facility. Non-medical or social services are care management, homemaker, companion, personal emergency response system, home delivered meals, non-medical transportation, adult day health, chore, elderly foster care, mental health counseling, and respite care.

Resultant Contractor Requirements

The Resultant Contractor shall develop, monitor, and be responsible for individual plans of care adhering to the Department's plan of care cost limits: The Resultant Contractor shall

A. Complete the "CHCPE Care Plan Cost Worksheet" (Exhibit 7) to determine the monthly or annual cost of services identified in the plan of care and ensure plan of care costs are at or below the allowed amount;

B. Prepare annualized care plan costs when a plan of care requires home care services whose monthly cost in state administered public funds temporarily exceeds the category of service cost limit.

   1. costs must be projected over a twelve-month period. If the projected annualized cost falls within the category cost limit, the Department may accept the care plan;
   2. prior authorization must be obtained from the Department before implementing a plan of care that's cost has been annualized;
   3. Annualizations cannot be done retrospectively;
   4. The specific service and the length of time the service needs to be increased must be identified and documented;
   5. The reduction of the annualized service cannot compromise the applicant's or program participant's safety over the expected period of annualization;
   6. The period of annualization cannot exceed twelve (12) months; and
   7. A plan of care cost limit exception cannot be made once an annualization has already been approved.

C. If an applicant's or program participant's plan of care cost still exceeds the cost limits, the care manager may request, in writing, an administrative exception on behalf of the applicant or program participant. Administrative exceptions are granted only in cases of extreme hardship. Such approvals shall be time limited and are never granted for plan of care costs that exceed one hundred percent (100%) of the weighted average Medicaid cost of a nursing facility;

D. If a program applicant's or program participant's plan of care cost exceeds the cost limits, the client and/or family has the option of paying the difference between the limit and the care plan cost;

E. If the Resultant Contractor does not have information on the actual cost of services on the plan of care being paid for by other state administered programs, the Resultant Contractor must estimate the cost based upon payments made for similar services; and

1. If the rate(s) for a home care service covered by the CHCPE is increased, decreased or otherwise modified, the Resultant Contractor must update the plans of care to reflect those changes at the next scheduled monthly monitoring activity or at the six (6) month visit (whichever occurs first) following receipt of the new and/or modified rate(s). The Resultant Contractor and other providers will be liable for costs in excess of the cost limit following that transition period unless the plan of care is under appeal or the Department grants an administrative exception.

F. The costs of any program participant services that were implemented prior to July 1, 1992 that now exceed the current cost limits shall be retained at the same rate in the participant's current plan of care.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe how the bidder will ensure that individual plans of care adhere, at all times, to the Department's plan of care cost limits.

B. Describe how the bidder will monitor compliance with the resultant contractor requirements for client plans of care cost limits. Include a description of how the bidder will remediate and improve compliance if noncompliance occurs.

5. SELF DIRECTED CARE

The Self Directed Care program option allows individuals to receive home care services without the ongoing intervention of a care manager from an Access Agency. Self Directed Care is offered to clients and/or their family when the client's situation is conducive to working directly with the provider agency(s) to coordinate and monitor the client's care. Individuals must be CHCPE participants for six (6) months before the Self Directed Care option can be offered. Appropriate Individuals for self directed care are identified and referred to the Department by the Access Agency. Although the Access Agency is not providing care management services to Self Directed Care clients, the Access Agency may still be required to process claims for the CHCPE client services.

Resultant Contractor Requirements

The Resultant Contractor shall:

A. At the time of reassessment, or any time after the client has been a participant for six (6) months or more, identify and refer to the Department CHCPE clients appropriate for Self directed Care. Clients are considered to be appropriate when:

1. Their functional and cognitive status has been determined to be stable including when there are chronic health problems but the conditions are stable and do not require involvement by the care manager;
2. The client and/or the client's representative is able to assume responsibility for coordinating and monitoring services; and
3. The client and/or the client's representative is amicable to choosing the Self Directed Care option;

B. Adhere to the Department's procedures for referring clients to Self Directed Care as described in "Self Directed Care- How It Works" (Exhibit 20).

BIDDER REQUIREMENTS: A responsive proposal shall

A. Propose a procedure the bidder will use to ensure that appropriate CHCPE clients will be referred for Self Directed Care.

B. Describe how the bidder will evaluate the effectiveness of the proposed procedure in ensuring appropriate referrals to Self Directed Care.

6. HEARINGS AND APPEALS

The applicant or client may appeal decisions. Appeals and requests for reconsideration must be addressed to the Department when the matters are not resolved in a timely manner to the satisfaction of all parties. It is the responsibility of the Resultant Contractor to ensure that the client and/or the client's representative are provided with appropriate written material(s) noting the client's right to grieve and appeal and the steps involved with each process.

DSS or Resultant Contractor decisions that may be appealed are:

- Level of Care Determination (Appealed directly to the Department);
- Denial of assessment (Appealed directly to the Department);
- Denial of home care upon completion of the assessment and plan of care development (Initial appeal to the Resultant Contractor);
- Content of the plan of care including type and frequency of service(s) and designated provider (Initial appeal to the Resultant Contractor);
- Provision of community based services such as dissatisfaction with a provider (Initial appeal to the Resultant Contractor); and
- Client applied income.

Resultant Contractor Requirements

The Resultant Contractor shall:

A. Have a written grievance and appeals procedure, approved by the Department that governs the grievance decisions made by the Resultant Contractor and under the CHCPE;

B. Provide the client and/or the client's representative appropriate written materials describing the Resultant Contractor grievance process;

C. Provide all applicants and clients the right to appeal any decision that adversely affects them;

D. Have a written procedure approved by the Department for providing applicants and clients the opportunity to appeal. The appeal process shall include at a minimum the following provisions;

1. Notification of all applicants and clients of their appeal rights according to DSS policy;
2. A requirement that appeals be submitted in writing to the Resultant Contractor;
3. A procedure for determining whether the appeal has merit based on program regulations;
4. A procedure for correcting errors in cases where the appeal is ruled to be justified.
5. A procedure for negotiating disputes; and
6. The right of a client to further appeal CHCPE related decisions through the DSS fair hearing process, if the Resultant Contractor does not resolve the grievance.

E. Provide the client and/or the client's representative appropriate written materials describing the appeal process;

F. Document in the client record:

1. The Resultant Contractor's verbal review of the client's grievance and appeal rights;
2. The client's or the client's representative's receipt of written description of the grievance and appeals process; and
3. The client's or the client's representative's acknowledgement of understanding the client's grievance and appeal rights;

G. Act on behalf of the Department regarding client grievances and appeals;

1. Attend hearings at the request of the Department;
2. Document all grievances filed and their outcomes; and
3. Assist the Department in the preparation of summaries for Fair Hearings when an appeal is made to DSS including conducting a client reevaluation upon Department request.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Include a proposed grievance and appeals procedure that meets or exceeds the Resultant Contractor Requirements identified above.

B. Describe the process by which the bidder will document client notification and understanding of their right to grieve and appeal.

C. Describe how the bidder will monitor compliance with the requirements for client grievance and appeals as described above. Include a methodology to identify, remediate and improve compliance.

7. SUBCONTRACTS AND SERVICE PROVIDERS

The Resultant Contractor is responsible for forming working relationships and establishing subcontracts with service providers to provide CHCPE services to program participants. The Resultant Contractor can only subcontract with service providers that meet all CHCPE program requirements for providers as set forth in this RFP. The Resultant Contractor must document that the providers meet established standards of provider participation.

The Resultant Contractor is responsible for the quality of services provided by their subcontractors and that services are provided as stipulated in the client's plan of care.

7.1. Direct Service Providers

The Resultant Contractor can only subcontract with established direct service providers that meet the eligibility criteria for CHCPE performing providers and is responsible for implementing a verification procedure to determine that a direct service provider meets the eligibility criteria for CHCPE performing providers. The Resultant Contractor is also responsible for maintaining documentation that the verification process was conducted for each of their subcontractors.

The Resultant Contractor is responsible for supervising its subcontracted providers. At a minimum, the Resultant Contractor is responsible for monitoring their subcontractor's CHCPE performing provider eligibility, adherence to program requirements and standards and quality of

service delivery. The Resultant Contractor is also responsible for monitoring its subcontractors for type, frequency and cost of service(s) delivery that is in accordance with the client plans of care.

Resultant Contractor Requirements

The Resultant Contractor shall only subcontract with direct service providers who meet the eligibility criteria to be registered as CHCPE performing providers.

To be eligible to be registered as a CHCPE performing provider the direct service provider must:

A. Meet all requirements of the CHCPE including applicable sections of the Connecticut Statutes, Regulations of Connecticut State Agencies, Sections 17b-342-1 through 17b-342-5;

B. Meet all applicable state and/or federal regulations;

C. Agree to all provisions set forth in the DSS "Provider Agreement Guidelines" (Exhibit 2);

D. Be a licensed Medicaid provider if contracted to perform home health aide services, skilled nursing services, and/or physical, occupational or speech therapy;

E. Possess all applicable licensing, registrations, certificates or permits and make available to the Department upon request;

F. Have been in business at least one (1) year actively performing the service(s) they are contracted to provide:

    1. *Exception*: A direct service provider agency that has been in business less than one (1) year can be subcontracted when the provider meets an unmet or emergent community need and after receiving approval from the Department. The direct service provider agency must still meet all other CHCPE requirements for direct service providers;

G. Produce financial statements that demonstrate that the provider agency's financial status is stable. Financial statements are defined as:

    1. A balance sheet or statement of position;
    2. A profit or loss statement or statement of activities;
    3. A statement of cash flow;
    4. Internal Revenue Service Records for the previous three (3) years;
    5. Written assurance that the provider:
        i. Has not filed bankruptcy at any time under the present or past name or ownership;
        ii. Has no judgments against them currently or in the past five (5) years;
        iii. Is Not party to any ongoing investigation; and
        iv. Has no lawsuits pending and/or is not a party to any lawsuits;

H. Inform the Resultant Contractor if the provider has been in business under another name, entity or ownership;

I. Have no previous history of unresolved quality assurance issues as a CHCPE provider under the present or past name or ownership;

J. Be listed with the State's Better Business Bureau/Consumer Relations;

K. Conduct, at a minimum, annual external quality assurance reviews appropriate for the services the organization provides;

1. A formal process for determining degree of client satisfaction with services may be substituted for providers offering only non-medical services;

L. Demonstrate a working knowledge of eldercare issues;

M. Conduct at least one (1) in-service program for employees annually;

N. Have a written personnel policy and procedures manual including written employee supervision and discipline policies and procedures;

O. Have no unresolved negative rating on the most recent local health department inspection report if providing home delivered meal services;

P. Submit four (4) references including:
   1. Two (2) professional references specific to the type of service(s) that the prospective provider would provide to CHCPE clients;
   2. One (1) business reference; and
   3. One (1) client/family reference.

Q. Agree to all relevant provisions of any resulting subcontract; and

R. be contracted to deliver CHCPE services by the Resultant Contractor.

Resultant Contractor Requirements

The Resultant Contractor is responsible for ensuring that all subcontracted service providers have and understand the Department's requirements and standards for CHCPE performing providers. The Resultant Contractor is responsible for verifying that the provider meets the program's standards and requirements. The Resultant Contractor is also responsible for submitting to the Department, upon request, documentation that a subcontracted provider meets all Department requirements.
Once a provider is determined to meet the Department's standards and requirements for CHCPE performing provider status, the Resultant Contractor is responsible to register the provider as a CHCPE performing provider with the Department.

The Resultant Contractor shall:

A. Implement a procedure, which includes obtaining and maintaining necessary documentation, for verifying that subcontractors meet the eligibility criteria to qualify as a CHCPE performing provider;

B. Provide each subcontractor with the Department's standards and requirements for registration as a CHCPE performing providers and document that the subcontractor has;
   1. Received and reviewed the CHCPE performing providers standards and requirements;
   2. provided adequate documentation to ensure the subcontractor meets the Department's standards and requirements; and
   3. signed and submitted to the Resultant Contractor a written statement(s) verifying the subcontractor's understanding of provider participation standards and their capacity to meet the standards.

C. Register qualified providers as CHCPE performing providers prior to a request for reimbursement for CHCPE services provided;

BIDDER REQUIREMENTS: A responsive proposal shall:

A. Document a proposed method that meets or exceeds the Resultant Contractor Requirements for verifying and documenting that a potential subcontractor meets the CHCPE's requirements for direct service providers.

B. Document a proposed method that meets or exceeds the Resultant Contractor Requirements for verifying and documenting a subcontractor's continued compliance with the CHCPE's requirements for direct service providers for the period of time the subcontract is in effect.

7.2. Subcontract Contents

The Resultant Contractor is responsible for developing subcontracts between the Resultant Contractor and all direct service provider agencies for which services are to be purchased by the Resultant Contractor for CHCPE clients. All subcontracts for CHCPE services must include the requirements presented in the CHCPE regulations, DSS "Provider Agreement Guidelines" (Exhibit 2), and in this RFP.

Resultant Contractor Requirements

The Resultant Contractor's subcontracts with direct service providers must include, at a minimum:

A. A description of the services to be procured;

B. The rate of reimbursement for each service which shall not exceed the subcontractor's usual and customary rate or the rate set by the Department;

C. The duration of the subcontract which shall not exceed two (2) years;

D. A description of or reference to the quality standards to be maintained by the subcontractor including verification of personnel requirements;

E. A clause that makes applicable all relevant provisions of the contract between the Department and the Resultant Contractor, including the affirmative action regulations as communicated by the Commission on Human Rights and Opportunities;

F. A provision that clearly states that services are to be performed in accordance with individual service orders and that the subcontract alone does not commit the Resultant Contractor to purchase a specific amount of service from the provider;

G. Record keeping and reporting requirements that are sufficient to document the delivery of service and establish a clear audit trail to verify that the services billed were actually provided;

H. Billing and payment procedures (Refer to Part III Section H of this RFP – "Billing and Payment");

I. A clause that requires the subcontractor to ensure the Contractor that billed services are provided in accordance with all program requirements.

J. A clause that allows the Resultant Contractor to recover from a subcontractor any payments for services subsequently paid for by a third party funding source. All subcontractors will be required to cooperate with the Department's Medicare Advocacy programs and to refer all questionable Medicare denials to the Department or its designated contractor for review;

K. A statement from the subcontractor that acknowledges charges for care will be limited to the fees specified in the Contractor/ community service agency contract, and no additional charges will be billed to either the resultant contractor or the client;

L. A statement that the Department, state and federal auditors shall have access to records and may be subject to an audit;

M. A requirement that the subcontractor's financial records shall be audited at least annually by an independent auditor and that the audit will comply with Federal and State Single Audit Standards if the aggregate funding is $25,000 or more;

N. A clause that requires the subcontractor to ensure the Resultant Contractor that all necessary steps have and will be taken by the subcontractor to safeguard the confidentiality of information or material in conformance with Federal and State statutes and regulations;

O. A provision that clearly requires the subcontractor to continue a service(s) unless or until the care manager provides the subcontractor with an authorization to discontinue service(s) even if the client or client's representative requests the discontinuance of the service;

P. Specifications of any subcontractor responsibilities for resolving disputes;

Q. A requirement that the subcontractor must immediately notify the Resultant Contractor of any decision by the subcontractor to pursue bankruptcy or if any liens or any other legal action is taken against the subcontractor for damages;

R. Subcontractor requirements for bi-monthly, client specific provider reports for agencies providing companion services, homemaker services, chore services, and adult day health services; and

S. If the subcontractor is contracted to provide home delivered meals the subcontract must require that the subcontractor:

1. Shall leave home delivered meals with the client or someone on behalf of the client at the client's place of residence. Meals can be left in a safe and appropriate container *only* at the client's request because of extenuating circumstances;

2. Notify the Resultant Contractor when an unscheduled, undelivered meal has occurred;

3. Comply with "Connecticut Statutes, Section 17b-423-5(e)" "Nutrition Standards [of the Connecticut Elderly Nutrition Program] (Exhibit 21) as their standards of practice; and

4. Have all menus formally reviewed and verified by a Registered Dietitian to meet the "Nutrition Standards of the Connecticut Elderly Nutrition Program" (Exhibit 21).

BIDDER REQUIREMENTS: A responsive proposal shall

A. Include a proposed direct service provider subcontract template that meets or exceeds all of the Resultant Contractor Requirements that are identified in this RFP.

7.3. Subcontract Management and Monitoring

The Resultant Contractor is the Department's representative with the CHCPE direct service providers. The Resultant Contractor shall be responsible for the overall CHCPE management and oversight of subcontractors performing services for CHCPE clients. At a minimum, the Resultant Contractor shall monitor their subcontractor's CHCPE performing provider eligibility, adherence to program requirements and standards, quality of service delivery and service delivery in accordance to client plans of care.

Resultant Contractor Requirements - Subcontract Management

The Resultant Contractor shall establish, implement and maintain subcontract management procedures that will ensure the Department that:

A. A subcontract has been fully executed prior to the provision of services;

B. A subcontract has been fully executed prior to any request for reimbursement;

C. Subcontracts are maintained on file at a designated location and can be made available to the Department upon request;

D. A record by contract year of the number of referrals made to each subcontractor shall be maintained;

E. Subcontracts will be updated no less than biannually;

F. The Resultant Contractor shall not enter into an agreement with a close relative of the client (defined for this purpose as a spouse, parent, child, grandchild, sibling or any other relative who lives with the client);

G. The relationship between the Resultant Contractor and the individual provider satisfies the requirements of applicable state labor statutes when the contractor enters into agreements with individual private persons to provide highly skilled chore services that are customarily provided by self-employed individuals;

H. The Resultant Contractor shall investigate all client complaints about a subcontractor and take appropriate action to resolve the complaint; and

   1. When a client complaint about a subcontractor has been made directly to the Department, the Resultant Contractor shall investigate and take appropriate corrective action. The Resultant Contractor shall submit, in a timely manner, a written report to the Department that describes the complaint, the information gathered during the investigation, and the corrective action taken.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Include a proposed method for the management of subcontractors that meets or exceeds the Resultant Contractor Requirements identified above. The Bidder's response must describe how the Resultant Contractor will investigate client complaints about a subcontractor including the completion of specific investigative steps in accordance with anticipated timeframes.

Resultant Contractor Requirements - Subcontract Monitoring

The Resultant Contractor shall be responsible for regularly monitoring direct service provider adherence to their subcontract, adherence to all relevant sections of this RFP, and the quality of services provided by their subcontractors.

The Resultant Contractor shall:

A. Establish, implement and maintain a quality assurance plan for the monitoring of subcontracted direct service providers. At a minimum the quality assurance plan for the monitoring of subcontracted direct service providers shall include a process through which the Resultant Contractor shall:

   1. Monitor subcontractors for CHCPE overall program compliance and quality of service delivery including service delivery in accordance to the plan of care and the reporting of service deviation from the plan of care to the care manager;

2. Conduct onsite reviews at subcontracted agencies providing social services that include client record reviews for adequate documentation;
3. Determine the percentage of all subcontractors will be reviewed annually; and
4. Identify the specific personnel or position within the Resultant Contractor's organization that shall conduct subcontractor monitoring activities.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Include a proposed quality assurance plan for the monitoring of direct service providers that meets or exceeds the Resultant Contractor Requirements set forth in this RFP.

7.4. Subcontractor Grievance Procedures

Occasionally, a dispute will arises between the Resultant Contractor and a subcontractor. The development and implementation of a dispute resolution process will ensure the fair and organized dispute settlement of disputes.

The Department's CHCPE Manager will attempt to informally settle disputes that cannot be resolved between the Resultant Contractor and the subcontractor. The CHCPE Manager will request assistance from the DSS Contract Administrator and/or any other appropriate DSS administrator when the dispute cannot be informally resolved. The DSS Commissioner will determine the final resolution of any dispute for the Department if necessary.

Resultant Contractor Requirements

The resultant Contractor shall:

A. Establish a written procedure to govern the settlement of disputes that might arise with subcontractors under the CHCPE;
B. Prior to the implementation of the written procedure and in accordance with a time frame established by the Department, submit the procedure to the Department for its review and approval;
C. Following the Department's approval of the written procedure, distribute the procedure to each proposed subcontractor and document that each proposed subcontractor was provided the approved procedure prior to the implementation of his or her subcontract;
D. Ensure that the Resultant Contractor's subcontract with the direct service providers specify any subcontractor responsibilities for resolving disputes; and
E. Inform the CHCPE Manager in writing any dispute that cannot be settled between the Resultant Contractor and the subcontractor.
F. Establish and implement a process to monitor and, if necessary, propose and implement revisions to the dispute settlement process.

BIDDER REQUIREMENTS: A responsive proposal shall:

A. Include a proposed outline of a dispute resolution process and workplan for the development of the proposed process that will govern the settlement of disputes between the Resultant Contractor and their CHCPE subcontractors and will, at a minimum, meet or exceed the Resultant Contractor Requirements set forth in this RFP.

B. The proposed workplan shall include submission of the process to the Department, the Department's review and approval of the same and following the Department's review and approval, implementation of the process.

8. CLIENT CONTRIBUTION

8.1. Definitions

CHCPE clients are required to contribute to the cost of his/her CHCPE services when the client's income exceeds an amount established by the Department. This is referred to as an "applied income". Clients are required to contribute when the following conditions are met:

- **Medicaid Clients**

  The contribution of individuals whose services are funded by Medicaid will be an "applied income" amount calculated by DSS. The DSS Regional Office determines the exact amount of an individual's applied income. The DSS Regional Office is responsible for all financial matters related to Medicaid eligibility. The Department shall protect an amount equal to 200% of the individual poverty level. This means that clients with income at or below that amount who are funded by Medicaid will have no contribution.

- **State-Funded Clients**

  The fee paid by state funded clients is established from a Medicaid Waiver applied income methodology and is provided by the Department. The basis for the methodology is set forth in the CHCPE statute and program regulations.

8.2. Reimbursement /Settlement

The Department shall reduce its reimbursement to the Resultant Contractor by the amount of the designated client contribution. The client contribution shall be applied to the cost of all community-based services, including care management services. Assessments and status reviews are not subject to the client contribution.

The Resultant Contractor shall document its action regarding the collection of client fees. The Resultant Contractor shall follow the Department's settlement process to arrange for the payment of properly authorized services for persons from whom client fees were uncollectible.

Resultant Contractor Requirements

The Resultant Contractor is responsible for explaining the client cost contribution requirements to clients and completing the collection of preliminary financial information by completing and submitting to the Department a "CHCPE Applied Income Worksheet" (Exhibit 10). When the Department determines that an applied income is required, the Resultant Contractor is responsible for explaining the amount of the applied income to the client and/or client's legal representative, obtaining a signed and dated "Client Applied Income Contribution Agreement" (Exhibit 6), collecting the applied income from the client and keeping complete and accurate records.

The Resultant Contractor shall:

A. Educate the client and/or the client's legal representative about the CHCPE client cost contribution requirements;

B. Complete a "CHCPE Applied Income Worksheet" (Exhibit 10) and submit to the Department when an applied income appears applicable;

C. Ensure that the client and/or the client's legal representative understands the amount he/she is required to contribute before the individual makes a decision to accept CHCPE services;

D. Document the client's or the client's legal representative's agreement to the contribution, prior to the receipt of services, by obtaining a signed DSS' "Client Applied Income Contribution Agreement"" (Exhibit 6);

E. Collect a client's contribution to the cost of care.

F. Comply with the Department's procedures governing collection. The payment of the client contribution is required as a condition of continued program participation. The Department is committed to assuring that the clients receive sufficient notice of their rights and responsibilities prior to taking any action due to an individual's failure to pay. The procedures to be used in collecting client contributions allow for handling such situations;

G. Maintain specific data for each client regarding the amount of contribution paid;

H. Maintain copies of the client's signed statement and written notices; and

I. Complete and submit to the Department, on an annual basis, a "CHCPE Applied Income Worksheet" (Exhibit 10) for state-funded clients. The amount of an individual's contribution to the cost of care shall be recalculated every year at the same time that the individual's financial eligibility is re-determined. DSS will re-determine the applied income amount for all other clients.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Acknowledge the Bidder's understanding of the Resultant Contractor Requirements and include a written assurance of the Bidder's ability and commitment to meet each of the Resultant Contractor Requirements for reimbursement/settlement.

9. NOTICE OF LIABILITY TO APPLICANT OR RECIPIENT OF CARE OR LEGALLY LIABLE RELATIVE

The State of Connecticut has the authority to recover money from a CHCPE client or a legally liable relative for the cost of the services received under the CHCPE. The Department is required to provide notice to all applicants and/or recipients of services of the State's right to recover. DSS' "Notice of Liability To Applicant or Recipient of Care or Legally Liable Relative" form (Exhibit 17) is the method the Department uses to document that the applicant and/or client's legal representative has been properly notified that the State may require a legally liable relative (LLR) to reimburse the State for the cost of the CHCPE services.

Resultant Contractor Requirements

The Resultant Contractor shall:

A. Educate state- funded clients and/or their legal representatives, that the client's spouse may be considered a legally liable relative (LLR);

B. Educate state- funded clients and/or their legal representatives that a LLR may also be required to contribute to the cost of care if the income of the client's community spouse exceeds the allowed amount;

C. Obtain and submit to the Department a signed "Notice of Liability To Applicant or Recipient of Care or Legally Liable Relative" (Exhibit 17) prior to the client's acceptance of services; and

D. Inform the client and/or the client's legal representative whether or not the Department has determined if the client's spouse is considered to be a legally liable relative.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe the bidder's methodology to provide the Department with assurances that the client understands and agrees to contribute the amount the client and/or their spouse is required to contribute before the client makes a decision to accept community based services.

