COUNTY OF OSCEOLA
BOARD OF COMMISSIONERS’
COMMITTEE OF THE WHOLE
AGENDA
Tuesday, September 17, 2019
301 West Upton Ave., Reed City, Michigan
2nd Floor, Board of Commissioners’ Room, 9:30 a.m.

NOTE: Claims will be available for review from 9:00 – 9:30 a.m.

1. Meeting Called to Order by Chairperson.
2. Additions or Deletions to the Agenda – Approval of the Agenda.
4. Employee/Board Comments.
5. Consider Approval of the Minutes of September 4, 2019.
6. Consider Payment of Claims.

7. Consider Other Budget Amendments, Cash Transfers, and Journal Register Report from Treasurer.

8. Old Business – Discuss:
   a. Various Items – Susan Vander Pol:
      1. County 2020 Budget Update.
      2. County Policy Updates – Personal Appearance and Personal Conduct and Code of Ethics.

9. New Business – Discuss:
   a. Orient-Fork Drain Assessment – David Belden.
   b. Appointment to Board of Canvassers – Karen Bluhm.
   c. Building Inspection Items – Tony Gagliardo:
      2. Fees for Handicapped Ramps/Accesses.
   d. Various Items – Susan Vander Pol:
      1. Appointment to 911 Authority Board - City Representative.
      2. Building Inspections BS&A Software Online Permit Fees for Application.
      4. Contract for Audit Services – RFP or Extension.

10. Other Business:
11. Employee/Board Comments.
12. Extended Public Comments (Six Minute Limit).

Note: A quorum of the Board of Commissioners may be present at the Committee meetings.

PUBLIC COMMENT: The Committee welcomes public comment. We appreciate your attendance and look forward to hearing any concerns you may have. We request that the following rules of procedure be followed: At the beginning and at the end of each Committee meeting, there is time to receive public comment from the audience. If you wish to address the Committee, we ask that you stand, give your name and present your concern.

If you wish to speak while the Committee is addressing a specific issue, you are asked to make arrangements ahead of time with the Committee Chairperson. No comments or questions will be taken at any other time.

If you should require special assistance in order to attend the meeting, please notify the County Coordinator at (231) 832-6196, twenty-four (24) hours before the posted meeting time, for arrangements to be made.
The Committee meeting was called to order at 9:32 a.m. by Chairman Nehmer.

Present: Commissioners Larry Emig, Jill Halladay, Mark Gregory, Tim Michell, James Custer, Roger Elkins and Jack Nehmer.

Also present: Sheriff Justin Halladay, E.M.S. Director Jeremy Beebe, E.M.D. Director Mark Watkins, Judge Scott Hill-Kennedy, County Coordinator Susan Vander Pol, County Clerk Karen Bluhm and members of the public.

Motion by Commissioner Emig, seconded by Commissioner Elkins, to approve the agenda as amended. Motion carried.

Brief Public Comment: None.

Employee/Board Comments: None.

Moved by Commissioner Gregory, seconded by Commissioner Custer, to approve the minutes of August 21, 2019 as presented. Motion carried with unanimous voice vote.

Recommended by Commissioner Halladay, seconded by Commissioner Custer, to approve the claims of the County in the amount of $38,733.61. Recommendation was unanimously supported.

Budget Amendments, Cash Transfer & Journal Register Report
Commissioner Halladay reviewed the budget amendments and cash transfer presented for approval.

Recommended by Commissioner Halladay, seconded by Commissioner Gregory, to approve the budget amendments and cash transfers as presented. Recommendation was unanimously supported.

Update from Health, Safety & Grounds Committee Meeting
Commissioner Gregory updated everyone on the committee meeting of August 21, 2019. Discussion was also held on whether the County needs to consider a new County building.

Road Commission Meeting
Commissioner Custer spoke about a joint meeting with township officials, a couple of members of the Road Commission and a couple County Commissioners. Discussion was held with Commissioners Custer and Michell volunteering to represent the County Board.

2020 County Budget Update
Susan Vander Pol, County Coordinator, updated Commissioners on the 2020 budget process. Discussion was held regarding some requests for additional employees, building improvements and technology requests.

Court Security/Policy
Judge Scott Hill-Kennedy spoke to the Board about a requirement from the Michigan Supreme Court for a specific committee for safety. Since the County’s Health, Safety & Grounds Committee has been working diligently on this specific matter, he suggested a collaborative effort between this committee and several other suggested employees to comply with the requirement. Discussion was held with Commissioner Nehmer indicating these individuals should be invited to the next meeting of the Health, Safety & Grounds Committee.
Resignation Letter-911 Authority Board and Purchase of Duty Firearm
Justin Halladay, Sheriff, asked the Board to accept his letter of resignation from the 911 Authority Board representing the County as its Sheriff and appoint the new incoming Sheriff Ed Williams to that position. He also asked to be allowed to purchase his duty firearm which has been done with past employees. He would pay the replacement cost for the weapon. Discussion was held.

Recommended by Commissioner Michell, seconded by Commissioner Gregory, to approve Sheriff Halladay purchasing his weapon from the Sheriff Department at the replacement value of the weapon, and to establish the policy of allowing at the Sheriff’s discretion and in accordance with Sheriff Department development of a policy to allow future employees leaving the Sheriff Department to purchase their weapon at a replacement cost. Recommendation was unanimously supported.

Recommended by Commissioner Gregory, seconded by Commissioner Elkins, to approve the resignation of Sheriff Halladay from the 911 Authority Board and appoint incoming Sheriff Ed Williams to the 911 Authority Board. Recommendation was unanimously supported.

USDA Grant-E.M.S.
Jeremy Beebe, E.M.S. Director, asked the Board to accept the approved USDA Grant to help in the cost of an E.M.S. remount.

Recommended by Commissioner Michell, seconded by Commissioner Halladay, to approve the acceptance of the USDA Grant for ambulance replacement as presented and authorize the Chairman to sign. Recommendation was unanimously supported.

E.M.D.-WMSRDC Agreement
Mark Watkins, E.M.D. Director, explained the transfer of ownership of property from WMSRDC. A brief discussion was held.

Recommended by Commissioner Gregory, seconded by Commissioner Custer, to accept the transfer of ownership for equipment agreement with WMSRDC and authorize the Chairman to sign. Recommendation was unanimously supported.

E.M.D. Performance Grant (EMPG) FY2019
Mark Watkins, E.M.D. Director, explained the grant presented for Board approval, noting it pays for 33% of his salary. A brief discussion was held.

Recommended by Commissioner Emig, seconded by Commissioner Gregory, to approve the Emergency Management Performance Grant (EMPG) FY2019 and authorize the Chairman to sign. Recommendation was unanimously supported.

CMHCM Resolution Oppose Termination of Contract with Lakeshore Regional Entity
Commissioners discussed a resolution presented for Board consideration regarding the loss of local control by the Michigan Department of Health and Human Services terminating their contract with the Lakeshore Regional Entity. Discussion was held.

Recommended by Commissioner Elkins, seconded by Commissioner Gregory, to approve the Resolution to Express Opposition to Termination of State Contract with Lakeshore Regional Entity as presented. Recommendation was unanimously supported.
**DHHS Board Appointment**
DHHS has requested the re-appointment of Glenn Bluhm to their Board for a three-year term.

Recommende by Commissioner Emig, seconded by Commissioner Halladay, to approve the appointment of Glenn Bluhm to the DHHS Board. Recommendation was unanimously supported.

**Veterans' Services Travel Out of County**
Susan Vander Pol, County Coordinator, asked for the Board to approve the use of a County vehicle for out-of-county travel for our Veterans’ Services employees to a required training. A brief discussion was held.

Recommended by Commissioner Custer, seconded by Commissioner Halladay, to approve the overnight travel for conference and training for the Veterans’ Services staff for September 12-14, 2019. Recommendation was unanimously supported.

Extended Public Comment: Alan Gingrich, Road Commissioner, spoke about representation from the Road Commission regarding the meeting Commissioner Custer mentioned earlier in the meeting today.

Moved by Commissioner Gregory, seconded by Commissioner Custer, to adjourn at 11:06 a.m. Motion carried unanimously.

Karen J. Bluhm, County Clerk
Jack Nehmer, Chairman
County of Osceola

BUDGET AMENDMENT

TO: County Treasurer and County Clerk

As provided in the Uniform Budgeting and Accounting Act of 1978, as amended, and as approved by the direction of the Board of Commissioners or as established by policy, it is hereby authorized to record the following adjustments to the budget:

FUND: General ( ), 245 Capital ( ), Special Revenue ( ), Debt Service ( ), Other ( )

REVENUE:

<table>
<thead>
<tr>
<th>ACCT. NAME</th>
<th>ACCOUNT NUMBER</th>
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EXPENSES:

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<th>ACCT. NAME</th>
<th>ACCOUNT NUMBER</th>
<th>INCREASE</th>
<th>DECREASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travel expenses</td>
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<td>$(1,374)</td>
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<tr>
<td>Contracted services</td>
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<td>$(_____ )</td>
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<tr>
<td>Training</td>
<td>273.157.951.000</td>
<td>$(39)</td>
<td>$(_____ )</td>
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<tr>
<td>Training</td>
<td>273.133.951.000</td>
<td>$(39)</td>
<td>$(_____ )</td>
</tr>
</tbody>
</table>

TOTAL $(1,374) $(1,374)

Commission on Aging
Department

Susan VanderPlo
Department Head Signature

Board of Commissioners/Representative

Recorded ( ) Motion/Resolution No. 
Budget Amendment No. 

