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

Request for Applications ("RFA")

1.0 PURPOSE

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

2.0 SUPPORTED AGING PROGRAMS

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

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

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

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

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

Client eligibility is required for all four programs.

3.0 APPLICATION INFORMATION

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

Applications can be submitted anytime between September 1st, 2025 and June 30, 2030. Applications should be submitted electronically to jnahas@saltlakecounty.gov

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

a. Provider Application Checklist – Exhibit 1
b. Completed General Provider Information – Exhibit 2
c. Completed Service Selection Table – Exhibit 3
d. Subcontracting Information – Exhibit 6
e. Current Business License
f. Current Certificate of Insurance based on your service selection in Exhibit 3
g. Current Professional License based on your service selection in Exhibit 3
h. Current Federal Communications Commission Registration based on Exhibit 3
i. Continuity of Operations ("COOP")/Emergency Plan
j. Provider policies and procedures that conform with HIPAA, HITECH, HIPAA Privacy and Security Rules.
k. Company Brochure

Awards. Contracts will be awarded starting January 1, 2026, upon contract execution. The period of performance of the said agreement shall extend until December 31, 2030. Contracts shall expire on March 31, 2031, unless terminated earlier.

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

Applicants must have been in business for a minimum of one year before they can apply.

4.0 TRAINING AND NETWORKING

Provider Training. Provider is required to attend AAS training once a year. The date for the training will be announced. These training sessions will last approximately 2 hours. If the provider cannot attend this training, they must schedule a one-on-one appointment with Supported Aging.

Provider Open House. Provider Open Houses may be organized by Supported Aging once a year. The Open House will bring providers and case managers together. It is an opportunity for Providers to showcase their products and services.

5.0 SERVICE CATEGORIES

The services being sought through this RFA under the Supported Aging Programs are listed below. Clients are allowed to choose their service providers from an alphabetical list of approved providers using a Provider Choice Form. If a client does not have a preference, the program case manager will educate them on all possible choices. Referrals cannot be guaranteed by AAS.

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

a. Home Health Agency ("HHA")
b. Personal Care Agency ("PCA")
c. Emergency Response System and Medication Reminder System ("ERS/MRS")
d. Specialized Medical Equipment, Supplies and Assistive Technology ("SMESAT")
e. Adult Day Care ("ADC")
f. Fiscal Intermediary ("FI")
g. Assisted Living Facility Services ("ALF")
h. Nursing Facility Respite Services ("NFR")

6.0 PURCHASES

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

7.0 SERVICE RATES

All four programs under this RFA use a unit cost for the direct provision of services. The unit cost for the purposes of the resulting contracts will be referred to as service rates. The service rates stipulated by AAS, and the service rates the provider will

specify in Exhibit 3, are the rates allowed for each of the units of service to be delivered. Monthly reimbursement received for all four programs is based on the number of actual units of service provided as authorized by the program case manager.

Providers will not be reimbursed for services rendered without receiving written service authorization from AAS. This requirement is, however, waived for the VDC program. Verbal authorization is not binding under any circumstances.

8.0 SERVICE RATE ESCALATION/DE-ESCALATION

Service rates stipulated in Exhibit 3 will be firm for the initial year of the resulting contract(s), or until a new contract term begins. Provider may issue a written request for a rate increase at least sixty (60) days prior to the contract anniversary date. The request must include sufficient supporting documentation. The justification for rate increases should be linked to an independent index or indicator not controlled by either AAS or the provider and cannot exceed the cap rate set by AAS. Any service rate increase to the contract must be approved by a written amendment to the contract. Service rate decreases shall also be passed on to AAS immediately and incorporated through a contract amendment.

9.0 LICENSING REQUIREMENTS

Licensing requirements may vary based on the applicant's selected service(s). All applicants must have a current business license issued by the City in which they are located. Out-of-State applicants that do not require a business license because their city of business does not require it, must apply for an Authority to Transact Business Certificate from the State of Utah Department of Commerce.

A professional license is required for the following providers:

Personal Care – License for Personal Care Agency

Home Health – License for Home Health Agency

Assisted Living Respite – License for Assisted Living Facility

Adult Day Care – License for Adult Day Care

Nursing Facility or Long-Term Care – License for Nursing Facility

Fiscal Intermediary – License for Certified Public Accountants (CPA)

Emergency Response System – Federal Communication Commission Registration.