B. Describe the bidder's plan to maintain specific data for each client regarding the amount of contribution paid and copies of the client's signed agreement and written notices.

10. WAITING LIST

The state-funded portion of the CHCPE is subject to availability of funds. The portion of the program funded under the federal waiver is subject to continued approval of the Medicaid waiver and to any limits on expenditures or the number of persons who can be served under the federal waiver application.

The number of persons admitted to the program may be limited when the state appropriation or the limits under the federal waiver are insufficient to provide services to all eligible persons. The Department may establish a waiting list when these limits are reached. The Department shall serve applicants that meet all program requirements from the waiting list. The selection from the waiting list will be regional and in the order the applications were received.

Available openings within the program will be allocated based on the proportion of the region's elder population adjusted to take into consideration the ratio of elders who are poor, minority, 75 years of age or older, or living in rural areas. The Department may from time to time establish priorities that ensure that persons with the greatest medical, social and economic need receive timely assistance when funds are available under the state-funded portion of the program.

Resultant Contractor Requirements

The Resultant Contractor shall:

A. Comply with the Department's requirements and procedures for client waiting lists; and

B. Work collaboratively with the Department in the administration of the CHCPE client waiting list.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe how it the Resultant Contractor will ensure the Department that persons with the greatest medical, social and economic need receive timely assistance when funds are available.

11. QUALITY ASSURANCE PROGRAM

The Resultant Contractor shall implement a quality assurance program for monitoring adherence to CHCPE policies and procedures including quality care management services. The quality assurance program shall be reviewed and approved by the Department prior to implementation. The quality assurance programs shall, at a minimum, include a review of client records (without client identifiers) by professionals not employed by the Resultant Contractor, the development and implementation of client satisfaction surveys and cooperation with the Department's client record and administrative reviews.

11.1. Review of Resultant Contractor's CHCPE Client Records

The Resultant Contractor shall be is responsible for monitoring adherence to the Department's requirements for maintaining client records including documentation of quality care management activities.

The Resultant Contractor shall:

A. Submit to the Department for approval a quality assurance procedure to review the Resultant Contractors CHCPE client records of active program participants that includes:
   1. An explanation of the sampling methodology;
   2. A description of the factors used to determine the appropriate management of a client;
   3. Process to identify and utilize reviewers who are not professionals employed by the Resultant Contractor;
   4. A review for adherence to CHCPE requirements for client records;
   5. A review of the appropriateness of the care plan for clients whose care plan cost is less than twenty percent (20%) or greater than eighty-percent of their category cost cap;
   6. A description of the review process;
   7. A requirement that the Resultant Contractor:
      i. review a sample of cases quarterly;
      ii. conduct an annual review of a minimum of one percent (1%) of active CHCPE client records;
      iii. commit to take effective and appropriate corrective action; and
      iv. submit an annual report to the Department including the names, titles, and employers of the reviewers, the results of the review and the corrective action(s) taken.

B. Implement the Resultant Contractor's approved procedure for internal client record reviews.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Include a proposed outline of the quality assurance process and workplan for the development of the proposed quality assurance procedure to review the Resultant Contractors CHCPE client records of active program participants that will, at a minimum, meet or exceed the Resultant Contractor Requirements set forth in this RFP.

B. The proposed workplan shall include submission of the process to the Department, the Department's review and approval of the same and following the Department's review and approval, implementation of the process.

11.2. Monitoring of CHCPE Client Satisfaction

The Resultant Contractor shall be responsible for the monitoring of client satisfaction among CHCPE participants and implementing appropriate and timely corrective action when indicated.

Resultant Contractor Requirements

The Resultant Contractor shall:

A. Develop and implement a strategy for measuring client satisfaction with CHCPE services among active program participants. The strategy for measuring client satisfaction shall include the use of client surveys that are conducted for new clients within sixty (60) days of admission to the CHCPE and randomly thereafter;

B. Conduct random client satisfaction surveys at least annually;

C. Conduct the random client satisfaction process through a randomly selected sample size that must be at least 15% of the total client population which results in an average reported sampling size of no less than 10% of the total client population per year/per region.

D. Use both telephone and print surveys to gather information;

E. Address all CHCPE services, availability of providers and service delivery, intake procedures, on-going Resultant Contractor contact,

F. Conduct the survey with a client representative when the client is unavailable or unable to participate;

G. Commit to the Department that appropriate and effective corrective action will be taken based on survey results; and

H. Include reporting the Resultant Contractors activities to measure client satisfaction to the Department annually. The report shall:

1. Provide the specifics of the administration of the survey(s) including:
   - i. Number and percentage of the client population who were sent or contacted for survey participation;
   - ii. Date(s) survey(s) sent or conducted;
   - iii. Methodology used to select survey participants; and
   - iv. A copy of the survey instrument.
2. Provide the results of the survey including:
   - i. Number of surveys completed; and
   - ii. Results for each question on the survey instrument.
3. Describe the corrective action taken as a result of the surveys; and
4. Demonstrate that the Resultant Contractor is in compliance with DSS' requirements for measuring client satisfaction.

I. Use client satisfaction survey tools approved by the Department; and

J. Following the Department's approval, implement the approved procedure for measuring client satisfaction.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Propose a procedure for measuring and reporting client satisfaction among CHCPE participants that meets or exceeds the Resultant Contract Requirements set forth in this RFP.

B. Describe how the bidder will conduct remedial activities based on the results of the client satisfaction surveys.

C. Propose client satisfaction survey tools.

11.3. DSS' Client Record and Administrative Review

The Department reserves the right to conduct client record and administrative reviews encompassing an evaluation of the assessment, care management, and community based services provided under the program as well as adherence to CHCPE policies and procedures.

Resultant Contractor Requirements

The Resultant Contractor shall:

A. Cooperate fully with the Department or its designees with the evaluation including providing access to all requested program forms, records, documents, and reports;

B. Take corrective action(s) based on the results of DSS' client record and administrative reviews within an established timeframe deemed appropriate by the Department; and

C. Respond, in writing, to the Department's recommendations resulting from the client record and administrative reviews and the corrective action taken by the Resultant Contractor.

BIDDER REQUIREMENTS: A responsive proposal shall

A. Describe the process for meeting or exceeding the Resultant Contractor Requirements for DSS' client record and administration reviews

12. PROTOCOLS FOR THE TRANSFER OF EXISTING CLIENTS

The Department may, through this competitive procurement, award the right to negotiate a contract to an organization that is new to the CHCPE program. In the event that occurs, the agency selected through this procurement will be required to work with the organization currently under contract with the Department to transfer the clients from the current contractor to the contractor selected through this procurement. Such transfer shall be conducted in accordance with the method and timetable approved by the Department following consultation with the existing and new contractor. The Department shall approve the date and methodology of transfer. All costs to the new access agencies for transfers will be included in the per diem rate for care management.

Resultant Contractor Requirements: The Resultant Contractor shall:

A. Following consultation with the Department and current Contractor, establish and submit for the Department's approval a timetable and methodology for accepting transferring clients;

B. Be required to conduct a face to face visit with the client before the transfer;

C. Ensure continuity of care by employing the same service providers unless otherwise requested by the client or extenuating circumstances exist;

   1. Obtain prior approval from the Department for any changes in service providers;
   2. Upon request of the Department and in a timely manner, submit to the Department and/or any agency designated by the Department the following client information;
      i. Copy of the most recent "Modified Community Care Assessment" tool;
      ii. Current plan of care and "CHCPE Care Plan Cost Worksheet (Exhibit 7);
      iii. Summary Report including but not limited to:
         1. Recent medical history;
         2. History of service delivery;
         3. Current information on the existing informal support system; and
         4. Any outstanding issues that need to be resolved.
         5. Copy of most recent fee agreement (if applicable); and
         6. Copy of the most recent "Special Eligibility Determination Document" (Exhibit 9).

BIDDER REQUIREMENTS: A responsive proposal shall

A. Propose a timetable for accepting clients who will be transferred.

B. Describe how the bidder will monitor compliance to the requirements for the transferring of clients as described in the RFP.

C. Describe how the bidder will remediate and improve compliance if noncompliance occurs

13. LOBBYING

The Resultant Contractor shall be required to abide by state and federal lobbying laws, and further specifically agree not to include in any claim for reimbursement any expenditures associated with activities to influence, directly or indirectly, legislation pending before Congress, the Connecticut Legislature or any administrative or regulatory body.

14. ARCHIVING

The Resultant Contractor and their subcontracted direct service providers shall be required to maintain records to support claims made for payment for at least seven (7) years following the last date of service. The Department may audit such claims during this period.

PART THREE OF THE BIDDER'S PROPOSAL
THE ORGANIZATION AND KEY PERSONNEL

PART THREE of the Bidder's Proposal must describe the background and experience of the bidder's organization and subcontractors (if any) and include details regarding its size and resources, its experience relevant to the functions to be performed under this contract or recent contracts for similar services. All corporation identifiable aspects of the services described in this RFP must be addressed in Part 3 in the following order:

A. GOVERNANCE:

BIDDER REQUIREMENTS: A responsive proposal shall include the following information for the bidder as the proposed prime contractor and any proposed subcontractor:

1. Provide documentation, in the form of either an excerpt from the agency's bylaws or a sworn affidavit signed by the Secretary of the corporation, showing that the governing authority has full legal authority over the operation of the agency.
2. The name, work address, home address, social security number, gender, and percentage of time spent on this contract of each responsible director.
3. A current organizational chart defining levels of ownership, governance and management.

B. OWNERSHIP – DISCLOSURE:

BIDDER REQUIREMENTS: To submit a responsive proposal the Bidder shall provide the following:

1. A complete description of percent of ownership by the principals of the company or any other individual or organization that retains 5% or more including name, work address, home address, social security number and gender.
2. The relationship of the persons so identified to any other owner or governor as the individual's spouse, child, brother, sister, or parent.
3. The name of any person with an ownership or controlling interest of five percent or more, in the bidder, who also has an ownership or control interest of five percent or more in any other related entity including subcontracting entity or parent entity or wholly owned entity. The bidder shall include the name or names of the other entity.
4. The name and address of any person with an ownership or controlling interest in the disclosing entity or is an agent or employee of the disclosing entity who has been convicted of a criminal offense related to that person's involvement in any program under Title XVIII, XIX, XX or XX1 of the Social Security Act, since the inception of such programs.
5. Whether any person identified in subsections (a) through (d) above, has been terminated, suspended, barred or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, from any program under Titles XVIII, XIX, or XX of the Social Security Act, or has within the last five years been reinstated to participation in any program under Titles XVIII, XIX, XX or XXI of the Social Security Act, and prior to said reinstatement had been terminated, suspended, barred or otherwise excluded from participation, or has voluntarily withdrawn as the result of a settlement agreement, in such programs.

6. A description of the relationship with other entities including:
   Whether the bidder is an independent entity or a subsidiary or division of another company. If the bidder is not an independent entity, the bidder shall describe the organization linkages and the degree of integration/collaboration between the organizations including any roles of the organization's principals.
7. A complete listing and explanation of any financial relationship with any other health management or consulting organization.
8. Describe the relationship of any parent company when the bidder is an affiliate of another organization.

C. PROGRAM STAFFING: Key Personnel and Staff Resources

Program Staffing: Key Personnel and Staff Resources
Resultant Contractor Requirements

The Resultant Contractor shall:

1. Maintain organizational charts, personnel and affirmative action policies, job descriptions and qualifications for each staff and consultant position related to the program;
2. Inform the Department in writing of any revisions to the organizational charts, personnel and affirmative action policies at the time revisions occur;
3. Submit to the Department for prior written approval changes in key personnel;
4. Submit to the Department the name and credentials of any persons who are proposed to replace existing or previously proposed project management staff or other key personnel identified by the state;
5. Refrain from initiating any change(s) that may or will negatively impact the Department or adversely affect the ability of the Resultant Contractor to meet any requirement or deliverable set forth in this RFP;
6. Meet the needs of the clients and estimated caseloads of the service area through the maintenance of a sufficient staffing pattern by providing a full time Director and such other administrative staff as may be required by the CHCPE regulations or needed to adequately administer the CHCPE as well as any other programs the Resultant Contractor may operate;
7. Meet the needs of non-English speaking clients by employing bilingual staff needed to adequately provide CHCPE services to this population; and
8. Provide supervision for all agency staff.

BIDDER REQUIREMENTS: A responsive proposal shall

1. Provide a functional organization chart of the organization detailing how the proposed project structure fits within the entire organizational structure.
2. Describe the relationship between specific personnel, for whom resumes have been submitted, and the specific tasks and assignment proposed to accomplish the scope of work.
3. Provide a client/staff ratio that ensures effective provision of services and timely compliance with the reporting requirements of each program.
4. Identify a project manager who will be responsible for the implementation and management of the project, day to day oversight of the project and who will be available to attend all

project meetings at the request of DSS. The project manager shall respond to DSS requests for status updates, and ad hoc and interim reports.

5. Provide a proposed personnel job description and resume for the Project Manager indicating contract-related experience. Each project referenced in a resume should include both the customer, and a brief description of the responsibility of the individual to the project. The resume of the project manager shall include:

   a. Experience with bidder (or Subcontractor).
   b. Relevant education, experience, and training, names, positions, titles, and telephone numbers of persons who can provide information on the individual's experience and competence.

6. Include proposed personnel job descriptions and resumes for key personnel in addition to the project manager. Resumes of key personnel are limited to two (2) pages per resume. The resumes of personnel proposed will include:

   a. Experience with bidder (or Subcontractor).
   b. Relevant education, experience, and training.
   c. Names, positions, titles and telephone numbers of persons who can give information on the individual's experience and competence. The references should include a brief description of the responsibility of the key person to the named reference.

7. Describe the relationship of any subcontractor with the bidding organization.

D. Organization: Qualifications and Corporate Experience

BIDDER REQUIREMENTS: A responsive proposal shall:

1. Include a description of the bidder's overall qualifications to carry out a project of this nature and scope.

2. Include a description of the bidder's previous experience including methods and processes for providing home care services.

3. Demonstrate the bidder's strong presence in the region that the bidder contemplates providing services.

4. Demonstrate the bidder's ability to administer the CHCPE on a regional basis

5. Identify any other local, state or federal agency(s) in which the bidder performs or has performed similar work.

6. Describe the bidders' projects for the agencies identified in 5 above, including a description of the work performed, the time period of the project, the staff-months expended, and the contract costs.

7. Justify its staffing resources to successfully meet its RFP response requirements in light of any other similar obligations for any other entity.

8. Identify the percentage of time for each of its key personnel dedicated to this project.

9. Describe any other state or federal program operated by the organization or any of its subcontractors and any key staff of the applicant and subcontractors during the past five years that was terminated or not renewed for failure to perform or properly administer the program. Include a brief description of the program, the nature of the problem, the role that the key staff played and the outcome.

E. Bidder References

BIDDER REQUIREMENTS: A Responsive Proposal Shall:

1. Supply at least four specific (corporation) references (for the bidder) from entities for which the bidder has conducted similar projects. If the bidder has, during the past five (5) years, been under contract with the State of Connecticut, the bidder MUST include a reference from the State of Connecticut.

2. Include at least one reference from another federal, state or local governmental; entity or firm regarding the bidder's capability of providing services similar to the services presented in this RFP.

3. References must include a specific contact person, organization name, address, and current telephone number. The Department expects to utilize these references in its evaluation process.

F. Facilities and Operating Hours

The Resultant Contractor shall:

1. Maintain facilities to meet all applicable inspection requirements, including certification of appropriate inspection for health, fire and safety. Facilities must meet accessibility standards as defined in the Americans with Disabilities Act;
2. Operate the program during hours that make them available to the community and clients;
3. Establish, implement and maintain policies and procedures to manage CHCPE client emergencies that occur after hours and on weekends;
4. Maintain appropriate insurance including general liability, workers compensation, and malpractice;
5. Locate offices serving participants in the CHCPE within the State of Connecticut accessible to the public;
6. Establish a communication system adequate to receive requests and referrals for service, including the capacity to respond to clients and health professionals in emergencies on a 24-hour basis.

While the Department will not require that access agencies have offices staffed seven (7) days a week the Resultant Contractor shall be required to have the capability to accommodate service needs on a seven (7)-day a week basis.

BIDDER REQUIREMENTS: A responsive proposal shall

1. Include a proposed plan to accommodate service needs on a 7-day a week basis.
2. Include proposed policies, procedures and a communication system adequate to respond to client and health professionals with emergencies that occur after hours and on weekends.

3. Include a proposed plan that includes a communication system to receive requests and referrals for services.

4. Include proposed locations of offices serving within the State of Connecticut and accessible to the public.

G. Accounting System – Resultant Contractor Requirements

The Resultant Contractor shall:

1. Implement and maintain a uniform accounting system that, budgets, accounts for, and reports all actual program revenues and expenditures and units of service provided. This system must reflect the application of generally accepted accounting procedures (GAAP), principles and practices that are approved by the American Institute of Certified Public Accounting;
2. Implement the accrual method of accounting;
3. Maintain records in sufficient detail to support all financial and statistical information provided to the Department, and provide a clear audit trail;
4. Differentiate between DSS and non-DSS funding sources in income and expenditure reports;
5. Differentiate the costs for both waiver and state- funded clients;
6. Allocate the costs by services, administrative, and general categories;
7. Account for all purchased services, as described in the billing and payment procedures (Section IV, Part Three, H below)) and clearly document the service authorization, verification, billing (to Access and DSS) and payment;
8. Segregate and report this information by CHCPE region if it is under contract with more than one region; and
9. Allocate costs directly attributable to each of the primary Resultant Contractor functions (care management and assessments) performed for each program region directly to an account for that region. Allocate costs that cannot be directly related to a specific regional operation on the basis of care manager time. The Resultant Contractor must demonstrate that a cost cannot reasonably be attributed to CHCPE operations before the cost may be allocated.

BIDDER REQUIREMENTS: A responsive proposal shall

Describe previous programs, projects or services where the Bidder has implemented an accounting System that meets or exceeds the Resultant Contractor Requirements for an Accounting System.

H. Billing and Payment

The Resultant Contractor must adhere to the Department's Policies and Procedures relative to the Access Agency's billing procedures to receive reimbursement for services performed.

1. The Department shall not:

a. Reimburse any access agency that fails to meet the terms of its contract or provider agreement with the Department;

b. Reimburse for canceled services;

c. Reimburse for services not used by an individual or for arranged services refused by a client;

d. Reimburse any services while an individual is institutionalized, except for:
respite care provided in a nursing facility, status reviews in hospitals or nursing facilities, and transition services in accordance with approved procedures;

e. Reimburse invoices for services after the death of an individual. The count of client days for purposes of billing for care management services begins on the effective date of a written plan-of-care. The effective date must be subsequent to the completion of an assessment performed by an access agency. The day of death, the end date for self-directed clients, or the day of institutionalization may be billed but no date of service may be billed after these dates;

f. Reimburse services that are not provided or not provided in accordance with CHCPE procedures, including prior authorization when appropriate;

g. Reimburse services not included as part of the plan-of-care or not included under the CHCPE regulations or Medicaid program;

h. Reimburse incorrect, incomplete, or duplicative claims or when the client is no longer eligible for the CHCPE; and

i. Reimburse for services that do not adhere to timely billing procedures when an invoice for a service is received later than twelve months from the date the service was deliver

I. General

Resultant Contract Requirements: The Resultant Contractor shall:

1. Invoice all community based (social) services and all medical services provided to Medicaid-funded clients in accordance with Department procedures. All medical services provided to these clients are to be billed directly by the enrolled Medicaid provider in accordance with Department procedures;

2. Invoice the Department for all home health services for non-Medicaid clients and community-based services for all clients in accordance with the plan-of-care and Department procedures;

3. Submit bills to the Department within the time specified for the filing of Medicaid claims of one year. Invoices for services *must* be received within twelve months of the services being delivered;

4. Invoice for services provided to each CHCPE client. The Department shall reimburse on a two times per month financial cycle. The Department shall pay all valid and proper claims within 30 days after receipt of said claims. A valid and proper bill for services is one that has no defects and requires no additional information for processing;

5. Submit bills to the Department through its contracted fiscal administrator. The HCFA 1500 Form or other form as designated by the Department shall be used as the billing document;

6. Submit the designated form within thirty (30) days after receiving bills from subcontractors; and

7. Submit a "Magnetic Tape for Billing" when the Resultant Contractor has the computer capability and when authorized in advance to do so by the Department. The Magnetic Tape shall provide the same information requested on the designated form in a format acceptable to DSS' contracted fiscal administrator for CHCPE claims.

   DSS' contracted fiscal administrator will provide the Resultant Contractor with bi-monthly remittance advices that discloses all payments authorized and paid based on the designated forms on each individual client. The remittance advice will also indicate those payments that were processed and denied and the reason for the denial.

BIDDER REQUIREMENTS: A responsive proposal shall

1. Describe the bidder's plan to document service cancellations and non-utilization of scheduled services.

J. Authorization of Services

Resultant Contractor Requirements

Assessments

The Department shall reimburse the Resultant Contractor for only those assessments that have been conducted on persons who were referred to the Resultant Contractor by the Department and for whom the Resultant Contractor has obtained a signed consent form authorizing the assessment. The Resultant Contractor may not bill the Department and the Department will not reimburse the Resultant Contractor for client contacts that were made to explain the program but did not result in client consent to conduct an assessment.

The Department shall reimburse the Resultant Contractor at the same assessment rate when:

- The client consents to an assessment;
- A face to face interview is conducted; and
- The client is determined to be ineligible or inappropriate for community placement.

The Department shall reimburse the Resultant Contractor for a status review conducted on a hospitalized client or a client admitted to a nursing facility for a short-term placement. The status review rate shall be 33% of the Resultant Contractor's assessment rate.

Community Based Services

The Department shall authorize all initial delivery of community-based services prior to the delivery of the service. This includes care management services provided to Medicaid and state-funded clients as well as home health services provided to state-funded clients. The services must be specified in the client's plan-of care to receive Department authorization.

The Resultant Contractor shall maintain documentation of the authorization for community-based services in the client records. The Resultant Contractor shall use the "CHCPE Provider Service Authorization" form (Exhibit 15) to authorized services provided by subcontractors. The Resultant Contractor is responsible for forwarding a copy of the signed form to the subcontractor.

The "CHCPE Provider Service Authorizations" (Exhibit 15) must be consistent with the approved costs and services on the plan-of-care for the client.

Subcontractors shall not change the plan-of-care without approval from the Resultant Contractor. Changes and approvals must be recorded in the case record and conform to all program requirements.

The Department requires prior authorization for a status review for any client served under the Self Directed portion of the CHCPE. The Resultant Contractor must receive authorization from the Department prior to reinstating care management.

K. Resultant Contractor Requirements - Review of Bills

The Resultant Contractor Shall:

1. Require an invoice(s) for services performed by a subcontractor for each client. The invoice must include any computerized bills or any other type of billing document the subcontractor utilizes;
2. Review invoices and notify the subcontractor immediately of any discrepancies, errors, miscalculations or lack of information in relation to the billings received by the service providers;

3. Review all billings from subcontractors to ensure the Department that there is no duplication of charges from any other payment source;
4. Maintain an account for each subcontractor that, at a minimum, includes the following:
   Name;
   Address;
   Tax number;
   License or certification verification (if applicable), and
   Verification of registration as a CHCPE provider.
5. Maintain all files current and updated as needed.
6. Ensure that billed services are provided in accordance with all program requirements. The Department will not pay for services that do not meet program requirements, and reserves the right to recoup from the Resultant Contractor all improper payments made. The Resultant Contractor may pursue recovery of payments for billed services that were not provided in accordance with all program requirements from the specific subcontractor and may petition the Department for forgiveness of the recoupment following the Contractor's demonstration to the Department of the Contractor's diligent, but unsuccessful pursuit of the receivable from the subcontractor;
7. Maintain a file of the "CHCPE Provider Service Authorizations" (Exhibit 15) by service providers in accounts payable with paid claims in similar order.

   Each paid claim for community based services must have time slips retained in the provider's record with the client or family member's signature for verification of service delivery, unless the care manager has confirmed and documented such verification is not obtainable. A copy of the "CHCPE Provider Service Authorizations" (Exhibit 15) shall also be kept in the client's case record.

BIDDER REQUIREMENTS: A responsive proposal shall

Describe the bidder's methodology to implement, monitor and adhere to the Resultant Contractor Requirements – Review of Bills. Propose a method to validate and ensure that billed services are provided in accordance with all program requirements and a specific process to comply with the Department's request for recoupment, the Contractor's pursuit of a subcontractor and the circumstances under which the Contractor will pursue forgiveness of the recoupment.

L. Disbursement

The Resultant Contractor Shall:

1. Reimburse sub contractors not more than sixty (60) days after receipt of the service provider's legitimate invoice for services; and

2. Reimburse sub contractors for only those invoices submitted for services rendered to a CHCPE client within one (1) year from the date of service.

