

CONTRACT FOR
TRAUMA SPECIALIST

BETWEEN

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

AND

STEPHANIE SKLODOWSKI

A) Introduction

1. This contract is entered into between the Delaware Department of Health and Social Services (the Department), Division of Substance Abuse and Mental Health (Division) and Stephanie Sklodowski (the Contractor).
2. The Contract shall commence on September 30, 2012 and terminate on August 31, 2013 unless specifically extended by an amendment, signed by all parties to the Contract. Time is of the essence.

B) Administrative Requirements

1. Contractor recognizes that it is operating as an independent Contractor and that it is liable for any and all losses, penalties, damages, expenses, attorney's fees, judgments, and/or settlements incurred by reason of injury to or death of any and all persons, or injury to any and all property, of any nature, arising out of the Contractor's negligent performance under this Contract, and particularly without limiting the foregoing, caused by, resulting from, or arising out of any act of omission on the part of the Contractor in their negligent performance under this Contract.
2. The Contractor shall maintain such insurance as will protect against claims under Worker's Compensation Act and from any other claims for damages for personal injury, including death, which may arise from operations under this Contract. The Contractor is an independent contractor and is not an employee of the State.

3. During the term of this Contract, the Contractor shall, at its own expense, carry insurance with minimum coverage limits as follows:

- | | |
|------------------------------------|--------------------------|
| a) Comprehensive General Liability | \$1,000,000 |
| and | |
| b) Medical/Professional Liability | \$1,000,000/ \$3,000,000 |
| or | |
| c) Misc. Errors and Omissions | \$1,000,000/\$3,000,000 |
| or | |
| d) Product Liability | \$1,000,000/\$3,000,000 |

All contractors must carry (a) and at least one of (b), (c), or (d), depending on the type of service or product being delivered.

If the contractual service requires the transportation of Departmental clients or staff, the contractor shall, in addition to the above coverage, secure at its own expense the following coverage:

- | | |
|---|---------------------|
| e) Automotive Liability (Bodily Injury) | \$100,000/\$300,000 |
| f) Automotive Property Damage (to others) | \$ 25,000 |

4. Notwithstanding the information contained above, the Contractor shall indemnify and hold harmless the State of Delaware, the Department and the Division from contingent liability to others for damages because of bodily injury, including death, that may result from the Contractor's negligent performance under this Contract, and any other liability for damages for which the Contractor is required to indemnify the State, the Department and the Division under any provision of this Contract.
5. The policies required under Paragraph B3 must be written to include Comprehensive General Liability coverage, including Bodily Injury and Property damage insurance to protect against claims arising from the performance of the Contractor and the contractor's subcontractors under this Contract and Medical/Professional Liability coverage when applicable.
6. The Contractor shall provide a Certificate of Insurance as proof that the Contractor has the required insurance. The certificate shall identify the Department and the Division as the "Certificate Holder" and shall be valid for the contract's period of performance as detailed in Paragraph A 2.

7. The Contractor acknowledges and accepts full responsibility for securing and maintaining all licenses and permits, including the Delaware business license, as applicable and required by law, to engage in business and provide the goods and/or services to be acquired under the terms of this Contract. The Contractor acknowledges and is aware that Delaware law provides for significant penalties associated with the conduct of business without the appropriate license.

8. The Contractor agrees to comply with all State and Federal licensing standards and all other applicable standards as required to provide services under this Contract, to assure the quality of services provided under this Contract. The Contractor shall immediately notify the Department in writing of any change in the status of any accreditations, licenses or certifications in any jurisdiction in which they provide services or conduct business. If this change in status regards the fact that its accreditation, licensure, or certification is suspended, revoked, or otherwise impaired in any jurisdiction, the Contractor understands that such action may be grounds for termination of the Contract.

a) If a contractor is under the regulation of any Department entity and has been assessed Civil Money Penalties (CMPs), or a court has entered a civil judgment against a Contractor or vendor in a case in which DHSS or its agencies was a party, the Contractor or vendor is excluded from other DHSS contractual opportunities or is at risk of contract termination in whole, or in part, until penalties are paid in full or the entity is participating in a corrective action plan approved by the Department.

A corrective action plan must be submitted in writing and must respond to findings of non-compliance with Federal, State, and Department requirements. Corrective action plans must include timeframes for correcting deficiencies and must be approved, in writing, by the Department.

The Contractor will be afforded a thirty (30) day period to cure non-compliance with Section 8(a). If, in the sole judgment of the Department, the Contractor has not made satisfactory progress in curing the infraction(s) within the aforementioned thirty (30) days, then the Department may immediately terminate any and/or all active contracts.

9. Contractor agrees to comply with all the terms, requirements and provisions of the Civil Rights Act of 1964, the Rehabilitation Act of 1973 and any other federal, state, local or any other anti discriminatory act, law, statute, regulation or policy along with all amendments and revision of these laws, in the performance of this Contract and will not discriminate against any applicant or employee or service recipient because of race, creed, religion, age, sex, color, national or ethnic origin, disability, status as a person in a marriage versus a person in a civil union, veteran's status or any unlawful discriminatory basis or criteria.
10. The Contractor agrees to provide to the Divisional Contract Manager, on an annual basis, if requested, information regarding its client population served under this Contract by race, color, national origin or disability.
11. This Contract may be terminated in whole or in part by the Department upon five (5) calendar days written notice for cause or documented unsatisfactory performance, provided that, in its sole discretion, the Department may impose sanctions in lieu of termination as set forth in Appendix A attached to and incorporated into this Contract.

This Contract may be terminated in whole or in part by either party in the event of substantial failure of the other party to fulfill its obligations under this Contract through no fault of the terminating party; but only after the other party is given:

- a. Not less than 30 calendar days written notice of intent to terminate; and
- b. An opportunity for consultation with the terminating party prior to termination.

This Contract may be terminated in whole or in part by Delaware for its convenience, but only after Contractor is given:

- a. Not less than 30 calendar days written notice of intent to terminate; and
- b. An opportunity for consultation with Delaware prior to termination.

If termination for default is effected by Delaware, Delaware will pay Contractor that portion of the compensation which has been earned as of the effective date of termination but:

- a. No amount shall be allowed for anticipated profit on performed or unperformed services or other work, and

- b. Any payment due to Contractor at the time of termination may be adjusted to the extent of any additional costs occasioned to Delaware by reason of Contractor's default.
- c. Upon termination for default, Delaware may take over the work and prosecute the same to completion by agreement with another party or otherwise. In the event Contractor shall cease conducting business, Delaware shall have the right to make an unsolicited offer of employment to any employees of Contractor assigned to the performance of the Contract, notwithstanding any provisions in this document to the contrary.

If after termination for failure of Contractor to fulfill contractual obligations it is determined that Contractor has not so failed, the termination shall be deemed to have been effected for the convenience of Delaware.

The rights and remedies of Delaware and Contractor provided in this section are in addition to any other rights and remedies provided by law or under this Contract.

In the event of termination, all finished or unfinished documents, data, studies, surveys, drawings, models, maps, photographs, and reports or other material prepared by Contractor under this contract shall, at the option of the Department, become the property of the Department.

In the event of termination, the Contractor, upon receiving the termination notice, shall immediately cease work and refrain from purchasing contract related items unless otherwise instructed by the Department.

The Contractor shall be entitled to receive reasonable compensation as determined by the Department in its sole discretion for any satisfactory work completed on such documents and other materials that are usable to the Department. Whether such work is satisfactory and usable is determined by the Department in its sole discretion.

Should the Contractor cease conducting business, become insolvent, make a general assignment for the benefit of creditors, suffer or permit the appointment of a receiver for its business or assets, or shall avail itself of, or become subject to any proceeding under the Federal Bankruptcy Act or any other statute of any state relating to insolvency or protection of the rights of creditors, then at the option of

the Department, this Contract shall terminate and be of no further force and effect. Contractor shall notify the Department immediately of such events.

12. Delaware may suspend performance by Contractor under this Contract for such period of time as Delaware, at its sole discretion, may prescribe by providing written notice to Contractor at least 30 working days prior to the date on which Delaware wishes to suspend. Upon such suspension, Delaware shall pay Contractor its compensation, based on the percentage of the project completed and earned until the effective date of suspension, less all previous payments. Contractor shall not perform further work under this Contract after the effective date of suspension. Contractor shall not perform further work under this Contract after the effective date of suspension until receipt of written notice from Delaware to resume performance.

In the event Delaware suspends performance by Contractor for any cause other than the error or omission of the Contractor, for an aggregate period in excess of 30 days, Contractor shall be entitled to an equitable adjustment of the compensation payable to Contractor under this Contract to reimburse for additional costs occasioned as a result of such suspension of performance by Delaware based on appropriated funds and approval by Delaware.

Any notice required or permitted under this Contract shall be effective upon receipt and may be hand delivered with receipt requested or by registered or certified mail with return receipt requested to the addresses listed below. Either Party may change its address for notices and official formal correspondence upon five (5) days written notice to the other.

To the Department at:

Division of Substance Abuse and Mental Health

Business Operations Unit

Springer Building/Room 419

1901 N. Dupont Highway

New Castle, DE 19720

To the Contractor at:

Stephanie Slodowski, LPCMH, NBCC
48 Neponset Road
Wilmington, DE 19810

13. In the event of amendments to current Federal or State laws which nullify any term(s) or provision(s) of this Contract, the remainder of the Contract will remain unaffected.
14. This Contract shall not be altered, changed, modified or amended except by written consent of all Parties to the Contract.
15. The Contractor shall not enter into any subcontract for any portion of the services covered by this Contract without obtaining prior written approval of the Department. Any such subcontract shall be subject to all the conditions and provisions of this Contract. The approval requirements of this paragraph do not extend to the purchase of articles, supplies, equipment, rentals, leases and other day-to-day operational expenses in support of staff or facilities providing the services covered by this Contract.
16. This entire Contract between the Contractor and the Department is composed of these several pages and the attached:
 - Appendix A - Divisional Requirements
 - Appendix A-1 – Trauma Grant Requirements
 - Appendix B - Services Description
 - Appendix C - Contract Budget
 - Attachment 1 -- Policy Memorandum 46
 - Attachment 3 -- Policy Memorandum 40
 - Attachment 4 -- Policy Memorandum 36
 - (By Reference RFP HSS-11-060 and response to same)
17. This Contract shall be interpreted and any disputes resolved according to the Laws of the State of Delaware. Except as may be otherwise provided in this contract, all claims, counterclaims, disputes and other matters in question between the Department and Contractor arising out of or relating to this Contract or the breach thereof will be decided by arbitration if the parties hereto mutually agree, or in a court of competent jurisdiction within the State of Delaware.

18. In the event Contractor is successful in an action under the antitrust laws of the United States and/or the State of Delaware against a vendor, supplier, subcontractor, or other party who provides particular goods or services to the Contractor that impact the budget for this Contract, Contractor agrees to reimburse the State of Delaware, Department of Health and Social Services for the pro-rata portion of the damages awarded that are attributable to the goods or services used by the Contractor to fulfill the requirements of this Contract. In the event Contractor refuses or neglects after reasonable written notice by the Department to bring such antitrust action, Contractor shall be deemed to have assigned such action to the Department.
19. Contractor covenants that it presently has no interest and shall not acquire any interests, direct or indirect, that would conflict in any manner or degree with the performance of this Contract. Contractor further covenants that in the performance of this contract, it shall not employ any person having such interest.
20. Contractor covenants that it has not employed or retained any company or person who is working primarily for the Contractor, to solicit or secure this agreement, by improperly influencing the Department or any of its employees in any professional procurement process; and, the Contractor has not paid or agreed to pay any person, company, corporation, individual or firm, other than a bona fide employee working primarily for the Contractor, any fee, commission, percentage, gift or any other consideration contingent upon or resulting from the award or making of this agreement. For the violation of this provision, the Department shall have the right to terminate the agreement without liability and, at its discretion, to deduct from the contract price, or otherwise recover, the full amount of such fee, commission, percentage, gift or consideration.
21. The Department shall have the unrestricted authority to publish, disclose, distribute and otherwise use, in whole or in part, any reports, data, or other materials prepared under this Contract. Contractor shall have no right to copyright any material produced in whole or in part under this Contract. Upon the request of the Department, the Contractor shall execute additional documents as are required to assure the transfer of such copyrights to the Department.

If the use of any services or deliverables is prohibited by court action based on a U.S. patent or copyright infringement claim, Contractor shall, at its own expense, buy for the Department the right to continue using the services or deliverables or modify or replace the product with no material loss in use, at the option of the Department.