9-5-19 Date
County of Osceola

BUDGET AMENDMENT

TO:      County Treasurer and County Clerk

As provided in the Uniform Budgeting and Accounting Act of 1978, as amended, and as approved by the direction of the Board of Commissioners or as established by policy, it is hereby authorized to record the following adjustments to the budget:

FUND: General () 245 Capital () Special Revenue () Debt Service () Other ( )

REVENUE:

ACCT. NAME ACCOUNT NUMBER DECREASE INCREASE
--- --- --- ---
Transfer In 802.000.695.000 $(__,____) $(2,084)
Transfer Out 101.275.808.000 $(__,____) $(2,084)
Orient-Fork Drain 802.000.700.004 $(__,____) $(2,084)

EXPENSES:

ACCT. NAME ACCOUNT NUMBER INCREASE DECREASE
--- --- --- ---
Contracted Services 101.275.808.000 $(__,____) $(2,084)
Transfer Out 101.965.999.020 $(__,____) $(2,084)
Orient-Fork Drain 802.000.700.004 $(__,____) $(2,084)

TOTAL $(4,168) $(4,168)

Drain Commission
Department

Susan (Signature)
Department Head Signature

Board of Commissioners/Representative

Recorded ( ) Motion/Resolution No. ___
Budget Amendment No. __________

9-12-19 Date

EXPLANATION:
Orient-Fork Drain payment (County share) and Township/Taxpayers billed in special assessment district.
COUNTY OF OSCEOLA

AUTHORIZATION TO TRANSFER FUNDS

The County Treasurer is hereby directed to transfer funds in the following manner:

<table>
<thead>
<tr>
<th>FUND/ACCT</th>
<th>BUDGETED TRANSFER</th>
<th>REMAINING</th>
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</thead>
<tbody>
<tr>
<td>FROM:</td>
<td>101</td>
<td>$2,084</td>
</tr>
<tr>
<td>TO:</td>
<td>802</td>
<td></td>
</tr>
</tbody>
</table>

COMMENTS: for work on Orient-Fork Drain (Special Assessment).

The above transfer has been appropriated by the Board of Commissioners by previous resolution and may be less than the full amount appropriated in the source fund. The appropriating action was by:

( ) Appropriation Act  
( ) Budget Resolution
( ) Transfer Resolution

The County Treasurer is to complete the transfer within three business days following the date of this authorization order. A copy of the executed transfer is to be issued to the County Clerk. Should the County Treasurer be unable to complete the transfer, in whole or in part, within the time prescribed, a statement will be sent to the authorizing party within the same time limit, giving reason why the transfer can not be completed.

( ) By direction of the Board  
( ) By direction of the Finance Committee

Date: 9-12-2019

Chairman

Finance Chairperson
County of Osceola

BUDGET AMENDMENT

TO: County Treasurer and County Clerk

As provided in the Uniform Budgeting and Accounting Act of 1978, as amended, and as approved by the direction of the Board of Commissioners or as established by policy, it is hereby authorized to record the following adjustments to the budget:

FUND: General (X) 245 Capital ( ) Special Revenue ( )
Debt Service ( ) Other _______ ( )

REVENUE:

<table>
<thead>
<tr>
<th>ACCT. NAME</th>
<th>ACCOUNT NUMBER</th>
<th>DECREASE</th>
<th>INCREASE</th>
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EXPENSES:

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<tr>
<th>ACCT. NAME</th>
<th>ACCOUNT NUMBER</th>
<th>INCREASE</th>
<th>DECREASE</th>
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</thead>
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<td>Employee First</td>
<td>101.861.719.00</td>
<td>$(1,200)</td>
<td>$(<strong><strong>,</strong></strong>)</td>
</tr>
<tr>
<td>Employee Leave</td>
<td>101.861.720.00</td>
<td>$(1,650)</td>
<td>$(<strong><strong>,</strong></strong>)</td>
</tr>
<tr>
<td>Employee Benefits</td>
<td>101.861.702.05</td>
<td>$(<strong><strong>,</strong></strong>)</td>
<td>$(2,850)</td>
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<tr>
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<td>$(<strong><strong>,</strong></strong>)</td>
<td>$(<strong><strong>,</strong></strong>)</td>
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<tr>
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<td></td>
<td>$(2,850)</td>
<td>$(2,850)</td>
</tr>
</tbody>
</table>

TOTAL $(2,850) $(2,850)

Employee Benefits (Return)  Archbishop/Representative

Department Head Signature: L. Federman Trees

Recorded ( ) Motion/Resolution No.__
Budget Amendment No. __________

Date: 09.3.19

EXPLANATION: Open shortage in FICA 4 misc.

(Retire payments)
County of Osceola

BUDGET AMENDMENT

TO: County Treasurer and County Clerk

As provided in the Uniform Budgeting and Accounting Act of 1978, as amended, and as approved by the direction of the Board of Commissioners or as established by policy, it is hereby authorized to record the following adjustments to the budget:

FUND: General ( )  245 Capital ☑ Special Revenue ☑ Debt Service ( ) Other _______ ( )

REVENUE:

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<th>ACCT. NAME</th>
<th>ACCOUNT NUMBER</th>
<th>DECREASE</th>
<th>INCREASE</th>
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</thead>
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<tr>
<td>TRANS IN</td>
<td>245.120.695.000</td>
<td>$(<strong><strong>,</strong></strong>)</td>
<td>$(1,200)</td>
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EXPENSES:

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<th>ACCT. NAME</th>
<th>ACCOUNT NUMBER</th>
<th>INCREASE</th>
<th>DECREASE</th>
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<tbody>
<tr>
<td>Equip Maint Rep</td>
<td>267.000.951.000</td>
<td>$(<strong><strong>,</strong></strong>)</td>
<td>$(1,200)</td>
</tr>
<tr>
<td>Vehicle - Sheriff</td>
<td>245.905.971.005</td>
<td>$(1,200)</td>
<td>$(<strong><strong>,</strong></strong>)</td>
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<tr>
<td>TRANS OUT</td>
<td>247.000.999.000</td>
<td>$(1,200)</td>
<td>$(<strong><strong>,</strong></strong>)</td>
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<td>$(<strong><strong>,</strong></strong>)</td>
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<td>$(<strong><strong>,</strong></strong>)</td>
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</table>

TOTAL $(2,400) $(2,400)

Department

Sheriff / Aug Fund

Board of Commissioners/Representative

Recorded ( ) Motion/Resolution No. __

Budget Amendment No. __________

Department Head Signature

L. Feeney, Trea

Date

9-6-19

EXPLANATION: per Sheriff
COUNTY OF OSCEOLA

AUTHORIZATION TO TRANSFER FUNDS

The County Treasurer is hereby directed to transfer funds in the following manner:

<table>
<thead>
<tr>
<th>FUND/ACCT</th>
<th>BUDGETED</th>
<th>TRANSFER</th>
<th>REMAINING</th>
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<tbody>
<tr>
<td>FROM:</td>
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<td>$</td>
<td>$1,200</td>
</tr>
<tr>
<td>TO:</td>
<td>245</td>
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<td></td>
</tr>
</tbody>
</table>

COMMENTS: per Sheriff

The above transfer has been appropriated by the Board of Commissioners by previous resolution and may be less than the full amount appropriated in the source fund. The appropriating action was by:

- [ ] Appropriation Act
- [ ] Budget Resolution
- [X] Transfer Resolution

The County Treasurer is to complete the transfer within three business days following the date of this authorization order. A copy of the executed transfer is to be issued to the County Clerk. Should the County Treasurer be unable to complete the transfer, in whole or in part, within the time prescribed, a statement will be sent to the authorizing party within the same time limit, giving reason why the transfer can not be completed.

- [X] By direction of the Board
- [ ] By direction of the Finance Committee

Date: 20__

Chairman

Finance Chairperson
<table>
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<tr>
<th>Journal Number</th>
<th>Date</th>
<th>JNL</th>
<th>Description</th>
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<td>10472</td>
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<tr>
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<td>TRAINING/LICENSE</td>
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<td>PER COMM - ADD FOR MECH CONT SERV</td>
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<td>Journal Number</td>
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Total: 125,837.00 125,837.00
OSCEOLA COUNTY
PERSONNEL AND OPERATIONS POLICY MANUAL

POLICY NUMBER: 1024

POLICY TITLE:  Personal Appearance

Authorized by:  Board of Commissioners

Date Implemented:  09/01/1997       Date Amended:

POLICY:

Osceola County strives to maintain a workplace environment that is well functioning and free from unnecessary distractions and annoyances. As part of that effort, the County requires employees to maintain a neat and clean appearance that is appropriate for the workplace setting and for the work being performed. To that end, Osceola County department heads and elected officials may determine and enforce guidelines for workplace-appropriate attire and grooming for their areas; guidelines may limit natural or artificial scents that could be distracting, annoying or a health risk to others.