M. Reporting Requirements and Data Collection

1. The Resultant Contractor shall submit the following reports to the Department:

a. *Annual Audited Financial Report*

The "Annual Audited Financial Report" is due within 90 days of the end of each fiscal year.

b. *Annual Length of Stay Report*

The "Annual Length of Stay Report" is due within 90 days of the end of each fiscal year. This report is to be prepared by client category with a total page for all categories.

c. *Annual Grievance and Appeals*

The "Annual Grievance and Appeals" is due within 90 days of the end of each fiscal year. This report is a listing of grievances filed by CHCPE clients including a description of the grievance(s) filed, what action(s) were taken by the Resultant Contractor, and the final resolution(s).

d. *Semi-annual Female and Minority Business Enterprises Report*

The "Semi-Annual Female and Minority Business Enterprises Report' is due by December 31st and June 30th of each contract year.

e. *Semi-Annual Client List*

The **"**Semi-Annual Client List" is due by December 31st and June 30th of each contract year. This report is to be prepared by region.

f. *Bi-Annual Quantitative Assessment Data*

The "Bi-Annual Quantitative Assessment Data**"** report is due by December 31st and June 30th of each contract year. This report is a computerized data transfer as detailed in the Department's "Data Specifications for Resultant Contractor File Transfer" (Exhibit 12). The data file includes comprehensive, client specific information on assessment data, care plans, client fees and such other information as may be required by the Department. The data file will be updated quarterly and shall be submitted to the Department on October 31st, January 31st, April 30th, and July 31st of each contract year.

g. *Quarterly Assessment and Care Management Activities Report*

The "Quarterly Assessment and Care Management Activities Report" is due on October 31st, January 31st, April 30th, and July 31st of each contract year. This report is to be prepared by region with a total page for all regions.

h. *Quarterly Financial Schedules*

The "Quarterly Financial Schedules" are due on October 31st, January 31st, April 30th, and July 31st of each contract year. This report is to be prepared by client funding source by region with a total page for all regions.

i. *Quarterly Client Contribution Report*

The "Quarterly Client Contribution Report" is due on October 31st, January 31st, April 30th, and July 31st of each contract year. This report is to include a report on contributions overdue by client as of the last month in the quarter.

j. *Monthly Activity Report*

The Monthly Activity Report is due on October 31st, January 31st, April 30th, and July 31st of each contract year. This report is to be prepared on the DSS standardized monthly activity report form. Required reporting is by region and a total for all regions.

k. *Miscellaneous Reports*

The Resultant Contractor is responsible for submitting unscheduled reports requested by the Department about any aspect of CHCPE operations and in a timeframe determined by the Department.

NOTE WELL: The Department shall require the Resultant Contractor to submit complete and accurate data files within the designated timeframe. Resultant Contractor failure to submit accurate and complete reports as defined above is subject to financial withholding to be determined by the Department. Consistent failure to meet this requirement may result in the termination of the contract.

BIDDER REQUIREMENTS: A responsive proposal shall

1. Propose a data system that will provide the capability to comply with DSS' "Data Specifications for Resultant Contractor File Transfer" (Exhibit 12).
2. Propose a mechanism to ensure the quarterly submittal of complete and accurate data that includes the implementation of data edit checks in the data collection and data entering processes.
3. Include a process to ensure compliance with and adherence to the Resultant Contractor Requirements and the methods to identify, remediate and improve compliance.

N. Customer service, Training and Education Requirements

BIDDER REQUIREMENTS: A responsive proposal shall:

1. Provide examples of the bidder's training, and education activities with consumers and the public at large.

PART FOUR OF THE BIDDER'S PROPOSAL
BUSINESS SECTION

A. FINANCIAL INFORMATION

Each response to this RFP must include an original Part 4 (clearly marked) and five (5) copies submitted in a separate, sealed envelope and properly marked "Part Four: CT Home Care Program for the Elderly RFP." In addition to submitting a spending plan for each region, the bidder shall also include a line item budget. The budget must include proposed service targets for the average monthly caseload and number of individuals the bidder proposes to serve.

BIDDER REQUIREMENTS: A responsive proposal shall:

Include all cost and financial information in the following order:

1. Audited Financial Statements:
Audited financial statements or equivalent information for the applicable legal entity (Contractor) must be provided for each of the last two (2) appropriate fiscal years.

2. Business Narrative
A narrative that explains and details the CHCPE project's costs. The narrative should include the total number of hours the bidder expects to spend on the project by category of the staff. In addition, the business narrative must explain any anticipated costs to the Department that would result, including any startup inefficiencies, if the selection of the bidder's proposal would necessitate

changing the current provider of service in a region. The business narrative must also propose a plan and methodology to avoid any contractor breach of contract.

Bidder Requirements: A responsive proposal shall:

1. Present a projection of the number of clients served by this program and strategies to ensure the provision of required services.

3. Business Cost: Home Care Fees:

The Resultant Contractor shall implement a fee system based upon rates approved by the Department and acknowledging the following constraints:

a. The Department shall operate the CHCPE program on a fee for service basis. The Department shall review all proposed cost settlements for limited conditions related to client contributions; and.

b. Bad Debt - Federal regulations prohibit the Department from recognizing bad debt as an allowable cost either as a direct or indirect expense.

c. Submit to the Department any changes in fees for adult day care providers due to their changing from a non-medical to a medical model provider or vice versa; and

d. File changes with the Department in the providers' usual and customary rates within 30 days of the change.

4. Rates

The Department shall, at the discretion of the Commissioner, provide each Access Agency with pertinent information regarding the revision of fees for home health and community based services resulting from legislative action.

BIDDER REQUIREMENTS: A responsive proposal shall:

1. Propose the bidder's rates for each of the following four (4) tasks that do not exceed DSS' maximum allowable rate:

Task	Frequency	Maximum Rate
Initial Assessments	One Time Only	
Status Reviews	See Section Page Section Page	
Care Management	Per Diem	
Claims Processing Self-Directed Care Clients	Per month	

a. Annual reassessments shall be included in care management and shall not be considered in the proposed rates as a separate entity.

b. Proposals shall consider the initial assessment (per assessment), care management services (per day), status reviews, and claims processing for each year of the contract (or for the first year and annually thereafter by May 31st for each subsequent year of the contract).

2. Submit cost and service volume projections that support the proposed rates.

3. Include all revenues to be generated on behalf of clients in the CHCPE with the proposed rates for the services provided directly by the Resultant Contractor.

4. Detail projected costs in the quarterly format separately for waiver and state-funded clients for each region in which the Resultant Contractor proposes to operate and in total for all regions in which the Resultant Contractor proposes to operate.

5. Submit projected costs with a description of the allocation method(s) used to compute cost and rate projections for services for the CHCPE.

6. Fees for Other Community Based Services. The Department establishes fee schedules for community-based services in accordance with P.A. 93-418. In no event shall the fee paid by the Resultant Contractor to a subcontractor exceed the fee set by the Department or the subcontractor's charge for a similar service to the general public.

7. Provide the following regarding each subcontractor:

a. The rate to be paid for each service with each subcontractor for community based services.
b. Evidence that each subcontractor has a signed an agreement with the Resultant Contractor or a plan to provide the Department with such evidence.
c. Evidence of the Department's Performing Provider registration of each subcontractor or a plan to achieve such registration.
d. Documentation of the subcontractor's average usual and customary rate for each service to be provided by the subcontractor during the twelve-month period prior to the date of the subcontract.
e. The subcontractor's current usual and customary rate, or a plan to obtain such rates.
f. Subcontractor certification that bathing services and consultation in physical, occupational and speech therapy, are included in the fee, or a plan to obtain such certification.

8. Fees for Home Health Services: The fees for home health services provided to state-funded clients shall be the same as those paid under the Medicaid Program.

5. Advance for Start-up Costs

DSS recognizes that access agencies participating in the CHCPE for the first time, or expanding their service areas, may have difficulty covering expenses during the start-up period. The Department shall provide a cash advance of up to three months of start-up operating funds if the Resultant Contractor meets all conditions as specified in this RFP. This amount shall be kept in a separate General Ledger liability account for the purposes of tracking and accounting. The funds shall be repaid to the Department within twelve (12) months of the start of operations.

BIDDER REQUIREMENTS: IF APPROPRIATE, A RESPONSIVE PROPOSAL SHALL

1. Propose an advance of up to three months of start-up operating funds.

2. Outline how the funds are essential for the effective operation of the CHCPE.

3. Outline the specific use of the money.

6. Continuing Advance for Provider Services

On an ongoing basis, the Department may allow a continuing advance to cover the costs of provider services purchased by the Resultant Contractor from other agencies. Such an advance shall not exceed the anticipated costs of such purchased services for a two-week period. This amount shall be kept in a separate General Ledger liability account for the purposes of tracking and accounting. The funds shall be returned to the Department upon the expiration of the contract. Claims shall be electronically submitted bi-monthly to DSS' contracted fiscal administrator to assure rapid cash turnaround. Unreimbursed claims shall be reviewed, corrected and resubmitted promptly to avoid advanced funds from being consumed by non-reimbursed and rejected claims

BIDDER REQUIREMENTS: A responsive proposal shall

1. Account for such funds.

   a. Keep advanced funds in separate and distinct accounts.

7. All Inclusive Fixed-Price Rate Cost

BIDDER REQUIREMENTS: The Responsive Proposal Shall:

1. Provide an all-inclusive annual cost with an accompanying budget and cost with an accompanying budget for a five-year contract term, although the actual contract term will be subject to negotiation.

SECTION V PROPOSAL EVALUATION

A. EVALUATION OVERVIEW

DSS will conduct a comprehensive, fair and impartial evaluation of proposals received in response to this competitive procurement effort. Only those proposals passing the minimum RFP bidder requirements will be considered. The State reserves the right to reject any and all proposals.

1. Evaluation Organization:

An evaluation team will be established to assist DSS in selection of a Contractor. DSS reserves the right to determine the composition of this Team. The evaluation team will be responsible for the review and scoring of all proposals. This group will be responsible for the recommendation to the Commissioner of the Department. The Commissioner will notify the selected bidder(s) that the organization(s) has been awarded the right to negotiate a contract with DSS for this project.

B. EVALUATION STEPS:

The proposal evaluation will be based on a total of 1000 available points and conducted in five steps.

Step 1: Evaluation of Bidders Proposal Part One: Transmittal, Communication, Forms and Acceptance (Acceptance of the proposal for review.)

Step 2: Evaluation of Bidders Proposal Part Two: Work Plan and Program Management (400 points)

Step 3: Evaluation of Bidders Proposal Part Three: Organization and Key Personnel (300 points)

Step 4: Evaluation of Bidders Proposal Part Four: Costs and Business Information (300 points)

Step 5: Proposal Ranking

Step 1: Evaluation of Bidders Proposal Part One: Transmittal, Communication, Forms and Acceptance (Acceptance of the proposal for review.)

The purpose of this step is to determine whether the proposal is sufficiently responsive to the minimum RFP bidder requirements to permit a complete evaluation of Parts 2, 3 and 4. Proposals must comply with the instructions to bidders contained throughout. Failure to comply with the instructions will deem the proposal non-responsive and subject to rejection without further consideration. The Department reserves the right to waive minor irregularities.

The minimum requirements for Part One: Transmittal, Communication, Forms and Acceptance that entitle the proposal for consideration include:

1. Deadline - Closing Date: The proposal must have been received by 3:00 P.M. January 12, 2007.
2. Delivery Condition - Copies Necessary: The original (clearly marked) and Five (5) exact, legible copies of the Proposal (Parts 1, 2, 3 and 4) must be submitted in properly marked, separately sealed envelopes or sealed boxes by the deadline.
3. Transmittal Letter: The proposal contains a transmittal letter of no more than two (2) pages.
4. Mandatory Conditions: The bidder must accept the RFP Mandatory Terms and Conditions of the POS contract (Appendix I) Statement of Acceptance Procurement and Contractual Agreements (Appendix II).
5. Required Forms: The bidder must provide the necessary signed forms.

Step 2: Evaluation of Part Two: Work Plan and Program Management (400 points)

The proposed work plan and proposed strategies to manage the overall program will be evaluated for its responsiveness to the RFP minimum bidder's requirements, it's organization, appropriateness, completeness, and logic. The evaluation will consider how innovative and creative the bidder is in responding to the functional and technical requirements outlined in this document. The Workplan and Program Management will be worth 40% of the available points.

Step 3: Evaluation of Part Three: Organization and Key Personnel (300 points)

The Department will evaluate the experience of key members of the team, corporate and individual resources, corporate qualifications and affirmative action achievement (as demonstrated on the Workforce Analysis Form) of the bidder and any subcontractors. The Department will determine to what extent the organization and its key personnel have the ability to work effectively with DSS to develop and implement a successful system. The Department will also assess the capability of the organization to take on the additional workload that would be generated by this contract and the bidder's financial ability to undertake the contract. References will be checked. Organization and Key Personnel will be worth 30% of the available points.

Step 4: Evaluation of Part Four: Costs and Business Information (300 points)

The business proposal will only be evaluated for bidders who have met the minimum requirements of Step 1 and achieved a minimum of 70% of the available points in Step 2 and 3. The business proposal will be worth 30% of the available points.

The business proposal will be scored for cost and cost reasonableness. Cost reasonableness will be determined by examining the business narrative and the relationship between costs, personnel and the work plan outlined in the proposal.
While cost is a factor in determining the bidder with the right to negotiate a contract with the Department, price alone shall not determine the winning bidder.
Any business proposal that is incomplete or that has significant inconsistencies or inaccuracies may cause the entire proposal to be rejected by the State.

Step 5: Proposal Ranking

Upon completion of Steps 1-4, it is possible that persons participating on the evaluation team will interview the finalists.
After the evaluation team has scored the proposals, the points awarded will be totaled to determine the ranking. Recommendations, along with pertinent supporting materials, will then be conveyed to the Commissioner of DSS.

APPENDIX 1 - Purchase of Service Contract

II. MANDATORY TERMS AND CONDITIONS:
The Contractor agrees to comply with the following mandatory terms and conditions.

A. Client-Related Safeguards

1. **Inspection of Work Performed:** The Department or its authorized representative shall at all times have the right to enter into the Contractor's premises, or such other places where duties under the contract are being performed, to inspect, to monitor or to evaluate the work being performed. The Contractor and all subcontractors must provide all reasonable facilities and assistance for Department representatives. All inspections and evaluations shall be performed in such a manner as will not unduly delay work. The Contractor shall disclose information on clients, applicants and their families as requested unless otherwise prohibited by federal or state law. Written evaluations pursuant to this section shall be made available to the Contractor.

2. **Safeguarding Client Information:** The Department and the Contractor agree to safeguard the use, publication and disclosure of information on all applicants for and all clients who receive service under this contract with all applicable federal and state law concerning confidentiality.

3. **Reporting of Client Abuse or Neglect:** The Contractor shall comply with all reporting requirements relative to client abuse and neglect, including but not limited to requirements as specified in C.G.S. 17a-101 through 103, 19a-216, 46b-120 related to children; C.G.S. 46a-11b relative to persons with mental retardation and C.G.S. 17b-407 relative to elderly persons.

B. Contractor Obligations

1. **Credits and Rights in Data:**

   a. Unless expressly waived in writing by the Department, all documents, reports and other publications for public distribution during or resulting from the performances of this contract shall include a statement acknowledging the financial support of the state and the Department and, where applicable, the federal government. All such publications shall be released in conformance with applicable federal and state law and all regulations regarding confidentiality. Any liability arising from such a release by the Contractor shall be the sole responsibility of the Contractor and the Contractor shall indemnify the Department, unless the Department or its agents co-authored said publication and said release is done with the prior written approval of the commissioner of the Department. Any publication shall contain the following statement: "This publication does not express the views of the Department or the State of Connecticut. The views and opinions expressed are those of the authors." The Contractor or any of its agents shall not copyright data and information obtained under the terms and conditions of this contract, unless expressly authorized in writing by the Department. The Department shall have the right to publish, duplicate, use and disclose all such data in any manner and may authorize others to do so. The Department may copyright any data without prior notice to the Contractor. The Contractor does not assume any responsibility for the use, publication or disclosure solely by the Department of such data.

   b. "Data" shall mean all results, technical information and materials developed and/or obtained in the performance of the services hereunder, including but not limited to all reports, surveys, plans, charts, recordings (video and/or sound), pictures, curricula, public awareness or prevention campaign materials, drawings, analyses, graphic representations, computer programs and printouts, notes and memoranda and documents, whether finished or

unfinished, which result from or are prepared in connection with the services performed hereunder.

2. **Organizational Information (NEW), Conflict of Interest, IRS Form 990:** Annually during the term of the Contract, the Contractor shall submit to the Department the following:

   a. a copy of its most recent IRS Form 990 submitted to the federal Internal Revenue Service and

   b. its most recent Annual Report as filed with the Office of the Secretary of the State or such other information that the Department deems appropriate with respect to the organization and affiliation of the Contractor and related entities.

3. **Prohibited Interest:** The Contractor warrants that no state appropriated funds have been paid or will be paid by or on behalf of the Contractor to contract with or retain any company or person, other than bona fide employees working solely for the Contractor, to influence or attempt to influence an officer or employee of any state agency in connection with the awarding, extension, continuation, renewal, amendment, or modification of this agreement, or to pay or agree to pay any company or person, other than bona fide employees working solely for the Contractor, any fee, commission, percentage, brokerage fee, gift or any other consideration contingent upon or resulting from the award or making of this Agreement.

4. **Offer of Gratuities (NEW):** By its agreement to the terms of this contract, the Contractor certifies that no elected or appointed official or employee of the State of Connecticut has or will benefit financially or materially from this contract. The Department may terminate this contract if it is determined that gratuities of any kind were either offered or received by any of the aforementioned officials or employees from the Contractor or its agents or employees.

5. **Related Party Transactions (NEW):** The Contractor shall report all related party transactions, as defined in this Section, to the Department on an annual basis in the appropriate fiscal report as specified in Part II of this contract. "Related party" means a person or organization related through marriage, ability to control, ownership, family or business association. Past exercise of influence or control need not be shown, only the potential or ability to exercise influence or control, directly or indirectly. "Related party transactions" between a Contractor, its employees, Board members or members of the Contractor's governing body and a related party include, but are not limited to, (a) real estate sales or leases; (b) leases for equipment, vehicles or household furnishings; (c) mortgages, loans and working capital loans and (d) contracts for management, consultant and professional services as well as for materials, supplies and other services purchased by the Contractor.

6. **Insurance:** The Contractor will carry insurance, (liability, fidelity bonding or surety bonding and/or other), as specified in this agreement, during the term of this contract according to the nature of the work to be performed to "save harmless" the State of Connecticut from any claims, suits or demands that may be asserted against it by reason of any act or omission of the Contractor, subcontractor or employees in providing services hereunder, including but not limited to any claims or demands for malpractice. Certificates of such insurance shall be filed with the Department before the performance of services.

7. **Reports (NEW):** The Contractor shall provide the Department with such statistical, financial and programmatic information necessary to monitor and evaluate compliance with the contract. All requests for such information shall comply with all applicable state and federal confidentiality laws. The Contractor agrees to provide the Department with such reports as the Department requests.

8. **Delinquent Reports:** The Contractor will submit required reports by the designated due dates as identified in this agreement. After notice to the Contractor and an opportunity for a meeting with a Department representative, the Department reserves the right to withhold payments for services performed under this contract if the Department has not received acceptable progress reports, expenditure reports, refunds and/or audits as required by this agreement or previous agreements for similar or equivalent services the Contractor has entered into with the Department.

9. **Record Keeping and Access:** The Contractor shall maintain books, records, documents, program and individual service records and other evidence of its accounting and billing procedures and practices which sufficiently and properly reflect all direct and indirect costs of any nature incurred in the performance of this contract. These records shall be subject at all reasonable times to monitoring, inspection, review or audit by authorized employees or agents of the state or, where applicable, federal agencies. The Contractor shall retain all such records concerning this contract for a period of three (3) years after the completion and submission to the state of the Contractor's annual financial audit.

10. **Workforce Analysis:** The Contractor shall provide a workforce analysis affirmative action report related to employment practices and procedures.

11. **Audit Requirements:** The Contractor shall provide for an annual financial audit acceptable to the Department for any expenditure of state-awarded funds made by the Contractor. Such audit shall include management letters and audit recommendations. The State Auditors of Public Accounts shall have access to all records and accounts for the fiscal year(s) in which the award was made. The Contractor will comply with federal and state single audit standards as applicable.

12. **Litigation:** The Contractor shall provide written notice to the Department of any litigation that relates to the services directly or indirectly financed under this contract or that has the potential to impair the ability of the Contractor to fulfill the terms and conditions of this contract, including but not limited to financial, legal or any other situation which may prevent the Contractor from meeting its obligations under the contract.

    The Contractor shall provide written notice to the Department of any final decision by any tribunal or state or federal agency or court which is adverse to the Contractor or which results in a settlement, compromise or claim or agreement of any kind for any action or proceeding brought against the Contractor or its employee or agent under the Americans with Disabilities Act of 1990, executive orders Nos. 3 & 17 of Governor Thomas J. Meskill and any other provisions of federal or state law concerning equal employment opportunities or nondiscriminatory practices.

13. **Lobbying:** The Contractor agrees to abide by state and federal lobbying laws and further specifically agrees not to include in any claim for reimbursement any expenditures associated with activities to influence, directly or indirectly, legislation pending before Congress, or the Connecticut General Assembly or any administrative or regulatory body unless otherwise required by this contract.

C. Statutory and Regulatory Compliance

1. **Compliance with Law and Policy (NEW):** Contractor shall comply with all pertinent provisions of local, state and federal laws and regulations as well as Departmental policies and procedures applicable to Contractor's programs as specified in this contract. The Department shall notify the Contractor of any applicable new or revised laws, regulations, policies or procedures that the Department has responsibility to promulgate or enforce.

2. **Federal Funds (NEW):** The Contractor shall comply with requirements relating to the receipt or use of federal funds. The Department shall specify all such requirements in Part I of this contract.

3. **Facility Standards and Licensing Compliance:** The Contractor will comply with all applicable local, state and federal licensing, zoning, building, health, fire and safety regulations or ordinances, as well as standards and criteria of pertinent state and federal authorities. Unless otherwise provided by law, the Contractor is not relieved of compliance while formally contesting the authority to require such standards, regulations, statutes, ordinance or criteria.

4. **Suspension or Debarment (NEW):**

   a. Signature on contract certifies the Contractor or any person (including subcontractors) involved in the administration of Federal or State funds:

      (1) is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any governmental Department or agency (Federal, State or local);

      (2) within a three year period preceding this Contract, has not been convicted or had a civil judgment rendered against him/her for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property;

      (3) is not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the above offenses;

      (4) has not within a three year period preceding this agreement had one or more public transactions terminated for cause or fault.

   b. Any change in the above status shall be reported to the Department immediately.

5. **Non-discrimination Regarding Sexual Orientation:** Unless otherwise provided by Conn. Gen. Stat. §46a-81p, the Contractor agrees to the following provisions required pursuant to §4a-60a of the Conn. Gen. Stat.:

   a. The Contractor agrees:

      (1) and warrants that in the performance of the contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of sexual orientation, in any manner prohibited by the laws of the United States or of the State of Connecticut and that employees are treated when employed without regard to their sexual orientation;

      (2) to provide each labor union or representatives of workers with which such Contractor has a collective bargaining agreement or other contract or understanding and each vendor with which such Contractor has a contract or understanding a notice to be provided by the commission on human rights and opportunities advising the labor union or workers' representative of the Contractor's commitments under this section and to post copies of the notice in conspicuous places available to employees and applicants for employment;

(3) to comply with each provision of this section and with each regulation or relevant order issued by said commission pursuant to §46a-56 of the Conn. Gen. Stat.;

(4) to provide the commission on human rights and opportunities with such information requested by the commission and permit access to pertinent books, records and accounts concerning the employment practices and procedures of the Contractor which relate to provisions of this section and §46a-56 of the Conn. Gen. Stat.

b. The Contractor shall include the provisions of Subsection a of this section in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the state and such provisions shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with §46a-56 of the Conn. Gen. Stat. provided, if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the commission, the Contractor may request the State of Connecticut to enter into any such litigation or negotiation prior thereto to protect the interests of the state and the state may so enter.

6. **Executive Orders Nos. 3, 17, 16 & 7C:**

a. This Contract is subject to the provisions of **Executive Order No. 3 of Governor Thomas J. Meskill promulgated June 16, 1971,** and, as such, this Contract may be cancelled, terminated or suspended by the state labor commissioner for violation of or noncompliance with said Executive Order No. Three, or any state or federal law concerning nondiscrimination, notwithstanding that the labor commissioner is not a party to this contract. The Parties to this Contract, as part of the consideration hereof, agree that said Executive Order No. Three is incorporated herein by reference and made a part hereof. The Parties agree to abide by said Executive Order and agree that the state labor commissioner shall have continuing jurisdiction in respect to contract performance in regard to nondiscrimination, until the contract is completed or terminated prior to completion. The CONTRACTOR agrees, as part consideration hereof, that this Contract is subject to the Guidelines and Rules issued by the state labor commissioner to implement Executive Order No. Three, and that it will not discriminate in its employment practices or policies, will file all reports as required, and will fully cooperate with the State of Connecticut and the state labor commissioner.

b. This Contract is subject to the provisions of **Executive Order No. 17 of Governor Thomas J. Meskill promulgated February 15, 1973,** and, as such, this Contract may be cancelled, terminated or suspended by the contracting agency or the State Labor Commissioner for violation of or noncompliance with said Executive Order No. Seventeen, notwithstanding that the Labor Commissioner may not be a party to this Contract. The Parties to this Contract, as part of the consideration hereof, agree that Executive Order No. Seventeen is incorporated herein by reference and made a part hereof. The Parties agree to abide by said Executive Order and agree that the contracting agency and the State Labor Commissioner shall have joint and several continuing jurisdiction in respect to contract performance in regard to listing all employment openings with the Connecticut State Employment Service.

c. This Contract is subject to the provisions of **Executive Order No. 16 of Governor John G. Rowland promulgated August 4, 1999**, and, as such, the Contract may be canceled, terminated or suspended23 by the state for violation of or noncompliance with said

Executive Order No. Sixteen. The Parties to this Contract, as part of the consideration hereof, agree that

(a) The CONTRACTOR shall prohibit employees from bringing into the state work site, except as may be required as a condition of employment, any weapon or dangerous instrument as defined in (b):

(b) Weapon means any firearm, including a BB gun, whether loaded or unloaded, any knife (excluding a small pen or pocketknife), including a switchblade or other knife having an automatic spring release device, a stiletto, any police baton or nightstick or any martial arts weapon or electronic defense weapon.