All licensing requirements must be maintained throughout the life of the contract. Providers must submit a copy of all required licensures to AAS at the time of application and provide an updated copy to AAS prior to expiration.

10.0 INSURANCE

a. Provider shall, at its sole cost and expense, secure and maintain during the term of this Agreement, including all renewal or additional terms, the following minimum insurance coverages:

i. GENERAL INSURANCE REQUIREMENTS FOR ALL POLICIES.

1. Any insurance coverage required herein that is written on a "claims made" form rather than on an "occurrence" form shall (i) provide full prior acts coverage or have a retroactive date effective before the date of this Agreement, and (ii) be maintained for a period of at least three (3) years following the end of the term of this Agreement or contain a comparable "extended discovery" clause. Evidence of current extended discovery coverage and the purchase options available upon policy termination shall be provided to County.

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

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

   —OR—

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

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

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

5. All required certificates and policies shall provide that coverage thereunder shall not be canceled or modified without providing thirty (30) days prior written notice to the County.

6. In the event Provider fails to maintain and keep in force any insurance

policies as required herein, County shall have the right at its sole discretion to obtain such coverage and reduce payments to Provider for the costs of said insurance.

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

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

2. Commercial general liability insurance on an occurrence form with County as an additional insured, in the minimum amount of $1,000,000 per occurrence with a $3,000,000 general policy aggregate. The policy shall protect County and Provider from claims for damages for personal injury, including accidental death, and from claims for property damage that may arise from Provider's acts or omissions under this Agreement, wither performed by Provider itself, any subcontractor, or anyone directly or indirectly employed by either of them. Such insurance shall provide coverage for premises operations, acts of independent contractors, and completed operations.

   a. Sexual abuse and molestation endorsement with a required minimum amount of $25,000 and a recommended amount of $1,000,000.

   OR

   b. Provider providing Emergency Response Systems ("ERS") whom shall not be visiting or entering any client's home under this Agreement specifically agrees to the following conditions:
      i. Provider shall not visit or enter any client's home in connection with any services rendered under this Agreement. Inasmuch as Provider agrees not to visit or enter any client's home in connection with services rendered under this Agreement, County shall not require Provider to provide a sexual abuse and molestation endorsement. Provider agrees to indemnify and hold

County harmless for any claims, actions, demands, lawsuits (hereinafter collectively referred to as "Claims"), resulting from any and all sexual abuse and molestation Claims and Provider's failure to carry insurance against such Claims.

3. If Provider provides services under this Agreement, Provider shall carry Professional liability insurance, in the minimum amount of $1,000,000 per occurrence with a $2,000,000 general policy aggregate. County is not to be an additional insured for professional liability insurance.

    a. Professional liability insurance is required for the following services – Home Health Agencies; Personal Care Agencies; Adult Day Cares; Fiscal Intermediaries; and Assisted Living Facilities.

4. Commercial automobile liability insurance that provides coverage for owned, hired, and non-owned automobiles, with County as an additional insured, in the minimum amount of $1,000,000 per occurrence with a $2,000,000 general policy aggregate.
   For Providers that do not own vehicles, automobile liability coverage can be added to the General Liability policy by endorsement for Hired (Rented) and Non-Owned (Personal) vehicles.)

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

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

    Except for professional liability insurance, Salt Lake County must be included as an Additional Insured on all required certificates of insurance as follows:

    Salt Lake County

    2001 South State Street

    Salt Lake City, Utah 84190

11.0 GENERAL REQUIREMENTS FOR PROVIDERS

Administrative:

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

Provider certifies with respect to this agreement that all eligible clients can be served and Provider will abide by the provisions of Title VI and Title VII of the Civil Rights Act of 1964; Section 504 of the Rehabilitation Act of 1973; the Americans with Disabilities Act (P.L. 101-336, 28 CFR Part 36); the Fair Labor Standards Act, the Hatch Act, the Age Discrimination Act of 1975; and will comply with the Immigration and Naturalization requirement to maintain a signed copy of the U.S. Citizenship and Immigration Services 1-9 form for each employee. Provider will maintain a drug-free workplace in compliance with the requirement of 45 CFR, Part 76. Provider agrees to abide by Utah Executive Order dated June 30, 1989, which prohibits sexual harassment in the workplace. Provider shall comply with the provisions of Utah Indoor Clean Air Act 26-38-1 et. seq., Utah Code Annotated, as amended, relative to smoking in public and other places. Provider agrees to abide by the Utah Civil Rights Act Utah Code 13-7-1 et seq, prohibiting discrimination based on race, color, sex, religion, ancestry, or national origin.

