

**County Primary Healthcare Contract with Bond Community Health Center,
Inc. for Women's and Children's Healthcare Services**

This Agreement dated this ___ day of October, 2009, by and between LEON COUNTY, FLORIDA, a charter county and political subdivision of the State of Florida, hereinafter referred to as the "County" and Bond Community Health Center, Inc., hereinafter referred to as the "Contractor."

WHEREAS, the Board has identified the need to further the provision of primary and specialized healthcare services to the citizens of our community; Services to include basic diagnostic procedures and drug or other therapeutic modalities ordered or provided by the care practitioner in the course of treating the patient, along with ambulatory care, preventive health services and continuing management of the healthcare needs of registered clients; and

WHEREAS, the CareNet group of providers, including Neighborhood Health Services, Bond Community Health Center, Inc., the Capital Medical Society, the FAMU College of Pharmacy, Tallahassee Memorial Healthcare, Capital Regional Medical Center and Leon County Health Department have provided primary and specialty healthcare services to the citizens of Leon County in a coordinated fashion for a number of years; and

WHEREAS, the Board has determined that a great need for women's and children's healthcare in our community exists above the current level of services offered by the CareNet partners at their current levels of funding and participation; and

WHEREAS, the Board has found it in the best interest of Leon County to dedicate funding for the expansion of the existing CareNet program to service the community's additional need for women's and children's health care services, and

WHEREAS, the CareNet group of providers have agreed to work cooperatively with the Board to meet that additional community need for women's and children's health care services.

NOW, THEREFORE, the parties hereto agree as follows:

Section 1: Clients To Be Served

The Contractor hereby agrees to serve the following residents of the County in accordance with the following:

1. Eligibility for services under this contract shall be limited to those residents of Leon County with net incomes less than 200% of the most current federal poverty levels established by the U.S. Office of Management and Budget, who seek women's and children's medical care and who, initially, have no health insurance. Residents with net incomes between 100 and 200% federal poverty level shall be charged a sliding scale rate.

2. No fees of any kind shall be collected for registered comprehensive healthcare clients who are below 100% of the most current federal poverty levels.
3. Clients who are not currently receiving Medicaid or Healthy Kids, or any other state or federal program, and who appear, to meet the income and categorical eligibility requirements of Medicaid or Healthy Kids, should be strongly encouraged to pursue obtaining eligibility for those programs.
4. The Contractor will determine eligibility for enrollment into primary and specialty care. Eligibility will be determined at least annually. A client shall be allowed, however, to request determination of eligibility after submitting verified confirmation of changes to his/her income.
5. The Contractor will abide by Health Insurance Portability and Accountability Act (HIPAA) policies and procedures established for the Primary Health Care Program as related to the processing of client's medical information of the women's and children's healthcare program.

Section 2: Services to be offered by the Contractor

1. The Contractor shall provide women's and children's specialty healthcare services to qualifying recipients.

Section 3: Reports to be performed by Contractor

1. The Contractor must submit a monthly invoice to the County on or before the 15th day of the month. The invoice shall be sent to the following address to the attention of the Human Services Analyst.

Leon County Health and Human Services Division
918 Railroad Ave.
Tallahassee, FL 32301

2. The Contractor must submit attachments in the monthly invoice which at a minimum contain the following information:
 - A. A comprehensive list of all clients registered during the month to include the unique client identification number and program start date.
 - B. Number of total patients (seen by Contractor entirely) and total patient encounters per month.
 - C. Number of new and existing Women's Health program patients and number of new and existing Women's Health program patient encounters per month.
 - D. Total amount of sliding scale fee revenues collected specifying the number of patients from which it was collected.