Dangerous instrument means any instrument, article, or substance that, under the circumstances, is capable of causing death or serious physical injury.

(c) The CONTRACTOR shall prohibit employees from attempting to use, or threaten to use, any such weapon or dangerous instrument in the state work site and employees shall be prohibited from causing, or threatening to cause, physical injury or death to any individual in the state work site.

(d) The CONTRACTOR shall adopt the above prohibitions as work rules, violations of which shall subject the employee to disciplinary action up to and including discharge. The CONTRACTOR shall insure and require that all employees are aware if such work rules.

(e) The CONTRACTOR agrees that any subcontract it enters into in furtherance of the work to be performed hereunder shall contain provisions (a) through (d) of this Section.

d. This Contract is subject to **Executive Order No. 7C of Governor M. Jodi Rell, promulgated on July 13, 2006.** The Parties to this Contract, as part of the consideration hereof, agree that:

(a.) The State Contracting Standards Board ("the Board") may review this contract and recommend to the state contracting agency termination of the contract for cause. The state contracting agency shall consider the recommendations and act as required or permitted in accordance with the contract and applicable law. The Board shall provide the results of its review, together with its recommendations, to the state contracting agency and any other affected party in accordance with the notice provisions in the contract no later than fifteen (15) days after the Board finalizes its recommendation. For the purposes of this Section, "for cause" means:

(1.) a violation of the State Ethics Code (Conn. Gen. Stat. Chapter 10) or Section 4A-100 of the Conn. Gen. Statutes or

(2.) wanton or reckless disregard of any state contracting and procurement process by any person substantially involved in such contract or state contracting agency.

(b.) For the purposes of this Section, "contract" shall not include real property transactions involving less than a fee simple interest or financial assistance comprised of state or federal funds, the form of which may include but is not limited to grants, loans, loan guarantees, and participation interests in loans, equity investments and tax credit programs. Notwithstanding the foregoing, the Board shall not have any authority to recommend the termination of a contract for the sale or purchase of a fee simple interest in real property following transfer of title.

(c.) Notwithstanding the contract value listed in sections 4-250 and 4-252 of the Connecticut General Statutes and section 8 of Executive Order Number 1, all State Contracts between state agencies and private entities with a value of $50,000 or more in a calendar or fiscal year shall comply with the gift and campaign contribution certification requirements of section 4-252 of the Connecticut General Statutes and section 8 of Executive Order Number 1. For purposes of this section, the term "certification" shall include the campaign contribution and annual gift affidavits required by section 8 of Executive Order Number 1.

7. **Nondiscrimination and Affirmative Action Provisions in Contracts of the State and Political Subdivisions Other Than Municipalities:** The Contractor agrees to comply with provisions of § 4a-60 of the Connecticut General Statutes

a. Every contract to which the state or any political subdivision of the state other that a municipality is a party shall contain the following provisions: (1) The Contractor agrees and warrants that in the performance of the contract such Contractor will not discriminate or permit discrimination against any person or group of persons on the grounds of race, color, religious creed, age, marital status, national origin, ancestry, sex, mental retardation or physical disability, including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved, in any manner prohibited by the laws of the United States or of the state of Connecticut. The Contractor further agrees to take affirmative action to insure that applicants with job-related qualifications are employed and that employees are treated when employed without regard to their race, color, religious creed, age, marital status, national origin, ancestry, sex, mental retardation, or physical disability, including, but not limited to, blindness, unless it is shown by such Contractor that such disability prevents performance of the work involved; (2) the Contractor agrees, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, to state that is an "affirmative action-equal opportunity employer" in accordance with regulations adopted by the commission; (3) the Contractor agrees to provide each labor union or representative of workers with which such Contractor has a collective bargaining agreement or other contract or understanding and each vendor with which such Contractor has a contract or understanding, a notice to be provided by the commission advising the labor union or workers' representative of the Contractor's commitments under this section and to post copies of the notice in conspicuous places available to employees and applicants for employment; (4) the Contractor agrees to comply with each provision of this section and Conn. Gen. Stat. §§ 46a-68e and 46a-68f and with each regulation or relevant order issued by said commission pursuant to Conn. Gen. Stat. §§ 46a-56, 46a-68e and 46a-68f; (5) the Contractor agrees to provide the commission of human rights and opportunities with such information requested by the commission and permit access to pertinent books, records and accounts, concerning the employment practices and procedures of the Contractor as relate to the provisions of this section and Conn. Gen. Stat. § 46a-56. If the contract is a public works contract, the Contractor agrees and warrants that he will make good faith efforts to employ minority business enterprises as subcontractors and suppliers of materials on such public works project.

b. For the purposes of this section, "minority business enterprise" means any small Contractor or supplier of materials fifty-one per cent or more of capital stock, if any, or assets of which is owned by a person or persons: (1) Who are active in the daily affairs of the enterprise, (2) who have the power to direct the management and policies of the enterprise and (3) who are members of a minority, as such term is defined in Subsection (a) of Conn. Gen. Stat. § 32-9n; and "good faith" means that degree of diligence which a reasonable person would exercise in the performance of legal duties and obligations. "Good faith efforts" shall include, but not be limited to, those reasonable initial efforts necessary to comply with statutory or regulatory

requirements and additional or substituted efforts when it is determined that such initial efforts will not be sufficient to comply with such requirements.

c. Determinations of the Contractor's good faith efforts shall include but shall not be limited to the following factors: The Contractor's employment and subcontracting policies, patterns and practices; affirmative action advertising; recruitment and training; technical assistance activities and such other reasonable activities or efforts as the commission may prescribe that are designed to ensure the participation of minority business enterprises in public works projects.

d. The Contractor shall develop and maintain adequate documentation, in a manner prescribed by the commission, of its good faith efforts.

e. Contractor shall include the provisions of Subsection a of this section in every subcontract or purchase order entered into in order to fulfill any obligation of a contract with the state and such provision shall be binding on a subcontractor, vendor or manufacturer unless exempted by regulations or orders of the commission. The Contractor shall take such action with respect to any such subcontract or purchase order as the commission may direct as a means of enforcing such provisions including sanctions for noncompliance in accordance with Conn. Gen. Stat. § 46a-56; provided, if such Contractor becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the commission, the Contractor may request the state of Connecticut to enter into such litigation or negotiation prior thereto to protect the interests of the state and the state may so enter.

8. **Americans with Disabilities Act of 1990:** This clause applies to those Contractors which are or will come to be responsible for compliance with the terms of the Americans with Disabilities Act of 1990 (42 USCS §§12101-12189 and §§12201-12213) (Supp. 1993); 47 USCS §§225, 611 (Supp. 1993). During the term of the contract, the Contractor represents that it is familiar with the terms of this Act and that it is in compliance with the law. The Contractor warrants that it will hold the state harmless from any liability which may be imposed upon the state as a result of any failure of the Contractor to be in compliance with this Act. As applicable, the Contractor agrees to abide by provisions of Sec. 504 of the federal Rehabilitation Act of 1973, as amended, 29 U.S.C. §794 (Supp. 1993), regarding access to programs and facilities by people with disabilities.

9. **Utilization of Minority Business Enterprises**: It is the policy of the state that minority business enterprises should have the maximum opportunity to participate in the performance of government contracts. The Contractor agrees to use best efforts consistent with 45 C.F.R. 74.160 et seq. (1992) and paragraph 9 of Appendix G thereto for the administration of programs or activities using HHS funds; and §§13a-95a, 4a-60, to 4a-62, 4b-95(b) and 32-9e of the Conn. Gen. Stat. to carry out this policy in the award of any subcontracts.

10. **Priority Hiring:** Subject to the Contractor's exclusive right to determine the qualifications for all employment positions, the Contractor shall use its best efforts to ensure that it gives priority to hiring welfare recipients who are subject to time limited welfare and must find employment. The Contractor and the Department will work cooperatively to determine the number and types of positions to which this paragraph shall apply. The Department of Social Services regional office staff or staff of Department of Social Service Contractors will undertake to counsel and screen an adequate number of appropriate candidates for positions targeted by the Contractor as suitable for individuals in the time limited welfare program. The success of the Contractor's efforts will be considered when awarding and evaluating contracts.

11. **Non-smoking:** If the Contractor is an employer subject to the provisions of §31-40q of the Conn. Gen. Stat., the Contractor agrees to provide upon request the Department with a copy of its written

rules concerning smoking. Evidence of compliance with the provisions of §31-40q of the Conn. Gen. Stat. must be received before contract approval by the Department.

12. **Government Function; Freedom of Information (NEW):** If the amount of this contract exceeds two million five hundred thousand dollars ($2,500,000) and the contract is for the performance of a governmental function, as that term is defined in Conn. Gen. Stat. Sec. 1-200(11), as amended by Pubic Act 01-169, the Department is entitled to receive a copy of the records and files related to the Contractor's performance of the governmental function and may be disclosed by the Department pursuant to the Freedom of Information Act.

13. **HIPAA Requirements (NEWLY Revised, effective 4/20/05,):**

NOTE: Numbering in this Section may not be consistent with the remainder of this contract as much of it is presented verbatim from the federal source.

a. If the Contactor is a Business Associate under HIPAA, the Contractor must comply with all terms and conditions of this Section of the Contract. If the Contractor is not a Business Associate under HIPAA, this Section of the Contract does not apply to the Contractor for this Contract.

b. **The Contractor is required to safeguard the use, publication and disclosure of information on all applicants for and all clients who receive, services under the contract in accordance "with all applicable federal and state law regarding confidentiality, which includes but is not limited to the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C and E; *and***

c. The State of Connecticut Department named on page 1 of this Contract (hereinafter "Department") is a "covered entity" as that term is defined in 45 C.F.R. §160.103; *and*

d. The Contractor, on behalf of the Department, performs functions that involve the use or disclosure of "individually identifiable health information," as that term is defined in 45 C.F.R. §160.103 ; *and*

e. The Contractor is a "business associate" of the Department, as that term is defined in 45 C.F.R. §160.103; *and*

f. The Contractor and the Department agree to the following in order to secure compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), more specifically with the Privacy and Security Rules at 45 C.F.R. Part 160 and Part 164, subparts A, C and E:

I. Definitions

A. Business Associate. "Business Associate" shall mean the Contractor.

B. Covered Entity. "Covered Entity" shall mean the Department of the State of Connecticut named on page 1 of this Contract.

C. Designated Record Set. "Designated Record Set" shall have the same meaning as the term "designated record set" in 45 C.F.R. §164.501.

D. Individual. "Individual" shall have the same meaning as the term "individual"' in 45 C.F.R. §160.103 and shall include a person who qualifies as a personal representative as defined in 45 C.F.R. §164.502(g).

E. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. part 160 and parts 164, subparts A and E.

F. Protected Health Information. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 C.F.R. §160.103, limited to information created or received by the Business Associate from or on behalf of the Covered Entity.

G. Required by Law. "Required by Law" shall have the same meaning as the term "required by law" in 45 C.F.R. §164.103.

H. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

I. More Stringent. "More stringent" shall have the same meaning as the term "more stringent" in 45 C.F.R. §160.202.

J. Section of Contract. "(T)his Section of the Contract" refers to the HIPAA Provisions stated herein, in their entirety.

K. Security Incident. "Security Incident" shall have the same meaning as the term "security incident" in 45 C.F.R. §164.304.

L. Security Rule. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Part 160 and Parts 164, subpart A and C.

II. Obligations and Activities of Business Associates

A. Business Associate agrees not to use or disclose PHI other than as permitted or required by this Section of the Contract or as Required by Law

B. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of PHI other than as provided for in this Section of the Contract.

B1. (NEW) Business Associate agrees to use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information that it creates, receives, maintains or transmits on behalf of the Covered Entity.

C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate of a use or disclosure of PHI by Business Associate in violation of this Section of the Contract.

D. Business Associate agrees to report to Covered Entity any use or disclosure of PHI not provided for by this Section of the Contract or any security incident of which it becomes aware.

E. Business Associate agrees to insure that any agent, including a subcontractor, to whom it provides PHI received from, or created or received by Business Associate, on behalf of the Covered Entity, agrees to the same restrictions and conditions that apply through this Section of the Contract to Business Associate with respect to such information.

F. Business Associate agrees to provide access, at the request of the Covered Entity and in the time and manner agreed to by the parties, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. §164.524.

G. Business Associate agrees to make any amendments to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. §164.526 at the request of the Covered Entity and in the time and manner agreed to by the parties.

H. Business Associate agrees to make internal practices, books and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by, Business Associate on behalf of Covered Entity, available to Covered Entity or to the Secretary in a time and manner agreed to by the parties or designated by the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

I. Business Associate agrees to document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528.

J. Business Associate agrees to provide to Covered Entity, in a time and manner agreed to by the parties, information collected in accordance with paragraph I of this Section of the Contract, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. §164.528.

K. Business Associate agrees to comply with any state law that is more stringent than the Privacy Rule.

III. Permitted Uses and Disclosure by Business Associate

A. General Use and Disclosure Provisions: Except as otherwise limited in this Section of the Contract, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in this Contract, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

B. Specific Use and Disclosure Provisions:

1. Except as otherwise limited in this Section of the Contract, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

2. Except as otherwise limited in this Section of the Contract, Business Associate may disclose PHI for the proper management and administration of 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 Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

3. Except as otherwise limited in this Section of the Contract, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. §164.504(e)(2)(i)(B).

IV. Obligations of Covered Entity

A. Covered Entity shall notify Business Associate of any limitations in its notice of privacy practices of Covered Entity, in accordance with 45 C.F.R. 164.520, or to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

B. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

C. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

V. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by the Covered Entity, except that Business Associate may use and disclose PHI for data aggregation and management and administrative activities of Business Associate, as permitted under this Section of the Contract.

VI. Term and Termination

A. **Term. The Term of this Section of the Contract shall be effective as of the date the Contract is effective 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 infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.**

B. Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:

1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by the Covered Entity; or

2. Immediately terminate the Contract if Business Associate has breached a material term of this Section of the Contract and cure is not possible; or

3. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

C. Effect of Termination.

1. Except as provided in paragraph (ii) of this Subsection c, upon termination of this Contract, 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 of the PHI.

2. 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 documentation by Business Associate that return of destruction of PHI is infeasible, Business Associate shall extend the protections of this Section of the Contract to such PHI and limit further uses and disclosures of PHI to those purposes that make return or destruction infeasible, for as long as Business Associate maintains such PHI. Infeasibility of the return or destruction of PHI includes, but is not limited to, requirements under state or federal law that the Business Associate maintains or preserves the PHI or copies thereof.

VII. Miscellaneous HIPAA Provisions

A. Regulatory References. A reference in this Section of the Contract to a section in the Privacy Rule means the section as in effect or as amended.

B. Amendment. The Parties agree to take such action as in necessary to amend this Section of the Contract from time to time as is necessary for Covered Entity to comply with requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.

C. Survival. The respective rights and obligations of Business Associate under Section 6, Subsection c of this Section of the Contract shall survive the termination of this Contract.

D. Effect on Contract. Except as specifically required to implement the purposes of this Section of the Contract, all other terms of the contract shall remain in force and effect.

E. Construction. This Section of the Contract shall be construed as broadly as necessary to implement and comply with the Privacy Standard. Any ambiguity in this Section of the Contract shall be resolved in favor of a meaning that complies and is consistent with, the Privacy Standard.

F. Disclaimer. Covered Entity makes no warranty or representation that compliance with this Section of the Contract will be adequate or satisfactory for Business Associate's own purposes. Covered Entity shall not be liable to Business Associate for any claim, loss or damage related to or arising from the unauthorized use or disclosure of PHI by Business Associate or any of its officers, directors, employees, Contractors or agents, or any third party to whom Business Associate has disclosed PHI pursuant to paragraph II D of this Section of the Contract. Business Associate is solely responsible for all decisions made and actions taken, by Business Associate regarding the safeguarding, use and disclosure of PHI within its possession, custody or control.

G. Indemnification. The Business Associate shall indemnify and hold the Covered Entity harmless from and against 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 and costs of investigation, litigation or dispute resolution, relating to or arising out of any violation by the Business Associate and its agents, including subcontractors, of any obligation of Business Associate and its agents, including subcontractors, under this Section of the Contract.

D. Miscellaneous Provisions

1. **Liaison:** Each party shall designate a liaison to facilitate a cooperative working relationship between the Contractor and the Department in the performance and administration of this contract.

2. **Choice of Law and Choice of Forum:** The Contractor agrees to be bound by the law of the State of Connecticut and the federal government where applicable and agrees that this contract shall be construed and interpreted in accordance with Connecticut law and federal law where applicable.

3. **Subcontracts**: For purposes of this clause subcontractors shall be defined as providers of direct human services. Vendors of support services, not otherwise known as human service providers or educators, shall not be considered subcontractors, e.g. lawn care, unless such activity is considered part of a training, vocational or educational program. The subcontractor's identity, services to be rendered and costs shall be detailed in PART I of this contract. Notwithstanding the execution of this contract before a specific subcontractor being identified or specific costs being set, no subcontractor may be used or expense under this contract incurred before identification of the subcontractor or inclusion of a detailed budget statement as to subcontractor expense, unless expressly provided in PART I of this contract. Identification of a subcontractor or budget costs

for such subcontractor shall be deemed a technical amendment if consistent with the description of each contained in PART I of this contract. No subcontractor shall acquire any direct right of payment from the Department by virtue of the provisions of this paragraph or any other paragraph of this contract. The use of subcontractors, as defined in this clause, shall not relieve the Contractor of any responsibility or liability under this contract. The Contractor shall make available copies of all subcontracts to the Department upon request.

4. **Mergers and Acquisitions:**

a. Contracts in whole or in part are not transferable or assignable without the prior written agreement of the Department.

b. At least ninety (90) days before the effective date of any fundamental changes in corporate status, including merger, acquisition, transfer of assets and any change in fiduciary responsibility, the Contractor shall provide the Department with written notice of such changes.

c. The Contractor shall comply with requests for documentation deemed necessary by the Department to determine whether the Department will provide prior written agreement as required by Section II.D.3 above. The Department shall notify the Contractor of such determination not later than forty-five (45) business days from the date the Department receives such requested documentation.

5. **Equipment:** In the event this contract is terminated or not renewed, the Department reserves the right to recoup any equipment, deposits or down payments made or purchased with start-up funds or other funds specifically designated for such purpose under this contract. For purposes of this provision, equipment means tangible personal property with a normal useful life of at least one year and a value of at least $2,500. Equipment shall be considered purchased from Contractor funds and not from Department funds if the equipment is purchased for a program that has other sources of income equal to or greater than the equipment purchase price.

6. **Independent Capacity of Contractor:** The Contractor, its officers, employees, subcontractors, or any other agent of the Contractor in the performance of this contract will act in an independent capacity and not as officers or employees of the state of Connecticut or of the Department.

7. **Settlement of Disputes and Claims Commission:**

a. Any dispute concerning the interpretation or application of this contract shall be decided by the commissioner of the Department or his/her designee whose decision shall be final subject to any rights the Contractor may have pursuant to state law. In appealing a dispute to the commissioner pursuant to this provision, the Contractor shall be afforded an opportunity to be heard and to offer evidence in support of its appeal. Pending final resolution of a dispute, the Contractor and the Department shall proceed diligently with the performance of the contract.

b. Claims Commission. The Contractor agrees that the sole and exclusive means for the presentation of any claim against the State arising from this contract shall be in accordance with Chapter 53 of the Connecticut General Statutes (Claims Against the State) and the Contractor further agrees not to initiate legal proceedings except as authorized by that Chapter in any State or Federal Court in addition to or in lieu of said Chapter 53 proceedings.

E. **Revisions, Reductions, Default and Cancellation**

1. **Contract Revisions and Amendments:**

a. A formal contract amendment, in writing, shall not be effective until executed by both parties to the contract and, where applicable, the Attorney General. Such amendments shall be required for extensions to the final date of the contract period and to terms and conditions specifically stated in Part II of this contract, including but not limited to revisions to the maximum contract payment, to the unit cost of service, to the contract's objectives, services, or plan, to due dates for reports, to completion of objectives or services and to any other contract revisions determined material by the Department.

b. The Contractor shall submit to the Department in writing any proposed revision to the contract and the Department shall notify the Contractor of receipt of the proposed revision. Any proposal deemed material shall be executed pursuant to (a) of this section. The Department may accept any proposal as a technical amendment and notify the Contractor in writing of the same. A technical amendment shall be effective on the date approved by the Department, unless expressly stated otherwise.

c. No amendments may be made to a lapsed contract.

2. **Contract Reduction:**

a. The Department reserves the right to reduce the contracted amount of compensation at any time in the event that:

(1) the Governor or the Connecticut General Assembly rescinds, reallocates, or in any way reduces the total amount budgeted for the operation of the Department during the fiscal year for which such funds are withheld; or

(2) Federal funding reductions result in reallocation of funds within the Department.

b. The Contractor and the Department agree to negotiate on the implementation of the reduction within 30 days of receipt of formal notification of intent to reduce the contracted amount of compensation from the Department. If agreement on the implementation of the reduction is not reached within thirty (30) calendar days of such formal notification and a contract amendment has not been executed, the Department may terminate the contract sixty (60) days from receipt of such formal notification. The Department will formally notify the Contractor of the termination date.

3. **Default by the Contractor:**

a. If the Contractor defaults as to, or otherwise fails to comply with, any of the conditions of this contract the Department may:

(1) withhold payments until the default is resolved to the satisfaction of the Department;

(2) temporarily or permanently discontinue services under the contract;

(3) require that unexpended funds be returned to the Department;

(4) assign appropriate state personnel to execute the contract until such time as the contractual defaults have been corrected to the satisfaction of the Department;

(5) require that contract funding be used to enter into a sub-contract arrangement with a person or persons designated by the Department in order to bring the program into contractual compliance;

(6) terminate this contract;

(7) take such other actions of any nature whatsoever as may be deemed appropriate for the best interests of the state or the program(s) provided under this contract or both;

(8) any combination of the above actions

b. In addition to the rights and remedies granted to the Department by this contract, the Department shall have all other rights and remedies granted to it by law in the event of breach of or default by the Contractor under the terms of this contract.

c. Prior to invoking any of the remedies for default specified in this paragraph except when the Department deems the health or welfare of service recipients is endangered as specified in Part II Section A.3 of this agreement or has not met requirements as specified in clause 8, the Department shall notify the Contractor in writing of the specific facts and circumstances constituting default or failure to comply with the conditions of this contract and proposed remedies. Within five (5) business days of receipt of this notice, the Contractor shall correct any contractual defaults specified in the notice and submit written documentation of correction to the satisfaction of the Department or request in writing a meeting with the commissioner of the Department or his/her designee. Any such meeting shall be held within five (5) business days of the written request. At the meeting, the Contractor shall be given an opportunity to respond to the Department's notice of default and to present a plan of correction with applicable time frames. Within five (5) business days of such meeting, the commissioner of the Department shall notify the Contractor in writing of his/her response to the information provided including acceptance of the plan of correction and, if the commissioner finds continued contractual default for which a satisfactory plan of corrective action has not been presented, the specific remedy for default the Department intends to invoke. This action of the commissioner shall be considered final.

d. If at any step in this process the Contractor fails to comply with the procedure and, as applicable, the agreed upon plan of correction, the Department may proceed with default remedies.

4. **Non-enforcement not to constitute waiver:** The failure of either party to insist upon strict performance of any terms or conditions of this agreement shall not be deemed a waiver of the term or condition or any remedy that each party has with respect to that term or condition nor shall it preclude a subsequent default by reason of the failure to perform.

5. **Cancellation and Recoupment:**

a. This agreement shall remain in full force and effect for the entire term of the contract period specified on page 1 of this agreement, unless either party provides written notice ninety (90) days or more from the date of termination, except that no cancellation by the Contractor may be effective for failure to provide services for the agreed price or rate and cancellation by the Department shall not be effective against services already rendered, so long as the services were rendered in compliance with the contract during the term of the contract.

b. In the event the health or welfare of the service recipients is endangered, the Department may cancel the contract and take any immediate action without notice it deems appropriate

to protect the health and welfare of service recipients. The Department shall notify the Contractor of the specific reasons for taking such action in writing within five (5) business days of cancellation. Within five (5) business days of receipt of this notice, the Contractor may request in writing a meeting with the commissioner of the Department or his/her designee. Any such meeting shall be held within five (5) business days of the written request. At the meeting, the Contractor shall be given an opportunity to present information on why the Department's actions should be reversed or modified. Within five (5) business days of such meeting, the commissioner of the Department shall notify the Contractor in writing of his/her decision upholding, reversing or modifying the action of the Department. This action of the commissioner shall be considered final.

c. The Department reserves the right to cancel the contract without prior notice when the funding for the contract is no longer available.

d. The Department reserves the right to recoup any deposits, prior payment, advance payment or down payment made if either party terminates the contract. Allowable costs incurred to date of termination for operation or transition of program(s) under this contract shall not be subject to recoupment. The Contractor agrees to return to the Department any funds not expended in accordance with the terms and conditions of the contract and, if the Contractor fails to do so upon demand, the Department may recoup said funds from any future payments owing under this contract or any other contract between the state and the Contractor.