11.2. Provider assures that standards of service provision, licensure, and codes of behavior are established to protect eligible clients from unsafe or unhealthful conditions and/or unprofessional conduct. Provider agrees to follow and enforce the State of Utah Department of Health and Human Services DHHS Code of Conduct and Client Rights. Every year provider must maintain a signed and dated DHHS Code of Conduct and Client Rights (Exhibit 4 or Exhibit 5) for each volunteer, direct service worker, and administrative staff member.

11.3. Provider shall ensure that all applicable licensure and training of direct service workers is documented under procedures established by the State of Utah Nurse Practice Act and Medical Practices Act, the Utah State Division of Aging and Adult Services, and AAS rules and regulations, and other Federal, State, Salt Lake County or City licensing and regulatory agencies.

In the event any work is subcontracted, Provider shall require its subcontractors, at no cost to the County, to maintain all required licensure and training.

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

Salt Lake County rules and regulations.

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

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

Service Delivery:

11.7. Provider shall deliver services in compliance with the program case manager's authorized care plan. Provider shall ensure that the direct service worker will perform and document the tasks or services specified in the client's approved care plan.

11.8. Provider shall maintain the flexibility to serve clients with special needs, including but not limited to medical, social, emotional, environmental, and mental health issues.

11.9. Provider shall ensure adequate supervision is provided for all direct service workers. Supervision will include service delivery, monitoring, and documentation of services in the type and amount authorized by the program case manager.

11.10. Provider shall ensure that the direct service worker will not conduct other business while delivering service to the client.

11.11. Provider must immediately stop providing services to the client when the program case manager notifies them that the client is put on hold because of hospitalization, nursing home placement, or other changes in residence whether temporary or permanent. Services may resume only after the provider has been instructed by the program case manager.

Training:

11.12. Provider shall ensure that all direct service workers assigned under this agreement will receive appropriate orientation and training, exhibit sufficient skill and capability to meet the needs of the individual clients to whom they are assigned.

11.13. Provider is required to attend the annual provider training conducted by Salt Lake County AAS.

11.14. Provider shall attend special individual case staffing as deemed necessary by the program case manager.

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

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

b. Administrative Remedies for False Claims and Statements, 31 United States Code §§3801-3812.
c. The Utah False Claims Act, Utah Code § 26-20-1, et seq.
d. The Utah Protection of Public Employees Act, Utah Code §67-21-1, et seq. (if applicable).
e. Policies and procedures for detecting and preventing fraud, waste, and abuse.
f. How to report suspected fraud, waste, and abuse of Medicaid funds.
g. The whistleblower protections afforded employees that report suspected fraud, waste, and abuse of Medicaid funds in good faith.
h. The penalties for filing false or fraudulent claims for Medicaid payment.

11.16. Provider shall train each direct service worker and administrative staff in the following:

a. Signed State of Utah Department of Health and Human Services DHHS Code of Conduct and Client Rights (Exhibit 4 or Exhibit 5);
b. Signed I-9; and
c. COOP/Emergency Plan

Documentation must include the dates of training, sign-in sheets, attendee names, training topics, name of instructor, etc. Upon request, provider must produce this documentation.

Communication:

11.17. Provider will notify program case manager as to whether a client can be accepted for services within twenty-four (24) hours or none (1) working day. Once a client has been accepted for services, provider agrees to process the intake and initiate approved services within seven (7) days of the start date found on the service authorization. Delays in starting approved services must be documented in the client's file, as well as any communication efforts made to resolve the delay.

11.18. Provider will notify the program case manager of needed adjustments in authorized services and levels of service within twenty-four (24) hours or one (1) working day. The program case managers will make the final decision on authorized changes. No changes will be made without a new service authorization generated and provided by the program case manager.

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

11.20. Provider shall respond to direct service worker issues within three (3) business days.

11.21. Provider must communicate any changes in admin, billing, case manager, and licensing and insurance contacts. Failing to update this information could result in a decrease in new client referrals and late or no payment.

11.22. Provider shall not contact the client to solicit business or to inquire about increasing or changing services. All inquiries shall be directed to the program case manager.