3. Each client must sign a client participation agreement which acknowledges that the client understands the services that will be provided, the limits of the Contractor's service capability and the responsibilities of the client. A sample participation agreement is provided as Exhibit A. Each client must also receive a copy of the client rights statement (Exhibit C) and a listing of the services that can be obtained through the provider.
4. The Contractor shall provide a Client Satisfaction Survey (Exhibit D) to randomly sample a minimum of 20 women's and children's care clients seen during each quarter of the contract period. Completed forms will be forwarded to the Human Services Analyst. A monthly progress report (Exhibit B) shall be submitted to the County, which shall include Exhibit A.
5. Annually, the County shall submit a final report that provides a detailed summary of all expenditures utilizing the funds from this contract. The annual report shall include a comprehensive detail of the amount of new women and children patients as compared to overall patients served by the Contractor and the types of service performed in the reporting year. The report will also compare the current period against measures from previous years.

Section 4: Audits, Records, and Records Retention

The Contractor agrees:

1. To establish and maintain books, records, and documents (including electronic storage media) in accordance with generally accepted accounting procedures and practices, which sufficiently and properly reflect all revenues and expenditures of funds provided by the County under this contract.
2. To retain all client records, financial records, time sheets, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to this contract for a period of five (5) years after termination of the contract, or if an audit has been initiated and audit findings have not been resolved at the end of five (5) years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of this contract.
3. Upon completion or termination of the contract and at the request of the County, the Contractor will cooperate with the County to facilitate the duplication and transfer of any said records or documents during the required retention period as specified in paragraph I above.
4. To assure that these records shall be subject at all reasonable times to inspection, review, or audit by Federal, state, or other personnel duly authorized by the County subject to HIPAA.
5. Persons duly authorized by the County and Federal auditors, pursuant to 45 CFR, Part 92.36(I)(10), shall have full access to and the right to examine any of provider's contract

and related records and documents, regardless of the form in which kept, at all reasonable times for as long as the records are retained.

6. To include these aforementioned audit and record keeping requirements in all approved subcontracts and assignments.

Section 5: Monitoring

The Contractor agrees:

1. To permit persons duly authorized by the County to inspect any records, papers, documents, facilities, goods, and services of the provider which are relevant to this contract, and, interview any clients and employees of the provider to assure the County of satisfactory performance of the terms and conditions of this contract.
2. Following such evaluation, the County will deliver to the provider a written report of its findings and will include written recommendations with regard to the provider's performance of the terms and conditions of this contract. The Contractor will correct all noted deficiencies identified by the County within the specified period of time set forth in the recommendations. The Contractor's failure to correct noted deficiencies may, at the sole and exclusive direction of the County, result in anyone or any combination of the following: (a) the provider being deemed in breach or default of this contract; (b) the withholding of payments to the Contractor by the County; and (c) the termination of this contract for cause.

Section 6: Payment

1. Payment shall be made by the County upon receipt of valid invoice by Contractor at a monthly rate equal to no more than one twelfth (1/12) of the following total contractual amount: \$248,260 for a period of twelve (12) months. The contractual amounts which follow are based upon the following line items for a twelve months period.

Women and Children's Health Care Services:

OB/GYN Physician @ 12 Hrs/ Week @ \$100 per hour	\$62,400
Pediatrics Physician @ 8 Hrs/ week @ \$75 per Hour	\$31,200
On call Coverage @ 200 per call	\$ 5,168

The specialty physicians contracted hereunder shall have admitting privileges at Tallahassee Memorial Hospital and/or Capital Regional Medical Center, or both, and shall have back-up coverage.

2. The payment shall be made by the County within 30 days of receipt and approval by the County of a monthly invoice (Exhibit E). The monthly invoice is to be completed and submitted by the Contractor to the County.

3. No line item (as identified in paragraph 1 above) payment shall be made until such time as the staff members identified in Section 6 of this contract are hired by the Contractor. Similarly, no payment shall be made if the required monthly reports, as delineated in Section 3 of this contract, are not attached to the monthly invoice appropriately.

Section 7: Sliding Scale Fees

Sliding scale fees shall be charged to qualifying patients who are above 100% and at or below 200% of federal poverty levels. No fees of any kind shall be collected for registered comprehensive healthcare clients who are below 100% of the most current federal poverty levels

Section 8: Term

The length of this contract shall be for a term of twelve (12) months beginning on October 1, 2009 and ending on September 30, 2010.