6. **Transition after Termination or Expiration of Contract:** In the event that this contract is terminated for any reason except where the health and welfare of service recipients is endangered or if the Department does not offer the Contractor a new contract for the same or similar service at the contract's expiration, the Contractor will assist in the orderly transfer of clients served under this contract as required by the Department and will assist in the orderly cessation of operations under this contract. Prior to incurring expenses related to the orderly transfer or continuation of services to service recipients beyond the terms of the contract, the Department and the Contractor agree to negotiate a termination amendment to the existing agreement to address current program components and expenses, anticipated expenses necessary for the orderly transfer of service recipients and changes to the current program to address service recipient needs. The contractual agreement may be amended as necessary to assure transition requirements are met during the term of this contract. If the transition cannot be concluded during this term, the Department and the Contractor may negotiate an amendment to extend the term of the current contract until the transition may be concluded.

7. **Program Cancellation:** Where applicable, the cancellation or termination of any individual program or services under this contract will not, in and of itself, in any way affect the status of any other program or service in effect under this contract.

APPENDIX II

PROCUREMENT AND CONTRACTUAL AGREEMENTS

STATEMENT AND ACCEPTANCE

The terms and conditions contained in this Request for Proposal constitute a basis for this procurement. These terms and conditions, as well as others so labeled elsewhere in this document, are mandatory for this contract. The Department is solely responsible for rendering decisions in matters of interpretation on all terms and conditions.

ACCEPTANCE STATEMENT

On behalf of _____(Bidding Organization) I, _____(Name) _____ (Title) of _____(Bidding Organization) **accept the Mandatory Terms and Conditions as set forth in the Department of Social Services' "Connecticut Home Care Program for Elders" Request for Proposal.**

_____ _____

Signature **Date**

APPENDIX III - WORKFORCE ANALYSIS

ORGANIZATION:	**Number of Connecticut employees:** Full-time: **[#]** Part-time: **[#]**
Address:	
	Employment figures obtained from: Visual Check ☐; Employment Records ☐; Other ☐ Explain:

JOB CATEGORIES	TOTALS	WHITE (Not of Hispanic Origin)		BLACK (Not of Hispanic Origin)		HISPANIC		ASIAN OR PACIFIC ISLANDER		AMER. INDIAN OR ALASKAN NATIVE		PERSON WITH DISABILITIES	
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Officials & Managers													
Professionals													
Technicians													
Service Workers													
Office & Clerical													
Craft Workers (Skilled)													
Operators (Semi-Skilled)													
Laborers (Unskilled)													
TOTAL													
Totals One Year Ago													

FORMAL ON-THE-JOB-TRAINEES

Apprentices														
Trainees														

1. **Have you successfully implemented an Affirmative Action Plan?**
   Yes ☐ No ☐ If yes, date of implementation ; If No, explain:

a) **Do you promise to develop and implement a successful Affirmative Action Plan?**
   Yes ☐ No ☐ N/A ☐ Explain:

2. **Have you successfully developed an apprenticeship program complying with Sec. 46a-68-1 to 46a-68-17 of the Connecticut Department of Labor Regulations, inclusive:**
   Yes ☐ No ☐ N/A ☐ Explain:

3. **According to EEO-1 data, is the composition of your work force at or near parity when compared with the racial and sexual composition of the work force in the relevant labor market area?**
   Yes ☐ No ☐ Explain:

4. **If you plan to subcontract, will you set aside a portion of the contract for legitimate minority business enterprises?**
   Yes ☐ No ☐ Explain:

Authorized Signature_____Date_____

APPENDIX IV

NOTIFICATION TO BIDDERS

The contract to be awarded in response to this RFP is subject to contract compliance requirements mandated by Section 4-114a of the Connecticut General Statutes, and when the awarding agency is the State, Section 46a-71(d) of the Connecticut General Statutes. Contract Compliance Regulations codified at Section 4-114a et. seq. of the Regulations of the Connecticut State Agencies establish a procedure for the awarding of all contracts covered by Section 4-114a and 46a-71(d) of the Connecticut General Statutes.

According to Section 4-114a-3(9) of the Contract Compliance Regulations, every agency awarding a contract subject to the contract compliance regulations has an obligation to "aggressively solicit participation of legitimate minority business enterprises as bidders, contractors, subcontractors and suppliers of materials." "Minority business enterprise" is defined in Section 4-114a of the Connecticut General Statutes as a business wherein fifty-one percent or more of the capital stock or assets belong to a person or persons: "(1) Who are active in the daily affairs of the enterprise; (2) who have the power to direct the management and policies of the enterprise, and (3) who are members of a minority, as such term is defined in subsection (a) of Section 32-9n." "Minority" groups are defined in Section 32-9n of the Connecticut General Statutes as "(1) Black Americans..(2) Hispanic Americans. (3) Women. (4) Asian Pacific Americans and Pacific Islanders; or (5) American Indians" The above definitions apply to the contract compliance requirements by virtue of Section 4-114a (10) of the Contract Compliance Regulations.

The awarding agency will consider the following factors when reviewing the bidder's qualifications under the contract compliance requirements:

1. The bidder's success in implementing an affirmative action plan;
2. The bidder's success in developing an apprenticeship program complying with Sections 46a-68-1 to 46a-68-17 of the Connecticut General Statutes, inclusive;
3. The bidder's promise to develop and implement an affirmative action plan;
4. The bidder's submission of EEO-1 data indicating that the composition of its workforce is at or near parity when compared to the racial and sexual composition of the workforce in the relevant labor market;
5. The bidder's promise to set aside a portion of the contract for legitimate minority businesses (See section 4-114a3 (10) of the Contract Compliance Regulations) and to provide the Department set aside reports in a format required by the Department.

INSTRUCTION TO THE BIDDER: The Bidder must sign the acknowledgement below and return it to the Awarding Agency along with the bid proposal. Retain a signed copy in your files.

The undersigned acknowledges receiving and reading a copy of the "Notification to Bidders" form:

_____ _____

Signature Date

On Behalf of:_____

Organization Name_____ Address_____

APPENDIX V

Connecticut General Statutes

Sec. 31-40q. Smoking in the workplace: Definitions; employers to establish nonsmoking areas; exemptions. (a) As used in this section:

(1) "Person" means one or more individuals, partnerships, associations, corporations, limited liability companies, business trusts, legal representatives or any organized group of persons.

(2) "Employer" means a person engaged in business that has employees, including the state and any political subdivision thereof.

(3) "Employee" means any person engaged in service to an employer in the business of his employer.

(4) "Business facility" means a structurally enclosed location or portion thereof at which twenty or more employees perform services for their employer.

(5) "Smoking" means the burning of a lighted cigar, cigarette, pipe or any other matter or substance that contains tobacco.

(b) Each employer shall establish one or more work areas, sufficient to accommodate nonsmokers who request to utilize such an area, within each business facility under his control, where smoking is prohibited. The employer shall clearly designate the existence and boundaries of each nonsmoking area by posting signs that can be readily seen by employees and visitors. In the areas within the business facility where smoking is permitted, existing physical barriers and ventilation systems shall be used to the extent practicable to minimize the effect of smoking in adjacent nonsmoking areas. Nothing in this section may be construed to prohibit an employer from designating an entire business facility as a nonsmoking area.

(c) The Labor Commissioner may exempt any employer from the provisions of this section if he finds that (1) the employer made a good faith effort to comply with the provisions of this section and (2) any further requirement to so comply would constitute an unreasonable financial burden on the employer.

(P.A. 83-268; P.A. 87-149, S.1,3; P.A. 91-94; P.A. 95-79, S. 109, 189.)

History: P.A. 87-149 amended Subsec. (b) to require employers to establish sufficient nonsmoking areas in business facilities and added Subsec. (c) to enable the labor Commissioner to exempt certain employers from compliance with those requirements, effective April 1, 1988; P.A. 91-94 amended Subsec. (a) by reducing the minimum number of employees from fifty to twenty in Subdiv. (4); P.A. 95-79 amended Subsec. (a) to redefine "person" to include limited liability companies, effective May 31, 1995.

Cited. 24C. 666,672-674. Subsec. (b):
Cited. 224C. 666, 674.

APPENDIX VI

Certification Regarding Lobbying

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No federal appropriated funds have been paid or will be paid by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a member or Congress, an officer or employee of Congress or an employee of a member of Congress in connection with the awarding of any federal contract, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

(2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress or an employee of a member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, " Disclosure Form to Report Lobbying," in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award document for sub-awards at all tiers (including subcontracts, sub-grants and contracts under grants, loans and cooperative agreements) and that all sub-recipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more that $100,000 for each such failure.

Signature	Typed Name & Title
Firm/Organization	Date

APPENDIX VII
STATE OF CONNECTICUT - Gift Certification

Gift certification to accompany State Contracts with a value of $50,000 or more in a calendar or fiscal year, pursuant Conn. Gen. Stat. §§ 4-250 and 4-252, and Governor M. Jodi Rell's Executive Order No. 7C, para. 10.

I, Type/Print Name, Title and Name of Firm or Corporation, am authorized to execute the attached contract on behalf of the Name of Firm or Corporation (the "Contractor"). I hereby certify that between mm/dd/yy (planning date) and mm/dd/yy (date of the submission of this proposal) that neither myself, the Contractor, nor any of its principals or key personnel who participated directly, extensively and substantially in the preparation of the bid or proposal (if applicable) or in the negotiation of this contract, nor any agent of the above, gave a gift, as defined in Conn. Gen. Stat. § 1-79(e), including a life event gift as defined in Conn. Gen. Stat. § 1-79(e)(12), to (1) any public official or state employee of the contracting state agency or quasi-public agency who participated directly, extensively, and substantially in the preparation of the bid solicitation or request for proposals for the contract (if applicable) or in the negotiation or award of this contract; or (2) any public official or state employee of any other state agency who has supervisory or appointing authority over the state agency or quasi-public agency executing this contract, except the gifts listed below:

Name of Benefactor	Name of recipient	Gift Description	Value	Date of Gift
List information here				

Further, neither I nor any principals or key personnel of the Contractor, nor any agent of the above, knows of any action by Contractor to circumvent such prohibition on gifts by providing for any other principals, key personnel, officials, employees of Contractor, nor any agent of the above, to provide a gift to any such public official or state employee.

Further, the Contractor made its bid or proposal without fraud or collusion with any person. Sworn as true to the best of my knowledge and belief, subject to the penalties of false statement.

_____ _____
Signature Date

Sworn and subscribed before me on this _____ day of _____, 200__

_____
Commissioner of the Superior Court
Notary Public

APPENDIX VIII

STATE OF CONNECTICUT

Campaign Contribution Affidavit

(Bid or Proposal)

Campaign contribution affidavit to accompany bids or proposals for Large State Contracts (having a total cost to the State of more than $500,000), pursuant to Governor M. Jodi Rell's Executive Order No. 1, para 8. and Conn. Gen. Stat. § 4-250

I, Type/Print Name, Title and Name of Firm or Corporation, hereby swear that during the two-year period preceding the submission of this bid or proposal, neither I nor any principals or key personnel of the submitting firm or corporation who participated directly, extensively and substantially in the preparation of this bid or proposal nor any agent of the above gave a contribution to a candidate for statewide public office or the General Assembly, as defined in Conn. Gen. Stat. §9-333b, except as listed below:

Contributor	Recipient	Amount/Value	Date of Contribution	Contribution Description
List information here				

Sworn as true to the best of my knowledge and belief, subject to the penalties of false statement.

_____ _____

Signature Date

Sworn and subscribed before me on this _____ day of _____, 200__

_____

Commissioner of the Superior Court
Notary Public

APPENDIX IX
STATE OF CONNECTICUT - Consulting Agreement Affidavit

Consulting agreement affidavit to accompany state contracts for the purchase of goods and services with a value of $50,000 or more in a calendar or fiscal year, pursuant to Section 51 of Public Act 05-287.

This affidavit is required if a bidder or vendor has entered into any consulting agreements whereby the duties of the consultant include communications concerning business of such state agency, whether or not direct contact with a state agency, state or public official or state employee was expected or made. Pursuant to Section 51 of P.A. 05-287, "consulting agreement" means any written or oral agreement to retain the services, for a fee, of a consultant for the purposes of (A) providing counsel to a contractor, vendor, consultant or other entity seeking to conduct, or conducting, business with the State, (B) contacting, whether in writing or orally, any executive, judicial, or administrative office of the State, including any department, institution, bureau, board, commission, authority, official or employee for the purpose of solicitation, dispute resolution, introduction, requests for information or (C) any other similar activity related to such contract. Consulting agreement does not include any agreements entered into with a consultant who is registered under the provisions of chapter 10 of the general statutes as of the date such affidavit is submitted in accordance with the provisions of this section.

I, Type/Print Name, Title and Name of Firm or Corporation, hereby swear that I am the chief official of the bidder or vendor of the Contract or authorized to execute such Contract. I further swear that I have not entered into any consulting agreement in connection with such contract, except the agreements listed below:

Contractor's Name, Title and Firm or Corporation:

Terms of Consulting Agreement (Date of Execution, Amount, Expiration Date):

Brief Description of Services Provided (Purpose, Scope, Activities, Outcomes):

☐ Yes ☐ NoIs the Consultant a former state employee or public official?

If yes, provide the following information about the former state employee or public official:

- Former Agency:
- Date Such Employment Terminated:

Attach additional sheets if necessary. This affidavit must be amended if Contractor enters into any new consulting agreements during the term of this Contract

Sworn as true to the best of my knowledge and belief, subject to the penalties of false statement.

_____ _____

Signature Date

Sworn and subscribed before me on this _____ day of _____, 200___

_____

Commissioner of the Superior Court
Notary Public

APPENDIX X - SEEC

Prohibition on Campaign Contributions by Prospective State Contractors

Pursuant to Public Act 05-05 of the October 25, Special Session, as amended by Public Act 06-137, effective on December 31, 2006, "principals" of state contractors and prospective state contractors are prohibited from donating and soliciting certain campaign contributions.

For purposes of this prohibition, a "prospective state contractor" includes the organization submitting a bid or proposal in response to this RFP. Effective December 31, 2006, the "principals" of a prospective state contractor are prohibited from making and soliciting contributions to, or for the benefit of, any candidate for statewide office, the General Assembly, or any political committee authorized to make contributions to any such candidate, or any party committee. This prohibition remains in effect throughout the entire term of the resulting contract for the organization awarded the contract through this RFP. For those prospective state contractors who are not awarded a state contract as a result of this RFP, the prohibition terminates upon receipt of notice that the resulting contract has been awarded to a different organization.

A responsive proposal MUST include a completed SEEC SC 1 .

State Elections Enforcement Commission
State Contractor Principals Collection Form (Form SEEC - SC 1 (Rev. 7/2006))

Principal Key	Designation
Owner/Shareholder	O
Member/Board of Director	B
President	P
Chief Executive Officer	CEO
Treasurer	T
Exec./Senior Vice Pres.	V
Employee	E
Spouse	S
Dependent Child	C

Total Number of Pages Submitted

Contracting Agency	Contractor Name	Alternate Name 1	Alternate Name 2	Alternate Name 3

Designation of Principal	First Name	M.I.	Last Name	PACs Name if any
Principal's Spouse/Child	**First Name**	**M.I.**	**Last Name**	**PACs Name if any**
Designation of Principal	**First Name**	**M.I.**	**Last Name**	**PACs Name if any**
Principal's Spouse/Child	**First Name**	**M.I.**	**Last Name**	**PACs Name if any**

Designation of Principal	First Name	M.I.	Last Name	PACs Name if any
Principal's Spouse/Child	First Name	M.I.	Last Name	PACs Name if any
Designation of Principal	First Name	M.I.	Last Name	PACs Name if any
Principal's Spouse/Child	First Name	M.I.	Last Name	PACs Name if any
Designation of Principal	First Name	M.I.	Last Name	PACs Name if any
Principal's Spouse/Child	First Name	M.I.	Last Name	PACs Name if any
Designation of Principal	First Name	M.I.	Last Name	PACs Name if any
Principal's Spouse/Child	First Name	M.I.	Last Name	PACs Name if any
Designation of Principal	First Name	M.I.	Last Name	PACs Name if any
Principal's Spouse/Child	First Name	M.I.	Last Name	PACs Name if any
Designation of Principal	First Name	M.I.	Last Name	PACs Name if any
Principal's Spouse/Child	First Name	M.I.	Last Name	PACs Name if any

(**Enter information in this section for principals within your organization unique to a particular state agency).**

Contracting Agency	Contractor Name	Alternate Name 1	Alternate Name 2

Designation of Principal	First Name	M.I.	Last Name	PACs Name if any
Principal's Spouse/Child	First Name	M.I.	Last Name	PACs Name if any
Designation of Principal	First Name	M.I.	Last Name	PACs Name if any
Principal's Spouse/Child	First Name	M.I.	Last Name	PACs Name if any
Designation of Principal	First Name	M.I.	Last Name	PACs Name if any
Principal's Spouse/Child	First Name	M.I.	Last Name	PACs Name if any

CHCPE RFP EXHIBITS

EXHIBIT 1 "DSS Medicaid Provider Enrollment Agreement"

EXHIBIT 2 "DSS Provider Agreement Guidelines" (W-1217PG)
EXHIBIT 3 "CHCPE - Your Rights and Responsibilities" (W-990)
EXHIBIT 4 "Intra Referral DSS ACU Access Agency/Provider/DMR/ DMH" (W-1547)
EXHIBIT 5 "Uniform Client Care Plan" (W-1510)
EXHIBIT 6 "Client Applied Income Contribution Agreement" (W-1514)
EXHIBIT 7 "CHCPE Care Plan Cost Worksheet, Part II" (W-1510)
EXHIBIT 8 "CHCPE Notification of Delay of Assessment" (W-950)
EXHIBIT 9 "Special Eligibility Determination Document" (W-1F) – NOT INCLUDED
EXHIBIT 10 "CHCPE Applied Income Worksheet" (W-1523)
EXHIBIT 11 "Checklist to Authorize Care Management" (W-143)
EXHIBIT 12 "Data Specifications for Access Agency File Transfer"
EXHIBIT 13 "CHCPE Referral Form" (W-616)
EXHIBIT 14 "Guidelines for Coordination Between the Protective Services for the Elderly Program (PSE), Connecticut Home Care Program for Elders (CHCPE), the Alternate Care Unit (ACU), the Contracted Access Agencies (AA), and the Contracted Assisted Living Service Agencies (ALSAs)"
EXHIBIT 15 "CHCPE Provider Service Authorization" (W-211)
EXHIBIT 16 "Alternate Care Unit Progress Notes" (W-1551)
EXHIBIT 17 "Notice of Liability To Applicant or Recipient of Care or Support or Legally Liable Relative" (W-997)

EXHIBIT 18 "CHCPE Discontinuance Recommendation Form" (W-1529)
EXHIBIT 19 "CHCPE Potential Discharge Recommendation Due to Non-Payment of Client Contribution" (W-1531)
EXHIBIT 20 "Self Directed Care – How It Works"
EXHIBIT 21 "Nutrition Standards [of the CT Elderly Nutrition Program]"

Exhibit 1

CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

HEALTH CARE FINANCING

PROVIDER ENROLLMENT AGREEMENT

_____,
(Name of Applicant)

(hereinafter "Provider") wishes to participate in the Connecticut Medical Assistance Program and, therefore, represents and agrees as follows:

General Provider Requirements

1. To comply continually with all enrollment requirements established under rules adopted by the Connecticut Department of Social Services (hereinafter DSS) or any successor agency, as they may be amended from time to time.

2. To abide by and comply with all federal and state statutes, regulations, and policies pertaining to Provider's participation in the Connecticut Medical Assistance Program, as they may be amended from time to time.

3. To continually adhere to professional standards governing medical care and services and to continually meet state and federal licensure, accreditation, certification or other regulatory requirements, including all applicable provisions of the Connecticut General Statutes and any rule, regulation or DSS policy promulgated pursuant thereto and certification in the Medicare program, if applicable.

4. To furnish all information requested by DSS specified in this Agreement and the Application Form, and, further, to notify DSS or its designated agent, in writing, of all material and/or substantial changes in information contained on the Application Form.

   To furnish material and/or substantial changes in information including changes in the status of Medicare or Medicaid eligibility, provider's license, certification, or permit to provide services in/for the State of Connecticut, and any change in the status of ownership of the Provider, if applicable.

5. To provide services and/or supplies covered by Connecticut's Medical Assistance Program to eligible clients pursuant to all applicable federal and state statutes, regulations, and policies.

6. To maintain a specific record for each client eligible for the Connecticut Medical Assistance Program benefits, including but not limited to name; address; birth date; Social Security Number; Connecticut Medical Assistance Program identification number; pertinent diagnostic information including x-rays; current treatment plan; treatment notes;

documentation of dates of services and services provided; and all other information required by state and federal law.

7. To maintain all records for a minimum of five years or for the minimum amount of time required by federal or state law or regulation governing record retention, whichever period is greater. In the event of a dispute concerning goods and services provided to a client, or in the event of a dispute concerning reimbursement, documentation shall be maintained until the dispute is completely resolved or for five years, whichever is greater.

   The Provider acknowledges that failure to maintain all required documentation may result in the disallowance and recovery by DSS of any amounts paid to the Provider for which the required documentation is not maintained and provided to DSS upon request.

8. To maintain, in accordance with the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. §§ 1320d through 1320d-8, inclusive, and regulations promulgated thereto, the confidentiality of client's record, including, but not limited to:

   a. client's name, address, and Social Security number;

   b. medical services provided;

   c. medical data including diagnosis and past medical history;

   d. any information received for verifying income eligibility;

   e. any information received in connection with the identification of legally liable third party resources.

   Disclosure of clients' personal, financial, and medical information may be made under the following circumstances:

   f. to other providers in connection with their treatment of the client;

   g. to DSS or its authorized agent in connection with the determination of initial or continuing eligibility, or for the verification or audit of submitted claims;

   h. in connection with an investigation, prosecution, or civil, criminal, or administrative proceeding related to the provision of or billing for services covered by the Connecticut Medical Assistance Program;

   i. as required to obtain reimbursement from other payer sources;

   j. as otherwise required by state or federal law; and

k. with the client's written consent to other persons or entities designated by the client or legal guardian, or, in the event that the client is a minor, from theclient's parents or legal guardian.

Upon request, disclosure of all records relating to services provided and payments claimed must be made to the Secretary of Health and Human Services; to DSS; and/or to the State Medicaid fraud control unit, in accordance with 42 C.F.R. § 431.300 et seq.

In the event that the Provider authorizes a third party to act on the Provider's behalf, the Provider shall submit written verification of such authorization to DSS.

9. To maintain a written contract with all subcontractors which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract, and, in accordance with 42 C.F.R. § 455.105 and § 431.115 et seq., to provide upon request of the Secretary of Health and Human Services and/or DSS, full and complete information about the ownership of any subcontractor or any significant business transaction.

   No subcontract, however, terminates the legal responsibility of the Provider to DSS to assure that all activities under the contract are carried out. Provider shall furnish to DSS upon request copies of all subcontracts in which monies covered by this Agreement are to be used. Further, all such subcontracts shall include a provision that the subcontractor will comply with all pertinent requirements of this Agreement.

10. To abide by the DSS' Medical Assistance Program Provider Manual(s), as amended from time to time, as well as all bulletins, policy transmittals, notices, and amendments that shall be communicated to the Provider, which shall be binding upon receipt unless otherwise noted. Receipt of amendments, bulletins and notices by Provider shall be presumed when the amendments, bulletins, and notices are mailed to Provider's current address on file with DSS or its fiscal agent.

11. To make timely efforts to determine clients' eligibility, including verification of resources, and to pursue insurance, Medicare and any other third party payor prior to submitting claims to the Connecticut Medical Assistance Program for payment.

    Provider further acknowledges the Connecticut Medical Assistance Program as payer of last resort. Provider agrees to exhaust clients' medical insurance resources prior to submitting claims for reimbursement and to assist in identifying other possible sources of third party liability, which may have a legal obligation to pay all or part of the medical cost of injury or disability.

12. To comply with the advance directives requirements set forth specified in 42 C.F.R. Part 489, Subpart I, and 42 C.F.R. § 417.436(d), if applicable.

Billing/Payment Rates

13. To submit timely billing in a form and manner approved by DSS, as outlined in the Provider manual, in an amount no greater than the rates and/or amounts in accordance with those established by the Connecticut Medical Assistance Program, after first ascertaining whether any other insurance resources may be liable for any or all of the cost of the services rendered and seeking reimbursement from such resource(s).

14. To comply with the prohibition against reassignment of provider claims set forth in 42 C.F.R. § 447.10.

15. To submit only claims for goods and services covered by the Connecticut Medical Assistance Program and that are documented by Provider as being:

    a. for medically necessary medical assistance goods and services;

    b. for medical assistance goods and services actually provided to the person in whose name the claim is being made;

    c. for compensation that Provider is legally entitled to receive; and

    d. in compliance with DSS requirements regarding timely filing.

16. To accept payment as determined by DSS or its fiscal agent in accordance with federal and state statutes and regulations and policies as payment in full for all services, goods, and products covered by Connecticut Medical Assistance Program and provided to program clients.