Procedures

All Osceola County staff members are expected to present a professional, businesslike image to clients, visitors, customers and the public. Acceptable personal appearance, like proper maintenance of work areas, is an ongoing requirement of employment with Osceola County.

Supervisors should communicate any department-specific workplace attire and grooming guidelines to staff members during new-hire orientation and evaluation periods. Any questions about the department's guidelines for attire should be discussed with the immediate supervisor.

Any staff member who does not meet the attire or grooming standards set by his or her department will be subject to corrective action and may be asked to leave the premises to change clothing. Hourly paid staff members will not be compensated for any work time missed because of failure to comply with designated workplace attire and grooming standards.

All staff members must carry or wear the Osceola County identification badge at all times while at work as applicable per County policy.

Specific requirements

Certain staff members may be required to meet special dress, grooming and hygiene standards, such as wearing uniforms or protective clothing, depending on the nature of their job. Uniforms
and protective clothing may be required for certain positions and will be provided to employees by Osceola County per policy or collective bargaining agreement.

At the discretion of the department head, in special circumstances, such as during unusually hot or cold weather or during special occasions, staff members may be permitted to dress in a more casual fashion than is normally required. On these occasions, staff members are still expected to present a neat appearance and are not permitted to wear ripped, frayed or disheveled clothing or athletic wear. Likewise, tight, revealing or otherwise workplace-inappropriate dress is not permitted.

**Reasonable accommodation of religious beliefs**

Osceola County recognizes the importance of individually held religious beliefs to persons within its workforce. Osceola County will reasonably accommodate a staff member’s religious beliefs in terms of workplace attire unless the accommodation creates an undue hardship. Accommodation of religious beliefs in terms of attire may be difficult in light of safety issues for staff members. Those requesting a workplace attire accommodation based on religious beliefs should be referred to the human resource staff in the County Clerk’s office.

**Casual or dress-down days**

Departments that adopt casual or dress-down days must use the following guidelines to define appropriate casual attire.

<table>
<thead>
<tr>
<th>Appropriate</th>
<th>Inappropriate</th>
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<tbody>
<tr>
<td><strong>Slacks</strong></td>
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<tr>
<td>• Khakis or corduroys</td>
<td>• Sweatpants, and exercise wear</td>
</tr>
<tr>
<td>• Jeans (must be clean and free of rips, tears and fraying; may not be excessively tight or revealing)</td>
<td>• Shorts</td>
</tr>
<tr>
<td>• Skorts, capris</td>
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</tbody>
</table>

**Shirts**
OSCEOLA COUNTY
PERSONNEL AND OPERATIONS POLICY MANUAL

- Polo collar knit or golf shirts
- Oxford shirts
- Company logo wear
- Short-sleeve blouses or shirts
- Turtlenecks
- Blazers or sport coats
- Jackets or sweaters

- T-shirts or sweatshirts
- Beachwear
- Exercise wear
- Crop tops, clothing showing midriffs

Shoes

- Boating or deck shoes, moccasins
- Casual, low-heel, open-back or open toe shoes (e.g., mules, sling backs)
- Sandals
- Athletic shoes

- thongs, flip flops

Addressing workplace attire and hygiene problems

Violations of the policy can range from inappropriate clothing items to offensive perfumes and body odor. If a staff member comes to work in inappropriate dress, the staff member will be required to go home, change into conforming attire or properly groom, and return to work.

If a staff member's poor hygiene or use of too much perfume/cologne is an issue, the supervisor should discuss the problem with the staff member in private and should point out the specific areas to be corrected. If the problem persists, supervisors should follow the normal corrective action process.
OSCEOLA COUNTY
PERSONNEL AND OPERATIONS POLICY MANUAL

POLICY NUMBER: 1025

POLICY TITLE: Personal Conduct & Code of Ethics Policy

Authorized by: Board of Commissioners

Date Implemented: Date Amended:

POLICY:
Purpose: To remain in compliance with all federal, state, and local rules, laws, and ordinances that relate to the provision of county services, with clearly stated examples of conduct that is unacceptable for our various professions and departmental operations.

I. Personal Conduct.

a. All personnel shall conduct themselves professionally at all times, with respect for fellow personnel and the public. Employees are expected to be courteous and polite to each other and to those with whom they deal. Employees shall, during working hours refrain from conduct of any kind of offensive personality that will adversely reflect upon their reputations and/or the reputation of Osceola County.

1. Inappropriate conduct, including intimate, sexual, or other behavior between individual members, employees, or outside persons (as defined in the “Sexual and other Harassment” Policy) while on Osceola County premises or while engaged in Osceola County activities is prohibited.

2. Such inappropriate conduct seriously undermines our ability to function and to maintain a cordial and professional atmosphere.

3. If the personal conduct or relationships between personnel causes others to feel uncomfortable or make it difficult for them to function, then the conduct creates a particularly difficult situation for morale, discipline, and the ability to work together as a team. This type of behavior cannot be tolerated.

b. All policies that relate to personnel conduct shall be followed, including standards contained within this Policy.

c. The following unprofessional conduct shall not be tolerated. This list is not all inclusive and simply provides examples of prohibited conduct, each of which may be grounds for discipline:

1. Calling someone a derogatory name.
2. Use of profanity.
3. Display of sexually explicit literature, photographs, movies, videotapes or computer images.
4. Use of pornographic material (such as magazines) or use of pornographic devices or paraphernalia on Osceola County premises or on/in its vehicles.
5. Internet access and viewing of sexually explicit web sites.
OSCEOLA COUNTY
PERSONNEL AND OPERATIONS POLICY MANUAL

6. Sending sexually explicit or offensive e-mail messages, notes or letters.
7. Watching sexually explicit or offensive television programs or videotapes while on Osceola County premises.
8. Unwelcome physical contact with another person, or purposely detaining or restricting another person’s movement.
9. Exhibiting inappropriate outward personal affection of a sexual nature toward another employee, volunteer, member or outside person.
10. Telling jokes or stories that are based on race, color, national origin, ancestry, religion, sex, age, disability, political belief, military service, or any other protected class.
11. Posting sexually explicit or otherwise offensive material on bulletin boards or walls.
12. Violation of the non-discrimination commitment and the “Sexual and Other Harassment” Policy.
13. Wearing inappropriate clothing that is sexually provocative or distracting to others so as to interfere with their ability to function.
14. Tampering with another person’s time record, work papers, or personal belongings and/or in any way falsifying personnel records (including time cards, job application or other work records).
15. Falsifying official records.
16. Removing or discarding records, material, or other property from the premises without permission.
17. Theft of private or County-property, including property of the public or employees or inappropriate removal or possession of property.
18. Having intimate personal relations with other employees, members, volunteers or any outside person while on Osceola County premises, in its vehicles, or while engaged in its activities.
19. Fighting with or threatening others.
20. Defacing another person’s personal affects.
21. Gambling on Osceola County property, in its vehicles or at its functions.
22. Possession of weapons on Osceola County property or in its vehicles (except for approved or other exception as outlined in Osceola County policies.)
23. Abuse, unprofessional behavior, insubordination, or disrespect to clients, family members, or other employees, supervisors, officers, volunteers, or members.
24. Accepting tips or gratuities (gifts or money) outside the scope of adopted Osceola County policies.
25. Solicitation or distribution in violation of the no solicitation and distribution rules.
26. Unauthorized or careless use or, malicious destruction or damage of property, tools or vehicles.
27. Unlawful or unauthorized release of confidential or proprietary information.
28. Unlawful or unauthorized manufacture, distribution, dispensation, possession, sale, transfer or use, of any controlled substance or alcohol on Osceola County property or while performing Osceola County duties.
29. Reporting to work or working under the influence of alcohol, illegal drugs or a legal drug that adversely affects safety or job performance.
30. Poor or unsatisfactory work performance or conduct.
31. Disorderly conduct or boisterous or disruptive activity such as but not limited to horseplay in the workplace.
OSCEOLA COUNTY
PERSONNEL AND OPERATIONS POLICY MANUAL

32. Violation of established safety rules (including smoking & tobacco use rules).
33. Unreported or excessive absenteeism or tardiness.
34. Gossip about fellow employees or management.
35. Failure to report a workplace accident or damage to Osceola County property.
36. Refusal to accept a job assignment or reasonable work order, insubordinate conduct and behavior.
37. Creating unsafe or unsanitary conditions.
38. Use of computer equipment for personal use without permission.
39. Any other unauthorized use of telephones, faxes, computers, mail system, electronic mail, or other Osceola County owned equipment.
40. Failure to maintain a current and valid driver’s license (if required)
41. Failure to maintain a current and professional license (if required)
42. Failure to maintain current and valid required professional certifications (if required)
43. Felony Conviction
44. Misdemeanor Conviction (disclosed or undisclosed) including but not limited to; violent or assaultive offense, driving offense, controlled substance conviction.
45. Assisting or advising another Employee in the violation of any provision of Policy or Procedure.
46. Being incompetent or inefficient in the performance of duty.
47. Failure to immediately make written notification to management when you have knowledge that you are under investigation by any law enforcement agency.
48. Failure to report promptly any anticipated absence from work. Being absent from work without proper authorization.
49. Leaving work assignment without being properly relieved or without proper authorization.
50. Conducting private personal business to the extent that it interferes with the performance of official duties.
51. Gambling during work hours.
52. Falsification of or supplying false information in records or reports, including employment applications, absence and sickness records.
53. Deliberate destruction or abuse of employee, public, or County owned property.
54. Immoral or unethical conduct or indecency.
55. Unauthorized use of County facilities or operation of County equipment.
56. Violation of the smoking, tobacco use or drug free work place policy.
57. Violation of any safety rule or practice or conduct which tends to create a safety hazard, including failure to use or wear required safety equipment.
58. Failure to report injuries, accidents, or abuse of safety equipment.
59. Recommending any agency, vendor, or service for profit or gain.
60. Violation of personnel policies.