Section 9: Hold Harmless

The Contractor agrees to indemnify and hold harmless the County from and against any and all claims, damages, liabilities, or suits of any nature whatsoever arising out of, because of, or due to any act or occurrence of omission or commission of the Contractor its delegates, agents or employees, as a result of the services provided under this agreement including but not limited to costs and a reasonable attorney's fee. The County may, at its sole option, defend itself or allow the Contractor to provide the defense. The Contractor acknowledges that ten dollars (\$10.00) of the amount paid to the Contractor is sufficient consideration for the Contractor's indemnification of the County.

Section 10: Termination

1. The County may terminate this contract without cause, by giving the Contractor thirty (30) days written notice of termination. Either party may terminate this contract for cause by giving the other party hereto thirty (30) days written notice of termination. The County shall not be required to give the Contractor such thirty (30) day written notice if, in the opinion of the County, the Contractor is unable to perform its obligations hereunder, or if in the County's opinion, the services being provided are not satisfactory. In such case, the County may immediately terminate the Contract by mailing a notice of termination to the Contractor.
2. Termination with cause shall include but not be limited to the discovery of improper or inappropriate accounting, expenditures, reporting or service delivery by the contractor or due to the discovery of noncompliance with any item detailed within the sections of this contract.

Section 11: Revisions

In any case where, in fulfilling the requirements of this contract or of any guarantee, embraced in or required thereby it is necessary for the Contractor to deviate from the requirements of the contract, Contractor shall obtain the prior written consent of the County. The parties agree to renegotiate this contract if revision of any applicable laws or regulations make changes in this contract necessary.

Section 12: Construction

The validity, construction, and effect of this Contract shall be governed by the laws of the State of Florida.

Section 13: Budget

The performance of Leon County of any of its obligations under this Agreement shall be subject to and contingent upon the availability of funds lawfully expendable for the purposes of the agreement for the current and any future periods provided for within budget allocations for the current fiscal year.

Section 14: Status

The Contractor at all times relevant to this Agreement shall be an independent contractor and in no event shall the Contractor nor any employees or sub-contractors under it be considered to be employees of Leon County.

Section 15: Assignments

This Contract shall not be assigned or sublet as a whole or in part without the written consent of the County nor shall the contractor assign any monies due or to become due to it hereunder without the previous written consent of the County.

Section 16: Public Entity Crimes Statement

In accordance with Section 287.133, Florida Statutes, Contractor hereby certifies that to the best of his/her knowledge and belief neither Contractor nor his/her affiliates has been convicted of a public entity crime. Contractor and his affiliates shall provide the County with a completed public entity crime statement form no later than January 15 of each year this agreement is in effect. Violation of this section by the Contractor shall be grounds for cancellation of this agreement by Leon County.

Section 17: Contractor's Responsibility

It shall be the sole responsibility of the Contractor to comply with all applicable Federal, State, County and City, statutes, ordinances, rules and regulations in the performance of the Contractor's obligations under this agreement.

WHERETO, the parties have set their hands and seals effective the date whereon the last party executives this Agreement

**CONTRACTOR
BOND COMMUNITY HEALTH CENTER, INC.**

BY: _____

Title: _____

Date: _____

**BOARD OF COUNTY COMMISSIONERS
FOR LEON COUNTY, FLORIDA**

By: _____
Parwez Alam
County Administrator

Date: _____

**ATTESTED BY:
Bob Inzer, Clerk of the Court
LEON COUNTY, FLORIDA**

By: _____

**APPROVED AS TO FORM:
LEON COUNTY ATTORNEY'S OFFICE**

By: _____
Herbert W.A. Thiele, Esq.
County Attorney

CLIENT PARTICIPATION AGREEMENT

Attachment # 2
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This is to certify that (Name of Applicant)
SSN and the following member(s) of his or her family may
receive primary care medical services from Bond Community Health Center for the period
through