22. Contractor agrees that no information obtained pursuant to this Contract may be released in any form except in compliance with applicable laws and policies on the confidentiality of information and except as necessary for the proper discharge of the Contractor's obligations under this Contract.
23. Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver or breach of any provision of this Contract shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of the Contract unless stated to be such in writing, signed by authorized representatives of all parties and attached to the original Contract.
24. If the amount of this contract listed in Paragraph C2 is over \$25,000, the Contractor, by their signature in Section E, is representing that the Firm and/or its Principals, along with its subcontractors and assignees under this agreement, are not currently subject to either suspension or debarment from Procurement and Non-Procurement activities by the Federal Government.

C) Financial Requirements

1. The rights and obligations of each Party to this Contract are not effective and no Party is bound by the terms of this contract unless, and until, a validly executed Purchase Order is approved by the Secretary of Finance and received by Contractor, *if required by the State of Delaware Budget and Accounting Manual*, and all policies and procedures of the Department of Finance have been met. The obligations of the Department under this Contract are expressly limited to the amount of any approved Purchase Order. The State will not be liable for expenditures made or services delivered prior to Contractor's receipt of the Purchase Order.
2. Total payments under this Contract shall not exceed **\$56,000.00** in accordance with the budget presented in Appendix C. Payment will be made upon receipt of an itemized invoice from the Contractor in accordance with the payment schedule, if any. The contractor or vendor must accept full payment by procurement (credit) card and or conventional check and/or other electronic means at the State's option, without imposing any additional fees, costs or conditions. Contractor is responsible for costs incurred in excess of the total cost of this Contract and the Department is not responsible for such costs.

3. The Contractor is solely responsible for the payment of all amounts due to all subcontractors and suppliers of goods, materials or services which may have been acquired by or provided to the Contractor in the performance of this contract. The Department is not responsible for the payment of such subcontractors or suppliers.
4. The Contractor shall not assign the Contract or any portion thereof without prior written approval of the Department and subject to such conditions and revisions as the Department may deem necessary. No such approval by the Department of any assignment shall be deemed to provide for the incurrence of any obligations of the Department in addition to the total agreed upon price of the Contract.
5. Contractor shall maintain books, records, documents and other evidence directly pertinent to performance under this Contract in accordance with generally accepted accounting principles and practices. Contractor shall also maintain the financial information and data used by Contractor in the preparation of support of its bid or proposal. Contractor shall retain this information for a period of five (5) years from the date services were rendered by the Contractor. Records involving matters in litigation shall be retained for one (1) year following the termination of such litigation. The Department shall have access to such books, records, documents, and other evidence for the purpose of inspection, auditing, and copying during normal business hours of the Contractor after giving reasonable notice. Contractor will provide facilities for such access and inspection.
6. The Contractor agrees that any submission by or on behalf of the Contractor of any claim for payment by the Department shall constitute certification by the Contractor that the services or items for which payment is claimed were actually rendered by the Contractor or its agents, and that all information submitted in support of the claims is true, accurate, and complete.
7. The cost of any Contract audit disallowances resulting from the examination of the Contractor's financial records will be borne by the Contractor. Reimbursement to the Department for disallowances shall be drawn from the Contractor's own resources and not charged to Contract costs or cost pools indirectly charging Contract costs.
8. When the Department desires any addition or deletion to the deliverables or a change in the services to be provided under this Contract, it shall so notify the Contractor. The Department will develop a Contract Amendment authorizing said change. The Amendment shall state whether the change shall cause an alteration in the price or time required by the Contractor for any aspect of its performance under the Contract. Pricing of changes shall be consistent with those prices or costs established within

this Contract. Such amendment shall not be effective until executed by all Parties pursuant to Paragraph B 14.

D) Miscellaneous Requirements

1. *If applicable*, the Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 46, (PM #46, effective 3/11/05), and divisional procedures regarding the reporting and investigation of suspected abuse, neglect, mistreatment, misappropriation of property and significant injury of residents/clients receiving services, including providing testimony at any administrative proceedings arising from such investigations. The policy and procedures are included as **Attachment # 1** to this Contract. It is understood that adherence to this policy includes the development of appropriate procedures to implement the policy and ensuring staff receive appropriate training on the policy requirements. The Contractor's procedures must include the position(s) responsible for the PM46 process in the provider agency. Documentation of staff training on PM46 must be maintained by the Contractor.
2. The Contractor, including its parent company and its subsidiaries, and any subcontractor, including its parent company and subsidiaries, agree to comply with the provisions of 29 Del. Code, Chapter 58: "Laws Regulating the Conduct of Officers and Employees of the State," and in particular with Section 5805 (d): "Post Employment Restrictions."
3. *When required by Law*, Contractor shall conduct child abuse and adult abuse registry checks and obtain service letters in accordance with 19 Del. Code Section 708; and 11 Del. Code, Sections 8563 and 8564. Contractor shall not employ individuals with adverse registry findings in the performance of this contract.
4. *If applicable*, the Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 40 (PM #40, effective 3/10/2008), and divisional procedures regarding conducting criminal background checks and handling adverse findings of the criminal background checks. This policy and procedure are included as **Attachment #3** to this Contract. It is understood that adherence to this policy includes the development of appropriate procedures to implement the policy and ensuring staff receive appropriate training on the policy requirements. The Contractor's procedures must include the title of the position(s) responsible for the PM40 process in the contractor's agency.

5. *If applicable*, the Contractor agrees to adhere to the requirements of DHSS Policy Memorandum # 36 (PM #36, effective 9/24/2008), and divisional procedures regarding minimal requirements of contractors who are engaging in a contractual agreement to develop community based residential arrangements for those individuals served by Divisions within DHSS. This policy and procedure are included as **Attachment # 4** to this Contract. It is understood that adherence to this policy includes individuals/entities that enter into a contractual arrangement (*contractors*) with the DHSS/Division to develop a community based residential home(s) and apartment(s). Contractors shall be responsible for their subcontractors' adherence with this policy and related protocol(s) established by the applicable Division.

6. All Department campuses are tobacco-free. Contractors, their employees and subcontractors are prohibited from using any tobacco products while on Department property. This prohibition extends to personal vehicles parked in Department parking lots.

E) Authorized Signatures:

For the Contractor:

Stéphanie Sklodowski, LPCMH, NBCC

10/3/12
Date

For the Department:
N/A Delegation Agreement

Rita M. Landgraf
Secretary

Date

For the Division:

Kevin A. Huckshorn
Director

10/15/12
Date

APPENDIX A

Division Requirements

The Contractor certifies, to the best of its knowledge and belief that all services provided under this contract shall be in compliance with all the terms, requirements and provisions of:

I. General

- A. The Contractor agrees to provide the staff and services (as described in Appendixes) and to seek reimbursement for services provided according to the terms and conditions set forth in this contract. Delaware residents shall be given priority over residents of other states in determining eligibility for services provided under this contract.
- B. The Division reserves the right to reduce the number of people a Contractor currently serves, restrict the number of referrals a Contractor may receive, or rescind authorization to operate one or more service sites (e.g., neighborhood home, apartment) or any combination of such measures as sanctions for documented unsatisfactory contract performance as determined by the Division. The Division may impose such sanctions for a period of between 30 to 365 days, with the right to renew the sanctions at the Division's sole discretion.
- C. The Contractor agrees to acknowledge, in any communication involving the public, the media, the legislature or others outside of DSAMH, that the services provided under the terms of this contract are funded by and are part of the system of public services offered by DSAMH.
- D. The Contractor agrees to participate in the DSAMH reporting and identification system and to use such forms as are approved/required by or supplied by DSAMH. Any modifications to the approved forms must have prior authorization from DSAMH.
- E. The Contractor agrees to maintain such participant record systems as are necessary and required by DSAMH and/or federal mandate to document services. Program record systems shall be compatible with existing DSAMH systems, including the management information system (MIS), be based on project objectives and measure and track the movement of clients through the program.

- F. The Contractor agrees to provide DSAMH copies of such records, statistics and other data required for research, evaluation, client follow-up, training needs assessment and program or financial monitoring or audit.
- G. DSAMH retains the specific right of access to all treatment records, plans, reviews and essentially similar materials that relate to the services provided to clients/consumers under the terms of this contract. DSAMH shall be entitled to make and retain possession of copies of any treatment records, plans, reviews and essentially similar materials which relate to the services provided to clients/consumers under the terms of this contract and the contractor shall not restrict DSAMH from such possession.
- H. The Contractor shall have a disaster response plan in conjunction with DSAMH's Planning, Evaluation and Program Development Unit and to coordinate with DSAMH in the event that implementation of either the Contractor's or DSAMH's disaster response plan is required. This plan will not include DPC unless otherwise pre-negotiated.
- I. The Contractor agrees that no employee, board member, or representative of the Contractor, either personally or through an agent, shall solicit the referral of clients to any facility or program in a manner, which offers or implies an offer of rebate to persons referring clients or other fee-splitting inducement. This applies to contents of fee-schedules, billing methods, or personal solicitation. No person or entity involved in the referral of clients may receive payment or other inducement by a facility/program or its representatives. No person shall be employed for the sole reason to direct people with serious mental illness to a facility that they are employed by or get remuneration of any kind.
- J. The Contractor and DSAMH mutually understand and agree that DSAMH may at any time elect to seek another provider to provide the services required by this contract. In the event that DSAMH selects another provider, the Contractor agrees and shall be required to cooperate fully in the development and execution of an orderly and coordinated close-out of the Contractor's program operation to ensure the continuity of appropriate client care during the transition to another service provider.
- K. The Contractor agrees to apportion the delivery of services as purchased under this contract and to assure that services are reasonably available to DSAMH-approved and/or funded consumers/clients throughout the term of the contract. DSAMH reserves the right to delay or withhold payments for services provided under this contract when it appears that services are being provided in a manner that threatens reasonable availability of services or

delays the expected provision of client specific data reports on a monthly basis throughout the term of the contract.

II. DSAMH Requirements

A. Community Integration: General Principles

- i. Individuals with disabilities should have the opportunity to live like people without disabilities. They should have the opportunity to be employed, have a place to call home that is their own, and be engaged in the community with family and friends.
- ii. Individuals with disabilities should have control over their own daily activities to the extent they can, including which job, educational, or leisure activities they pursue.
- iii. Individuals with disabilities should have control over where and how they live, including the opportunity to live in their own apartment or home. Living situations that require conformity to a collective schedule or that restrict personal activities limit the right to choose. Restrictive living arrangements must be supported with clear documentation of clinical needs by the community provider.

B. Employment

Individuals with disabilities should have the opportunity to be employed in non-segregated, regular workplaces. Philosophically, most individuals with disabilities can be employed and earn the same wages as people without disabilities based only on their employment skills. When needed, people with mental health conditions should have access to supported or customized employment. They should be afforded options other than sheltered work, day treatment, clubhouses, and other segregated programs.

C. Housing

- i. Virtually all individuals with disabilities can live in their own home with supports. Like people without disabilities, they should get to decide where they live, with whom they live, when and what they eat, who visits and when, etc.
- ii. To this end, individuals with disabilities should have access to housing other than group homes, other congregate arrangements, and multi-unit

buildings or complexes that have been heretofore developed for people with disabilities. They should have access to "scattered site" housing, with ownership or control of a lease. Housing should not be conditioned on compliance with treatment or with a service plan. DHSS and DSAMH ascribe to the Housing First model of care that mean that individual housing arrangements are not coupled with clinical services.

- iii. Housing, in all forms, must meet the following criteria (from the Bazelon Center for Mental Health Law):
 - a) Housing units are scattered-site or scattered in a single building with no more than 20% of the total building population having mental health or substance use (co-occurring conditions) as best as can be determined.
 - b) A wide array of flexible, individualized services and supports is available to ensure successful tenancy and support participants' recovery and engagement in community life.
 - c) Services are delinked from housing. Participants are not required to use services or supports to receive or keep their housing.
 - d) Participants have direct input in choosing their housing unit, any roommates (if they choose not to live alone) and which services and supports (if any) they want to use.
 - e) Participants have the same rights and responsibilities as all other tenants. They should have their own personally signed lease agreement. They should be given any accommodations necessary to help ensure successful tenancy.
 - f) Appendices provide additional guidance

D. Choice

- i. Individuals with disabilities should have the opportunity to make informed choices. They must have full and accurate information about their options, including what services and financial supports are available in integrated settings. They should have the opportunity to visit integrated settings and talk to individuals with similar disabilities working and living in integrated settings. Their concerns about integrated settings should be explored and addressed.