II General Standards of Care

a. Conduct that is dangerous to others, dishonest, immoral, illegal or abusive will not be tolerated. Violation of these standards of conduct will be grounds for disciplinary action, up to and including termination.

b. Notwithstanding any “Progressive Discipline” Policy, Osceola County reserves the right to dismiss any non union employee without warning, progressive discipline, or notice, if
we determine that continued employment is not in the best interests of Osceola County, other employees, or the people we serve. In other words, at all times, employment is "at will."

c. Osceola County reserves the right to suspend a non union employee (with or without pay) as it deems appropriate, as part of its investigation of a staff member's conduct. Osceola County reserves the right to take any action, which differs from the progressive disciplinary steps, including suspension and termination from employment as a first step.
September 11, 2019

To: Osceola County Board of Commissioners

Attached you will find an invoice from Mecosta County Drain Commissioner’s Office in the amount of $2,083.67 for what we believe to be the final maintenance work needed on the Orient-Fork Intercounty Drain. The work was completed on August 21, 2019. The total cost of this portion of the project was $7,185.07 and Osceola County’s portion being the $2,083.67 (29%) of the project.

There are two options available:

Option #1: Osceola County pays the entire portion due to Mecosta County in the amount of $2,083.67

Option #2: Split the cost by Special Assessment (SA) to the parcels within the Intercounty drain district and the remaining portion divide between Orient Township and Osceola County.

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<th>SA District (Nine parcels)</th>
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<tr>
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<td>$694.55</td>
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<td>Total</td>
<td>$2,083.67</td>
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It is my recommendation to borrow money from the general fund to pay this invoice in full to Mecosta County and then repay the General Fund as the revenue is received from Orient Township and the Special Assessment District. I have broken down the Osceola County portion in thirds, with portions being spread out to Osceola County as a whole, Orient Township and the nine (9) property/parcel owners within the Intercounty Drain district (see the attached spread sheet). This special assessment would only be for one year.

Thank you,

David Belden
Osceola County Drain Commissioner
September 6, 2019

David Beldon
Osceola County Drain Commissioner
301 W. Upton Ave.
Reed City, MI 49677

Re: Orient-Fork Intercounty Drain

Dear David:

Enclosed, please find a copy of the Mecosta County Drain Order for Barryton Excavation for construction costs on the above drain. This bill was paid by Mecosta County as approved during the January 18, 2019 board meeting. This concludes the maintenance project.

We are requesting reimbursement of all outstanding costs of the project. These costs did not change since the Treasurer's Report presented at the last board meeting. These costs are as follows:

Cost of Engineering and Design Services $528.43
Publication and Mailings for Day of Review $719.64
Maintenance $5,000.00
Contingency Expenses (15%) $937.00
Total $7,185.07

Orient-Fork Intercounty Drain apportionments:

Clare 2% $143.70
Isabella 6% $431.10
Mecosta 63% $4,526.60
Osceola 29% $2,083.67
Total $7,185.07

Please make check payable to Mecosta County Drain Commissioner for $2,083.67 (29%).

If you have any questions, please feel free to contact my office. Thank you.

Sincerely,

Jackie Fitzgerald
Mecosta County Drain Commissioner

Enclosures

cc: Michigan Department of Agriculture & Rural Development
## 1-Year Winter Special Assessment

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<td>11.98</td>
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186.26 acres  33.330%  $694.57

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<th>TAXPAYER</th>
<th>ACRES</th>
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<td>ORIENT TOWNSHIP</td>
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<td>11</td>
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<td>OSCEOLA COUNTY</td>
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100.000%  $2,083.67

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<tr>
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<td>Clare</td>
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<td>Isabella</td>
<td>6%</td>
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Total  100%  Project To  $7,185.07
To: Osceola County Board of Commissioners:

County Coordinator: Susan Vander Pol

Ref: Appointment To Central Dispatch Board:

This letter is to inform you I will be retiring September 27th 2019. This wasn’t an easy decision but necessary. I’ve enjoyed working with the City of Reed City and the citizens of Osceola county and I was always trying to make it a better place to live. As I end my current 45 years I have a lot of new adventures to hopefully enjoy.

I am requesting that my current sergeant Brian Koschmider be appointed to the central dispatch board to take my place. He will be the acting chief and we are so involved with the dispatch center and assisting calls in the county almost 200 times a year.

I feel it’s very important to keep the great communication line open and he is a person to fill that vacancy. Thank you for your consideration and all my best in the future.

Sincerely:

[Signature]

Police Chief
Charles M Davis
**INVOICE**  
Invoice Number: 124970  
Invoice Date: Aug 1, 2019  
Page: 1

**Bill To:**  
OSCEOLA COUNTY  
301 W UPTON  
ATTN: SUSAN VANDER POL  
REED CITY, MI 49677  
OSCEOLA

<table>
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<tr>
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<th>Unit Price</th>
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<td>1.00</td>
<td>Animal License System - annual service/support fee per contract for the coverage dates of August 1st, 2019-August 1st, 2020</td>
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<td>Permit Application Submission (PAS) - Service Fee for previous quarter for online Permit Applications (for April 2019 to June 2019 - billing error caught)</td>
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Subtotal: 9,108.00
Sales Tax: 
Total Invoice Amount: 9,108.00
Payment/Credit Applied: 
TOTAL DUE: 9,108.00

Check/Credit Memo No: [RECEIVED AUG-2 2019]

Date: [RECEIVED AUG-2 2019]
Cost Summary

On-Line Services for BS&A Building Department (requires the use of Building Department .NET)

**Annual Service Fee**
$1,020
Due to continuous changes and improvements in technology, BS&A Software reserves the right to increase the Annual Service Fee yearly, based on the CPI.

**Application Fee**
$2/application
This fee is for permit application submission only. Fees are accumulated and billed to the municipality.

**Remote Implementation/Setup/Training on the use of AMG-Building Department Services**
$850
Includes implementation of the items selected below. On-site training is available as an option, and will be quoted separately.

Project Management and Implementation Planning

**Services include:**
- Analyzing customer processes to ensure all critical components are addressed.
- Creating and managing the project schedule in accordance with the customer’s existing processes and needs.
- Planning and scheduling training around any planned process changes included in the project plan.
- Modifying the project schedule as needed to accommodate any changes to the scope and requirements of the project that are discovered.
- Providing a central contact between the customer’s project leaders, developers, trainers, IT staff, conversion staff, and other resources required throughout the transition period.
- Installing the software and providing IT consultation for network, server, and workstation configuration and requirements.
- Reviewing and addressing the specifications for needed customizations to meet customer needs (when applicable).
- Please select the features you would like to use. All of the features can be included without impacting the Annual Service Fee or Project Management and Implementation Planning Fee.

- **View My Activity (always enabled):** Enables contractors and the general public to easily access inspections and permits they have requested.
- **Inspection Scheduling:** Enables contractors and the general public to submit requests for inspections online.
- **Building Department Search:** Performs a search by any record number, including addresses, permits, and certificates.
- **Rental Property Search:** Enables users to search for addresses that are flagged as rental properties.
- **Permit Applications:** Enables contractors and the general public to submit permit applications online (see “Application Fee,” below). This feature requires the Payment of Fees feature.
- **Payment of Fees:** Enables contractors and the general public to pay for permit and other fees online (see “Payment Processing Requirements,” below).

$215
Dear Provider,

August 2019

Thank you for your continued involvement with Reliance Community Care Partners (RelianceCCP) in providing services to those in our community. It is our privilege to work with you on this endeavor.

We have included provider specific information in this packet. Please fill out the required documentation in its entirety and return it by Friday, September 13, 2019.

We have included a document outlining the changes that were made for this coming Fiscal Year. Please review all the documents and update appropriate staff with the changes.

Agreement and Business Associate Agreement

These documents have been updated and require a signature on the Medicaid Provider Agreement page as well as the end of the Contract Agreement and the end of the Business Associate Agreement. Failure to sign these Agreements could indicate a desire to terminate the Agreement as of 9/30/2019.

Conditions of Participation

There were multiple changes to these documents this year. Please review and sign the acknowledgement of receipt.

Fraud, Waste, and Abuse

The Deficit Reduction Act Information has been updated and replaced with False Claim Act and Fraud, Waste and Abuse Information.

Provider Policy

The Provider Policy was included for review.

Demographic Information

Please fill out the demographic forms completely and legibly. We use this information throughout the year to provide Case Managers with information about you and your organization and also to contact you. Your services and rates for each service will be listed on this demographic form. Please keep a copy of the completed demographic form for your records. If there are changes, please let us know as soon as possible.

Insurance

Please submit copies of your current insurance for the insurances identified in your packet. Please also add RelianceCCP as a “certificate holder” if you have not already done so. This will allow the insurance company to send us the updates without any prompting from you.