    The Provider further agrees not to bill clients or any other party for any additional or make-up charge for services covered by the Connecticut Medical Assistance Program, excluding any co-payment permitted by law, even when the Program does not pay for those covered services for technical reasons, such as a claim not timely filed or a client being Medicaid managed-care eligible, or a billed amount exceeding the program allowed amount.

    The Provider shall refund to the payor any payment made by or on behalf of a client determined to be eligible for Medicaid to the extent that eligibility under the program overlaps the period for which payment was made and to the extent that the goods and services are covered by Medicaid.

17. To timely submit all financial information required under federal and state law.

18. To refund promptly (within 30 days of receipt) to DSS or its fiscal agent any duplicate or erroneous payment received, including any duplication or erroneous payment received for prior years or pursuant to prior provider agreements.

19. To make repayments to DSS or its fiscal agent, or arrange to have future payments from the DSS program(s) withheld, within 30 days of receipt of notice from DSS or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made. This obligation includes repayment of an overpayment received for prior years or pursuant to prior provider agreements. The Provider is liable for any costs incurred by DSS in recouping any overpayment.

20. To promptly make full reimbursement to DSS or its fiscal agent of any federal disallowance incurred by DSS when such disallowance relates to payments previously made to Provider under the Connecticut Medical Assistance Program, including payments made for prior years or pursuant to prior provider agreements.

21. To maintain fiscal, medical and programmatic records which fully disclose services and goods rendered and/or delivered to eligible clients. These records and information will be made available to authorized representatives upon request, in accordance with all state and federal statutes and regulations, including but not limited to 42 C.F.R. § 431.107 including but not limited to, information regarding payments claimed by the Provider for furnishing goods or services.

22. To cooperate fully and make available upon demand by federal and state officials and their agents all records and information that such officials have determined to be necessary to assure the appropriateness of DSS payments made to Provider, to ensure the proper administration of the Connecticut Medical Assistance Program and to assure Provider's compliance with all applicable statutes and regulations and policies. Such records and information are specified in federal and state statutes and regulations and the Provider Manual and shall include, without necessarily being limited to, the following:

    a. medical records as specified by Section 1902(a)(31) of Title XIX of the Social Security Act, 42 U.S.C. § 1396a, (hereinafter the “Act”) and any amendments thereto;

    b. original prescriptions for and records of all treatments, drugs and services for which vendor payments have been made, or are to be made under the Connecticut Medical Assistance Program, including the authority for and the date of administration of such treatment, drugs, or services;

    c. any original documentation determined by DSS or its representative to be necessary to fully disclose and document the medical necessity of and extent of goods or services provided to clients receiving assistance under the provisions of the Connecticut Medical Assistance Program;

d. any other original documentation in each client's record which will enable the DSS or its agent to verify that each charge is due and proper;

e. financial records maintained in accordance with generally accepted accounting principles, unless another form is specified by DSS; and

f. all other records as may be found necessary by DSS or its agent in determining Provider's compliance with any federal or state law, rule, regulation, or policy.

23. That any payment, or part thereof, for Connecticut Medical Assistance Program goods or services which represents an excess over the appropriate payment or a violation due to abuse or fraud, shall be immediately paid to DSS. Any sum not so repaid may be recovered by DSS in accordance with the provisions below or in an action by DSS brought against the Provider.

Audits and Recoupment

24. That in addition to the above provisions regarding billing and payment, Provider agrees that:

a. amounts paid to Provider by DSS shall be subject to review and adjustment upon audit or due to other acquired information or as may otherwise be required by law;

b. whenever the commissioner of social services renders a decision, whether based upon a field audit or otherwise, which decision results in the Provider being indebted to the DSS for past overpayments, DSS may recoup said overpayments as soon as possible from the DSS's current and future payments to the Provider. DSS's authority to recoup overpayments includes recoupment of overpayments made for prior years or pursuant to prior provider agreements. A recomputation based upon such adjustments shall be made retroactive to the applicable period;

c. in a recoupment situation, DSS determine a recoupment schedule of amounts to be recouped from Provider's payments after consideration of the following factors:

(1) the amount of the indebtedness;

(2) the objective of completion of total recoupment of past overpayments as soon as possible;

(3) the cash flow of the Provider; and

(4) any other factors brought to the attention of DSS by the Provider relative to Provider's ability to function during and after recoupment.

d. whenever Provider has received past overpayments, the DSS may recoup the amount of such overpayments from the current and future payments to Provider regardless of any intervening change in ownership;

e. if Provider owes money to DSS, including money owed for prior years or pursuant to prior provider agreements, DSS or its fiscal agent may offset against such indebtedness any liability to another provider which is owned or controlled by the same person or persons who owned or controlled the first provider at the time the indebtedness to DSS was incurred. In the case of the same person or persons owning or controlling two or more providers but separately incorporating them, whether the person or persons own or control such corporations shall be an issue of fact. Where common ownership or control is found, this subsection shall apply notwithstanding the form of business organizations utilized by such persons e.g. separate corporations, limited partnerships, etc.; and

f. DSS's decision to exercise, or decision not to exercise its right of recoupment shall be in addition to, and not in lieu of, any other means or right of recovery the DSS may have.

Fraud and Abuse; Penalties

25. To cease any conduct that DSS or its representative deems to be abusive of the Connecticut Medical Assistance Program; and to promptly correct any deficiencies in Provider's operations upon request by DSS or its fiscal agent.

26. To comply with Section 1909 of the Act which provides federal penalties for violations connected with the Medical Assistance Program.

    Provider acknowledges and understands that the prohibitions set forth in the Act include but are not limited to:

    a. false statements, misrepresentation, concealment, failure to disclose and conversion of benefits;

    b. any giving or seeking of kickbacks, rebates, or similar remuneration;

    c. charging or receiving reimbursement in excess of that provided by the State; and

    d. false statements or misrepresentation in order to qualify as a provider.

27. That termination from participation in the Connecticut Medical Assistance Program will result if the Provider is convicted of a criminal offense as set forth in state or federal law, or by the Medicare Program or Connecticut Medical Assistance Program, and suspension may result if the Provider is so sanctioned by DSS pursuant to statute and regulation for having engaged in fraudulent or abusive program practices or conduct.

Nondiscrimination

28. To abstain from discrimination or permitting discrimination against any person or group of persons on the basis of race, color, religious creed, age, marital status, national origin, sex, sexual orientation, mental retardation or physical disability, including but not limited to blindness or payor source, in accordance with the laws of the United States or the State of Connecticut.

    Provider further agrees to comply with:

    a. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. § 2000d, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the regulations, 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 Applicant receives Federal Financial Assistance from the Department of Health and Human Services;

    b. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 et seq., (hereafter the "Rehabilitation Act") as amended, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of the Rehabilitation Act and the regulations, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services;.

    c. Title IX of the Educational Amendments of 1972, 20 U.S.C. § 1681, et seq., as amended, and all requirements imposed by or pursuant to the regulations of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the regulations, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any educational program or activity for which the Applicant receives Federal Financial Assistance from the Department of Health and Human Services; and

    d. the civil rights requirements set forth in 45 C.F.R. Parts 80, 84, and 90.

Termination

29. That this Agreement may be voluntarily terminated as follows:

    a. by DSS or its fiscal agent upon 30 days written notice; or

    b. by DSS or its fiscal agent upon notice for Provider's breach of any provision of this Agreement as determined by DSS; or

    c. by Provider, upon 30 days written notice, subject to any requirements set forth in federal and state law. Compliance with any such requirements is a condition precedent to termination.

Disclosure Requirements

30. To comply with all requirements, set forth in 42 C.F.R. §§ 455.100 through 455.106, inclusive, as they may be amended from time to time. These requirements include, but are not limited to, the full disclosure of the following information upon request:

    a. the name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more;

    b. whether any such person is related to another as spouse parent, child, or sibling;

    c. the name of any other disclosing entity in which such a person also has an ownership or control interest;

    d. the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000.00 during the 12-month period ending on the date of the request;

    e. any significant business transactions between Provider and any subcontractor during the 5-year period ending on the date of the request; and

    f. any person having an ownership or control interest in Provider, or as an agent or managing employee of Provider, who has been convicted of a civil or criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other Connecticut Medical Assistance Programs since the inception of these programs.

g. any other information requested in the Provider Enrollment application.

Provider further agrees to furnish, without a specific request by DSS, the information referenced above at the time of Provider's certification survey and also, without a specific request, disclose the identity of any person with ownership or control interest who has been convicted of a civil or criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other Connecticut Medical Assistance Programs prior to entering into or renewing this contract in accordance with 42 C.F.R. Part 455.

31. That the following penalties set forth in 42 C.F.R. Part 455 are applicable to Providers failing to make that section's required disclosures:

a. that DSS is required to either not approve a Provider Agreement or to terminate an existing Agreement if the Provider fails to make the disclosures required by that section; and

b. that federal financial participation is not available to Providers that fail to disclose the information required by that section; and

c. that DSS may refuse to enter into or renew an Agreement with a Provider if any person with ownership or management control, or an agent or a managing employee, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX Services Program; and

d. that DSS may refuse to enter into or may terminate a Provider Agreement if it determines that a Provider did not fully and accurately make the required disclosures concerning such convictions.

Miscellaneous

32. That this Agreement, upon execution, supersedes and replaces any Provider Agreement previously executed by the Provider. This Agreement does not impair Provider's obligation to repay to DSS any money owed to DSS pursuant to prior Provider agreements or the ability of DSS to recoup such amounts from payments made pursuant to this Agreement.

33. In the event that the Provider has been furnished with point of sale devices by DSS, such devices is to be returned to the DSS or its agent upon demand of DSS. If a provider refuses to return such devices the DSS may deduct the cost of the DSS-owned devices from any funds due the Provider, including future payments.

34. The Provider acknowledges that there is no right to renew this Agreement.

35. The Provider will examine publicly available data, including but not limited to the Health Care Financing Administration (hereafter "HCFA"), or any successor agency, Medicare/Medicaid Sanction Report and the HCFA website, to determine whether any potential or current employees have been suspended or excluded or terminated from the programs and shall comply with, and give effect to, any such suspension, exclusion, or termination in accordance with the requirements of state and federal law.

The effective date of this Agreement is _____. This Agreement shall thereafter be in effect for a period of _____, ending _____ unless terminated by either party prior to the stated ending date.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, BOTH INDIVIDUALLY AND ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH HEREIN.

THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 U.S.C. § 1320a-7b MAY BE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF UP TO FIVE YEARS OR BOTH.

_____

Provider Entity Name (doing business as);

_____

Name of Authorized Representative (typed) (Must be an Authorized Officer, Owner, or Partner):

_____

Signature: Date:

_____

Title: Deputy Commissioner for Administration

_____

Date of Signature:

EXHIBIT 2

DSS Provider Agreement Guidelines - (W-1217PG)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONNECTICUT HOME CARE PROGRAM FOR ELDERS

PROVIDER AGREEMENT GUIDELINES

The Provider _____ agrees to:

1. Follow the laws, rules, regulations, policies, and amendments which govern the CHCPE and the Connecticut Medical Assistance Program as specified by the Federal Government and State of Connecticut, including, but not limited to, the standards for participation and payments.

2. Provide services to waiver participants to the extent that such services are authorized in the individualized plan of care and are consistent with the provider's qualifications and the professional standards governing such services.

3. Render service or services as specified on the Standard Application Form and/or Addenda, and to disclose the methods, including subcontracting, to be used in carrying out the obligations of said agreement. Provider shall be responsible for the performance of any subcontractor and shall furnish the State Agency upon request with copies of all subcontracts in which monies covered by this agreement are to be used. Said subcontracts shall include a provision that the subcontractor will comply with all pertinent requirements of the agreement.

4. Fully disclose upon request in accordance with Chapter 42, Part 455, Subpart B of the Code of Federal Regulations, including but not limited to: the name and address of each person with an ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5 percent or more; the ownership of any subcontractor with whom the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; any significant business transactions between the Provider and any subcontractor, during the 5-year period ending on the date of request; and any person having ownership or control interest in the Provider, or as an agent of managing employee of the Provider and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or other Connecticut Medical Assistance programs since the inception of these programs.

5. Furnish all information requested by the Department specified on the provider agreement as well as the application form and further, to notify the Department, in writing, of all material and/or substantial changes in information contained on the application given to the Department by the Provider.

6. Accept the following terms and conditions:

   a. That the reimbursement which is established by the Department is the complete payment in full for service(s), goods, or product(s) delivered to eligible clients, and

   b. That the reimbursement amount from the Department, except for authorized co-payments, third party liability and/or payment made from eligible client's applied income, represents the sole and complete payment in full.

7. Exhaust client's medical insurance resources prior to submitting claims for reimbursement; to report third party payment, acknowledging the Connecticut Medical Assistance Program as payer of last resort; and to assist in identifying other possible sources of third party liability, which may have a legal obligation to pay all or part of the medical cost of injury or disability.

8. Maintain fiscal and medical records which fully disclose services and goods rendered and/or delivered to eligible clients. These records and information will be made available to authorized representatives in accordance with 42 C.F.R. section 431.107 upon request, including but not limited to, information regarding payments claimed by the Provider for furnishing goods or services.

9. Acknowledge that suspension or termination from participation in the Connecticut Medical Assistance Program will result if the provider is convicted of a criminal offense under Medicare or the Connecticut Medical Assistance Program and may result if the Provider is found by the Department to have engaged in abusive program services.

10. Abstain from discriminating or permitting discrimination against any person or group of persons on the basis of race, color, religious creed, age, marital status, national origin, sex, mental retardation or physical disability, including but not limited to blindness, unless it can be demonstrated that the disability may result in the performance of the work involved in a manner prohibited by the laws of the United States or the State of Connecticut.

11. Agree to comply with:

    a. Title VI of the Civil Rights Act of 1964 (Pub.L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI 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 benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

    b. Section 504 of the Rehabilitation Act of 1973 (Pub.L. 93-112), as amended and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

    c. Title IX of the Educational Amendments of 1972 (Pub.L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

12. A provider agreement is not a valid agreement for purposes of this part even though certified by the State survey agency, if the facility fails to meet the civil rights requirements set forth in 45 C.F.R. parts 80, 84, and 90.

13. Comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMOs specified in part 489, subpart I, and 417.436(d) of 42 C.F.R.

14. Understand that this provider agreement may be terminated by mutual consent or by either the Department or the Provider upon giving a thirty (30) day written notification or as otherwise required by law and regulation.

_____ _____

Provider Agreement Signature *Date*

NOTE: This original copy must be enclosed with the W-1217 "Performing Provider Registration Form".

EXHIBIT 3

CHCPE – Your Rights and Responsibilities (W- 990)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

W-990
(New 3/99)

The Connecticut Home Care Program for Elders

Your Rights & Responsibilities

Client Rights

As a home care client, you have a right to expect the following from home care providers:

1 YOU (and others whom you permit to take part in your care) SHOULD EXPECT TO BE FULLY INFORMED ABOUT YOUR SERVICES AND YOUR CHOICES BY YOUR HOME CARE AGENCY.

What this means:
This means that you should be informed of …

A all **SERVICES** available from the home care agency;

B **CHARGES** for services and whether they are covered by Medicare, Medicaid, health insurance, or other sources;

C **BILLING** procedures, and on request, you should receive an itemized copy of each bill submitted to any payor;

D the name of the home care worker and how to contact the worker's **SUPERVISOR;**

E where and how to obtain information on the agency's licensing, certification, or accreditation standing.

2 YOU SHOULD EXPECT TO PARTICIPATE IN AND HAVE CONTROL OVER YOUR HOME CARE SERVICES.

What this means:
This means that you should expect to…

A have a **CHOICE** in deciding who provides care or services;

B take an active part in creating and changing a **SERVICES PLAN**, which shall be provided to you in writing in plain language; the plan must meet your approval and include the goals of care and a description of the specific tasks to be performed by whom and when. Anyone whom you permit to participate in your care should be given an opportunity to provide input into the plan of care;

C have the opportunity to **REFUSE** all or part of any treatment, care, or service, and to be informed of the likely consequences of such refusal;

D receive **INSTRUCTION** so that you can care for yourself to the extent feasible and other participants in your care can understand your condition and effectively help;

E be encouraged to participate fully in **COMMUNITY LIFE** and exercise your civil rights, and to be assisted in doing so when assistance is needed;

F be asked to **EVALUATE** on a regular basis whether you received the care you expected to get;

G receive reasonable advance notice if services are to be **REDUCED** or **TERMINATED** by the provider. You should also receive help to promote a smooth transition in services appropriate for your needs.

Deaf and hearing impaired individuals may use a TDD/TTY by calling 1-800-842-4524. Questions, concerns complaints or requests for information in alternative formats must be directed to the Public and Government Relations Office 1-800-842-1508.

3 YOU SHOULD EXPECT THAT YOUR RIGHTS AND PRIVILEGES AS AN ADULT IN THE COMMUNITY AND IN YOUR HOME WILL BE RESPECTED BY HOME CARE PROVIDERS.

What this means:
*This means that the provider is a **guest** in your home, and you should expect…*

A to be treated with **COURTESY, RESPECT,** and full recognition of your right to control your own household and lifestyle;

B to be assured respect and security for your home and **PROPERTY;**

C freedom from mental and physical **ABUSE, NEGLECT,** and exploitation;

D freedom from chemical and physical **RESTRAINTS**, except as you authorize;

E **PRIVACY** in your treatment, in caring for your personal needs, in communications, and in all daily activities;

F **CONFIDENTIALITY** of personal, financial, and medical information and records;

G freedom from **DISCRIMINATION** in the provision or quality of services based on race, religion, gender, age, or creed, or source of payment.

4 YOU SHOULD EXPECT HIGH QUALITY IN THE CARE OR SERVICES YOU RECEIVE.

What this means:
This means that you should…

A receive a **PROMPT RESPONSE** from the agency to your request for services, and if any request is denied, be given the reason for denial and information about what you can do;

B receive the services you agreed upon, **EFFICIENTLY, EFFECTIVELY,** and **ON TIME;**

C receive **COORDINATED** services when there are multiple providers or services and **CONTINUITY** of services when any changes are made;

D be served by individuals who have the **TRAINING** and **COMPETENCE** you expect.

5 YOU SHOULD EXPECT TO HAVE ANY PROBLEMS OR QUESTIONS QUICKLY ADDRESSED AND RESOLVED.

What this means:
This means that you should expect to…

A be encouraged to voice complaints and recommend changes, and be assisted in doing so when assistance is needed, **WITHOUT FEAR** of reprisal;

B receive clear instructions on **HOW TO COMPLAIN** to your provider and to public authorities if your care or services are not satisfactory;

C receive a thorough and reasonable **RESPONSE** to all complaints or suggestions.

Client Responsibilities

YOU *(and other participants in your care) should expect to:*

1 provide accurate and complete information relevant to your care and service plan, and any changes in this information;

2 take an active part in planning and managing your own care to the extent you are able;

3 report problems to the home care agency and, if not satisfied with the response, then to public authorities;

4 treat care and service providers with respect and dignity.

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EXHIBIT 4

Intra Referral DSS ACU Access Agency/Provider/DMR/DMH (W- 1547)

W-1547
(Rev. 10/98)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

INTRA-REFERRAL
DSS ACU-ACCESS AGENCY/PROVIDER/DMR/DMH

DATE: _____

TO: _____

_____

FROM: _____

_____

Client's Name: _____

Address: _____

_____

_____

Case Number: _____

Date of Birth: _____

Home Phone No.: _____

Message Number: _____

Contact Person's Name *(If Message Number):* _____

INFORMATION/REQUEST:

Does the client need nursing facility care? ☐ Yes ☐ No

FOR DMR/DMH USE ONLY

Please check appropriate box:

☐ Eligible to enter or remain in nursing facility

☐ Requires active treatment for mental retardation

☐ Requires active treatment for mental illness

☐ Further information needed/requested

Comments:

EXHIBIT 5

Uniform Client Care Plan (W- 1510)

W-1510
(Rev. 3/00)

STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES
CONNECTICUT HOME CARE PROGRAM FOR ELDERS

UNIFORM CLIENT CARE PLAN

Client Name: _____ EMS Client ID #: 0

Nurse/Care Manager's Name (Print): _____ Telephone #: _____

Agency/Location: _____ Client/ Representative Signature: _____

Nurse/Care Manager Signature: _____ Date: _____

Service Start Date	Provider (Specify)		Service	Frequency Specify AM or PM and Days of Week		Unit Rate	Monthly Cost	Funding Source	Date Discontinued
	Informal	Agency		Hrs/Day	Days/Week				

Printed on Recycled or Recovered Paper

EXHIBIT 6

Client Applied Income Contribution Agreement (W- 1514)

W-1514
(Rev. 5/05)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONNECTICUT HOME CARE PROGRAM FOR ELDERS
CLIENT APPLIED INCOME CONTRIBUTION AGREEMENT

I, ______________________________________ , understand that I qualify to receive home care services
Client Name

and that I am required to help pay for the cost of those services. I will make a monthly payment of

$________________ effective date ________________ to:________________________________

____

____

I understand that the amount of my monthly applied income payment could change when my case is reviewed. If there is a change I understand that I will be notified.

I understand that if I have an emergency that makes me unable to pay my applied income, I must contact ___________________________________ at ___________________________as soon as possible.

I understand that I will not be allowed to receive services if I do not make my payment. I will be contacted by my care manager, provider and/or facility before services stop.

Before I am discontinued from the program, I will be given written notice. I will also be given an opportunity for a hearing.

My care manager, provider and/or facility has discussed the applied income with me. I understand that if I have questions I can call the Alternate Care toll-free number 1-800-445-5394.

________________________ ____
Date Client

________________________ ____
Date Family/Care Giver

________________________ ____
Date Care Manager/Provider/Facility

* *

If a family member or another individual has assumed liability for paying this client's mandatory contribution, that must be indicated by separate signature.

I,____, hereby agree to pay the client contribution
Name or Liable Party/Organization

for ____.
Name of Client

____ ____________________________
Signature (Liable Party/Organization) Telephone (Liable Party/Organization)

____ ____________________________
Address Date

The Department has a TDD/TTY hotline number for persons who are deaf or hearing impaired. If you have a TDD/TTY, you can call 1-800-842-4524. The Department also has auxiliary aids for the blind or visually impaired. Please call your local Department of Social Services for more information.

W-1514
(Rev. 5/05)

ESTADO DE CONNECTICUT - DEPARTAMENTO DE SERVICIOS SOCIALES

PROGRAMA DE CUIDADO EN EL HOGAR
PARA LOS ENVEJECIENTES DE CONNECTICUT

ACUERDO DE PAGOS CONTRIBUTIVOS DEL CLIENTE

Yo, ____, entiendo que estoy calificado para recibir servicios de
Nombre del Cliente

cuidado en casa, pero que debo ayudar a pagar el costo de tales servicios. Haré un pago mensual de
$_________________ efectivo fecha _________________ to: ___________________________________

____

____

Entiendo que la cantidad que pago mensualmente puede cambiar cuando mi caso sea revisado. Si hay un cambio, yo entiendo que seré notificado.

Entiendo que debo comunicarme con ____________________________ en _________________________ tan pronto sea posible, en caso que tenga una emergencia y no pueda pagar mi parte.

Entiendo que no podré recibir servicios si no hago mi pago. El administrador de mi caso, proveedor o facilidad se comunicará conmigo antes de parar los servicios.

Recibiré aviso por escrito, antes de ser descontinuado del programa. También me darán la oportunidad de una audiencia.

El administrador de mi caso, proveedor o facilidad ha discutido mis pagos conmigo. Entiendo que puedo llamar a la Unidad de Cuido Alterno al número gratis 1-800-445-5394, en caso que tenga preguntas.

_________________________ ____
Fecha Cliente

_________________________ ____
Fecha Familia/Cuidador

_________________________ ____
Fecha Administrador de Caso, Proveedor o Facilidad

* *

Si un miembro de la familia, u otra persona asume la responsabilidad de pagar la contribución obligatoria del cliente, tiene que indicarlo por firma separada.

Yo, ____, acuerdo pagar la contribución del cliente
Nombre de la Persona u Organización Responsable

para ____
Nombre del Cliente

____ __________________________
Firma de la Persona u Organización Responsable Teléfono

____ __________________________
Dirección Fecha

El Departamento tiene un número "TDD/TTY Hot Line" para personas sordas o con oído deteriorado. Si Ud. tiene un equipo TDD/TTY, puede llamar al 1-800-842-4524. El Departamento también tiene aparatos auxiliares para ciegos o personas de vista perjudicada. Para más información, favor de llamar a su Departamento de Servicios Sociales local.

EXHIBIT 7

CHCPE Care Plan Cost Worksheet, Part II (W- 1510)

W-1510 (Part II)
(Rev. 6/03)

STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES

CONNECTICUT HOME CARE PROGRAM FOR ELDERS

CARE PLAN COST WORKSHEET

Date_____

Client Name_____

Check Appropriate
Total Care Plan Limit:

☐ Category 1 ($1,033.90)
☐ Category 2A ($2,067.81)
☐ Category 2B ($3,308.49)*
☐ Category 3 ($4,135.62)

COMPLETE APPROPRIATE SECTIONS BELOW

1. State Cost of Total Plan of Care

a. Non-Annualized:

$_____ Less $_____ = $_____
Cost/Month Client Fee State Cost/Mo.

b. Annualized:
Projected Reduction/Increases:

_____

_____

_____

$_____ ÷ _____ = $_____ Less $_____ = $_____
Total Cost Length of Stay (Mos.) Average Cost/Month Client Fee State Cost/Month

Is the State cost of the total plan of care [Community Services plus medical (home health services)] less than or equal to the monthly limit checked above? ☐ Yes ☐ No

2. State Cost of Social Services *(only for Categories 2B and 3)*

a. Non-Annualized:

$_____ Less $_____ = $_____
Cost/Month Client Fee State Cost/Mo.

b. Annualized:
Projected Reductions/Increases:

_____

_____

_____

$_____ ÷ _____ = $_____ Less $_____ = $_____
Total Cost Length of Stay (Mos.) Average Cost/Month Client Fee State Cost/Month

Is the State cost of community based (social or waiver) services less than or equal to $3,010.00 per month? ☐ Yes ☐ No

* Category 2B only allowed for active State-Funded clients on program prior to 1992.