E. Public Funding

- i. Government funding for services should support implementation of these principles. Currently, public funding has a bias toward

institutionalization, forcing individuals to overcome myriad barriers if they wish to age in place or remain in the community.

- ii. These principles of community integration are embraced by:
 - a) Autistic Self-Advocacy Network
 - b) Bazelon Center for Mental Health Law
 - c) Disability Rights Education and Defense Fund
 - d) Mental Health America
 - e) National Association of Rights Protection and Advocacy
 - f) National Council on Independent Living
 - g) National Disability Rights Network
 - h) Delaware Division of Substance Abuse and Mental Health (DSAMH)

F. Inclusion of Peers

- i. Peers shall be received and treated as a meaningful addition to the agency's workforce and integrated into the philosophy and service system for their unique strengths and perspective that makes them so valuable. Contractors shall fully integrate Peers into their clinical operations as well as in various levels of management. Peers are not to be used as "add-on" staff, substitute staff, or volunteer labor except in time limited and very goal oriented projects. All peers, hired by providers to work with clients receiving services, shall go through the same hiring process as any other agency staff. The contractor shall make accommodations peer staff when work schedules or other issues specific to the ongoing success of the peer is needed.
- ii. Peer staff should be reimbursed based on their experience and their responsibilities. Contractors shall reimburse peers at a variety of salary levels that are in concert with other staff at the agency performing similar functions.
- iii. Contractors shall document that peers who are applying for peer specialist, or other peer work assignments, have received training and education on the knowledge, and skills to do the job for which they were hired. While training and education alone will not assure competence, documentation of completion of a nationally recognized Peer Specialist training curriculum is one step that potential peers may complete to be hired. The alternative to this training may include assurances by the hiring agency that the Peer Specialist will complete training that is comparable with a nationally recognized Peer Specialist training

curriculum within 30 days of employment. DSAMH will host the approved trainings throughout the year.

- iv. Peer staff requires ongoing support and education beyond the initial orientation program at the time of hire. A supervision schedule shall be developed for each Peer Specialist that shall include ongoing supervision that is equal to the supervision schedule of all clinical staff. A senior peer or other professional with skill and knowledge about the role of the Peer Specialist shall provide the supervision.
- v. Finally, it is noted in the literature and in best practices that peer staff needs to have ready access to executive agency staff at any time. There are issues that may arise when an agency starts to integrate peers into their workforce that can help or hinder the success of this work. The provider shall develop a policy and procedure that outlines expectations that peer staff are included in executive staff meetings and have access 24/7 to executive staff in every agency to mediate client decisions or conflicts.
- vi. DSAMH is also helping to support the development of a Delaware Consumer Resource Council (DCRC) that is an independent organization. DSAMH expects that every funded provider organization or stakeholder will assure for one or more peers, from that agency, to be free to attend these monthly and quarterly meetings and be reimbursed for their time.
- vii. Please access the following information to help guide your use of peer staff. DSAMH expects that all providers will access this information and use it to guide their work, policy and procedures, and agency behaviors going forward.

http://www.nasmhpd.org/general_files/publications/ntac_pubs/Bluebird%20Guidebook%20FINAL%20202-08.pdf

<http://www.jopm.org/evidence/case-studies/2011/05/09/promoting-recovery-oriented-mental-health-services-through-a-peer-specialist-employer-learning-community/>

http://www.samhsa.gov/news/newsreleases/060215_consumer.htm

G. Delivery of Co-Occurring Mental Health and Substance Abuse Services System Wide

- i. All DSAMH funded programs are expected to provide fully integrated, co-occurring services for individuals with both mental illness and substance use conditions. This care should be seamless, cognizant to each client's willingness and readiness, and flexible. In addition, programs should make use of all available psychiatric medications and other medication assisted treatments in the treatment of these disorders. People with COD require individualized care and this care needs to be monitored and tracked by the primary provider of record.
- ii. In addition, individuals with mental health disorders and medical issues should also receive treatment from consistent providers who work together to provide this care. Better is that care is provided in one setting, like a health home, where the individual can get all of their services in one place. Lacking that, DSAMH expects that DSAMH clients receive all necessary care for COD and that this care is documented in their record. Please note that most often the DSAMH provider is the primary provider to assure that this care is provided.

H. Certain EBPs

- i. Evidence based practices/promising practices that are specified in a contractual scope of service must be implemented according to published fidelity measures and monitored by the contracted program to insure fidelity to the model as part of the contractor's Quality Assurance (QA) program.
- ii. DSAMH will be adding an evidence-based physical assessment template to all of our contracts in July, 2012. All providers will have access to the expert that DSAMH will be bringing in to train on these procedures. These basic prevention and early intervention primary care practices will then need to be assumed by all DSAMH providers so they can stay current and be viable players in current and future health care reform changes. These expectations will be added to your contract post July 1, 2012. These primary care expectations can be fulfilled by DSAMH contractors or through MOUs with other providers. Performance on these measures will be reviewed annually at a minimum.
- iii. DSAMH will require evidence based fidelity scales for all ACT teams. During the initial year of the contract, the contractor shall employ staffing patterns that meet the requirements of the Tool for Measuring Assertive Community Treatment (TMACT). DSAMH will train agency staff during the initial year of the contract. The contractor will work with the Quality Assurance/Performance Improvement Unit to establish

programs that are in full fidelity with TMACT by the end of the contract cycle.

I. Care Coordination

- i. Each provider is expected to provide services that are of the intensity, quality and appropriateness necessary to support individuals to live in their chosen community, to avoid any and all unnecessary hospitalizations, and to minimize the time that one spends in an unavoidable hospitalization. Intensity of care decisions must be based in DE ASAM criteria.
- ii. Providers are expected to facilitate ALL care for their clients - they may not be responsible for providing (i.e., medical). DSAMH expects a good faith effort to be made to assertively coordinate care.

J. Notification to families and significant others

Programs must document attempts to engage family and other supports in treatment (e.g. letters letting supports know when Recovery Plan meetings are occurring, reminders of when office visits are scheduled and that supports should consider attending, monthly phone contact to identified supports to see if they have any questions and to give them updates/ask for their assistance in keeping the consumer engaged...). Documentation of attempts to engage family and other supports shall be placed in the client's treatment file and referenced on the client's recovery plan.

K. NAMI Family to Family Training

All DSAMH providers that serve people with mental health conditions shall include referrals for all family members or significant others to NAMI's Family to Family training program. This is an evidence-based training program that is educational and advocacy oriented. The process to refer family members and significant others shall be incorporated into all provider contracted DSAMH agency policy and procedure manuals. The success of referrals shall be tracked and reported internally and to DSAMH quarterly.

L. Grievance Procedures

- i. Any client or family member with legal standing that is unhappy or concerned about the services or supports being provided by DSAMH providers may access a formal, user friendly Grievance Process.

- ii. The Grievance Process shall be posted in a public area that is readily viewed by consumers and family members.
- iii. This formal Grievance Process will include the following steps:
- iv. Individuals receiving services from a DSAMH funded provider or DSAMH state staff may call or send an email to the following people:
 - 1) Penny.chelucci@state.de.us or 302-255- 9421
 - 2) Frann.anderson@state.de.us or 302-255- 9441
 - 3) Steven.dettwyler@de.state.us or 302-255- 9432
 - 4) Kevin.huckshorn@de.state.us or 302-255-9398
- v. Once contact is made with the DSAMH representative, the complainant will be contacted by the appropriate DSAMH staff person within 48 hours.
- vi. The DSAMH representative will gather information about the complaint during a phone interview. The information will be forwarded to the DSAMH employee that is best able to address the concern and the complaint will be resolved within 10 working days of the phone interview.
- vii. If the complainant is not satisfied with DSAMH's resolution to the problem, the complainant may contact Kathy Weiss Kathleen.weiss@de.state.us Constituent Relations Director, Department of Health and Social Services.
- viii. DSAMH has adopted a goal of a maximum of ten working days resolve any complaints.
- ix. If the individual making the complaint is not satisfied they may then contact Kathleen.weiss@de.state.us who is the Department's Constituent Relations Director.

III. Health Care and Pharmacy Expectations

All programs are expected to advocate for their clients by assertively assisting in maintaining their individual health, but also supporting prevention-oriented services and the development of a healthy lifestyle. Coordinating health care services can be complex for those individuals who have serious physical health

illness, in addition to co-occurring diagnoses. Program staff should employ or otherwise access a healthcare navigator who can assist clients in obtaining local healthcare providers, coordinating appointments to efficiently use the client's time and scheduling follow up for requested laboratory testing, mammograms, etc while coordinating their care across multiple providers to facilitate communication on integration of their healthcare needs. Healthcare navigators do not provide healthcare services, but are the coordinator of this complex process of integration of healthcare, including obtaining education for clients who need this education to participate in their own recovery process. Providers employing a health care navigator shall incorporate these duties into the job description of the staff person assigned to these duties.

A. Pharmacotherapy

Pharmacotherapy is an integral part of many individual's recovery. Individual's with serious and persistent mental illness (SPMI) and their families rely heavily on the judgment of the individual physicians who prescribe their medications to do so in a professionally responsible manner, adhering to the practice guidelines of the American Psychiatric Association, the American Medical Association, the American Osteopathic Association and the specific policy recommendations of the Medical Directors' Division of the National Association of State Mental Health Program Directors. (Principles of Antipsychotic Prescribing for Policy Makers, Circa 2008 Translating Knowledge to Promote Individualized Treatment, NASMHPD Technical Paper) The Federal Drug Administration (FDA) tests the safety and efficacy of medications and these guidelines with their dosage limits and approved indications will also be considered in establishing safe and efficacious prescribing practices. Prescribers of medications for those with SPMI and/or Co-occurring diagnoses, will maintain board certification or board eligibility in their area of specialty in addition to a current medical license in the state of DE. DSAMH will reserve the right to gather information on psychiatric prescribing practices on a case by case basis, as necessary.

B. Safety in Prescribing Practices

Medications for chronic illnesses may have significant risks, in addition to their benefit in controlling symptoms. It is the responsibility of every individual who prescribes medications, for those with SPMI and/or Co-occurring diagnoses, to discuss the risks, benefits, adverse response potential and alternatives to medication of each medication prescribed. Prescribing more than one medication in the same class of medications can increase risk factors for the individual being treated. For those instances where an individual is on two or more psychiatric medications from the same class of

medications, a second opinion or clinical consultation is recommended by a board certified psychiatrist. An example of this would be an individual on one first generation antipsychotic medication and one second generation antipsychotics; two second generation antipsychotic meds; two mood stabilizers; two antidepressants; or any combination of the above. DSAMH does not support the use of poly-pharmacy prescription practices as this prescribing practice is not supported in the literature.

C. Pharmacy and Therapeutics (P & T) Oversight

All DSAMH contracted Hospitals and Community programs that provide medications as part of the therapeutic process are required to have P & T oversight. There shall be coordination of the program's policies and procedures to insure consistency and continuity of care to individuals being served by DSAMH. Medication access, prescribing practices, medication utilization, costs of medications, efficiency and effectiveness of medications, dosage limits, FDA approved indications, etc are all under the purview of the agency and state P & T. Membership is multi-disciplinary and includes consumer representation.

The P&T committee is traditionally chaired by the Chief of Pharmacy Services or State Medical Director or Agency Pharmacy or Medical Director and includes a membership that is reflective of the disciplines permitted to prescribe medications in the state of Delaware and within the purview of each discipline's license.

D. Pharmacy Requirements

- i. Consumers with Medicaid/Medicare and/or other benefits for prescription coverage will have their choice of a pharmacy service provider with the ultimate goal of having consumers utilize their local neighborhood pharmacy when and if they are able.
- ii. While some consumers will require special packaging to manage their medications, DSAMH does not support the use of these packaging options when used as a convenience for the service provider. DSAMH clients shall be assessed on their ability to manage their own healthcare including the client's ability to provider manage the acquisition and administration of their medications. The assessment shall include the client's ability to understand side and adverse effects and how to manage these symptoms.
- iii. Uninsured consumers will be directed to the state pharmacy for their psychiatric medications until they become eligible for benefits or for as

long as they need. The provider is expected, and will be monitored by DSAMH, to take full advantage of available mechanisms for defraying these costs (e.g. Prescription Assistance Plans, appropriate use and management of Medicare Part D plans, collection of prescription co-pays, sample medications, use of generics when clinically appropriate, etc.) as well as all DSAMH pharmacy reporting requirements. The DSAMH pharmacy will not provide non-psychiatric "somatic" medications.