Eligible Family Members

- 1. SSN
2. SSN
3. SSN
4. SSN

These services have been explained to me. I certify that all information I have given regarding income and family size is true and correct to the best of my knowledge. I understand that although I, or a member of my family, may be referred for specialty care, hospitalization or other higher level care, there is no obligation for the Provider to pay for these services. I understand that I am responsible for following the treatment prescribed by medical personnel for my family and me. I will notify Bond Community Health Center when one of my family members cannot keep an appointment. If I do not use these services for one year, a letter may be sent advising me of the need to re-determine my eligibility, and if I do not respond within two weeks, my name may be removed from the client list. This does not prevent me from re-enrolling as an active client in the future.

Applicant's Signature

Date

Witness' Signature

Date

**Leon County
 Women and Children's Healthcare Monthly Report**

Provider Name _____

Reporting Month _____

Number of patients receiving services through the Leon County Health Department for this reporting period:

Adults _____ Children (0-17 yrs) _____ Total _____

Types of services provided (indicate # of encounters)

	Adult	Child		Adult	Child		Adult	Child
Case Mgt.			Pharmacy			Dental		
Adult Clinical			Lab			Optometry		
Child Clinical			Chronic Disease Management			Community Outreach		
Immunizations			Episodic Care			Transportation		
EPSDT			Tertiary Care			Social Services		
Acute Care			Specialty Care			Other (list below)		
Family Planning			Hospital Inpatient					
Maternity			Prevention/Welln					
STD			Radiology					

Selected Diagnoses and Services Rendered

Diagnostic Category	Applicable ICD-9-CM Code or CPT 4 Code	Numbers of Encounters by Diagnosis	Number of Users with Diagnosis
Tuberculosis	010.xx - 018.xx		
Venereal Diseases	090.xx - 099.xx		
Asthma	493.xx		
Chronic bronchitis and emphysema	490.xx - 492.xx 496.xx		
Abnormal Breast Findings - Female	174.xx; 198.81; 233.0x; 793.8		
Abnormal cervical Findings	180.xx; 198.82; 233.1 795.0x		
Diabetes mellitus	250.xx; 775.1x 790.2		
Heart Disease (Selected)	391.xx - 392.0x 410.xx - 429.xx		
Hypertension	401.xx - 405.xx		
Contact dermatitis & other eczema	692.xx		
Dehydration	276.5		
Exposure to heat or cold	991.xx - 992.xx		

Diagnostic Category	Applicable ICD-9-CM Or CPT 4Code	Numbers of Encounters by Diagnosis	Number of Users with Diagnosis
Otitis media and Eustachian tube disorders	381.xx – 382.xx		
Selected Perinatal conditions	770.xx; 771.xx; 773.xx; 774.xx – 779.xx (exclude 779.3)		
Lack of expected normal physiological development	260.xx – 269.xx 779.3x 783.3x – 783.4x		
Alcohol related disorders	291.xx; 303.xx; 305.0x; 357.5x		
Other substance related disorders	292.1x – 292.8x; 304.xx; 305.9x; 357.6x; 648.3x		
Other mental disorders, excluding drug or alcohol dependence; include mental retardation	290.xx 293.xx – 302.xx; (exclude 300.0x) 300.21; 300.22; <u>300.23; 300.29; 300.3</u> 306.xx – 319.xx (exclude 308.3; 309.81; 312.8x; 312.9x; 313.81; 314.xx		
Mammogram	76090 – 76092 ICD-9: V76.1		
Pap Smear	88141 -88155 88164 – 88167 ICD-9: v72.3; v76.2		
Selected Immunizations	90633-90634 90645 – 90648 90657-90660; 90669, 90700 -90702; 09704-90716; 90718 90720 – 90723 90743-90744; 90748		
Contraceptive Management	ICD-9: V25.xx		
Health Supervision of Infant or Child 0-11	99392-99393 99381-99383 99341-99433 ICD-9: V20.xx; V29xx		

SUMMARY OF THE FLORIDA PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

Florida law require that your health care provider or health care facility recognize your rights while you are receiving medical care, and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of patients. A summary of your rights and responsibilities follows:

- A patient has the right to be treated with courtesy and respect, with appreciation of his/her dignity, and with protection of his/her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests.
- A patient has the right to know who is providing medical services and who is responsible for his/her care.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he/she does not speak English.
- A patient has the right to know what rules and regulations apply to his/her conduct.
- A patient has the right to be given by his/her health care provider information concerning diagnosis, planned course of treatment, alternatives, risks, and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his/her care.
- A patient who is eligible for Medicare has the right to know, upon request and in advance of treatment; whether the health care provider or health care facility accepts the Medicare assignment rate.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonable clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his/her consent or refusal to participate in such experimental research.
- A patient has the right to express grievances regarding any violation of his/her rights, as stated in Florida law, through the grievance procedure of the health plan, the health care provider or health care facility which served him/her and to the appropriate state licensing agency.
- A patient is responsible for providing to his/her health care provider, to the best of his/her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- A patient is responsible for reporting unexpected changes in his/her condition to his/her health care provider.
- A patient is responsible for reporting to his/her health care provider whether he/she comprehends a contemplated course of action and what is expected of him/her.

CLIENT SATISFACTION SURVEY

Please help us improve our services by filling out this survey. Feel free to use the back of this page for additional comments.

Arrival time _____ Appointment time _____ Departure time _____

1. I came to this clinic for care because (check each one that applies):

- _____ My primary physician is here
- _____ I have no other doctor or health care provider
- _____ I was referred by another doctor, hospital, or clinic
- _____ It is convenient
- _____ It was easy to get an appointment
- _____ It is affordable
- _____ I needed the type of care that this doctor provides

2. I am here today for:

- _____ A physical or check-up (I am not sick)
- _____ Treatment of an illness or condition
- _____ Follow-up visit from an earlier illness or condition

3. How long did you have to wait before the doctor saw you?

- _____ Less the 10 minutes _____ 10 to 20 minutes
- _____ 20 to 30 minutes _____ More that 30 minutes

4. Was the staff pleasant to you on the telephone?

- _____ Yes _____ No

5. Is the cost of the clinic visit reasonable?

- _____ Yes _____ No

6. Did the care you received help you with your problem?

- _____ Yes _____ No If no, please let us know why:

7. How satisfied are you with the information you received from the clinic staff about your condition?

- _____ Very Satisfied _____ Satisfied
- _____ Not Satisfied _____ No opinion

8. Are the clinic hours convenient for you? ___ Yes ___ No

9. How satisfied are you with the information you received from the clinic staff about your condition?

- _____ Very Satisfied _____ Satisfied
- _____ Not Satisfied _____ No opinion

10. Overall, how satisfied are you with your visit today?

- _____ Very Satisfied _____ Satisfied
- _____ Not Satisfied _____ No opinion

11. Would you return to this clinic? ___ Yes ___ No

12. Would you recommend our services to your family or friends? ___ Yes ___ No

13. Who referred you to this clinic?

14. Please put any additional comment of the back of this survey. THANKS

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Attachment # 2
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LEON COUNTY

Under the terms of the Leon County Primary Healthcare contract this is a request for payment for services rendered by Bond Women and Children's Services. during the period from _____ through _____.

_____ children seen @ per visit \$ _____

_____ adults seen @ per visit \$ _____

Amount billed \$ _____

Less third party payments \$ _____

Total Payment Request \$ _____

YEAR TO DATE SUMMARY

Contract Amount \$ _____

Less: Prior Payments \$ _____

This Payment Request \$ _____

Contract Amount Remaining \$ _____

Provider Representative _____ Date _____

Approved for payment by:

Leon County Contract Manager _____ Date _____

Date Goods/Services Received _____ Initials _____

Date Goods Inspected/Approved _____ Initials _____

Approved for Payment _____ Date _____

Org Code: 64 37 37 71 229 (children) \$ _____

Org Code: 64 37 37 71 237 (adults) \$ _____

EO: PC Object Code: 251041 Category: 050331