EXHIBIT 8

CHCPE Notification of Delay of Assessment (W- 950)

W-950
(Rev. 7/06)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONNECTICUT HOME CARE PROGRAM FOR ELDERS

NOTIFICATION OF DELAY OF ASSESSMENT/SERVICES

Client Name:_____

Access Agency:_____

☐ The assessment for the above client has been delayed due to the following reasons:

- ☐ Client's health status unstable
- ☐ Client's supporter not available
- ☐ Client not available for assessment

Other:_____

_____

☐ The implementation of the plan of care for the above client is delayed due to the following reasons:

- ☐ Client's health status unstable
- ☐ Client's supporter status unstable
- ☐ Client's financial information under review by DSS
- ☐ Client's service providers unable to confirm availability of services
- ☐ Client or supporter uncertain about accepting the CHCP
- ☐ Client's date of discharge from hospital/nursing facility in question
- ☐ Client's housing problem requires resolution

Other:_____

_____

---

*The anticipated date the above situation(s) will be resolved is:*_____

Signature:_____ Date:_____

EXHIBIT 10

CHCPE Applied Income Worksheet (W- 1523)

W-1523
(Rev. 4/05)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONNECTICUT HOME CARE PROGRAM FOR ELDERS

APPLIED INCOME WORKSHEET

Case Name:_____

Client ID:_____ Telephone Number:_____

FOR ACCESS AGENCY/PROVIDER USE ONLY

Gross Monthly Income: $_____

Minus Personal Needs Allowance: $ 1,596.00

Minus Medicare Part B Premium: $ 78.20

Minus *Monthly* Medical Insurance Costs: $_____

_____
Insurance Company Name

Applied Income: ***Approximate amount –***
Subject to adjustment by the information below. $_____

If there is Applied Income indicated above:

Is the client responsible for any other medical expenses? ☐ Yes ☐ No

If Yes, name of medical service provider:_____

Address of medical service provider: _____

_____

_____

Amount of expense: $_____

Type of expense: _____

Date/frequency of expense: _____

Is the client responsible for the support of a related household member? ☐ Yes ☐ No

If Yes, name of household member: _____
If more than one person, please provide the information described below for each person. (Use the back of this form)

Relationship: _____

Gross monthly income of household member: $_____

Monthly shelter costs: $_____
(rent, mortgage, property taxes, insurance, condo fees etc.)

Access Agency/
Provider Worker_____ Date_____

FOR ACU USE ONLY

Community Spousal Allowance Computation

1.		$_____	Rent or Mortgage (Spouse's share)
2.	+	$_____	Property taxes (Spouse's share)
3.	+	$_____	Property insurance (Spouse's share)
4.	+	$_____	Condominium fees (Spouse's share)
5.	+	$ 390.00	Standard allowance for utilities
6.	=	$_____	Total shelter costs
7.	-	$ 468.38	Deduct Standard Shelter Allowance
8.	=	$_____	Excess shelter costs
9.	+	$ 1,561.25	Base minimum Monthly Needs Allowance
10.	=	$_____	Monthly Needs Allowance (capped by Federal law at $2,377.50)
11.	-	$_____	Spouse's Gross Monthly Income
12.	=	**$**_____	**Community Spousal Allowance**

Final Applied Income Calculation

	Approximate Applied Income (From other side)	$_____
-	**Other *Monthly* Medical Expenses** (From other side)	$_____
-	**Community Spousal Allowance** (From above)	$_____

=	**Final Applied Income**	**$**_____

ACU Worker _____ Date_____

Questions? Call the Alternate Care Unit at (860) 424-5185.

Notes:

EXHIBIT 11

Checklist to Authorize Care Management (W- 143)

W-143
(Rev. 8/03)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CHECKLIST TO AUTHORIZE CARE MANAGEMENT

Conducted by: ☐ NC CCCI ☐ NW CCCI ☐ E CCCI ☐ SCCAA ☐ SWCAA

Client Name:_____ EMS I.D. #_____

Name of Health Professional
Completing *(please print)*_____ Date:_____

PURPOSE:
☐ Initiate Self Directed Care
☐ Continue Self Directed Care
☐ Reinstate Care Management
☐ Initiate Care Management
☐ Continue Care Management
☐ Initiate Assisted Living Services

I. Do any of the following conditions apply which preclude Self Directed Care?

☐ A. Required to pay an applied income contribution, receiving PCA services, receiving Assisted Living services

IF ANY OF FOLLOWING CONDITIONS APPLY EXPLAIN BELOW

** ☐ B. Does not have a stable and appropriate living situation

** ☐ C. Is not obtaining appropriate health and medical care

** ☐ D. Activities related to obtaining social and/or economic resources/benefits are in process

☐ E. Exhibits Behavior Problems (Circle: Abusive/Assaultive; Wandering; Unsafe/Unhealthy Hygiene or Habits; Threats to Health/Safety)

☐ F. Has MSQ Score of 4+ errors and no informal caregivers available, willing and able to manage care

☐ G. Continuation of care by informal caregivers depends on active intervention by a care manager *(ATTACH DOCUMENTATION)*

☐ H. Functional and/or cognitive status have changed in a way that require care plan changes in the past 2 months or are expected to occur in the next 2 months *(ATTACH DOCUMENTATION)*

Explanation:_____

II. If none of the conditions listed above apply to the client, are there other factors that should preclude Self Directed Care? ☐ Yes ☐ No

If Yes, explain:_____

If No, when should Self Directed Care begin? Date:_____

III. If conditions preclude Self Directed Care, is there a projected date when it should be reconsidered?

☐ Yes Date:_____ ☐ No If No, explain:_____

** **NOTE: THESE CONDITIONS SHOULD ALWAYS BE CONSIDERED SHORT TERM.**

FOR DSS USE ONLY

Reviewed By:_____ Date:_____

☐ Authorized ☐ Denied

EXHIBIT 12

Data Specifications for Access Agency File Transfer

State of Connecticut

Department of Social Services

Data Specification for Access Agency File Transfer

Written by:
Ken Hook,
Evelyn Hernandez

Date: October 16, 2006

OVERVIEW

This document provides a description for transferring Access Agency (AA) data to The State of Connecticut, Department of Social Services (DSS), for use by the Alternate Care Unit (ACU). This process provides DSS with analytical data to report to the State of Connecticut Legislature pertaining to the expenditures incurred within the ACU program and also client demographic and social information, health status information, and indicators of physical and cognitive function. The continued successful transfer of AA data to DSS will allow for the evaluation of future direction of the program. It is required that all AA data be transferred in accordance with HIPAA guidelines, in the format and within the time frame specified in this document, and as stated in the contract between AA and the State of Connecticut, DSS.

All AA data files that are transferred to DSS will be validated by the CHIPAA System and is required to be in ASCII format. Each field should be contained within double quotes and each set of double quotes should be separated with a comma, ie. “xxxx”,”9999”. All records that are invalid will be rejected by the CHIPAA system. The appropriate AA will be notified by DSS, ACU of the rejected records and a resubmission of the invalid records will be required within the time frame specified, as stated in the contract between AA and the State of Connecticut, DSS. The CHIPAA System will generate a detailed error report describing the problem for each invalid record.

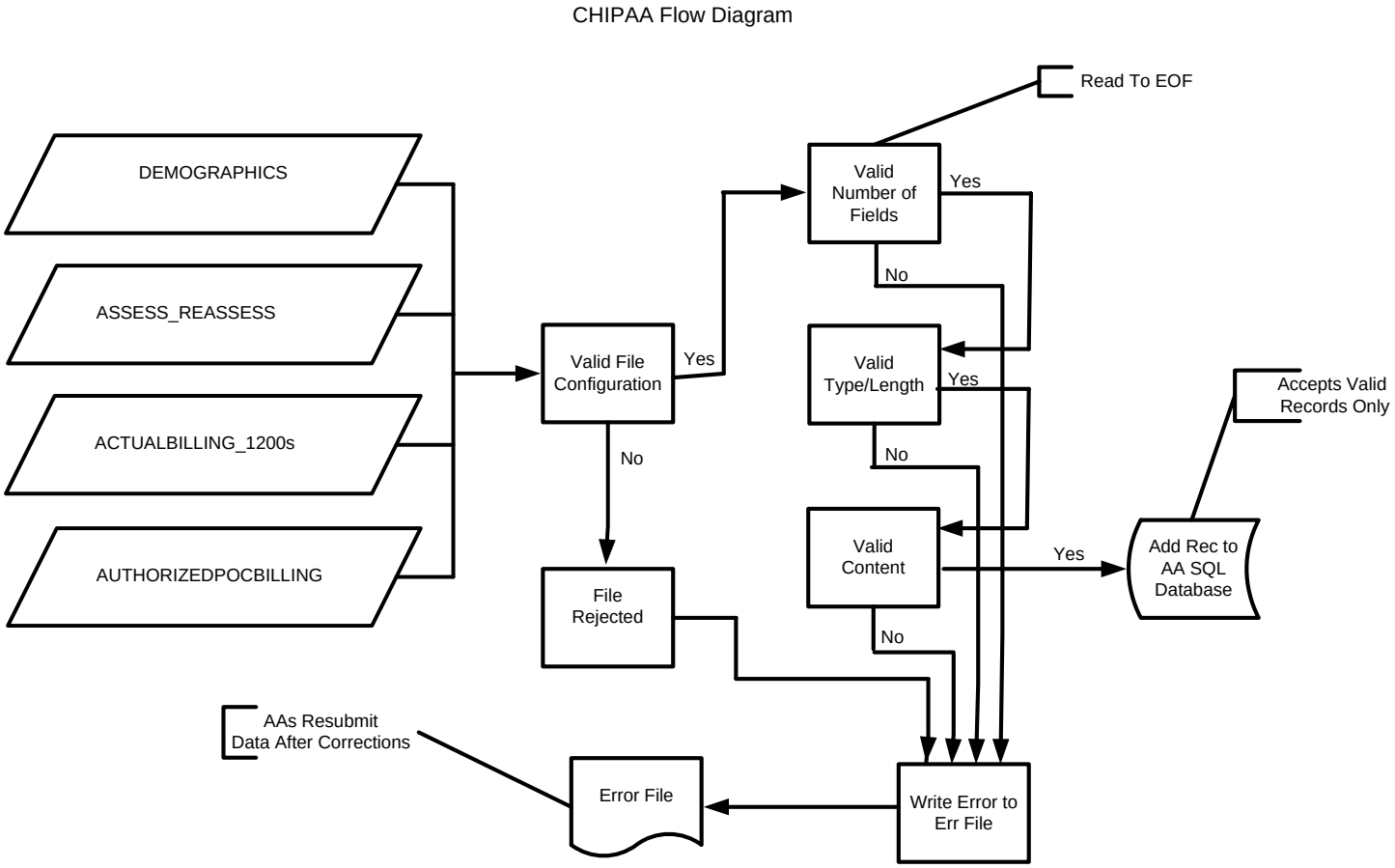
If any problems exist with the structure of an AA data file, the entire file will be rejected and must be resubmitted within the time frame specified in the contract between AA and DSS.

There are four AA data files that are to be transferred:

1. DEMOGRAPHICS.TXT
2. ASSESS_REASSESS.TXT
3. ACTUALBILLING_1200s.TXT
4. AUTHORIZEDPOCBILLING.TXT

The AA data files are to be transferred to DSS at six month intervals. The AA data will be for the previous 6 months and will be due approximately 45 days after the end of each year (12/31) and middle of each year (06/30).

The CHIPAA System process is illustrated in the following flow diagram:



The file layout (structure) for the four AA data files are as follows:

1) DEMOGRAPHICS.TXT FILE

One record required for every client receiving services (Active Client) from the specific AA. The purpose of these records are to update DSS, ACU's database (CHIPAA) with any changes to the client's demographic information.

Data Transfer Specification
Plan of Care Format 1 (Demographic)

Nbr.	Contents (description)	Type	Len	Allowable Values / Format
1	Record Identification Code	C	1	Leave Blank
2	Client First Name	C	10	
3	Client Last Name	C	16	
4	Client Date of Birth	C	8	CCYYMMDD
5	Client Social Security Number	C	9	Format = XXXXXXXXX / Required Field
6	E.M.S. Identification Number	C	9	Format = XXXXXXXXX / Required Field
7	Region	C	2	01, 02, 03, 04, 05
8	Agency	C	5	CCCI, SWAAA, AASCC
9	Most Recent Assessment Date	C	8	CCYYMMDD
10	Client Street Address	C	30	
11	Client City	C	20	
12	Client State	C	2	
13	Client Zip	C	10	XXXXX-XXXX
14	Client Phone	C	10	XXXXXXXXXX
15	Client Gender	C	2	01, 02
16	Client Marital Status	C	2	01 thru 05, 09
17	Client Termination Date	C	8	CCYYMMDD
18	Assessment/Reassessment Reference Number	C	14	This would be your internal reference number (not required)
19	Race	C	2	01-White, 02-Black, 03-Amer Indian, 04-Hispanic, 05 Asian PI, 06-Other, 99-Information Not Obtained

2) ASSESS_REASSESS.TXT FILE

One record will be required for each assessment or reassessment that is performed on the client during the specific reporting time period. DSS, ACU will maintain a history of the assessments and reassessments done by the AAs. This format generally follows the assessment instrument in use in the field. If there are any questions refer to this form for further clarification. A copy of this form is included in this document (EXHIBIT XXX)

Data Transfer Specification
Assessment / Reassessment

Nbr.	Contents (description)	Type	Len	Allowable Values / Format
1	Client First Name	C	10	
2	Client Last Name	C	16	
3	Client Date of Birth	C	8	CCYYMMDD
4	Client Social Security Number	C	9	Format = XXXXXXXXX / Required Field
5	Client EMS Identification Number	C	9	Format = XXXXXXXXX
6	Region Code	C	2	01,02,03,04,05,99
7	Agency (CCCI SWAAA, AASCC)	C	5	CCCI, SWAAA, AASCC
8	Date of Assessment / Reassessment	C	8	CCYYMMDD
9	Referral Source	C	2	01 THRU 17, 99
10	Referral Date	C	8	CCYYMMDD
11	Race	C	2	01,02,03,04,05,06,99
12	Perception of Health	C	1	1,2,3,9
13	C.V.A.	C	1	M-Major, S-Secondary, (blank)
14	Myocardial Infarction	C	1	M-Major, S-Secondary, (blank)
15	Congestive Heart Failure	C	1	M-Major, S-Secondary, (blank)
16	Other Heart Disease	C	1	M-Major, S-Secondary, (blank)
17	Hypertension	C	1	M-Major, S-Secondary, (blank)
18	Hip Fracture	C	1	M-Major, S-Secondary, (blank)
19	Other Fracture / Injury	C	1	M-Major, S-Secondary, (blank)
20	Rheumatoid / Osteoarthritis	C	1	M-Major, S-Secondary, (blank)
21	Osteoporosis	C	1	M-Major, S-Secondary, (blank)
22	Neuromuscular Disease	C	1	M-Major, S-Secondary, (blank)
23	Cancer	C	1	M-Major, S-Secondary, (blank)
24	Diabetes	C	1	M-Major, S-Secondary, (blank)
25	Blood Disorder or Disease	C	1	M-Major, S-Secondary, (blank)

26	Emphysema / COCD	C	1	M-Major, S-Secondary, (blank)
27	Other Chronic Lung Disease	C	1	M-Major, S-Secondary, (blank)
28	Digestive Disorder	C	1	M-Major, S-Secondary, (blank)
29	Urinary Track Disorders	C	1	M-Major, S-Secondary, (blank)
30	Decubitus / Stasis Ulcer	C	1	M-Major, S-Secondary, (blank)
31	Amputation	C	1	M-Major, S-Secondary, (blank)
32	Visual Impairment	C	1	M-Major, S-Secondary, (blank)
33	Hearing Impairment	C	1	M-Major, S-Secondary, (blank)
34	Alzheimers / Other Dementia	C	1	M-Major, S-Secondary, (blank)
35	Mental Illness	C	1	M-Major, S-Secondary, (blank)
36	Developmental Disability	C	1	M-Major, S-Secondary, (blank)
37	Other	C	1	M-Major, S-Secondary, (blank)
38	Analgesics / Narcotics	C	2	Nbr. of Medications, 99 = Unknown
39	Antihypertensive	C	2	Nbr. of Medications, 99=Unknown
40	Hypoglycemics / Insulin	C	2	Nbr. of Medications, 99=Unknown
41	Antianxiety / Hypnotic	C	2	Nbr. of Medications, 99=Unknown
42	Antidepressants	C	2	Nbr. of Medications, 99=Unknown
43	Antipsychotic	C	2	Nbr. of Medications, 99=Unknown
44	Anti-Parkinsonian	C	2	Nbr. of Medication, 99=Unknown
45	Other Medications	C	2	Nbr. of Medications, 99=Unknown
46	Primary Language	C	1	1 thru 9
47	Expressive Communication	C	1	1 thru 5, 9
48	Receptive Communication	C	1	1 thru 5, 9
49	How is your memory	C	1	1 thru 3, 9
50	MSQ Score (Error Count)	C	2	01 thru 10, 99
51	Abusive / Assaultive	C	1	0, 1, 2, 3, 9
52	Wandering	C	1	0, 1, 2, 3, 9
53	Unsafe / Unhealthy	C	1	0, 1, 2, 3, 9
54	Threats to Health / Safety	C	1	0, 1, 2, 3, 9
55	Other	C	1	0, 1, 2, 3, 9
56	Requires Supervision	C	1	0, 1, 2, 3, 9
57	Transfer	C	1	0, 1, 5
58	Toileting	C	1	0, 1, 5
59	Bathing	C	1	0, 1, 5
60	Dressing	C	1	0, 1, 5

61	Eating / Feeding	C	1	0, 1, 5
62	Stair Climbing	C	1	0, 1, 5
63	Mobility	C	1	0, 1, 5
64	Walking	C	1	0, 1, 5
65	Wheeling	C	1	0, 1, 5
66	Bowel	C	1	0, 1, 5
67	Bladder	C	1	0, 1, 5
68	Medication Administration	C	1	0, 1, 5
69	Meal Preparation	C	1	0, 1, 5
70	Housework	C	1	0, 1, 5
71	Laundry	C	1	0, 1, 5
72	Telephoning	C	1	0, 1, 5
73	Money Management	C	1	0, 1, 5
74	Travel From...	C	1	0, 1, 5
75	Shopping	C	1	0, 1, 5
76	Special Diet	C	1	0, 1, 9
77	Allergies	C	1	1 thru 6, 9
78	Vision	C	1	1 thru 4, 9
79	Hearing	C	1	1 thru 4, 9
80	Feeling Lonely	C	1	0, 1, 2
81	Sleeping Problem	C	1	0, 1, 2
82	Worried / Anxious	C	1	0, 1, 2
83	Irritable (easily)	C	1	0, 1, 2
84	Loss of Interest	C	1	0, 1, 2
85	Feeling Depressed	C	1	0, 1, 2
86	Suicidal Talk / Wish	C	1	0, 1, 2
87	Substance Abuse	C	1	0, 1, 2
88	Child	C	1	Nbr. of People who Support, 9=Unknown
89	Spouse	C	1	Nbr. of People Who Support, 9=Unknown
90	Other Relative	C	1	Nbr. of People Who Support, 9=Unknown
91	Neighbor / Friend	C	1	Nbr. of People Who Support, 9=Unknown
92	Landlord	C	1	Nbr. of People Who Support, 9-Unknown
93	Other	C	1	Nbr. of People Who Support, 9=Unknown
94	Spouse's Health	C	1	1, 2, 3, 7, 9

95	Main Supporters Health	C	1	1, 2, 3, 7, 9
96	Main Supporters Relationship	C	1	1 thru 0
97	How Often Support Given	C	1	1, 2, 3, 7, 9 ****
98	Usual Living	C	1	1 thru 6, 9
99	Housing	C	2	01 thru 16 (Except 09), 99
100	Architectual Barriers	C	1	0, 1
101	Environmental Hazards	C	1	0, 1
102	Walker	C	1	0, 1, 9
103	Wheelchair	C	1	0, 1, 9
104	Other	C	1	0, 1, 9
105	Medicare	C	1	1 thru 5, 9
106	Veterans Medical	C	1	1 thru 5, 9
107	Medicaid	C	1	1 thru 5, 9
108	State Supplement	C	1	1 thru 5, 9
109	S.S.I.	C	1	1 thru 5, 9
110	Food Stamps	C	1	1 thru 5, 9
111	Fuel Assistance	C	1	1 thru 5, 9
112	Rental Rebate	C	1	1 thru 5, 9
113	Other	C	1	1 thru 5, 9
114	Meets Nursing Home Level of Care (1-Yes, 0-No)	C	1	1, 0
115	Clients Fee (Clients Monthly Fee) ** (Comes from another source)	C	8	99999.99
116	Category of Service	C	3	L1, L2A, L2B, L3
117	Clients Address	C	30	
118	Clients City	C	20	
119	Clients State	C	2	
120	Clients Zip Code	C	10	
121	Clients Phone (Area Code + Number)	C	10	9999999999
122	Gender	C	2	01, 02
123	Marital Status	C	2	01 thru 05, 09
124	Termination Date	C	8	CCYYMMDD
125	Period From Date	C	8	CCYYMMDD
126	Period To Date	C	8	CCYYMMDD
127	Assessment Reassessment Reference Number	C	14	

128 Record ID	**C**	**1**	**A=Initial, B=Most Recent**
129 Patient Number	**N**	**7**	**(Internal DSS Number)**

3) ACTUALBILLING_1200s.TXT File

The Plan of Care Billing Information consists of the actual billing for clients that were done during the requested time frame. It is derived from billing that has been processed through EDS. The only codes allowable are the 1200 series service codes.

Data Transfer Specification
Plan of Care Format 1 (Plan of Care Detail)

Nbr.	Contents (description)	Type	Len	Allowable Values / Format
1	Record Id Code	C	1	Internal Use Only
2	Client Social Security Number	C	9	XXXXXXXXX - Required Field
3	E.M.S. Identification Number	C	9	Format = XXXXXXXXX / Required Field
4	Region	C	2	01, 02, 03, 04, 05
5	Agency	C	6	CCCI, SWAAA, AASCC
6	Plan of Care Service From Date	C	8	CCYYMMDD
7	Plan of Care Service To Date	C	8	CCYYMMDD
8	Service Area	C	5	Actual Procedure Code Used for Billing
9	Number of Units for Time Period	C	8	Numeric Field, Format-'99999999'
10	Plan of Care Unit Cost	C	10	Unit Cost for this Service, Format='9999999.99'
11	Performing Provider Number	C	9	State Issued Provider Number

4) AUTHORIZEDPOCBILLING.TXT FILE

The Plan of Care Billing Information consists of the proposed billing for clients that were scheduled during the requested time frame. Tertiary providers derive it from the actual plan of care for Medicaid services provided. Service Area Codes consist of standardized procedure codes using nationally recognized code sets with modifiers in order to be compliant with the Health Insurance Portability and Accountability Act (HIPAA).

(As explained in the previous section)
Each record should contain a summary of the number of service units delivered to the client for each individual service code by month. If a homemaker service was done for 4 units in a day for 20 days during the month the quantity should be 80 for that client for that month for that specific procedure and one record would be generated.

Data Transfer Specification
Plan of Care Format 2 (Plan of Care Detail)

Nbr.	Contents (description)	Type	Len	Allowable Values / Format
1	Record Id Code	C	1	Internal Use Only
2	Client Social Security Number	C	9	XXXXXXXXX - Required Field
3	E.M.S. Identification Number	C	9	Format = XXXXXXXXXXXX / Required Field
4	Region	C	2	01, 02, 03, 04, 05
5	Agency	C	6	CCCI, SWAAA, AASCC
6	Plan of Care Service From Date	C	8	CCYYMMDD
7	Plan of Care Service To Date	C	8	CCYYMMDD
8	Service Area	C	5	Actual Procedure Code Used for Billing
9	Modifier	C	6	Variable length field used to support national standard for Service Area
10	Number of Units for Time Period	C	8	Numeric Field, Format-'99999999'
11	Plan of Care Unit Cost	C	10	Unit Cost for this Service, Format='9999999.99'
12	Performing Provider Number	C	9	State Issued Provider Number

Attach assessment tool for visual reference

EXHIBIT 13

CHCPE Referral Form (W-616)

W-616
(Rev. 5/04)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONNECTICUT HOME CARE PROGRAM FOR ELDERS REFERRAL FORM

Applicant's Name *(last)* *(first)*	Telephone #	Date
Applicant's Address *(street)*		*(apt. #)*
(city)	*(state)*	*(zip code)*
Client location if not at home		
D.O.B.	Social Security No.	Sex: ☐ Male ☐ Female
Marital Status: ☐ M ☐ S ☐ D ☐ W	N H or Hospital for 30 days since 9-30-89 ☐ Yes ☐ No	
EMS Medicaid ID No._____ Medicaid Application Submitted ☐ Yes ☐ No	Monthly Gross Income:_____ Countable Assets:_____	
Does the applicant know the referral is being made? ☐ Yes ☐ No		
Client Representative	Relationship	Telephone No.
Home Health Agency	Contact Person	Telephone No.
Caller's Name	Relationship	Telephone No.
Comments:_____		
DSS/ACU Staff Taking Referral		

DSS REVIEWERS USE ONLY

Diagnosis_____

Category Type ☐ 1 ☐ 2 ☐ 3

Process for Assisted Living ☐ Yes ☐ No
☐ Demo ☐ Private ☐ Cong/Hud

Clinical Staff_____

☐ Essential Services
☐ PSE ☐ DMR ☐ PCA Waiver

Medicaid Status_____

Medicaid Coverage Group_____

Medicaid Redetermination Date_____

Services may begin ☐ Yes ☐ No

Note: Services may begin only if client meets all program requirements. Fee for service only.