RN and LPN Licenses

Please provide, as appropriate for your organization, copies of all current RN and LPN licenses for those staff employed by or contracted with your organization to provide services or supervision.
Capacity Reporting

It is a requirement that we report to the State of Michigan available capacity of our provider network. Please check Yes or No to being able to provide at least 125% of the services provided in the previous year on the demographic form. Also, fill out the specific unit information requested for each service area that you are contracted to provide for RelianceCCP.

Case Logic Users List

We are including a list of all active Case Logic users. If individuals need to be activated or deactivated, please complete the enclosed form(s) and send them back with the renewal. Also, remember to keep us updated throughout the year as changes occur.

Home and Community Based Services Assessment (HCBS)

For Residential Facilities and Adult Day Health Providers only, please complete the attached HCBS assessment. This will enable us to ensure continuing compliance with the Final Rule. If required, we will follow up with a phone call and/or visit to your facility.

Copy of Lease Agreement

For Residential Facility Providers only, please provide a blank copy of the lease agreement each resident / participant signs upon admission to your facility.

Satisfaction

Please fill out the enclosed satisfaction survey related to your experience with us over the past year. We are always looking to improve our services and your feedback is much appreciated in this endeavor.

Please provide the following required information to RelianceCCP by Friday, September 13, 2019. Information can be mailed to Vicki Holmes at 2100 Raybrook SE Suite 203 Grand Rapids, MI 49546 or faxed to (616) 954-1520 or emailed to Vicki.Holmes@Relianceccp.org. If all of the required information is not received by September 28, 2018, RelianceCCP may withhold payment for services until documentation is received or the Agreement may be terminated.

☐ Signed Compliance Acknowledgement of the receipt of the Conditions of Participation and other documents
☐ Signed Contract and Business Associate Agreement
☐ Updated Demographic form
☐ Copies of required insurance proofs
☐ Copies of RN and LPN licenses
☐ Updates to the Case Logic users list, if applicable
☐ Capacity Reporting
☐ HCBS Assessment for Residential Facilities
☐ Copy of Lease Agreement for Residential Facilities
☐ Satisfaction Survey

Sincerely,

Karla Wagner
Director of Contracts and Program Supports
Karla.Wagner@relianceccp.org
Phone: (616) 954-1554

Vicki Holmes
Contract Coordinator
Vicki.Holmes@relianceccp.org
Phone: (616) 954-1575
COMPLIANCE ACKNOWLEDGEMENT

I, Jack Nehmer, the authorized agent of Osceola County thru its C.O.A. under contract with Reliance Community Care Partner recognize that I have received, read, reviewed, and shared with appropriate staff and acknowledge my responsibilities and obligations to comply with contractual and regulatory compliance requirements as specified under the following documents:

- Contractual Requirements;
- Exhibit 1 Demographic;
- Exhibit 2 Conditions of Participation;
- Exhibit 3 Minimum Operating Standards;
- Exhibit 4 Service Priority Classification System;
- Exhibit 5 Home and Community Based Settings MI Choice Survey for Residential (H2016) and Adult Day Health (S5100) Providers only;
- Provider Policy;
- Fraud, Waste, and Abuse; and
- False Claim Act Information

I have shared the required information with appropriate staff in the following manner:

________________________________________________________________________
________________________________________________________________________

Signature Date

Printed Name

Note: Failure to sign and return this compliance attestation does not negate any agent of a network provider from his or her responsibility to adhere to the standards.
PURCHASE OF SERVICE AGREEMENT

THIS PROVIDER AGREEMENT ("Agreement") is made between Reliance Community Care Partners ("Reliance"), a Michigan non-profit corporation of 2100 Raybrook St. SE Suite 203 Grand Rapids, MI 49546 ("Reliance") and Osceola County Commission on Aging ("Provider"), effective the date of full execution hereof. Reliance and Provider are each individually referred to in this Agreement as a “party” and, collectively, as the "parties".

Provider Name: Osceola County Commission on Aging
EIN#: 38-6004880
Provider Address: PO BOX 594 Evart, Michigan 49631
732 W 7th St
Contract Contact Person: Scott Sohrycr Justin Halladay
Provider ID Number: 000107

Statement of Facts.

Reliance contracts with service Providers to perform services on behalf of Reliance clients (the "Clients"). This Agreement provides a mechanism for the creation of an individualized network of community resources on a client-by-client basis, through the Reliance Programs.

Purchase of Services.

Services are purchased at the levels specified in the Reliance Programs Person Centered Plan (PCP) and Confirmation of Services on a per client basis as developed by the Reliance Case Managers. The rates to be reimbursed for the Provider's products and services are established from the fee schedule presented in this Agreement ("Exhibit 1").

This Agreement is subject to the terms, Reliance Conditions of Participation ("Exhibit 2"), MI Choice Minimum Operating Standards ("Exhibit 3"), Service Priority Classification System ("Exhibit 4") and the Home and Community Based Settings survey for MI Choice Waiver ("Exhibit 5") as applicable (for Residential and Adult Day Care Providers) all of which are part of this Agreement. By signing below where indicated, the signer for the Provider agrees that he or she has read this Agreement, that he or she has reviewed it with advisors of his or her choosing, and that he or she has the authority to bind the Provider to this Agreement.
This form is to be completed by all Providers who wish to receive payment from Reliance Community Care Partners (Reliance) and the Michigan Department of Health and Human Services (MDHHS) for services provided under any Reliance Programs. An original payment agreement must be submitted for each eligible Provider.

**COMPLETION INSTRUCTIONS PLEASE TYPE OR PRINT CLEARLY**

Item #1: Individual Provider must enter their last name, first name, and middle initial. All other applicants (e.g., a licensed business) must enter the complete business name as licensed/certified.

Item #3: If the applicant is employed/contracted by a business, or in partnership, enter the name of the business you are employed by, affiliated with, contracted with, or in partnership with.

Item #4: Proof of the EIN number (federal tax number) is REQUIRED.

Item #5: Providers must attach a copy of their licensure/certification, as applicable.

Item #6: The SSN is required for an individual and is confidential to be used only for the administration of the program.

**APPLICANT INFORMATION**

<table>
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<tr>
<th>1. PROVIDER'S NAME (SEE INSTRUCTIONS)</th>
<th>2. PROFESSIONAL TITLE, IF APPLICABLE</th>
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<td>Osceola County Commission on Aging</td>
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<tr>
<th>3. EMPLOYER'S NAME (SEE INSTRUCTIONS)</th>
<th>4. EIN NUMBER (SEE INSTRUCTIONS)</th>
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<th>6. APPLICANT'S SOCIAL SECURITY NUMBER</th>
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**BUSINESS LOCATION**

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<tr>
<td>Evart</td>
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<td>49631</td>
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**PROVIDER PAYMENT AGREEMENT CONDITIONS**

1. All information furnished on this payment agreement form is true and complete.

2. I consent that, upon request and at a reasonable time and place, I will permit authorized agents of Reliance, the MDHHS, and the Center for Medicare & Medicaid Services (CMS), or other authorized funding representatives to inspect, and copy, any records related to my delivery of goods or services to, or on behalf of, a participant under the Reliance Programs.

3. I am not currently suspended, terminated, or excluded from any state Medicaid Program or by the CMS.

4. I agree to accept the payment as payment in full for the services rendered except when the Michigan Medicaid Program authorizes an exception. I will not seek nor accept additional or supplemental payment from the participant, his/her family, or representative(s) in addition to the amount paid by the Michigan Medicaid Program even when a participant has signed an agreement to do so.

5. I may be prosecuted under applicable federal or state criminal and civil laws for submitting false claims, concealing material facts, misrepresentation, falsifying data, other acts of misrepresentation, or conspiracy to engage therein.

6. I agree to comply with Reliance, MDHHS, CMS policies and procedures contained in manuals, manual updates, Provider bulletins, and other program notifications.

As a condition of receiving payment from Reliance Programs for services provided to an eligible participant. I certify and/or agree to all of the conditions listed above. I certify that the undersigned has the authority to execute this agreement.

Applicant’s Signature  Date  Title

Reliance and the MDHHS will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information, or reprisal or retaliation for prior civil rights.
Terms of Agreement

In consideration of these facts and the mutual covenants contained in this Agreement, the parties agree as follows:

Part I

1. Reliance Responsibilities.

A. Provide comprehensive care management services to individuals who are medically and financially eligible for one of Reliance's programs. The responsibilities of Reliance shall include:

   (1) Pre-screening of all individuals referred for case management intervention.
   (2) Client assessment, using assessment tools provided by the MDHHS and/or Reliance.
   (3) PCP development in consultation with the client, client's physician, and family. It will include frequency and duration of all services required under the PCP.
   (4) Service negotiation, including the arrangement of all health and human services as outlined in the PCP and that maximize all reimbursement sources available.
   (5) PCP monitoring, to track client progress, through direct observational visits.
   (6) Client re-assessment and appropriate PCP modification.