- iv. The contractor will assist the consumer in the management of finances to ensure the availability of funds to cover medication co-pays and deductibles. DSAMH will not routinely provide reimbursement for medication co-pays and deductibles as this practice is not the intent of the federal requirements. Any provider may appeal for an exclusion from this expectation if necessary. A procedure for submitting requests for reimbursement will be developed in coordination with the contractor.

IV. Benefits and Client Funds

A. Benefit entitlements

Contractor shall have staff with sufficient expertise and resources to assist individuals in care to receive any and all benefits to which the client is entitled. Contractor shall provide education to the individual that will assist the client in understanding all aspects of the benefit including services that are covered and those that are not.

B. Client fees

All providers must adhere to the DHSS Policy Memorandum #37 regarding the assessment and collection of client fees whenever applicable.

C. Rep Payee reports and related expectations

- i. DSAMH intends to contract out the representative payee service for all clients in care in early SFY 2013. It is an essential conflict of interest for a DSAMH provider of direct services to also manage that individual's monies. The financial goals for each individual should include the ability to independently manage their own money.
- ii. All DSAMH providers who are working with people with Rep Payees are expected to provide evidence-based trainings and supports to clients who cannot manage their money. The natural goal of this initiative is greater independence of the client with regard to money

management, budgeting and expenditures. It is expected that the number of individuals requiring rep payee service will decrease over time. It is also acknowledged that, due to the great variability in competencies in the individuals we serve, a number of clients will require Rep Payee services going forward. We expect the contractor to work directly with DSAMH before any changes are made to the current management of this program.

V. Provider Management and Oversight Structures

A. Policies and Procedures

- i. Contractor policies and procedures, rules, standards and regulations shall be written in Person-First Language.
- ii. Contractor policies, procedures and practices shall follow the principles of SAMSHA's Consensus Statement on what defines Recovery Oriented Care and the principles of Trauma Informed Care as defined by NASMHPD and SAMSHA. Contractor will ensure an implementation of these models within a two year maximum time period but will need to demonstrate an agency wide plan in 2012 to demonstrate their intent.
- iii. If Contractor uses the safety measures called Seclusion and Restraint, a plan must be designed to reduce the use of these restrictive, dangerous and traumatizing safety measures. Contractors using seclusion and restraint safety measures shall send aggregated data by unit and by month to DSAMH by the 15th of each month.

B. Monitoring

- i. The Contractor agrees to comply with DSAMH's monitoring/audit protocols and to submit documents necessary to comply with such protocol.
- ii. Contractor shall have a documented process to investigate allegations of abuse and/or neglect with written procedures for conducting PM46 and RI 33 investigations in residential settings.
- iii. Non-Residential services providers not covered by the terms of the Department of Health and Social Services Policy Memorandum #46, shall establish and implement policy and standardized written procedures for the reporting, investigation and follow-up of all incidents

involving suspected non-residential consumer/client abuse, neglect, mistreatment, financial exploitation or significant injury/death. The Contractor shall notify DSAMH of all cases of suspected non-residential consumer/client abuse, neglect, mistreatment, financial exploitation or significant injury/death within 24 hours of the incident. In addition, the contractor shall prepare for DSAMH an annual report of all incidents involving suspected non-residential consumer/client abuse, neglect, mistreatment, financial exploitation or significant injury/death. The annual report shall summarize the number, type and outcome of all reported incidents.

- iv. The Contractor shall: 1) notify DSAMH of any and all deaths of consumers/clients receiving services under the terms of this contract as soon as possible following the Contractor's becoming aware of the death; 2) complete and submit to DSAMH a Death Review Form within three business days of the death (or first knowledge of the death); and, 3) conduct a mortality conference for all deaths reported to DSAMH in accordance with DSAMH Policy #ADM 004 which has been distributed to the Contractor. A Root Cause Analysis will be conducted within five (5) business days of the death with input and participation from DSAMH at DSAMH's request.
- v. The Contractor shall conduct a Root Cause Analysis upon DSAMH request when an incident does not result in the death of a client, but has caused harm to a client and/or poses future jeopardy to the safety of clients in the future.

C. Licensing

- i. The Contractor agrees to comply with DSAMH's Licensure Standards and to submit documents necessary to comply with such standards.
- ii. The Contractor shall respond in writing to DSAMH-Initiated program licensure survey report findings and/or recommendations within ten (10) working days following receipt of DSAMH's written conveyance of such findings/recommendations to the Contractor.
- iii. The Contractor acknowledges that DSAMH required all entities receiving in excess of \$499,999.99 per annum (cumulative) in State payments through contracts with DSAMH and/or Medicaid payments for DSAMH-related services must obtain/retain accreditation from an accreditation body recognized by and acceptable to DSAMH. The Contractor further acknowledged and agrees that any failure to

obtain/retain required accreditation will be considered good cause under the termination provisions of this contract.

VI. EEU Process

All contractors will accept referrals from DSAMH's EEU and comply with all EEU policies and procedures for completion of referral packets and updating of utilization review documentation.

Contractor understands that no client will be discharged from this program without approval from DSAMH. Violation of this may result in the Contractor being fined for each event.

VII. Training and Education

The contracted provider is responsible for complying with all DSAMH mandatory training requirements as specified in the contractual scope of work.

Specifically and as defined in contract language and certification standards, in the first months of the contract programs are expected to support their leadership participation and staff participation in DSAMH opportunities (or comparable opportunities with faculty who have a recognized expertise) for training when applicable.

Additionally, programs are expected to provide assistance with Self Administration of Medication (AWSAM) training both prior to their working with consumers and annually thereafter. Programs may work together and/or contract with Delaware nurses who have been authorized by the DBN to provide that training. Within 18 months, all programs shall develop internal program capacity to provide in-service training on AWSAM.

Additional and ongoing expectations for program leadership and employee training beyond the first months may include the following topics: Ethics, Cultural Competency, ACT Team Management & Service Provision, supervision, trauma-informed care, integration of care, CBT, co-occurring, and illness management. Additional topics may be identified based on the needs of service recipients and the experience of employees in each program. The expectation is that programs will provide opportunity for all employees to attend, external to the program, training and education on an annual basis. The training and education is to be directly connected to providing more effective services and to attain better outcomes for the service recipients. In-services should also be provided to all employees, at a minimum quarterly, and documented.

Certificates of completion of the recommended training topics as well as in-service participation are to be maintained in personnel files.

DSAMH expects to coordinate mandatory trainings for current CRISP, ACT/ICM, TCM, CAPAC, and Rep Payee providers. DSAMH is noting that these state funded trainings are mandatory for the staff in your agencies that we identify. Unless that staff person can show current successful completion of this same course they will be expected to attend. A pattern or history of non attendance at DSAMH mandated training will be seen as a violation of your contract with DSAMH going forward. These DSAMH sponsored trainings will be rare but are not optional.

VIII. Data Submission

- A. Effective 7/1/2012 all providers submitting electronic data will be required to use the state's Secure File Transfer Protocol (SFTP) site. Contact the DSAMH MIS unit for information on creating an account and any other questions or concerns about data reporting requirements.
- B. Data submission elements will be specified in the scope of work for each contract.

IX. Fiscal

- A. All contracted programs are expected to inform DSAMH prior to the initial hire of or any changes in executive level staff that shall also be defined as senior executive management staff who make over \$80,000 annually excluding benefits. DSAMH expects to provide the final level of approval on these hires or changes in work assignment for all senior executive staff funded by DSAMH funding. DSAMH expects to be sent the credentials and resume prior to hire for all positions such as Executive Director, Chief Financial Officer, Clinical Director, Medical Director, Director of Nursing, Director of Substance Abuse or Co-occurring Disorders or equal positions regardless of the position title that the contracted agency has adopted. DSAMH will need to approve all senior executive staff hires to include offered salaries and benefit packages funded by state dollars.
- B. If applicable, purchase of any individual unit of capital property with a value in excess of \$1,000 with funds wholly or in part from any cost reimbursement portion of this contract must have prior written approval from DSAMH. Title to any capital property acquired with funds wholly or in part from any cost reimbursement portion of this contract shall revert to DSAMH upon the termination of services provided under this or subsequent renewal

contracts(s). With respect to capital property acquired with funds wholly or in part from any cost reimbursement portion of this Contract, the Contractor agrees to maintain detailed inventory of all such capital property and to submit a property inventory each quarter, indicating any new purchase(s) made during the quarter and a full inventory of all such property not later than thirty (30) days following the termination of this contract. The full inventory must indicate any loss, destruction or disposal of property appearing on any previous inventory. The contractor shall not transfer ownership of, sell, destroy, divert to use or purpose other than that of which purchased, or relocate such inventory items without prior written approval by DSAMH. The contractor shall make available all property inventory to DSAMH survey and audit staff upon request.

- C. Upon notice given to the Contractor's Executive Director or his/her designee, representatives of DSAMH or other duly authorized State or Federal agency shall inspect, monitor, audit and/or evaluate the program's fiscal records or other material relative to this contract. The contractor MUST comply with all audit activities.
- D. DSAMH agrees to provide funds for the Contractor's delivery of staff and services (as described in Appendix B in accordance with the approved budget (Appendix C). However, this provision is expressly subject to the understanding that DSAMH will not pay for services which: (1) have not been rendered, (2) cannot be verified as having been provided, according to standard DSAMH monitoring/audit procedures, (3) have not been provided by DSAMH-approved agencies/programs, (4) have been provided to persons not authorized by DSAMH, (5) have been provided to persons of less than 18 years of age unless such persons have been approved in writing by DSAMH as eligible to receive services under this contract, (6) have been paid for by MEDICAID/MEDICARE, by other third-party payers and/or by or on behalf of the recipient of services, and/or (7) are a benefit offered as a covered service in any healthcare plan under which the client has been determined to be covered or for which the client has been found to be eligible unless such clients are specifically approved in writing by DSAMH as eligible to receive services under this contract.
- E. The Contractor shall charge fees and will be expected to make reasonable efforts to collect such fees from all liable first and/or third party payer(s) for non-Medicaid clients receiving services for which reimbursement/payment is requested from DSAMH under terms of this contract. The maximum fee so charged to Non-Medicaid clients for Program Services shall not exceed the Fee-for-Service rate paid by Medicaid for services provided to Medicaid clients, except that such maximum fee limitation shall be waived with respect

to billings made to third-party payers (legitimate and generally recognized insurance carriers) which have recognized and approved an alternate fee structure. The disposition of any such fees collected will be subject to further written agreement between the Contractor and DSAMH. In the absence of such further agreement, all such fees shall be returned to DSAMH on or before the termination date of this contract. A current listing of Accounts Receivable must be maintained, and a copy forwarded to DSAMH on request, indicating Accounts Receivable Outstanding and Uncollected. Notice of a Fee Schedule shall be posted in a prominent place in each facility stating the availability and location of the schedule. The fee schedule will show base prices for the principal services and any change that may occur in such prices. The fee schedule shall be available for public inspection and a copy shall be furnished to the Internal Revenue Service upon request. The Contractor further agrees to provide DSAMH such policies as pertain to fee schedules, collection of fees and understandings with patients or patients' families concerning third party liability.

- F. The Contractor shall not refuse service provided under the terms of this contract to any individual on the basis of such individual's inability to pay for service in whole or in part.
- G. Upon termination or expiration of this contract all unexpended cost reimbursement funds involved on an accrual based system will be returned to DSAMH, Department of Health and Social Services.
- H. In the event of loss of funding or reduction of funding available to DSAMH for services purchased under the terms of this contract, and in lieu of termination of the contract in its entirety, DSAMH and the Contractor may mutually agree to negotiate a reduction in funding and services and amend this contract in a manner consistent with the nature, amount and circumstances of the loss or reduction of funds.
- I. The Contractor shall establish and implement policy and procedure to assure that client income, insurance status, and related ability-to-pay for services can be timely determined following initial contact. Clients whose income is determined to be less than ten percent (10.0%) in excess of that level which would qualify them for benefits under Medicaid/Medicare eligibility guidelines in Delaware must be advised and encouraged to apply for such benefits. DSAMH may withhold, deny, or request return of payments made to the Contractor for services provided to clients: a) whose income is determined to be less than ten percent (10.0%) in excess of that level which would qualify them for benefits under the Medicaid program in Delaware and who have not applied for such benefits within sixty (60) days of admission into the program offered by the Contractor under the terms of this contract OR, b) who have not

appropriately enrolled to receive benefits with thirty (30) days after having been determined to be eligible for Medicaid benefits.