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

Documentation, Security, and Retention:

11.24. Provider will maintain client files which shall contain the current AAS service authorization and current AAS care plan. Provider will also maintain records of all service delivery provided under the contract resulting from the RFA.
Upon request by AAS, Provider shall make available all client file documentation, as well as any other records related to service delivery under the contract resulting from the RFA, including but not limited to:

a. Time records
b. Client's progress notes documenting daily work accomplished
c. Problems or concerns and description
d. Dates and duration of actual services provided
e. Copies/duplicates of receipts for any shopping done on behalf of the client
f. Statistical and fiscal data
g. All other records necessary for reporting and accountability required by AAS

11.25. Provider shall have procedures in place to protect the confidentiality of clients' information. No information will be disclosed without the prior informed written consent of an individual. Client files and records related to this agreement shall be made available to AAS and/or the State of Utah upon request. (Provider shall submit, with this application, policies and procedures that conform with HIPAA, HITECH, HIPAA Privacy and Security Rules).

11.26. Provider shall retain client records for a period of six (6) years after the last payment has been made on said contract, or until all reviews initiated within six (6) years have been completed.

11.27. Provider shall retain all Direct Service Worker Files for a period of six (6) years after the last payment has been made on said contract, or until all reviews initiated within six (6) years have been completed.

11.28. Provider shall complete the General Provider Information Form at the time of applying and updated during the life of the contract as personnel and situations change. The updated Provider Contacts must be sent immediately to AAS. The

change may affect any of the following:

a. Client service or direct service worker contacts
b. Billing contacts
c. Administrative contacts
d. Licensing and Insurance contacts
e. Address (physical or billing)
f. Ownership
g. Tax ID information; and/or
h. Enrollment status

Provider shall designate at least one administrative contact, one case management contact, one billing contact, and one licensing and insurance contact who can answer contractual questions or concerns.

Billing:

11.29. Provider will only be reimbursed for actual services delivered.

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

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

11.32. Provider shall ensure that routine assessment and supervision visits are included in the approved rate.

11.33. Provider shall use the program funds as a "last resort" and will work with program case manager to access other available resources needed to meet client's in-home product and service needs.

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

12.1. Provider shall ensure that services are available seven (7) days a week, including holidays, for a minimum of one (1) full hour of service up to the maximum authorized by the program case managers. Provider will make every effort to ensure continuity of care for clients by providing services as normally scheduled even if a normally scheduled visit falls on a holiday. Provider may ask the client if they would be comfortable with a schedule change to accommodate holiday scheduling. If the client chooses not to have their schedule altered, or if doing so would cause undue hardship upon the client, services must still be performed as scheduled. Additionally, if services are normally rendered seven (7) days per week, the provider must still perform client care seven (7) days per week.

Provider may not impose rates upon the client nor AAS above the rates stipulated in Exhibit 3 for services performed under any circumstance including nights, weekends, and/or holidays.

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

12.3. Provider shall communicate with the program case manager if there is a client who frequently misses appointments. Should a missed visit occur, provider will document why and shall maintain the missed visit documentation in the client's file. AAS will pay provider for missed appointments when a client is not home without advance notice up to two (2) times per client. AAS will not pay for missed appointments if the program case manager has notified the provider in advance that the client will not be home. Although clients have a responsibility to let the provider know within 24 hours if they are not going to be home for a scheduled visit, it is best practice for provider to call in advance to ensure that client will be home.

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

12.5. TAP and CSP will use a unit cost for the direct provision of services. Monthly reimbursement received by TAP and CSP is based on the number of actual units of service provided as authorized by the program case manager. Personal care services are bundled into one category of service "Personal Care Service" and the unit cost shall be twenty-nine dollars ($29) per hour, billed in fifteen (15) minutes increments.

12.6. Provider will assure that the direct service worker will be with the client for the ENTIRE amount of authorized units per day or week.

12.7. Provider assures that when a client is receiving two or more categories of service through TAP or CSP funding (i.e., homemaking and home health), the categories of services and specific tasks performed within each category will be clearly documented. With the bundled service, provider will still need to report what types of services were provided. Regardless of what services are provided, the provider will ensure that every client's garbage is taken out, the bathroom and kitchen are clean or cleaned if needed.

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

of the client's residence.