B. Provide actual service delivery technical assistance to the Provider, as requested and available.

C. Offer the Provider information regarding the service utilization patterns of Clients.

2. Provider Services and Responsibilities.

A. Service Provisions.

Provider agrees that in the provision of services to Reliance clients, Provider shall:

   (1) Perform management of services in accordance with standards developed by Reliance, MDHHS, & CMS and in accordance with the participant's PCP.
   (2) Accept and serve on a priority basis clients referred to it by the Reliance Program, where openings do not exist in the Provider caseload, the Provider agrees to negotiate alternative arrangements with the Reliance staff in order to meet the needs of the client.
   (3) Accept the comprehensive assessment as completed by the Reliance staff and refrain from conducting duplicate assessment or reassessment activities.
   (4) Provide service delivery as prescribed in the directions received from the Reliance staff during service requisition.
   (5) Provide the Reliance staff with regular, on-going feedback, regarding clients referred for services.
   (6) Inform the Reliance staff of the appropriate Provider contact person to be notified in PCP development and modification.
   (7) Immediately notify the Reliance staff if, for any reason, the Provider is unable to provide services to the Clients, as negotiated, or if a service is not provided as agreed to.
   (8) Follow the Reliance pre-screening criteria when referring individuals who may be eligible for Reliance Programs intervention.
   (9) Meet service definitions, standards, and conditions presented in the Reliance Conditions of Participation ("Exhibit 2") and the MI Choice Minimum Operating Standards ("Exhibit 3"), as established by Reliance and the MDHHS.
   (10) Assure that all Provider employees furnishing Medicaid covered services meet MDHHS minimum qualification for service provision.
   (11) The Provider must not be excluded from receiving federal contracts, certain subcontracts, and from certain types of federal financial and non-financial assistance and benefits. The Provider will
perform employee checks using the System for Award Management (SAM) site at least monthly for all employees directly or indirectly providing services for MI Choice participants.

B. General Provisions.

(1) Provider agrees to accept and implement all MI Choice Waiver management, fiscal, participant, and other reporting requirements and shall maintain such records and accounts, including property, personnel, and financial records, as deemed necessary by Reliance to assure proper accounting of all funds expended under this program.
(2) Provider agrees to submit, in a timely manner, all periodic reports of work progress and financial status as required by Reliance.

C. MI Choice Minimum Operating Standards Assurance.

(1) Provider agrees that all services must be provided in compliance with the MDHHS and Reliance service definitions, unit definition, MI Choice Minimum Operating Standards and Reliance Conditions of Participation.
(2) Provider agrees that the persons involved in implementing the Services Agreement have read the Reliance Conditions of Participation and MI Choice Minimum Operating Standards for each of the services for which service may be purchased by the Reliance from the Provider.
(3) Provider assures that it has written policies and procedures compatible with the Reliance Conditions of Participation and MI Choice Minimum Operating Standards.
(4) Provider assures that it is completely in compliance with all conditions and standards for the services Provider contracts for and will maintain compliance with these conditions and standards throughout the term of this Agreement.

D. Licensing and Accreditation.

(1) Provider agrees to comply with all applicable accreditation and licensing standards as may be prescribed to assure quality service delivery to Clients and to comply with all service standards and definitions as established by the MDHHS and/or Reliance, (Private Providers must submit copies of current accreditation and license with this signed agreement.)
(2) Provider is required to notify Reliance of any licensure violations or changes in licensure immediately upon receipt of violation or change. Reliance will require corrective action in response to the recommendation of or adverse changes in licensure status.

E. Indemnification.

Each party agrees to indemnify, and defend, and hold harmless the other party and their respective officers, directors, employees, agents, and successors from and against claims, damages, expenses or liabilities, or losses (including attorney's fees) arising out of the performance or breach of this Agreement by the indemnifying party or the acts or omissions of the indemnifying party or its employees or agents; provided that neither party shall assume liability for any act or omission of the other party or its employees or agents. Provider agrees to immediately notify the Reliance Staff if the Provider becomes involved in, or is threatened with litigation related to any Reliance Programs client. Provider agrees to indemnify and defend Reliance, MDHHS, CMS and their respective officers, directors, employees, agents, and successors from any and all claims and losses incurred by, or resulting to, any person, firm, or corporation who may be damaged or injured by the Provider and/or its officers, directors, employees and agents in the performance of services.

F. Insurance Coverage.

(1) Provider agrees to maintain, in effect at all times during the course of this Agreement, General Liability Insurance, Property and Theft, Fidelity Bonding (for persons handling cash), No Fault Vehicle Insurance (for Agency Owned Vehicles) and Worker's Compensation insurance, where required. The
Provider shall accept full responsibility for payment of unemployment compensation, premiums for worker's compensation, and social security, as well as all income tax deductions, and other taxes or payroll deductions required by law for employees performing services under this Agreement, where required.

(2) Provider shall submit at the beginning of this Agreement and annually thereafter, Certificate of Insurance listing Reliance as the "Certificate Holder" or "Another Insured.'

(3) Provider agrees to submit such documentation as Reliance, MDHHS, and CMS deems necessary to show proof of sufficient insurance coverage (Exhibits 2 & 3). Further, Provider agrees that purchase of services cannot begin until such time as Reliance has in its possession such proof of insurance coverage.

G. Confidentiality and Nondisclosure.

(1) Provider agrees to protect client confidentiality, and agrees to not identify Reliance Programs clients by name or otherwise, in any reports, without a signed release from the client, and approval by Reliance, MDHHS, and/or CMS.

(2) Upon receipt of a copy of the general release of information signed by the client, Provider agrees to accept from and share with Reliance any information that may be necessary to better serve the client, or may be viewed as confidential.

(3) Each party agrees that the terms of this Agreement, and all oral or written information, correspondence and records of any nature concerning the Services (the "Protected Information") performed under the terms of this Agreement shall be maintained in strict confidence except as may be required by law. Each party's employees shall use the Protected Information strictly on a need-to-know basis. However, the disclosure of information to others does not, by itself, abrogate a client's expectation of privacy as protected by law. Those to whom disclosure is made have a duty to maintain the confidentiality of the disclosure. As such, it is permissible for the Reliance Staff to share with or request information from a Provider for the purpose of better serving the client based on the general release of information obtained from the client in writing by the Reliance staff at the time of the initial assessment.

H. Access to Books and Records; Audits.

(1) Until four (4) years after the expiration of this Agreement, each party agrees to make available, upon written request to the Comptroller General of the United States, the Department of Health and Human Services ("HHS"), or any other duly authorized representatives, this Agreement, books, documents and records and such other information as may be required by the Comptroller General of the Secretary of HHS to verify the nature and extent of the cost of the services -performed under this Agreement.

(2) Provider agrees to allow Reliance, MDHHS, and CMS to perform quality audits for service appropriateness and timeliness.

(3) Provider agrees to allow Reliance the right to review, approve and monitor the Provider's compliance with all rules, regulations, and requirements applicable to the Michigan MI Choice Waiver Program and other Reliance Programs, Reliance, MDHHS and CMS reserve the right, as a condition of funding, to require the development and implementation of corrective action plans if the Provider demonstrates inadequate performance.

(4) Provider will receive written notification at least two (2) weeks in advance of the date scheduled for audit.

I. Record Retention.

Provider agrees to retain all Information and service records for at least ten (10) years based on Reliance requirements and Michigan Statutes of Limitations.

J. Term/Termination.
(1) The initial term of this Agreement shall begin on the Effective Date, and shall continue in effect for a period of one (1) year, unless terminated prior as provided herein. The Agreement shall automatically renew for one (1) additional one (1) year period unless either party provides the other party terminates.
(2) This agreement may be terminated without cause and without reason by either party with sixty (60) days prior written notice.
(3) Provider agrees to submit, within thirty (30) days of the date of termination, all reports, records, and invoices necessary for the reimbursement of outstanding invoices and to complete final reporting.
(4) This Agreement will be reviewed annually and amended, if necessary. Annually, Provider will have the opportunity to present bids or charges for services.
(5) In the event that either party substantially fails to perform any of its material obligations under this Agreement, the other party may give written notice to the non-performing party specifying the obligation(s) not performed and demanding performance within thirty (30) days. If at the end of the thirty (30) day period the non-performing party has not performed the specified obligation(s), the party giving notice may terminate this Agreement immediately in writing. Each party is responsible for its own legal fees and costs incurred under this Section 5.
(6) Whenever contract suspension, termination, revocation, or cancellation, is considered by Reliance, Reliance shall first make a determination as to whether the noncompliance, although substantial, is amenable to correction. When the cause for contract suspension, termination, revocation, or cancellation is considered by Reliance to be substantial but subject to correction, Reliance Community Care Partners shall notify the Provider of the specific deficiency and shall request that the Provider develop and submit a plan of correction within ten (10) working days following receipt of a formal notice of deficiency. If approved by Reliance, the plan of correction shall be an amendment to the contract. Failure to meet or continue to meet the plan's requirement(s) shall constitute a substantial failure to comply with the contract and will result in an immediate suspension, termination, revocation, or cancellation of the contract.
(7) Should either party or any of its employees be debarred or excluded from participating in any federal or state health care program, fail to attain and/or retain licensure, appropriate insurance, a prerequisite and ongoing condition of the contract, receives an adverse finding from a state or federal court, or demonstrates a lack of quality of care that may adversely affect the health or safety of participants, then said failure may immediately cause this contract to be canceled and payment will be denied from the date the exclusion occurred.