- J. The Contractor's financial records must adequately reflect all direct and indirect administrative and service costs expended in the performance of this contract. The funds received and expended under this contract shall be accounted for and recorded by the Contractor in order to permit auditing and accounting for all expenditures in conformity with the terms and provision of this contract and State and Federal laws and regulations. Monthly expenditure/revenue reports will be submitted monthly in the required format. Payment for services will be delayed until the required reports are submitted.
- K. The Contractor's fiscal records and accounts, including those involving other programs which, by virtue of cost or material resources sharing, are substantially related to this contract, shall be subject to audit by duly authorized federal and state officials.
- L. The Contractor must have an annual audit, conducted by an independent auditor, and provide DSAMH with a copy of the most recently completed annual audit, including any related financial statements and management letters, not later than November 1 of the original term of this contract and any extensions thereof, as applicable. Any DSAMH initiated audit shall neither obviate the need for, nor restrict the Contractor from conducting required annual corporate audit(s). Financial statements are to be prepared in accordance with appropriate generally accepted accounting principles. Contractor audits must be performed in accordance with generally accepted auditing principles and, when required, comply with the requirements of the (Federal) Office of Management and Budget (OMB) Circular A-133.
- M. The Contractor is responsible for the safeguarding and management of Resident funds and will:
 - a) Provide accountability for the property and management, receipt and disbursement of each resident/client funds;
 - b) Notify DSAMH immediately of any incident of misappropriation of resident/client funds or property;
 - c) Provide or arrange for representative payee services when warranted by the residents ability to manage their own funds until DSAMH contracts with an independent entity to perform these services.
 - d) Conduct an independent annual professional audit of each of the resident/client funds and submit audit findings to DSAMH prior to the end of each fiscal year. Develop and submit internal policies and procedures regarding resident funds and property management to DSAMH.

- N. The Contractor agrees to monitor all expenditures of funds by any subcontractor, including verification of services rendered. The Contractor understands it shall be accountable for all sources of funds and all expenditures of funds for all agencies/programs receiving any funds under the provisions of this contract.
- O. Both DSAMH and the Contractor understand and agree that any budget that is part of this contract is presented in mutual realization that costs associated with program operation and related activities are good faith estimates and that this contract will be subject to administrative line-item budget adjustments as actual costs are determined provided that the contractor requests, and DSAMH approves, such adjustments prior to their implementation. Line-item adjustment requests and approvals must be documented in writing for adjustments in excess of 10% per category.
- P. Flow-Down of Requirements under Subawards and Contracts under Grants

The terms and conditions in the Health and Human Services Grants Policy Statement (HHS GPS) apply directly to the recipient of HHS funds. The recipient is accountable for the performance of the project, program, or activity; the appropriate expenditure of funds under the award by all parties; and all other obligations of the recipient, as cited in the NoA. In general, the requirements that apply to the recipient, including public policy requirements, also apply to sub-recipients and contractors under grants, unless an exception is specified.

The Contractor is required to be familiar with, and comply with all spending restrictions and certifications required in the most recent version of the HHS GPS. Including Time and Effort reporting and certifications for any positions funded with Federal Funds.

All Federal Grant funding shall be maintained and accounted for separate and apart from all other funds. Transaction documents for all federal funding shall be maintained so that all funds can be accounted for during a contract audit.

X. Department of Health and Social Services Requirements

- A. The Contractor shall ensure that its liability insurance extends coverage to such members of its governing and/or advisory boards as may be potentially liable for damages by virtue of their official position, service to, or otherwise apparent or presumed relationship to the Contractor and/or the services provided by the Contractor under the terms of this contract.

B. The Contractor agrees to comply with the following Delaware Health & Social Services Policy Memorandums as applicable.

1. Policy Memorandum #5 – Client Confidentiality
2. Policy Memorandum #7 – Client Service Waiting Lists
3. Policy Memorandum #24 – Safeguarding & Management of Resident/Client funds
4. Policy Memorandum #37 – Standard Ability to Pay Fee Schedule
5. Policy Memorandum #40 – Criminal Background Check Policy
6. Policy Memorandum #46 – Standardized Reporting and Investigation of Suspected Abuse, Neglect, Mistreatment, Financial Exploitation and Significant Injury of Residents/Clients Receiving Services in Residential Facilities Operated By Or For DHSS
7. Policy Memorandum #55 – Human Subjects Review Board

XI. Federal requirements

A. The following Federal Mandates:

1. The Drug-Free Workplace Act of 1988.
2. The Americans with Disabilities Act (PL 101-336).
3. P.L. 103-227, Sections 1041-1044, 20 U.S.C. Sections 6081-6084, also known as the Pro-Children Act of 1994.
4. Title IX of the Education Amendment of 1972 (45 CFR 86) which provides, in general, that no person shall on the basis of sex be excluded from program participation.
5. The Contractor agrees to maintain the confidentiality of all clients in accordance with 42 U.S.C. 290 dd-3 and/or 42 U.S.C. 290 ee-3 and 42 CFR part 2.

XII. Health Insurance Portability & Accountability Act (HIPAA)

DSAMH (Covered Entity) and Contractor (Business Associate) wish to comply with the provisions of 45 C.F.R. §160.101 et seq. (“Privacy Regulations”) and 45 C.F.R. §164.308 et seq. (“Security Regulations”) regarding the appropriate use and disclosure of Protected Health Information under this contract (Original Contract).

A. Definitions. The terms used in this Business Associate Agreement (“Agreement”) shall have the same meaning as those terms are used in HIPAA, 45 CFR § 160 et seq. and 45 CFR § 164.308 et seq.

B. Permitted uses and Disclosures of Protected Health Information.

Business Associate will not use or further disclose any Protected Health Information except in the provision of services to Covered Entity as specifically authorized under the Original Contract, including without limitation any use or disclosure which would violate the provisions of the Privacy Regulations. Notwithstanding the foregoing, Business Associate may use and disclose Protected Health Information to provide data aggregation services related to the healthcare operations of Covered Entity. Business Associate may also use and disclose Protected Health Information in the proper management and administration of Business Associate and to carry out its legal responsibilities, provided that the use and disclosure is either required by law or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially 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 information has been breached.

C. Responsibilities of Business Associate. Business Associate will:

1. Not use or further disclose Protected Health Information other than as permitted or required by the Original Contract or as required by law, including without limitation, the Privacy Regulations and any applicable State law.
2. Protected Health Information other than as provided for in the Use appropriate safeguards to prevent use or disclosure of Original Contract.
3. Implement administrative, physical, and technical safeguards that reasonably protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity.(d) Report to Covered Entity any use or disclosure of Protected Health Information not provided for in the Original Contract of which it becomes aware.
4. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from, or created or

received by Business Associate on behalf of, the Covered Entity, agrees to the same restrictions and conditions that apply to Business Associate with respect to Protected Health Information. Further any agent or subcontractor must agree to implement reasonable and appropriate safeguards to protect electronic protected health information.

5. Make available for inspection and copying Protected Health Information to an individual about such individual in accordance with 45 C.F.R § 164.524.
6. Make available Protected Health Information to an individual about such individual for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. § 164.526.
7. Make available Protected Health Information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;
8. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Secretary of HHS to whom the authority involved has been delegated for purposes of determining the Covered Entity's compliance with privacy Regulations.
9. At termination of the Original Contract, if feasible, return all Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity that Business Associates still maintains in any form and retain no copies of such Protected Health information or, if return is not feasible, extend the protections of the Original Contract and this Agreement to the information and limit further uses and disclosures to those purposes that make the return of the protected Health Information infeasible.

D. Other Arrangements.

1. If a business associate is required by law to perform a function or activity on behalf of a covered entity or to provide a service described in the definition of business associate as specified in §160.103 of this subchapter to a covered entity, the covered entity may permit the business associate to create, receive, maintain or transmit electronic protected health information on its behalf to the extent necessary to

comply with the legal mandate without meeting the requirements of (a) (2) (1) of §164.314, provided that the covered entity attempts in good faith to obtain satisfactory assurances as required by paragraph (a)(2)(ii)(A) of §164.314, and documents the attempt and the reasons that these assurances cannot be obtained.

2. The covered entity may omit from its other arrangements authorization of the termination of the contract by the covered entity, as required by paragraph (a)(2)(i)(D) of §164.314 if such authorization is inconsistent with the statutory obligations of the covered entity or its business associate.
3. Termination of Agreement. This HIPAA Agreement and the Original Contract may be terminated by Covered Entity if Covered Entity determines that Business Associate has violated a material term of this Agreement. The provisions of Paragraphs 1 and 2 hereof shall survive any termination of this Agreement and/or the Original Contract.
4. Miscellaneous. This HIPAA Agreement contains the final and entire agreement of the parties and supersedes all prior and/or contemporaneous understandings and may not be modified or amended unless such modification is in writing and signed by both parties and their successors, administrators and permitted assigns. All personal pronouns used in this Agreement whether used in masculine, feminine or neuter gender, shall include all other genders, the singular shall include the plural, and vice versa. Titles of Paragraphs are utilized for convenience only and neither limit nor amplify the provisions of this Agreement itself. If any provision of this Agreement or the application thereof to any person or circumstance shall be invalid or unenforceable to any extent, the remainder of this affected thereby and shall be enforced to the greatest extent permitted by law.

APPENDIX A-1

TRAUMA GRANT REQUIREMENTS

Terms and Conditions

Grant funds cannot be used to supplant current funding of existing activities. Under the DHSS Grants Policy Directives, 1.02 General-Definition: Supplant is to replace funding of a recipient's existing program with funds from a Federal grant.

By law, none of the funds awarded can be used to pay the salary of an individual at a rate in excess of the Executive Level I, which is \$199,700 annually.

"Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 CFR 2) are applicable to any information about alcohol and other drug abuse patients obtained by a "program" (42 CFR 2.11), if the program is federally assisted in any manner (42 CFR 2.12b)

Accordingly, all project patient records are confidential and may be disclosed and used only in accordance with (42 CFR 2). The contractor is responsible for assuring compliance with these regulations and principles, including responsibility for assuring the security and confidentiality of all electronically transmitted patient material.

Accounting Records and Disclosure – the contractor must maintain separate records which adequately identify the source and application of funds provided for financially assisted activities. These records must contain information pertaining to grant or subgrant awards and authorizations, obligations, unobligated balances, assets, liabilities, outlays or expenditures, and income. The contractor, and all its sub-recipients, should expect that SAMHSA, or its designee, may conduct a financial compliance audit and on-site program review on grants with significant amounts of Federal funding.

Per (45 CFR 92.34) and the HHS Grants Policy Statement, any copyrighted or copyrightable works developed under this cooperative agreement/grant shall be subject to a royalty free, nonexclusive and irrevocable license to the government to reproduce, publish, or otherwise use them and to authorize others to do so for Federal Government purposes. Income earned from any copyrightable work developed under this grant must be used as program income.

None of the Federal funds provided under this contract shall be used to carry out any program for distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

No DHHS funds may be paid as profit (fees) per (45 CFR Parts 74.81 and 92.22(2)).

RESTRICTIONS OR GRANTEE LOBBYING (APPROPRIATIONS Act Section 503).

(a) No part of any appropriation contained in this Act shall be used, other than normal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress, except in presentation to the Congress itself or any State legislature.

(b) No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

Where a conference is funded by a grant or cooperative agreement the recipient must include the following statement on all conference materials (including promotional materials, agenda, and Internet sites):

Funding for this conference was made possible (in part) by (insert grant or cooperative agreement award number) from SAMSHA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

If federal funds are used to attend a meeting, conference, etc. and meal(s) are provided as part of the program, then the per diem applied to the travel costs (ME&I allowance) must be reduced by the allotted meal cost(s).

This award is subject to the requirements of Section 106 (g) of the Trafficking Victims Protection Act of 2000, as amended (22 U.S.C. 7104).

Must comply with the requirements of the National Historical Preservation Act and EO 13287, Preserve America. The HHS Grants Policy Statement provides clarification and uniform guidance regarding preservation issues and requirements (pages i-20, "Preservation of Cultural and Historical Resources").

Executive Order 13410 Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs promotes efficient delivery of quality health care and price, and incentives to promote the widespread adoption of health information technology and quality of care.