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

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

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

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

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

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

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

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

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

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

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

15.0 ADDITIONAL REQUIREMENTS FOR FISCAL INTERMEDIARY ("FI") Documentation:

15.1. Provider shall ensure that all required employment forms and BCI approval are complete for each direct service worker before receiving payment.

15.2. Provider shall ensure all forms (including timesheets) are ADA-compliant. Forms must be legible and easy to read.

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

15.4. Provide shall obtain a Federal Employer Identification Number (FEIN) for each employer (or their representative, as applicable) it represents.

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

15.6. Provider shall retire employer's FEIN when they are no longer an employer and the employer requests this in writing.

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

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

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

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

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

a. USCIS Form I-9
b. IRS Form W-4

15.12. Provider shall register employer and obtain the appropriate State employer registration number for Utah State unemployment tax filing and payment purposes for all employers it represents.

15.13. Provider shall prepare, file, and distribute IRS Forms W-2, and wage and tax statement for employer's direct service worker per IRS instructions to include completing all year-end tax filings/reporting.

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

a. Authorization Form (provider-specific)
b. Employer/Fiscal Intermediary Agreement Form (provider-specific)
c. IRS Form SS-4
d. IRS Form 2678
e. IRS Form 8821 (Optional)

15.15. Provider shall establish a secure and encrypted method for document sharing and data transfer.

Payroll:

15.16. Provider will ensure that TAP and VDC approved clients will be assisted in managing direct service workers with payroll related issues. Provider will represent the approved employer (client) and will assume all their payroll duties.

15.17. Provider will ensure that direct service worker will be paid directly.

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

15.19. Provider shall pay direct service workers in compliance with Federal and State Department of Labor wage and hourly rules.

15.20. Provider shall pay direct service worker within the time period required by the Utah State Department of Labor via direct deposit or pay card.

15.21. Provider shall report new hires (direct service workers) per State requirements.

15.22. Provider shall process payments according to all FICA, FUTA, and State Unemployment Tax Act (SUTA) exemptions.

15.23. Provider is responsible for withholding, filing and depositing FICA, FUTA, and SUTA on behalf of the client. Any Federal and/or State penalties assessed for failure to withhold the correct amount and/or for untimely filing and depositing of required forms will be paid by the provider.

15.24. Provider shall pay Federal Insurance Contribution Act (FICA) and Federal income tax withholding in the aggregate using the Vendor Fiscal/Employer Agent's separate FEIN for all employers it represents, in accordance with IRS depositing rules.
15.25. Provider shall withhold federal unemployment taxes (FUTA) and file an IRS Form 940 annually in the aggregate using the separate FEIN for all employers it represents.
15.26. Provider shall pay FUTA in the aggregate using the Vendor Fiscal/Employer Agent's separate FEIN for all employers it represents per IRS depositing rules.
15.27. Provider shall withhold, file, and pay State income tax in the aggregate for all direct service workers using the Vendor Fiscal/Employer Agent's State income tax registration number and per State requirements.
15.28. Provider shall withhold and file State unemployment insurance tax individually for all employers it represents using each employer's State unemployment registration number and per State requirements.
15.29. Provider shall pay State unemployment insurance taxes individually for all employers it represents using each employer's State Unemployment Registration number and per State requirements.
15.30. Provider shall manage the application of all garnishments, levies, and liens on direct service worker's payroll checks in an accurate and timely manner and maintain the relevant documentation in the employer's file.
15.31. Provider shall adhere to all provider-specific stop payment policies.
15.32. Timesheets processing is accepted through web portal or other online tools.
15.33. Direct service worker may submit all forms manually or electronically.

Billing:

15.34. Provider will be reimbursed by AAS after invoices are submitted and approved by program case manager.
15.35. Provider shall clearly stipulate all overtime hours separately on invoices.
15.36. Invoices for the previous month's pay period (first through the last day of the month), administrative fees, and any needed billing addendum are due to AAS on the 17th or next business day of the following month. For example, January 1-30 invoices are due by February 17th or the next business day.
15.37. TAP and VDC will use a unit cost that will encompass gross hourly salary, direct service worker's paid taxes and worker's compensation.
15.38. A flat reimbursement rate will be charged monthly for administrative fees.
15.39. Administrative fees will be charged as of the good-to-go date. Fees begin once the employer is approved for services or on that date the service starts.
15.40. If the hours submitted by the direct service worker are more than the hours authorized by the program case manager, provider will notify the program case

manager in writing within twenty-four (24) hours of receiving the timesheet. All other billing discrepancies must be sent to the program case manager for review within the same time frame.