3. Responsibilities of both Parties

(1) The parties of the Agreement will, whenever possible, provide technical assistance and consultation to each other on matters pertaining to actual service delivery; will share as appropriate, the findings of research and results of service delivery; share relevant needs assessment information and activities so that the resources of concerned agencies may be maximized.

(2) Parties shall provide services in accordance with the Center for Medicare and Medicaid Services (CMS) approved MI Choice Wavier application including all amendments.

4. Relationship Between the Parties.

Reliance and Provider are independent contractors under the terms of this Agreement. Neither Provider nor any Provider employees or agents are agents, partners, joint ventures, or employees of Reliance, MDHHS, and CMS. Neither Provider nor any of Provider's employees are entitled to the benefits which Reliance, MDHHS, and CMS provides to its employees.

5. Compensation to Provider.

A. Submission of Invoices

(1) The Provider shall submit to Reliance its invoices for Services rendered, reflecting dates of service, discipline, and charge on a Reliance approved electronic or paper form.
(2) All claims for payment for Provider Services rendered by Provider shall be submitted to Reliance no later than ninety (90) days after the date of service. Reliance shall pay Provider for outstanding claims within thirty (30) days after receipt of Provider's invoice for services rendered, provided such invoice and other reports and/or clinical information reasonably required by Reliance are submitted in a format acceptable to Reliance.

(3) Provider shall submit invoices and/or resubmit corrected invoices before ninety (90) days of the date of service for the first nine (9) months of the fiscal year.

(4) Monthly invoices and corrected invoices for the last three (3) months of the fiscal year (July, August and September) must be submitted and received at Reliance before the last business day of the month of October.

(5) No Payment will be made by Reliance for Provider-preventive conditions, as identified in the state plan. Provider agrees to comply with the reporting requirements in 42 C.F.R. as a condition of payment from Reliance.

B. Sanctions

If either party determines that the other party is in material breach of any provision, warranty, standard, condition, or obligation of this Agreement including, but not limited to, performance obligations and compliance obligations, either party may immediately terminate this Agreement.

6. **Section 504 of the Rehabilitation Act of 1973, as Amended Compliance Assurance.**

Provider agrees that to receive funds from the MDHHS and/or Reliance it will comply with Section 504, of the Rehabilitation Act of 1973, as amended (29, USC 4); all requirements imposed by the applicable Health and Human Services regulations (45 CFR, Part 84) and all guidelines and interpretations issued pursuant thereto. Pursuant to 84.5 (a) of the regulation (45 CFR 84.5(a)) the Provider gives this assurance in consideration of, and for the purpose of, obtaining any and all grants, loans, contracts (except procurement contracts and contracts of insurance or guaranty), property, discounts, or other financial assistance extended by the above noted Department after the date of this Agreement, including payment of other assistance made after such date on applications for financial assistance will be extended in reliance on the representations and agreements made in this Agreement and that the above noted Department will have the right to enforce this Agreement through lawful means. This Assurance obligates the Provider for the period during which federal financial assistance is extended to by the above noted Department of the State of Michigan, or, where the assistance is in the form of real or personal property, for the period 84.5(b) of the regulation.


Each party will comply with the National Defense Authorization Act "Pilot Program for Enhancement of Grantee Employee Whistleblower Protections".

(1) This agreement and employees working on this agreement will be subject to the whistleblower rights and remedies in the pilot program on employee whistleblower protections established at 41 U.S.C.4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2012 and FAR 3.908.

(2) Each party shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

8. **Regulations Compliance Assurance.**

Each party will comply with the Anti-Lobbying Act, 31 USC 1352 as revised by the Lobbying Disclosure Act of 1995, 2 USC 1601 et seq, and Section 503 of the Departments of Labor, Health and Human Services, and Education, and Related Agencies section of the FY 1997 Omnibus Consolidated Appropriations Act (Public Law 104-208). Each party agrees that it will comply with Title VI of the Civil Rights Act of 1964 (P.A. 88-352); the Michigan Handicappers Civil Rights Act of 1976 (P.A. 220), as
amended; Michigan Civil Rights Act of 1976 (P.A. 453), as amended; American with Disabilities Act (P.L. 101-336, 1990); Equal Opportunity requirements of Executive Order 1979-4 issued by the Governor September 7, 1979; and Executive Order 16983-4 issued by the Governor on March 3, 1983. Each party will comply with the requirements imposed by, or pursuant to, the Regulation of the Department of Health and Human Services (45 CFR Part 80) issued pursuant to that Title to the end that, in accordance with the Title VI of the Act and the Regulation, no person in the United States shall, on the ground of race, color, sex, religion, age, height, weight, marital status, gender identification or expression, sexual orientation, political beliefs, disability or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Provider received federal or state financial assistance from Reliance, and hereby gives assurance that it will immediately take measures necessary to effectuate this agreement. Each party will not discriminate against contractual participation with minority-owned or women-owned businesses. If any real property or structure thereon is provided or improved with aid of federal or state financial assistance extended to the Provider by Reliance, this assurance shall obligate the Provider for the period during which said property or structure is used for a purpose for which federal and state financial assistance is extended. This assurance further certifies that the Provider has no other commitments or obligations that are inconsistent with compliance of these and any other pertinent federal or state regulations and policies, and that any other Provider, organization, or party that participated in this project shall have not such commitments or obligations, and all activities shall not run counter to the purpose and intent of the Agreement. The parties further agree that this Agreement is intended to comply with all applicable state and federal laws, rules, and regulations (collectively, "Laws"). If either party reasonably believes that this Agreement violates any Laws, then it shall inform the other party and the parties shall negotiate in good faith to amend this Agreement. If this Agreement cannot be amended to eliminate the problematic provision, then either party may terminate this Agreement upon thirty (30) days written notice to the other.

9. HIPAA Compliance.

Each party agrees that it will comply in all material respects with all federal and state mandated regulations, rules or orders applicable to privacy, security and electronic transactions, including without limitation, regulations promulgated under Title II Subtitle F of the Health Insurance Portability and Accountability Act (Public Law 104-191) ("HIPAA"). Furthermore, the parties shall promptly amend this Agreement to conform with any new or revised legislation, rules and regulations to which Provider is subject now or in the future including, without limitation, the Standards for Privacy of Individually Identifiable Health Information or similar legislation (collectively, "Privacy Laws") in order to ensure that they are at all times in conformance with all Privacy Laws. If, within thirty (30) days of either party first providing notice to the other of the need to amend this Agreement to comply with Privacy Laws, the parties, acting in good faith, are (i) unable to mutually agree upon and make amendments or alterations to this Agreement to meet the requirements in question, or (ii) alternatively, the parties determine in good faith that amendments or alterations to the requirements are not feasible, then either party may terminate this Agreement upon thirty (30) days prior written notice. The parties agree to abide by the Business Associate Addendum attached hereto and incorporated herein.


The Provider must have written policies for all employees that provide detailed information about the False Claims Act and other Federal and State Laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers. The provider agrees to provide prompt referral for any potential Fraud that is identified to MDHHS Office of Inspector General. Reliance will suspend payment to Provider when the State determines there is a credible allegation of fraud in accordance with 42 CFR 455.23.

The Provider must maintain books, records, documents and other evidence pertaining to services rendered, equipment, staff, financial records, medical records and the administrative costs and expenses incurred pursuant to this Contract as well as medical information relating to the individual Enrollees as required for the purposes of audit, or administrative, civil and/or criminal investigations and/or prosecution or for the purposes of complying with the requirements set forth in this contract.
The Provider must make all records available at the Provider’s expense for administrative, civil and/or criminal review, audit or evaluation, inspection, investigation and/or prosecution by authorized federal and state personnel, including representatives from MDHHS, OIG, the Michigan Department of Attorney General, DHHS OIG and the Department of Justice, or any duly authorized State for federal agency.

The Provider must provide and make available staff to assist in an inspection, review, audit, investigation, monitoring or evaluation including the provision of adequate space on the premises to reasonably accommodate MDHHS OIG or other state or Federal agency.

11. **Excluded Provider.**

By signing this Agreement, each party represents and warrants that neither it nor any of its employees is, or has been, excluded from participation in any federally and/or state funded health care programs, including but not limited to Medicare and Medicaid. Each party agrees to immediately notify the other party of any threatened, proposed or actual exclusion, of it or any of its employees, from any federally and/or state funded health care program.

12. **Miscellaneous.**

A. All notices, requests, demands and other communications of any kind which either party may be required or desires to give or serve upon the other party, shall be made in writing and must be delivered in person, by recognized overnight courier service, or sent by United States mail, first-class, registered or certified, postage prepaid, return receipt requested, and shall be deemed to have been given when mailed or hand delivered to the address listed below unless notice is given otherwise:

Provider:  
Osceola County Commission on Aging  
Attn: Justin Halladay  
PO BOX 594  
Evart, Michigan 49631

Reliance:  
Reliance Community Care Partners  
Attn:  
2100 Raybrook Street SE  
Grand Rapids, MI 49546

B. This Agreement shall not be assigned by any party without the written consent of the other parties to this Agreement. No services may be subcontracted by Provider.

C. All the terms and provisions of this Agreement shall be binding upon, shall ensure to the benefit of, and shall be enforceable by the respective successors and assigns of the Provider.