Trafficking Victims Protection Act of 2000

The Trafficking Victims Protection Act of 2000 is a comprehensive Federal law enacted to protect victims of trafficking or to prosecute their traffickers. All SAMHSA grantees are required to abide by the provisions of this law. For additional information, go to www.samhsa.gov/grants/trafficking.aspx

ACORN

In accordance with guidance provided by the Department of Health and Human Services, funding prohibitions regarding ACORN and related entities remain in effect pending further litigation as to ACORN's First Amendment and due process claims.

For additional information go to: www.whitehouse.gov/omb/assets/memoranda_2010/m10-12.pdf

INCENTIVES

"Incentives" refer to any monetary or service benefit provided to program participants to attract and retain them in the service or prevention program. The dictionary defines "incentive" as "something that encourages or motivates somebody to do something."

SAMHSA discretionary grant funds may be used for non-cash incentives that are considered **essential** to retain individuals to participate in prevention and treatment programs and to encourage attendance and attainment of treatment or prevention goals. All the non-cash incentives must be built into the program design and should be of minimal cash value, e.g. , food, prizes, small gifts.

Discretionary grant funds may **not** be used to make direct cash payments to individuals during the treatment or prevention program.

SAMHSA policy supports the appropriate, judicious, and conservative use of incentives in discretionary grant programs. Incentives should be the minimum amount necessary to meet the programmatic and evaluation goals of the grant **up to \$20**. Grant applicants/grantees should determine the minimum amount that is provided to be effective as follows:

Before the Program: SAMHSA discretionary grant funds may **not** be used to make direct payments to individuals to induce them to enter treatment or prevention programs.

During the Program: SAMHSA discretionary grant funds may be used for "wrap-around services" (non-clinical supportive services) intended to improve the individual's access to and retention in treatment, deemed essential to meet the program's goals relative to the target population, improve access to and retention in prevention programs or for meeting abstinence benchmarks.

After the program: CMHS and CSAT practice has allowed for SAMHSA discretionary grant funds to pay individuals to participate in required data collection follow-up. CSAP has **not** established practice related to payment for follow-up data collection.

Health and Human Services Grants Policy Statement:

The HHS GPS is general terms and conditions for Discretionary grants and Cooperative agreements. This directive covers policy topics including, but not limited to, general administrative and public policy terms, cost considerations and standards of conduct

Cost Principles:

Guidelines for determining allowable and unallowable expenditures are outlined in the Federal cost principles. The allowable, reasonable and allocable necessity of costs that may be charged to SAMHSA grants are outlined in the following cost principles:

2 CFR Part 230 and Office of Management and Budget (OMB) Circular A-122.

Uniform Administrative Requirements:

In addition to the cost principles, OMB has established Uniform Administrative Standards and audit requirements for organizations receiving Federal assistance. These Uniform Administrative Standards are contained in the following documents:

45 CFR Part 74

CFDA: 93.243

AMOUNT OF FUNDING:\$52,000.00

APPENDIX B

SERVICES DESCRIPTION

TRAUMA CLINICAL CONSULTANT

The Trauma Clinical Consultant will provide clinical consultation support on trauma-informed care (TIC) for grant staff, providers and trauma peers working with the five year Mental Health Transformation (Trauma) Grant obtained by the Division of Substance Abuse and Mental Health (DSAMH). This is a part-time contract position.

The Trauma Clinical Consultant will:

- provide technical assistance and coaching to the peer specialists and clinicians on trauma screening activities.
- provide technical assistance, coaching and informal training to clinicians on trauma assessment and treatment planning for persons who screen positive for trauma.
- provide technical assistance, coaching and informal training to clinicians on facilitating support groups for persons who are assessed to be experiencing trauma-related disorders.
- Observe and assess provider organizations regarding progress toward developing a comprehensive culture of trauma-informed care, in conjunction with other organizational assessment processes.
- Perform other duties as deemed appropriate to advance the goals of the MHTG, in consultation with the contractor.

The Trauma Clinical Consultant will provide these services in the State's community mental health centers, substance abuse outpatient clinics and/or ACT teams over the course of the grant. Locations will be determined by the Project Director and Assistant Director of Community Mental Health and Addiction Services in consultation with the contractor. The Trauma Clinical Consultant will report to the Project Director, who is overseen by the Assistant Director of Community Mental Health and Addiction Services.

APPENDIX C
CONTRACT BUDGET

MAXIMUM HOURS

Per Week	20
# of weeks	44
Per Week	30
# of weeks	8

RATE PER HOUR

Trauma Clinical Coordinator	\$ 50.00
	\$ 56,000.00

MAXIMUM AMOUNT FOR CONTRACT **\$56,000.00**

ATTACHMENT 1



DELAWARE HEALTH AND SOCIAL SERVICES

DHSS Policy Memorandum 46 August 2009

Subject: Injury to Clients

I. PURPOSE

- a. To protect the right of residents/clients of Delaware Health and Social Services (DHSS) facilities to be free from abuse, neglect, mistreatment, financial exploitation or significant injury.
- b. To require that each Division that has, or contracts for the operation of, residential facilities establish standardized written procedures for the reporting, investigation and follow up of all incidents involving suspected resident/client abuse, neglect, mistreatment, financial exploitation, or significant injury.
- c. To require that all DHSS residential facilities comply with The Patient Abuse Law (Title 16, Chapter 11, section 1131, et seq.) and Title 29, Chapter 79, sections 7970 and 7971 (Attachments I and II); and that all Medicaid and/or Medicare certified long term care facilities and Intermediate Care Facilities for Mental Retardation (ICF/MR) comply with the federal regulations (42 CFR) and State Operations Manual for such facilities. In addition, all residential facilities and Medicaid and/or Medicare certified long term care facilities and Intermediate Care Facilities for Mental Retardation (ICF/MR) comply with Title 11, Chapter 94, Victims Bill of Rights, Subchapter I and Subchapter II. Compliance with Title 11, Chapter 5, Subchapter V Offenses Relating to Children and Incompetants, Subpart A Child Welfare; Sexual Offenses is required by all facilities that provide residential and/or inpatient services to children.
- d. To require that all DHSS residential facilities comply with all applicable state and federal statutes, rules and regulations pertaining to suspected abuse, neglect, mistreatment, financial exploitation, or significant injury. Applicable statutes include Title 11, Chapter 5, Subchapter II Offenses Against the Person, Subpart A Assaults and Related Offenses.

II. SCOPE

- a. This policy applies to anyone receiving services in any residential facility operated by or for any DHSS Division, excluding any facilities/programs in which the only DHSS contract is with the DHSS Division of Social Services Medicaid Program.
- b. This policy is not intended to replace additional obligations under federal and/or state laws, rules and regulations.

III. DEFINITIONS

- a. Abuse shall mean:
 1. Physical abuse the unnecessary infliction of pain or injury to a resident or client. This includes, but is not limited to, hitting, kicking, pinching, slapping, pulling hair or any sexual molestation. When any act constituting physical abuse has been proven, the infliction of pain shall be assumed.
 2. Emotional abuse - This includes, but is not limited to, ridiculing or demeaning a resident or client, cursing or making derogatory remarks towards a resident or client, or threatening to inflict physical or emotional harm to a resident or client.
- b. Neglect shall mean:
 1. Lack of attention to the physical needs of the resident or client including, but not limited to, toileting, bathing, meals, and safety.
 2. Failure to report client or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse.
 3. Failure to carry out a prescribed treatment plan for a resident or client.
 4. A knowing failure to provide adequate staffing (where required) which results in a medical emergency to any patient or resident where there has been documented history of at least 2 prior cited instances of such inadequate staffing within the past 2 years in violation of minimum maintenance of staffing levels as required by statute or regulations promulgated by the department, all so as to evidence a willful pattern of such neglect. (Reference 16 DE Code, §1161-1169)
- c. Mistreatment shall mean the inappropriate use of medications, isolation, or physical or chemical restraints on or of a resident or client.
- d. Financial exploitation shall mean the illegal or improper use or abuse of a client's or resident's resources or financial rights by another person, whether for profit or other advantage.
- e. Significant Injury is one which is life threatening or causes severe disfigurement or significant impairment of bodily organ(s) or functions which cannot be justified on the basis of medical diagnosis or through internal investigation.

- f. Assault (including sexual assault) as defined in Del.Code Title 11 § 611, § 612 and § 613.
- g. Attempted Suicide shall mean an intentional attempt at the taking of one's own life.
- h. SANE – Sexual Assault Nurse Examiner.
- i. Residential Facility shall include any facility operated by or for DHSS which provides supervised residential services, including Long Term Care licensed facilities, group homes, foster homes, and community living arrangements.
- j. Long Term Care Facility is any facility operated by or for DHSS which provides long term care residential services and the Delaware Psychiatric Center.
- k. High managerial agent is an officer of a facility or any other agent in a position of comparable authority with respect to the formulation of the policy of the facility or the supervision in a managerial capacity of subordinate employees.

IV. RESPONSIBILITIES

- a. The Director, or his/her designee of each Division within the scope of this policy, is hereby designated as an official DHSS designee under the State Mandatory Patient Abuse Reporting Law.
- b. Each Division will develop written procedures consistent with the standards contained in this policy and which will be activated immediately upon discovery of any suspected abuse, neglect, mistreatment, financial exploitation or significant injury of or to a client of a residential or long-term care facility. These procedures must clearly outline the reporting chain from the witness to the Division Director, and other appropriate parties, to require the expedient relay of information within the required time frames.
- c. These standardized procedures shall also apply when the preliminary inquiry suggests that the assault, significant injury, suspected abuse, neglect, suicide attempt, mistreatment or financial exploitation may have been caused by a staff member of the residential facility, whether on or off the grounds of the residential facility. Suspicion of facility/program negligence (including inadequate supervision resulting in client-client altercations) and incidents involving abuse by persons who are not staff members of the residential facility shall also be reported.
- d. The standardized procedures shall be approved by the appropriate Division Director prior to implementation. The Division Director or designee shall forward a copy of the approved procedures to the Chief Policy Advisor, Office of the Secretary, and other appropriate agencies.
- e. Each Division will require that the standards established in this policy are incorporated in all residential operational procedures and all residential contracts. Each Division shall require that all residents and providers of these programs be informed of their specific rights and responsibilities as defined in the Division's written procedures.

- f. Each Division shall require that all levels of management understand their responsibilities and obligations for taking and documenting appropriate corrective action.
- g. Each Division shall require appropriate training of all staff and contract providers in the PM 46 policy and procedures. Such training shall also include the laws prohibiting intimidation of witnesses and victims (11 Del. C., sections 3532 through 3534) and tampering with a witness or physical evidence (11 Del. C., sections 1261 through 1263 and section 1269).
- h. Each Division shall develop quality assurance/improvement mechanisms to monitor and oversee the implementation of the PM 46 policy and procedures.
- i. Each Division must ensure that all employees of, or contractors for, residential facilities shall fully cooperate with PM 46 investigations.

V. STANDARDS/PROCEDURES

Standard and consistent implementation of this Department policy is required. Each Division's written procedures shall include the following:

- a. Employee(s) of the residential facility, or anyone who provides services to residents/clients of the facility, who have reasonable cause to believe that a resident/client has been assaulted, abused, mistreated, neglected, subjected to financial exploitation, or has received a significant injury, or attempted suicide shall:
 - 1. Take actions to assure that the residents/client(s) will receive all necessary medical attention immediately, including calling '911' for transportation to the hospital, especially in the cases of assault, sexual assault, and serious physical injury. In the cases of sexual assault, a SANE examination should be completed at the hospital.
 - 2. Take action to report all crimes to the police through the '911' call system. All victims of crimes must be offered the ability to access victim advocate services, either through the police agency or other agencies. Victim advocates can be contacted by calling 1-800-VICTIM1 (1-800-842-8461). The Delaware Helpline can provide advocate information and Contactlifeline can provide confidential accompaniment to the hospital in cases of sexual assault.
 - 3. Take actions to protect the residents/client(s) from further harm.
 - 4. Report immediately to the Division of Long Term Care Residents Protection (if the incident occurred in a long term care facility or if the client was a resident of a long term care facility); and to the Department of Services for Children, Youth and Their Families/Division of Family Services (if the client is a minor, as required under 16 Del. C., section 903). It is essential that the reporting person ensure that the report be made to the appropriate division designee immediately.
 - 5. Report immediately to the facility/program director and the Division's designated recipient(s) of PM 46 reports.