Liaison_____Date_____

Date Referred for Assessment_____

Agency Referred To_____

Comments:_____

EXHIBIT 14

Guidelines for Coordination Between the Protective Services for the Elderly Program (PSE), Connecticut Home Care Program for Elders (CHCPE), the Alternate Care Unit (ACU), the Contracted Access Agencies (AAs), and the Contracted Assisted Living Service Agencies (ALSAs)

CT Department of Social Services

Guidelines for Coordination Between the Protective Services for the Elderly Program (PSE), Connecticut Home Care Program for Elders (CHCPE), the Alternate Care Unit (ACU), the Contracted Access Agencies (AAs), and the Contracted Assisted Living Service Agencies (ALSAs)

The intent of these guidelines is to clarify and promote collaborative working procedures and to facilitate the communication and the coordination of care to active CHCPE clients among the AAs, the ALSAs, DSS ACU, CHCPE and the DSS PSE.

The PSE staff, Access Agency Care Managers and ALSA staff will be available to each other for emergencies through after hours on-call staff. Staff will respond promptly to one another's requests for emergency assistance. PSE on-call staff can be contacted by calling Infoline at 211. Access Agency and ALSA on-call staff can be contacted through their main telephone numbers. (See attachment)

Mandatory Reporting Requirements:
The PSE statutes (Chapter 319aa Sec. 17b-450 through Sec. 17b-460) require that nurses, social workers, and other health care providers serve as mandatory reporters of suspected abuse, neglect, exploitation and/or abandonment of persons sixty years of age and older. The AA and ALSA staff must refer CHCPE clients who may be abused, exploited, abandoned or who may suffer from caregiver or self neglect to the PSE program. It is expected that all contracted agencies will inform the AA Care Managers or ALSA of a PSE referral initiated by that agency for a CHCPE client. Appropriate referrals will be initiated via the telephone and followed up with a written referral, DSS form #W-675, (see attached) within 5 working days, to the PSE program in the appropriate DSS Regional or sub-office that serves the town in which the client resides. A list of towns, DSS offices, and PSE intake telephone numbers is located on the reverse side of form #W-675. A written copy of all referrals made to PSE, from the Access Agency, ALSA, or any contracted home care provider, shall be sent to the DSS ACU Health and Safety Nurse Consultant.

When issues of self-neglect arise, the AA or ALSA should attempt to resolve them by exploring all solutions, remedies and resources prior to making a report to PSE. In those cases that are not resolved, the AA or ALSA is to make a PSE referral immediately. The AA or ALSA must make a home visit to the client within 48 hours prior to initiating a verbal PSE referral. A written referral to PSE must follow the initial verbal referral within 5 working days. A copy is to be provided to the ACU Health and Safety Nurse Consultant.

If a third party makes a referral to PSE, regarding alleged neglect of an active CHCPE client, a PSE Social Worker or Supervisor will contact the AA or ALSA to discuss the status of the case. The PSE Social Worker and the AA Care Manager or ALSA professional staff will mutually determine whether the AA or ALSA should make a home

visit. If it is determined that a home visit is not necessary, based on the information the Care Manager or ALSA staff have, the Care Manager or ALSA staff will advise PSE of this. If mutually determined that no action is necessary, PSE and the AA or ALSA staff will document this in their records. If it is determined that a home visit by the AA or ALSA staff is necessary, the AA or ALSA staff will advise PSE of the results of their review and provide them with a written report within 5 working days of the home visit.

PSE Disposition

The PSE Social Worker is required to provide a written status report, regarding the disposition of the case, on the attached Case Disposition Report. This report is to be submitted to the referring agency within 5 working days of the completion of the investigation. A copy of the report will be kept in the confidential PSE client record. It is the responsibility of the AA to follow up with the provider who made the original report to PSE.

Referrals for Home Care Services:

All referrals made by PSE staff to CHCPE shall be processed according to established ACU procedures. If the client is found to be ineligible for CHCPE through the initial screening process with the ACU, the ACU staff will inform the PSE Social Worker of this determination. If the client is found ineligible through the assessment process, the AA or ALSA will inform the PSE Social Worker of this determination. When it has been determined, through the assessment process, that the client is to become a CHCPE client, the AA or ALSA is to inform the PSE Social Worker of the start date of CHCPE services. The PSE or Worker will discontinue payment for any services put in place by PSE from the start date of CHCPE services. Additionally, the PSE Social Worker will determine if further PSE intervention is needed and will inform the AA or ALSA of their decision. If no further intervention is needed, the PSE worker will close the case and inform the AA or ALSA.

Conservatorship:

The Access Agency will continue to file and initiate applications for conservatorship for active CHCPE clients, with the Probate Court, when such action is deemed clinically appropriate. In order to access reimbursement, prior written approval is required from the Manager of the ACU or her designee and the Manager of the Statewide PSE Program or her designee.

Every attempt must first be made to find an alternate source of payment. PSE funds may only be used as a last resort. When no other source of funding is available for the court fees, the AA may request payment reimbursement through the PSE Program. If the client is an active PSE client, and agrees that this action is necessary, they will file the petition directly with the appropriate court.

To apply for reimbursement, the AA must document the need for reimbursement, attempts made to secure other funds, and the dollar amount(s) necessary to complete the conservatorship process. The application (copy attached) should be submitted to the ACU Health and Safety Nurse Consultant for review. If the ACU approves the

application, it will be forwarded to the PSE Statewide Manager for final approval. The PSE Statewide Manager will convey the outcome to the appropriate local PSE office with copies to the Access Agency and the ACU Health and Safety Nurse Consultant. Local PSE staff will process the reimbursement as appropriate. The AA will submit the bill directly to the Statewide PSE Manager upon receipt of final approval.

Emergency Long Term Care Placement:
The AA or ALSA may also request that PSE assist in the emergency placement of an active CHCPE client in a nursing facility. PSE has the authority to jump a waiting list, in situations of extreme risk or imminent danger. This request should be made to the local PSE office serving the area in which the client resides.

The PSE Social Worker must complete a direct assessment of the client and the situation before approving the request to make an emergency placement and to invoke the authority to jump the existing waiting list for admission to a LTC facility. This cannot be done based solely on referral information. If an emergency assessment can not be provided by PSE staff, they should instruct the requestor to refer the client to the nearest emergency room for an assessment of current risk status. Based on the outcome of a licensed health care professional's assessment of the client's status, PSE staff can waive their direct assessment and authorize emergency LTC placement.

PSE staff cannot, under any circumstances, waive MI/ MR screening standards for admission to Long Term Care facilities.

Emergency After Hours PSE and Access Agency Coverage:
DSS contracts with Infoline to screen after hours emergency referrals to the PSE Program and to assist in locating local emergency service providers. Infoline casework staff function as an extension of PSE. When an emergency report is received by Infoline, it is screened for its emergency nature. Protective service emergencies are then transmitted to the PSE Social Worker who is "on call". The PSE Social Worker will contact the AA or ALSA to determine if those emergency referrals, age 65 and older, are active CHCPE clients in need of home care services to keep them safe until a full evaluation can be completed the next business day. If it is determined that it is an active CHCPE client, the AA or ALSA on call staff will arrange the necessary emergency services and inform PSE of the arrangements. When no other resource is available, the PSE Social Worker will handle the situation, per PSE protocol.

Dispute Resolution Process:
If difficulties in implementing any of the procedures outlined above occur and cannot be resolved at the local program level, mediation may be sought. If PSE staff have a problem, they will contact the PSE Statewide Manager for consultation. If an AA or ALSA staff have a problem, they will contact the ACU Health and Safety Nurse Consultant for consultation. This process should only be used as a last resort. Every attempt to come to a mutually agreeable resolution should have been exhausted, prior to initiating consultation.

If absolutely necessary, the PSE Manager and ACU Health and Safety Nurse Consultant may attempt to facilitate a mutually agreeable solution to the issue presented. To refer a case for such intervention, the following information must be provided:

1. Name and address of the client
2. Nature of the problem/ challenge/ issue
3. Other agencies involved with the client
4. Attempts to resolve the issue locally
5. Results of those attempts
6. Desired outcome of mediation process

Sharedoc\lynn\pse\guidelines for coordination between PSE and ACU--FINAL 6/30/04

EXHIBIT 15

CHCPE Provider Service Authorization (W-211)

W-211
(Rev. 10/03)

STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES
CONNECTICUT HOME CARE PROGRAM FOR ELDERS

PROVIDER SERVICE AUTHORIZATION

☐ NEW SERVICE ☐ RENEW ☐ CHANGE ☐ OTHER (specify) _____

CLIENT NAME (Last, First, M.I.)	CLIENT EMS I.D. NO.	ALTERNATE CARE UNIT	TITLE XIX ☐ Yes ☐ No
CLIENT ADDRESS (No., Street, Town)	DIAGNOSIS CODE	CLIENT PHONE NO.	CATEGORY ☐ 1 ☐ 2 ☐ 3
PROVIDER NAME	PROVIDER NO.	CONTACT PERSON/PHONE/FAX #	
PROVIDER ADDRESS (No., Street, Town)			

Service Plan: If signed below by the Department, the following services have been authorized and approved for payment. Services are to be provided for the period indicated below.

TYPE OF SERVICE	UNITS	FREQUENCY	VENDOR	UNIT/ COST	FROM	TO	DATE DISCONTINUED
NURSE							
HOME HEALTH AIDE							
THERAPY							
COMPANION							
DAY CARE							
CHORE							
HOMEMAKER							
TRANSPORTATION							
MEALS ON WHEELS							
E. R. S.							

EXPLANATION (including any changes in functional or cognitive status):

Completed By Access Agency/Provider/Date	DSS Authorization/Date	☐ Approved ☐ Denied ☐ Bill Access Agency ☐ Bill EDS

EXHIBIT 16

Alternate Care Unit Progress Notes
(W-1551)

W-1551
(Rev. 4/04)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

ALTERNATE CARE UNIT

PROGRESS NOTES

PAGE:_____

CLIENT NAME:_____ CLIENT ID:_____

DATE	REMARKS

CLIENT NAME:_____ PAGE:_____

DATE	REMARKS

EXHIBIT 17

Notice of Liability to Applicant or
Recipient of Care or Support or
Legally Liable Relative
(W-997)

STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

W-997
(Rev. 5/01)

Name of Applicant/Recipient_____

NOTICE OF LIABILITY
TO APPLICANT OR RECIPIENT OF CARE OR SUPPORT OR LEGALLY LIABLE RELATIVE

(for reimbursement of any cost incurred or amount paid by the State on behalf of a recipient)

Connecticut State law allows the State to recover money from you, or from your legally liable relatives (spouse or parent of a child under 18 years old) to cover the costs of the care or support provided to you or paid on your behalf. As an applicant/recipient of care or support or as a legally liable relative, you should understand that you may be required to pay for part or all of that care or support.

You and your legally liable relatives have a liability for the costs of your care and support from the date you begin to receive care or support. The Department of Administrative Services may subsequently contact you and your legally liable relative(s) to establish a repayment plan for the care and support received, at which time you will be notified whether the payments required of you represent full or partial payment of moneys owed to the State.

At the end of care or support, you or your legally liable relative(s) may request a list of services provided and the associated cost.

I acknowledge that I have been provided with a copy of this notice.

_____ _____
Applicant/Recipient's Signature Date

_____ _____
Relative's Signature Date

Check one: ☐ Spouse ☐ Mother ☐ Father

Check all that apply:

☐ On _____ , I provided a copy of this notice to _____ and she/he was unable to or refused to sign it.

☐ On _____ , I mailed a copy of this notice to _____ the legally liable relative(s) of _____, at the following address:

_____

☐ I made a good faith effort to locate the present whereabouts of the legally liable relative of _____ and could not.

_____ _____
Signature of State Employee Print Name

W-997
(Rev. 5/01)

ESTADO DE CONNECTICUT
DEPARTAMENTO DE SERVICIOS SOCIALES

Nombre del Solicitante/Recipiente_____

NOTIFICACION DE RESPONSABILIDAD
Para el Solicitante/Recipiente de Cuidado o de Apoyo, o al Pariente Legalmente Responsable

(Para el reembolso de cualquier costo incurrido o cantidad pagada por el Estado en nombre de un recipiente.)

La ley Estatal de Connecticut permite que el Estado recupere dinero de usted, o de sus parientes legalmente responsables (esposo(a) o madre/padre de un niño menor de 18 años), para cubrir los costos del cuidado o apoyo que le fue provisto o pagado en su beneficio. Como solicitante/recipiente de cuidado o apoyo o como un pariente legalmente responsable, usted debe entender que usted puede ser requerido a pagar en parte o por completo los costos de estos servicios.

Usted y sus parientes legalmente responsables tienen una responsabilidad por los costos de su cuidado y apoyo, desde la fecha que usted comienza a recibir los servicios. El Departamento de Servicios Administrativos puede subsiguientemente comunicarse con usted y con su pariente(s) legalmente responsable para establecer un plan para reembolsar los costos del cuidado y del apoyo recibido. Entonces, usted será notificado si los pagos requiridos de usted representan el pago completo o parcial del dinero debido al Estado.

A fines del cuidado o del apoyo, usted o su pariente(s) legalmente responsable puede solicitar una lista de servicios provistos del costo asociado.

Reconozco que he sido provisto con una copia de esta notificación.

_____ _____
Firma del solicitante/recipiente Fecha

_____ _____
Firma del pariente Fecha

Marque uno: ☐ Esposo(a) ☐ Madre ☐ Padre

Marque todo lo que aplica:

☐ En _____, yo proveí una copia de esta notificación a _____ y ella/el no pudo, o rehusó firmarla.

☐ En_____ , yo envié por correo una copia de esta notificación a _____ el/los pariente(s) legalmente responsable(s) de _____, a la siguiente dirección:

_____

☐ Hice un esfuerzo de buena fe de localizar el paradero actual del pariente legalmente responsable de _____ y no pude encontrarlo.

_____ _____
Firma del Empleado del Estado *Nombre en Letra de Molde*

EXHIBIT 18

CHCPE Discontinuance Recommendation Form
(W-1529)

W-1529
(Rev. 10/01)

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES

CONNECTICUT HOME CARE PROGRAM FOR ELDERS

DISCONTINUANCE RECOMMENDATION FORM

TO:_____ DATE:_____

FROM:_____

1. Client Name
2. Client EMS ID No.
3. Discontinuance reason (codes at bottom of form):_____
4. Date of the event resulting in the discontinuance recommendation

   Death:____/___/____ Admission to LTC:____/___/____ Nursing Facility:_____

   Other:____/___/____
5. Date of Status Reviews: ____/___/____ ____/___/____

Comments:_____

FOR DSS USE ONLY	**REASON CODES**
Discontinuance Date: _____/_____/_____ Comments:_____ _____ _____ _____ _____ _____ Staff Signature Date	1. Died 2. Hospital stay exceeds program limits 3. Became financially ineligible (over income, over assets) 4. Became ineligible due to level of care 5. Care plan exceeded Social Service cost limit 6. Care plan exceeded total cost limit 7. Moved out of state 9. Entered LTC due to health 10. Entered LTC due to client choice 11. Non-compliance with contribution requirements (refused to sign, refused to pay) 12. Refused services 13. Lack of services 17. Other

EXHIBIT 19

CHCPE Potential Discharge Recommendation
Due to Non-Payment of Client Contribution
(W-1531)

W-1531
(Rev. 5/98)

State of Connecticut
Department of Social Services

CONNECTICUT HOME CARE PROGRAM FOR ELDERS

Potential Discharge Recommendation Due to Non-Payment of Client Contribution

TO:_____
(DSS/ACU Unit - Location)

FROM:_____
(Access Agency - Location)

Client Name:_____ Client ID #:_____

Past Due Amount: $_____ Date Past Due:_____

The above named client is past due in making his/her client contribution of $_____/mo.

Date reminder was sent *(15 days after due date - 1st attempt)*: _____/_____/_____
(Month) (Day) (Year)

Date client was called *(1st attempt)*: _____/_____/_____
(Month) (Day) (Year)

Date family/caregiver was called *(1st attempt):* _____/_____/_____
(Month) (Day) (Year)

Comments:_____

_____

Date family was contacted *(2nd attempt)*: _____/_____/_____
(Month) (Day) (Year)

Comments:_____

_____

Other Payment Sources Explored:_____

_____

_____

Access Agency Staff:_____ _____/_____/_____
(Month) (Day) (Year)

NOTE: Attach all documents supporting efforts made by Access Agency for collection of non-payment of client contribution.

EXHIBIT 20

Self Directed Care – How It Works

SELF DIRECTED CARE: HOW IT WORKS

The Access Agency's care manager evaluates whether or not a client is appropriate to become a self directed care (SDC) client at the first six (6) month home visit. A client must have been a CHCPE client at least 6 months before a care manager can recommend that client for SDC. The client or family may request a review for SDC at any time.

When the care manager determines that a recommendation for SDC is appropriate for the client and the client is receptive to becoming self directed, the care manager submits the following to the CHCPE Self Directed Care Coordinator at DSS:

1. Completed "Checklist to Authorize Care Management" (W-143) reflecting recommendation to initiate self directed care.
2. Most recent "CHCPE Assessment/Reevaluation/Status Review Outcome Form" (W-1527)
3. Current client "Uniform Care Plan" (W-1510) and the associated "CHCPE Care Plan Cost Worksheet" (W-1510, Part II);
4. "Provider Service Authorization(s)" (W-211);
5. "Notification of Self Directed Care to Client" (W-203) (Exhibit 30)

DSS reviews client information, SDC Coordinator contacts care manager if any additional information is needed, and determines if client is appropriate for SDC or if care management should be continued.

Care Management Continues

If the client is not appropriate for SDC, care management services continue. The care manager should reevaluate appropriateness of another referral to SDC at least every six (6) months.

or

SDC Initiated

Date that care management ends and SDC begins is determined by the SDC Coordinator

Client and/or family manage care and work directly with providers

Requests for a change in the plan of care are directed to the SDC Coordinator and can be made by either the client or the provider with client approval.

Providers request reauthorization of services 6 months after the most recent assessment: or reassessment. Medical Providers submit a "Checklist to Authorize Care Management" (W-143) with recommendation to either continue SDC or to reinstate care management and an appropriate and completed Provider Service Authorization(s) (W-211).
Social Service providers submit appropriate and completed Provider Service Authorization(s).

DSS reviews client chart, plan of care and submitted paperwork and determines if SDC is continued or if the client needs to be returned to care management. The client or family can ask to be returned to care management at any time.

Care Management Reinstated
Client cannot be returned to SDC for 1 year.

or

SDC Continues

Annual Reassessment

Medical Providers – Nurse or social worker conducts reassessment and submits updated W—143, W-1527, W-1510, and appropriate W-211(s).

Social Service Providers – DSS staff conducts reassessment. Provider submits updated W-211(s).

EXHIBIT 21

Nutrition Standards of the CT Elderly Nutrition Program

From CT State Regulation Section 17b-423-5(e):

(4) **Nutrition Standards [of the CT Elderly Nutrition Program]**

(A) Nutritional Value of Menus

The nutritional value of menus shall be confirmed either by (i) nutritional analysis, (ii) conformance to a Department approved meal pattern, (iii) selection from a list of Department approved menus with accompanying recipes, or (iv) an individually prescribed menu.

If the value of menus is confirmed by nutritional analysis, each regular meal shall provide all essential food components in amounts specified in writing by the Department. If two meals are served per day, food components may be averaged over two meals; if three meals are served, over three meals. Fat and fat-soluble vitamins may be averaged over one week.

More rigorous dietary standards may be used at the discretion of the nutritionist to improve nutrition, flavor, appearance, texture or smell.

(B) Fruit Requirement

Fruit (including fruit juices) shall be served at least three times every six meals with fresh fruit served at least once subject to seasonal quality.

(5) Menu and Recipe Requirements

(A) Menus

Menus shall specify the amount of each item to be prepared and served, and shall reference all recipes used in the preparation of mixed dishes.

(B) Recipes

Tested quality recipes, adjusted to yield the numbers of servings needed, shall be used. Each recipe should specify cooking, cooling and storage procedures as well as exact ingredient amounts and preparation instructions, to assure the production of a uniform, high quality and safe food or dish.

(C) Certification Required

Menus shall be certified* in writing by the nutritionist as providing at least one-third of the current Recommended Dietary Allowances (RDA's) of the National Academy of Sciences for energy, protein, vitamins and essential minerals, and as conforming to the *Dietary Guidelines for Americans*. Menus shall be submitted to the Department or Area Agency on Aging nutritionist at least two weeks prior to use for review of nutritional adequacy.

(D) Certification Of Individually Prescribed and Therapeutic Menus

Individually prescribed menus, including menus for each type of therapeutic diet, shall be certified by a Registered Dietitian of the American Dietetic Association.

(E) Record Keeping

Recipes and certified menus shall be kept on file at the nutrition provider's office for a minimum of two years following the year during which they were in use.

(6) Funding Restricted for Foods Not Conforming to Menu

No funds authorized under this section shall be used to pay for foods served that fail to conform to the menu, without approval by the nutritionist.

*The certification statement recommended by our legal department follows: (Due to the complexity of the matter, it is not humanly possible to certify, without possible error, that every meal will provide all nutrients in required amounts.)

"I certify that, to the best of my knowledge, each meal in the attached menus provides one-third of the current Recommended Dietary Allowances established by the National Academy of Sciences for energy, protein, vitamins and essential minerals, and conforms to the Dietary Guidelines for Americans."

EXHIBIT 22

MAP OF ACU REGIONS

Connecticut Home Care Program For Elders

Connecticut Home Care Program For Elders

Alternate Care Unit Mission

The mission of the Alternate Care Unit is to develop and offer cost-effective community-based and other long term care alternatives to individuals and families with continuing care needs and policies pertinent to long term care residents.

The activities of the Alternate Care Unit take place under the overall mission of the Connecticut Department of Social Services which is to serve families and individuals who need assistance in maintaining or achieving their full potential for self-direction, self reliance and independent living.

EXHIBIT 23

LIST OF TOWNS WITHIN ACU REGIONS

CHCPE MAP BY REGION

Region I	**Region II**	**Region III**	**Region IV**	**Region V**
SouthWestern	**SouthCentral**	**Eastern**	**NorthCentral**	**Northwestern**
Bridgeport	Ansonia	Ashford	Andover	Barkhamsted
Darien	Bethany	Bozrah	Avon	Beacon Falls
Easton	Branford	Brooklyn	Berlin	Bethel
Fairfield	Chester	Canterbury	Bloomfield	Bethlehem
Greenwich	Clinton	Chaplin	Bolton	Bridgewater
Monroe	Cromwell	Colchester	Bristol	Brookfield
New Canaan	Deep River	Columbia	Burlington	Canaan
Norwalk	Derby	Coventry	Canton	Cheshire
Stamford	Durham	East Lyme	East Granby	Colebrook
Stratford	East Haddam	Eastford	East Hartford	Cornwall
Trumbull	East Hampton	Franklin	East Windsor	Danbury
Weston	East Haven	Griswold	Ellington	Goshen
Westport	Essex	Groton	Enfield	Hartland
Wilton	Guilford	Hampton	Farmington	Harwinton
	Haddam	Killingly	Glastonbury	Kent
	Hamden	Lebanon	Granby	Litchfield
	Killingworth	Ledyard	Hartford	Middlebury
	Lyme	Lisbon	Hebron	Morris
	Madison	Mansfield	Manchester	Naugatuck
	Meriden	Montville	Marlborough	New Fairfield
	Middlefield	New London	New Britain	New Hartford
	Middletown	North Stonington	Newington	New Milford
	Milford	Norwich	Plainville	Newtown
	New Haven	Plainfield	Plymouth	Norfolk
	North Branford	Pomfret	Rocky Hill	North Canaan
	North Haven	Preston	Simsbury	Oxford
	Old Lyme	Putnam	Somers	Prospect
	Old Saybrook	Salem	South Windsor	Redding
	Orange	Scotland	Southington	Ridgefield
	Portland	Sprague	Stafford	Roxbury
	Seymour	Sterling	Suffield	Salisbury
	Shelton	Stonington	Tolland	Sharon
	Wallingford	Thompson	Vernon	Sherman
	West Haven	Union	West Hartford	Southbury
	Westbrook	Voluntown	Wethersfield	Thomaston
	Woodbridge	Waterford	Windsor	Torrington
		Willington	Windsor Locks	Warren
		Windham		Washington
		Woodstock		Waterbury
				Watertown
				Winchester
				Wolcott
				Woodbury