15.41. AAS will approve manual and electronic timesheets. Approved paper timesheets will be submitted via email by AAS.

15.42. Provider shall deliver monthly reports to both the employer and to CCTPBilling@saltlakecounty.gov that include the following:

- The name of the employer with which the payment was associated
- The name of the direct service worker who was paid
- Beginning and ending balance for the employer's account
- The amount of any payments made from the employer's account
- Applicable payment service code(s)

TAP Specific Reporting and Payment Assurances:

15.43. Timesheets include the name of the employer, name of direct service worker, and representative's name.

15.44. Direct service workers submit timesheets directly to AAS twice per month [every two (2) weeks, 1st through the 15th, and 16th through the end of the month].

15.45. The provider pays the direct service worker for that pay period.

VDC (Other Adult Care) Specific Reporting and Payment Assurances:

15.46. Direct service worker may submit timesheets directly to the provider or through the program case manager.

15.47. The provider will pay the direct service worker for that pay period.

15.48. AAS will reimburse the provider for authorized services in accordance with the veteran's spending plan and monthly payment schedule.

15.49. Provider is expected to pay for all hours submitted. VDC may not place restrictions upon the payment of overtime. Provider shall contact the program case manager for further information.

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

16.0 ADDITIONAL REQUIREMENTS FOR ADULT DAY CARE ("ADC")

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

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

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

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

16.5 Provider must maintain documentation that lists the names of people who are authorized to pick up clients from the facility.

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

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

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

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

18.0 GENERAL REQUIREMENTS FOR SALT LAKE COUNTY AAS

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

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

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

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

19.0 REPORTING, BILLING, AND PAYMENT INSTRUCTIONS

19.1 By the sixth (6^{th}) working day of each month, provider (except for Fiscal Intermediary providers) must submit individualized invoices for each client served the previous month in an approved format. Invoices must be itemized by service. The invoices must include:

a. Business Name
b. Business Address
c. Business Phone Number
d. Invoice Number
e. Service Dates (Range)
f. Name of Client
g. Name of authorizing AAS Case Manager
h. Program under which the services were authorized, e.g., TAP, CSP, VDC, RPOA
i. Unit cost
j. Total cost
k. Amount of service provided; and
l. Description of service performed (must match AAS service authorization)

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

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

20.0 ERRORS IN PAYMENTS AND INVOICING

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

20.2 All billing information should be addressed to:

Supported Aging Accounts Receivable/Payable Coordinator
Salt Lake County Aging & Adult Services
2001 South State Street, Suite S1-600
Salt Lake City, Utah 84190

21.0 CONTINUITY OF OPERATIONS ("COOP")/EMERGENCY PLAN

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

a. Reduce/mitigate disruption to operations
b. Ensure continued performance of essential functions
c. Reduce loss of life/minimize damage
d. Ensure for the recovery and maintenance of client records
e. Provide full operational capability for essential functions not later than twelve (12) hours after COOP/Emergency Plan activation
f. Be capable of sustaining operations for up to thirty (30) days; and
g. Ensure communication with AAS, other appropriate government agencies, clients, and client families will be maintained

22.0 QUALITY ASSURANCE (QA) REVIEW

22.1 AAS will perform an annual QA Review with all Providers. Providers will be given thirty (30) days after the letter of notification to prepare for the review. The

letter of notification will include the QA Review Tools, the name of the client whose documents will be reviewed, and a list of documents to get ready or sent to AAS.

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

a. Client's name
b. Name of direct service worker performing services
c. What services were provided
d. Categories of service and the specific tasks performed within each category must be clearly documented (For example, time spent on homemaking tasks should be clearly distinguishable from time spent on home health tasks)
e. Dates of services performed (including month, day, and year)
f. Separate documentation of individual funding streams when more than one payer source is being utilized

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

23.0 GRIEVANCE PROCEDURES

23.1 The program case manager will document client complaints.

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

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

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

23.5 If issues are not resolved sufficiently after the on-site visit, a full contract review may take place.

24.0 CERTIFICATION

By signing on the signature form provided as part of the RFA agreement with this application, applicant certifies that all applicable licensing and standards required by Federal or State of Utah laws or regulations and ordinances of Salt Lake County and the city in which the services are provided, including all application information and forms is complete and correct.