6. Follow up the verbal report with a written initial incident report to the persons/agencies named in (a) 3 and (a) 4 (above) within 48 hours.
- b. In addition to the above named persons, any other person may make a report to a staff person of the facility or to the Division director or his/her designee. Such a report shall trigger activities under V(a), items 1 through 5.
 - c. Each written initial report of assault, suspected abuse, neglect, mistreatment, financial exploitation, attempted suicide, or significant injury (completed by the reporting employee) must include:
 1. The name and gender of the resident or client.
 2. The age of the resident or client, if known.
 3. Name and address of the reporter and where the reporter can be contacted.
 4. Any information relative to the nature and extent of the assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, or significant injury.
 5. The circumstances under which the reporter became aware of the assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, or significant injury.
 6. The action taken, if any, to treat or otherwise assist the resident or client.
 7. Any other information that the reporter believes to be relevant in establishing the cause of such assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, or significant injury.
 8. A statement relative to the reporter's opinion of the perceived cause of the assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, or significant injury (whether a staff member or facility program negligence).
 - d. The Division's designated recipient of PM 46 reports shall report all allegations of assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, and significant injury, to the Office of the Secretary; the Office of the Attorney General/Medicaid Fraud Control Unit (for Medicaid and/or Medicare certified long term care facilities); the appropriate state licensing agency for the program, if applicable; and the Division Director or designee, within 24 hours of receiving notification of such. In instances where a suspected crime has been committed, the police must be notified immediately and they will take the lead in the investigation of the suspected crime.
 - e. In instances where there is immediate danger to the health or safety of a resident/client from abuse, mistreatment or neglect; any sexual assault or alleged sexual assault; any physical abuse that leads to injury; any allegations of verbal abuse; any allegations of vandalism; any allegations of financial exploitation; any suicide; any assault or alleged assault, any suspected criminal action; or if a resident/client has died because of suspected assault, abuse, mistreatment, neglect, suicide, or significant injury, the Division Director or his/her designee shall immediately notify the appropriate police agency. The Division of Long Term Care

Residents Protection, and the Office of the Secretary, shall be notified if the police were contacted. Further, the Division Director or his/her designee shall notify the Office of the Attorney General/Medicaid Fraud Control Unit, the Office of the Secretary, the Chief Medical Examiner, if a resident/client has died because of suspected assault, abuse, mistreatment, neglect, suicide, significant injury, or as a result of any cause identified by 29 Del. C., section 4706 and Title 11, Chapters 5 and 94. In accordance with Title 16 § 5162, the Division Director or his/her designee shall notify the Community Legal Aid Society, Inc within seventy-two hours of the date of any patient or resident death.

- f. The Division Director or his/her designee shall review the initial incident report and initiate an investigation into the allegations contained in the report. The investigation, with a written report, shall be made within 24 hours, if the Division has reasonable cause to believe that the resident's/client's health or safety is in immediate danger from further assault, abuse, neglect, attempts of suicide, or mistreatment. Otherwise, the investigation and written Investigative Report, up to and including the Division Director's or designee's signed review of the report, shall be made to the Division of Long Term Care Residents Protection (DLTCRP) within 10 days. This timeframe may be extended by DLTCRP if extenuating facts warrant a longer time to complete the investigation. If the facility is a Medicaid-Medicare certified long-term care facility, or an ICF/MR facility, the report of suspected assault, abuse, neglect, mistreatment, financial exploitation, attempted suicide, or significant injury shall be sent to the appropriate authorities, as required in the respective regulations under 42 CFR, within 5 working days of the incident.
- g. The investigative process shall be confidential and not subject to disclosure both pursuant to 24 Del. C., section 1768 and because it is privileged under the governmental privilege for investigative files. Each Investigative Report shall be labeled as confidential and privileged, pursuant to 24 Del. C., section 1768. Each investigation shall include the following:
 1. A visit to the facility or other site of incident.
 2. A private interview with the resident or client allegedly abused, neglected, mistreated, whose finances were exploited or whose injury was significant.
 3. Interviews with witnesses and other appropriate individuals.
 4. A determination of the nature, extent and cause of injuries, or in the case of exploited finances, the nature and value of the property.
 5. The identity of the person or persons responsible.
 6. All other pertinent facts.
 7. An evaluation of the potential risk of any physical or emotional injury to any other resident or client of that facility, if appropriate.

- h. A written report (Investigative Report) containing the information identified in V (g) shall be completed within the time frames identified in V (f) and shall include a summary of the facts resulting from the investigation. (Attachment 3)
- i. The Investigative Report shall be sent to the facility director and to the Division Director or designee. The Facility Director and the Division Director or designee shall review the report. If the incident is serious, the

Division Director must review the incident with the Department Secretary prior to the completion of the report. The Facility Director and the Division Director or designee shall indicate in writing their concurrence or non concurrence with the report. If the facts show that there is a reasonable cause to believe that a resident/client has died as a result of the abuse, neglect, mistreatment, or significant injury, the Division Director or designee shall immediately report the matter to the Office of the Attorney General/Medicaid Fraud Control Unit, the Division of Long Term Care Residents Protection, and the Office of the Secretary.
- j. All Investigative Reports shall be forwarded by the reporting division, forthwith, to the Division of Long Term Care Residents Protection. The Division of Long Term Care Residents Protection shall complete the investigation by making a determination of findings and documenting their conclusions.
- k. If a determination is made at the Division level (upon consultation with the Division of Management Services, Human Resources office) that discipline is appropriate, the Investigative Report shall be forwarded to the Human Resources office. Human Resources shall determine the appropriate level of discipline, forward their recommendations to the Office of the Secretary and to the originating division for implementation, and proceed as appropriate.
- l. The Office of the Secretary shall be informed by the Division of Long Term Care Residents Protection, in writing, of the results of the investigation, including the findings and recommendations, within 5 days following the completion of the investigation.
- m. The Division Director or designee shall notify the appropriate licensing or registration board, if the incident involved a licensed or registered professional, and the appropriate state or federal agency, including the appropriate state licensing agency of the program, if applicable, upon a finding of: 1) assault, abuse, mistreatment, neglect, financial exploitation, attempted suicide, or significant injury; 2) failure to report such instances by a licensed or registered professional; or 3) failure by a member of a board of directors or high managerial agent to promptly take corrective action.
- n. The Division Director or designee shall notify the employee, resident/client, the guardian of the resident/client, if applicable, and the incident reporter of the results of the facility-based case resolution, unless otherwise prohibited by law. They shall also advise the parties of the fact that there is a further level of review that will occur through the Division of Long Term Care Residents Protection and/or the Office of the Attorney General/Medicaid Fraud Control Unit.

- o. The Division of Long Term Care Residents Protection shall, at the conclusion of their review of the case, notify the DHSS employee (or the agency director for contract providers), the resident/client, or the guardian of the resident/client, if applicable, and the originating Division Director or designee, of the substantiated or unsubstantiated status of the case, unless otherwise prohibited by law. The Division of Long Term Care Residents Protection shall also notify the Office of the Attorney General/Medicaid Fraud Control Unit of all substantiated cases.

VI. IMPLEMENTATION

- a. This policy shall be effective immediately (upon the completion of mandatory departmental training).
- b. In carrying out this policy, all parties must protect the confidentiality of records and persons involved in the case, and may not disclose any Investigative Report except in accordance with this policy.

VII. EXHIBITS

- a. Attachment 1 - Delaware Code, Title 16, Chapter 11, Sections 1131-1140.
- b. Attachment 2 - Delaware Code, Title 29, Chapter 79, Sections 7970-7971.
- c. Attachment 3 - Investigative Report form
- d. Attachment 4 - Delaware Code, Title 11, Chapters 5 and 94.

Rita M. Landgraf, August 2009

Rita M. Landgraf, Secretary

ATTACHMENT 3



DELAWARE HEALTH AND SOCIAL SERVICES

POLICY MEMORANDUM NUMBER 40 March 10, 2008

Subject: Criminal Background Check Policy

I. Purpose

Delaware Health and Social Services is committed to providing a safe and secure environment for our patients, residents and employees. Additionally, the Delaware Code (Title 16, sec. 1141) requires criminal background checks of all individuals seeking work in long term care facilities. To that end, it is the policy of DHSS to conduct criminal background checks for all persons hired or promoted into any permanent or temporary position with any long term care or psychiatric facility operated by the DHSS. The Delaware Psychiatric Center is licensed as a hospital and while the Code does not require criminal background checks for employees of the DPC, long standing policy and practice mandates a criminal background check on all prospective employees at the Psychiatric Center.

II. Scope

This policy applies to all applicants and employees of the five facilities operated by DHSS. Under this policy, a criminal background check is required for any current employee who applies for another position within a DHSS facility or laterally transfers or promotes into another position within any DHSS facility. In addition, a criminal background check can be conducted on an employee if an employee takes a voluntary demotion or where there is a reasonable suspicion that a staff person has been recently been involved in criminal activity.

If an applicant has been convicted of any crime, a review of the individual's complete record must be considered prior to permanent hire. If an applicant has been convicted of a disqualifying crime as enumerated by regulations promulgated by the Division of Long Term Care Residents Protection (DLTCRP) in accordance with Delaware Code, Title 16, sec. 1141(b)(e), that applicant is

deemed unsuitable for employment, unless the time parameters surrounding the conviction(s) have eliminated that automatic bar to employment. See Addendum A for a list of disqualifying crimes and conviction time parameters.

This policy covers all full-time and part-time permanent, limited term, temporary and casual/seasonal positions providing direct care, or serving within the facilities operated by DHSS. This policy also applies to all positions and temporary positions filled directly by contractors, vendors, and other entities providing services at DHSS facilities

III. Policy

A criminal background check will be conducted for all newly-hired employees for positions within DHSS facilities. The Division of Long Term Care Residents Protection (DLTCRP) is responsible for completing a criminal background check and review of the Adult Abuse Registry. Once the review has been completed, the DLTCRP will send a letter to the facility's Human Relations Representative outlining the applicant's status. A facility director may extend an offer of employment to an applicant prior to the completion of the criminal background check but that offer is conditional until the Director of Management Services or his/her designee reviews the criminal background check and determines that no adverse action will be taken based upon information contained in that report.

Although a disqualification is possible, a previous conviction does not automatically disqualify an applicant from consideration from employment within a DHSS facility. The Director of Human Resources and the Division Director or designee will together consider the following factors in determining whether a candidate is eligible for employment with DHSS:

1. the relevance of the conviction to the duties and responsibilities of the position for which selected;
2. the nature of the conviction(s);
3. the age of the candidate when the illegal activity occurred;
4. the dates of the convictions; and
5. the candidate's record since the date(s) of the conviction(s).

A pardon has no impact on a conviction. It may, however, be used as a consideration in the criteria above. However, if an applicant fails to reveal any previous conviction, he/she will be disqualified from employment in that or any other position at DHSS for falsification of an application.

If the facility director desires to retain the applicant, he or she may forward a request through the Director of Management Services for final consideration by the Cabinet Secretary.

IV. Procedure

When a hiring manager reaches the final selection stage in the hiring process, the applicant will be given a "DHSS Terms and Conditions of Employment" form authorizing the DLTCRP to conduct a criminal background check. The applicant is then sent to the state police for fingerprinting and initiation of the criminal background check process. The hiring manager then sends the completed and signed form to Human Resources staff person for the respective facility. Human Resources will submit the request to DLTCRP for processing. Refusal to provide a completed and signed DHSS Terms and Conditions of Employment form will be considered sufficient grounds to discontinue any employment consideration for that candidate.

When the investigation is complete, the DLTCRP will submit a report on each applicant to the facility's HR representative. If the criminal background check reveals a criminal history, HR will review and notify the facility director.

The facility director or designee will conduct an additional inquiry to determine the nature of the offense(s) and other circumstances surrounding the criminal record. It is expected that the investigation of an applicant will not take longer than ten days to complete. Applicant information is confidential personnel information, and all parties having access to this information will maintain it as confidential.

If adverse action is contemplated, based on information revealed in the criminal background report, the HR representative will inform the hiring manager and or HR Director to implement due process proceedings. The hiring manager will in turn notify the employee immediately verbally and in writing.

V. Responsibility

It shall be the responsibility of the affected Division Directors to ensure that they, their staff and contractors adhere to the procedures outlined in this policy as written.

It shall be the responsibility of contractors and vendors to conduct criminal backgrounds checks on their employees prior to their assignment to a DHSS facility.

VI. Implementation

This policy is effective immediately.

Vincent P. Meconi, Secretary

Date

Attachment:

Addendum A, List of Disqualifying Crimes and Conviction Time Parameters

DEPARTMENT OF HEALTH & SOCIAL SERVICES
 CRIMINAL BACKGROUND CHECK UNIT
 DISQUALIFYING CRIMES
 CONVICTION/TIME PARAMETERS

531. Attempt to Commit a crime: Attempt to commit a crime is an offense of the same grade and degree as the most serious offense, which the accused is found guilty of attempting. Use same disqualifying time limit as charge attempted.

502. Solicitation 2 nd	513. Conspiracy 1 st	631. Criminally negligent homicide
503. Solicitation 1 st	602b Aggravated Menacing	632. Manslaughter
512. Conspiracy 2 nd	604. Reckless Endangering 1 st Degree	633. Murder/abuse/neglect 2 nd Degree
601. Offensive Touching (If against Law Enforcement, Emergency, Medical or Corrections personnel) Class A Misdemeanor Only	605. Abuse of Pregnant Female in 2 nd Degree	634. Murder/abuse/neglect 1 st Degree
603. Reckless Endangering 2 nd	606. Abuse of a Pregnant Female in 1 st Degree	635. Murder 2 nd Degree
611. Assault 3 rd	612. Assault 2 nd	636. Murder 1 st Degree
621. Terroristic Threatening (Felony or Misdemeanor)	613. Assault 1 st	645. Promoting Suicide
625. Unlawfully administer drugs – Misdemeanor	614. Assault on a sports official 2 nd Offense	768. Unlawful sexual contact in 2 nd Degree
626. Unlawfully administer controlled substance, narcotic drugs.	615. Assault by Abuse or Neglect (Felony)	769. Sexual contact in 1 st
651. Commit Abortion (Other than Therapeutic, that causes miscarriage)	629. Vehicle Assault 1 st	770. Sexual penetration 3 rd or Rape 4 th Degree
785. Interference w/custody	630. Vehicle Homicide 2 nd	771. Sexual penetration 2 nd or Rape 3 rd Degree
801. Arson in 3 rd	630A Vehicle Homicide 1 st	772. Sexual penetration 1 st or Rape 2 nd Degree
804b2. Reckless burning \$1,500 or more in damage	782. Imprisonment 1 st	773. Sexual intercourse 3 rd or Rape 1 st Degree
811. Criminal Mischief \$1,500.00 or more damage	783. Kidnapping 2 nd	776. Sexual Extortion
824. Burglary in 3 rd	783A. Kidnapping 1 st	777. Bestiality
828. Possess Burglary Tools	802. Arson in 2 nd	778. Continuous sexual abuse of a child
840. Shoplifting \$1,000 or more	803. Arson in 1 st	779. Dangerous crime against child
841. Theft (over \$1,000)	825. Burglary in 2 nd	780. Female genital mutilation
842. Theft; lost or mislaid property; mistaken delivery \$1,000 or more	826. Burglary in 1 st	
	831. Robbery in 2 nd	
5 YEARS		10 YEARS
843. Theft; False pretense \$1,000 or more	832. Robbery in 1 st	
844. Theft; false promise \$1,000 or more	835. Carjacking 2 nd Degree	
845. Theft of Services \$1,000 or more	836. Carjacking 1 st Degree	

848. Misapplication of property over \$1,000	846. Extortion
849. Theft or rented property \$1,000 or more	1108. Sexual exploitation of a child
850. Possess/deal in device for unlawfully taking telecommunication services.- Over 5 devices	1109. Dealing in material depicting a child in a prohibited sexual act.
851. Receive Stolen Property – over \$1,000	1112A. Sexual solicitation of a child
854. Identity Theft	1250. Offenses against law-enforcement animals
859. Larceny of livestock	1253. Escape after conviction
860. Possession of Shoplifters Tools	1254. Assault in Detention Facility
861. Forgery 1 st & 2 nd Degree -Felonies	1256. Promoting prison contraband; deadly wpn.
862. Possession of Forgery Devices	1302. Riot
876. Tamper with public records in 1 st Degree	1304. Hate Crimes
878. Issuing false certificate	1312A. Stalking
900. Issuing Bad check –over \$1,000	1338. Bombs, incendiary devices, Molotov cocktails and explosive devices
903. Unlawful use of credit card (\$1,000 or more)	1339. Adulteration (Causing Injury or Death)
907A. Criminal impersonation, accident related	1353. Promoting prostitution in 1 st Degree
907B. Criminal impersonation of a police officer	1442. Carrying a concealed deadly weapon
908. Concealing a will	1444. Possessing a destructive weapon
911. Fraudulent conveyance of public lands	1445. Unlawfully dealing with a dangerous weapon. (If (4) or (5) violated)
912. Fraudulent receipt of public lands	1447. Possession of deadly weapon during commission of a felony
913. Insurance Fraud	1447A. Possession of a firearm during commission of a felony
913A. Health Care Fraud	1449. Wearing body armor during commission of a felony
916. Home Improvement fraud – 2 nd offense	1455. Engaging in a firearms transaction on behalf of another
917. New home construction fraud – over \$1,000	1503. Racketeering
920. Transfer of recorded sounds.	3533. Aggravated Act of Intimidation
932. Unauthorized access of computer Over \$500.00	4751. Controlled Narcotic substance- Possess, deliver, manufacturer with intent to deliver
933. Theft of Computer Services Over \$500.00	4752. Controlled Non-Narcotic substance
934. Interruption of computer services Over \$500.00	4752A. Delivery of noncontrolled substance
5 YEARS	10 YEARS
935. Misuse of computer system information Over \$500.00	4753A. Trafficking in marijuana, cocaine, illegal drugs, methamphetamines, LSD or designer drugs
936. Destruction of computer equipment) over \$500.00	4754A. Possession and delivery of noncontrolled prescription drug
937. Unrequested or unauthorized electronic mail or use of network or software to cause same. Damage over \$500.0	4755. Distribute, dispense a controlled substance. Maintain dwelling, vehicle etc.
938. Failure to promptly cease electronic communications upon request. Damage over \$500.00	4756. Schedule I & II violations as registrant
1001. Bigamy	4757. Disposal – hypodermic syringe or needle
1100. Dealing in children	4761. Distribution narcotics to minors

1102. Endangering the welfare of a child. (Felony if death or serious injury occurs)	4761A. Purchase narcotics from minors
1111. Possession of Child Pornography	4767. Distribution, delivery or possession of controlled substance within 1,000 feet of a school property
1201. Bribery	4768. Distribution, delivery or possession of controlled substance within 300 feet of a park or recreation area
1203. Receiving a bribe	4771(b) Deliver, possess with intent to deliver, convert, manufacture, convey sell or offer sale of Drug Paraphernalia knowing will be used to plant, grow, manufacture, process, pack, inject, ingest, inhale or otherwise introduce into human body a controlled substance.
1222. Perjury 2 nd Degree	4771 (c) Delivery to a minor of Drug Paraphernalia
1223. Perjury 1 st Degree	Title16/1136. Abuse, Mistreatment, Neglect of a Patient
1239. Wearing a disguise during commission of a felony	Title 31/3913. Abuse, Neglect, exploit, mistreat an infirm adult
1240. Threats to a Public Official	
1244b. Hindering Prosecution (If acts of Felony original charge)	
1248b. Obstructing control and suppression of Rabies during state of emergency	
1249. Abetting the violation of drivers license restrictions 2 nd Offense	
1252. Escape from Detention facility 2 nd Degree	
1259. Sexual relations in detention facility	
1260. Misuse of prisoner mail – 2 nd offense	
1261. Bribing a witness	
1262. Witness receiving bribe	
1263. Tampering with a witness	
1263A. Interfering with a child witness	
5 YEARS	10 YEARS
1264. Bribing a juror	
1265. Juror receiving bribe	
1269. Tampering with physical evidence	
1312. Aggravated Harassment	
1325. Cruelty to animals resulting in death or serious injury	
1326. Animals fighting and baiting	
1335(a)(6). Violation of Privacy	
1351. Promoting prostitution in 3 rd Degree	
1352. Promoting prostitution in 2 nd Degree	
1361. Obscenity	
1448. Possession and purchase of deadly weapons by a person prohibited.	
1450. Receiving a stolen firearm	
1451. Theft of a firearm	
1454. Giving a firearm to a person prohibited	

1457. Possession of a weapon in a Safe School and Recreation Zone	
1458. Removing a firearm from the possession of a law enforcement officer	
1459. Possession of a weapon with a removed, obliterated or altered serial number	
3532. Act of intimidation; class E felony	
4753. Possess, use or consume controlled substance, which is a narcotic drug without valid prescription. – Misdemeanor	
4754. Possess, use or consume controlled or counterfeit substance not a narcotic drug without valid prescription - Misdemeanor	
4771. (a) Possession of Drug Paraphernalia Class A Misdemeanor	
Any other Felony, not listed above, if convicted within last five years	

DESIGNED 05/04/1999 - 02/01/2000
UPDATED: 03/24/2000, 01/05/00, 10/26/01, 01/18/02, 01/24/03, 07/31/03, 12/24/03, 10/22/04,
08/16/05, 10/15/06
KEN THOMPSON
Investigative Administrator

ATTACHMENT 4



DELAWARE HEALTH AND SOCIAL SERVICES

Policy Memorandum 36

September 24, 2008

Subject: Standardized Requirements During the Development Phase of Community Based Residential Homes for the DHSS/Division

I. Background:

DHSS has funded and supported community based residential homes and supervised apartments, for people with disabilities, for many years. The DHSS believes that community based residential options provide individuals with more opportunities to become valued citizens, develop self-worth and self-direction and engage in lifestyles that are healthy and productive. Community based residential homes support the mission of the DHSS; "To improve the quality of life for Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations."

II. Purpose:

The purpose of this policy is to delineate minimal requirements of contractors who are engaging in a contractual agreement to develop community based residential arrangements for those individuals served by Divisions within DHSS. This policy seeks to enhance the transparency of the operations within DHSS Divisions and their contractors.

III. Application:

This policy applies to all DHSS Divisions who support community based housing to individuals qualified to receive their services. The policy also applies to individuals/entities that enter into a contractual arrangement (*contractors*) with the DHSS/Division to develop a community based residential home(s) and apartment(s). Contractors shall be responsible for their subcontractors' adherence with this policy and related protocol(s) established by the applicable Division.

IV. Procedures:

1. Contractors shall obtain written approval from the DHSS/Division prior to their acquisition of a site selected for development.

2. Contractors shall develop community based residential homes and supervised apartments efficiently and within a timely manner so as to avoid excessive delays for the individuals planning to transition into the home.
3. Contractors shall ensure that the development site does not present safety hazards to residents or neighbors or create appearances that degrade neighboring properties.
4. Contractors shall adhere to the Fair Housing Act which makes discrimination unlawful for "protected" persons with disabilities (i.e., treated less favorably than people without disabilities). Community based residential homes and supervised apartments shall meet the design and construct requirements set forth in the Fair Housing Act.
5. Contractors shall adhere to all applicable local and state housing codes, including zoning laws, permitting procedures and historical preservation requirements.
6. Contractors shall secure all applicable business licenses, certificates and insurance coverage prior to the development of a community based residential housing. They shall further ensure that the aforementioned remain active.
7. Contractor shall obtain the required licensing/certification and Fire Marshal inspection prior to occupancy.
8. The Contractor's conduct shall mirror community standards, ethical principles and professional standards. Business practices shall not degrade the individuals who will live in the community based residential home, the DHSS or the Division or be cause for community insult or offense.
9. The applicable Division shall monitor housing contract standards with the Contractor, to ensure compliance.
10. The applicable Division(s) shall monitor compliance with standards/regulations associated with the development of housing, environment and safety issues.
11. The applicable Division's Quality Assurance/Improvement unit shall serve as a resource to the Contractor re: issues concerning residential licensing/certification and occupancy readiness.

V. Responsibility

1. Each Division who supports community based residential homes and supervised apartments shall develop procedures/protocols that are consistent with this DHSS policy and make such procedures/protocols available to Contractors of community based residential homes.
2. Contractors with the DHSS/Division are responsible for ensuring that subcontractors they employ adhere to the requirements set forth in this policy and the applicable Division's procedures/protocol.

VI. Effective:

This policy shall be effective immediately.

Vincent P. Meconi
Secretary