D. This Agreement, and any Agreement to which it refers, contain all the terms of the Agreement between the parties with respect to their subject matter and may be amended only by writing signed by all the parties to this Agreement.

E. This Agreement shall be governed by, and construed in accordance with, Federal laws and State of Michigan laws and other contractual obligations.
IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year herein above written.

Osceola County Commission on Aging

Signature of Provider Representative

Typed/Printed Name

Title

Date

Reliance Community Care Partners

Signature of Reliance Representative

Steve Velzen-Haner

Typed/Printed Name

Executive Director

Title

Date
BUSINESS ASSOCIATE AGREEMENT

AGREEMENT made and entered into as of the date of full execution hereof between Osceola County Commission on Aging (hereinafter referred to as "VENDOR"), and Reliance Community Care Partners, a Michigan not-for-profit corporation (hereinafter referred to as "PROVIDER").

WITNESSETH

WHEREAS, VENDOR operates a company providing contracted services;

WHEREAS, PROVIDER purchases, obtains or otherwise acquires services from VENDOR;

WHEREAS, pursuant to recently enacted federal laws and regulations including the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as codified at 42 U.S.C. § 1320d ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act of 2009, as codified at 42 U.S.C.A. prec. § 101 ("HITECH Act"), PROVIDER may be considered a "covered entity";

WHEREAS, pursuant to 45 C.F.R. parts 160, 162 and 164 (the "HIPAA Regulations"), a covered entity has an obligation to implement measures to achieve satisfactory assurance that its trading partners and business associates will appropriately use and safeguard patient health information provided or disclosed by the covered entity; and

WHEREAS, pursuant to the HIPAA Regulations, VENDOR may be considered a "business associate" of PROVIDER.

NOW, THEREFORE, and in consideration of mutual promises and covenants hereinafter set forth, the parties hereto, hereby agree with each other as follows:

1 DEFINITIONS

1.1 Terms used but not otherwise defined in this Agreement shall have the same meaning as the meaning ascribed to those terms in HIPAA, the HITECH Act, the HIPAA Regulations, and any other current and future regulations promulgated under either HIPAA or the HITECH Act.

1.2 Business Associate. A Business Associate is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity, other than a member of the covered entity's workforce.

1.3 Covered Entity. A Covered Entity is a health plan, health care clearinghouse or health care provider who transmits any health information in electronic form in connection with a transaction covered by the HIPAA Regulations.

1.4 De-Identified Health Information. De-Identified Health Information is health information from which all identifiers of the individual or of relatives, employers, or household members of the individual are removed (as set forth in 45 CFR § 164.514(b)(2)(i)).

1.5 Electronic Transaction. An Electronic Transaction is a transmission of information between PROVIDER and VENDOR to carry out financial or administrative activities related to health care, including those transactions identified at 45 CFR § 160.103.
1.6 **Electronic Transaction Standards.** The Electronic Transaction Standards are those standards for the electronic transmission of health information promulgated under the HIPAA Regulations and set forth at 45 CFR Parts 160, 162 and 164.

1.7 **Protected Health Information or PHI.** "Protected Health Information" or "PHI" shall have the same meaning as the term "Protected Health Information" in 45 CFR § 160.103, limited to the information created or received by Business Associate (VENDOR) from or on behalf of Covered Entity (PROVIDER), including, but not limited to electronic PHI.

1.8 **Security Standards.** The Security Standards are the standards at 45 CFR parts 160, 162 and 164, which protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Standards require appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.

1.9 **Trading Partner.** A Trading Partner is a person or entity, not acting as an employee, trainee or volunteer under the direct supervision of a Covered Entity, which participates in or is party to an Electronic Transaction with a Covered Entity.

1.10 **Secretary.** Secretary shall mean the Secretary of the Department of Health and Human Services or his designee.

1.11 **Limited Data Set.** A Limited Data Set is protected health information that excludes the direct identifiers of the individual or of relatives, employers, or household members of the individual that are listed in 45 CFR § 164.514(e)(2).

1.12 **Designated Record Set.** A Designated Record Set is a group of records maintained by or for a covered entity that is (i) the medical records and billing records about individuals maintained by or for a covered health care provider; (ii) the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or (iii) used, in whole or in part, by or for the covered entity to make decisions about individuals.

1.13 **Unsecured Protected Health Information.** Unsecured Protected Health Information means protected health information that is not rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of a technology or methodology specified by the Secretary in the guidance issued under section 13402(h)(2) of Public Law 111-5.

1.14 **Breach.** The term "Breach" has the same meaning as that term is defined at 45 CFR § 164.402, and includes the acquisition, access, use or disclosure of PHI in a manner not permitted under 45 CFR Part 164 subpart E which compromises the security or privacy of PHI. Except for the exclusions established under 45 CFR § 164.402(1), an acquisition, access, use, or disclosure of PHI in a manner not permitted under subpart E of 45 CFR Part 164 is presumed to be a Breach unless the covered entity or business associate demonstrates that there is a low probability that the PHI has been compromised.

2 **VENDOR'S OBLIGATIONS**

VENDOR acknowledges that it is subject to the HIPAA Regulations in the same manner or similar manner as the covered entity (PROVIDER).

VENDOR agrees:

2.1 To not use or disclose PHI other than as permitted by this Agreement or as required by law. VENDOR may:

2.1.1 Use and disclose PHI to perform its obligations as set forth in the Service Agreement;

2.1.2 Use PHI for the proper management and administration to carry out its legal responsibilities;
2.1.3 Disclose PHI for the proper management and administration to carry out its legal responsibilities, if such disclosure is required by law or if VENDOR obtains reasonable assurances from the recipient that the recipient will keep the PHI confidential, use or further disclosure of the PHI only as required by law or for the purpose for which it was disclosed to the recipient. And, notify PROVIDER of any instance in which VENDOR is aware of a breach in PHI confidentiality;

2.1.4 Use PHI to provide data aggregation services relating to the health care operations of the PROVIDER; and

2.1.5 Use PHI to create De-Identified Health Information consistent with the standards set forth at 45 CFR § 164.514.

2.2 Not to receive remuneration in exchange for any PHI of an individual unless VENDOR first obtains a fully-executed HIPAA-compliant authorization from that individual, or unless receipt of such remuneration is specifically permitted by HIPAA, the HIPAA Regulations and the HITECH Act.

2.3 To limit its uses and disclosures of, and requests for PHI:

2.3.1 When practical, to the Limited Data Set; or

2.3.2 In all other cases, to the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request.

2.4 To use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 and to that end will develop, implement, maintain and use safeguards appropriate to the size and complexity of the VENDOR's operations and the nature and scope of its activities. Such safeguards include without limitation administrative, physical, and an information security program safeguards to protect the confidentiality, integrity, and availability of the PHI in compliance with the HIPAA Regulations. To ensure that to the extent VENDOR now or in the future conducts any transaction defined as an Electronic Transaction using PHI of the PROVIDER, VENDOR shall ensure that such transaction is conducted in full compliance with applicable Electronic Transaction Standards. Moreover, to the extent VENDOR transmits, receives or stores PHI electronically, irrespective of whether any such transmission or reception constitutes an Electronic Transaction, VENDOR agrees to conduct such transmissions, receptions and storage of PHI in a manner so as to be in full compliance with federal and state law, including but not limited to the final Security Standards.

2.5 To ensure that any agent, including a subcontractor, to whom VENDOR provides electronic PHI agrees to implement reasonable and appropriate safeguards to protect the PHI.

2.6 To require all of its subcontractors and agents that create, receive, maintain or transmit PHI on behalf of VENDOR to agree, in writing, to adhere to the same restrictions and conditions that apply to VENDOR with respect to such PHI.

2.7 Upon reasonable notice and prior written request, to make available during normal business hours at VENDOR's offices all records, books, agreements, internal practices, policies and procedures relating to the use or disclosure of PHI to the Secretary, in a time and manner designated by the Secretary, for purposes of determining VENDOR's compliance with the HIPAA Regulations, subject to attorney-client and other legal privileges.

2.8 To provide documentation regarding any disclosures by VENDOR that would have to be included in an accounting of disclosures to an Individual under 45 CFR § 164.528 (including without limitation a disclosure permitted under 45 CFR § 164.512) and the HITECH Act, within a reasonable amount of time after receipt of a request from PROVIDER.

2.9 If, and to the extent the VENDOR possesses an applicable Designated Record Set, within a reasonable amount of time of receipt of a request from the PROVIDER for the amendment of an individual's PHI contained in the Designated Record Set, VENDOR shall provide such information to the PROVIDER for amendment and shall also incorporate any such amendments in the PHI maintained by VENDOR as required by 45 CFR § 164.526.
To return to PROVIDER or destroy within thirty (30) days of the termination of this Agreement, any and all PHI in its possession and retain no copies (which for the purposes of this Agreement shall include without limitation destroying all back up tapes, and permanently deleting all electronic PHI). If mutually agreed upon that it is infeasible to return or destroy the PHI, VENDOR agrees to extend the protections of this Agreement for as long as necessary to protect the PHI and to limit any further use or disclosure to those purposes that make return or destruction infeasible.

To mitigate, to the extent practical, any harmful effects from any use or disclosure of PHI by VENDOR not permitted by this Agreement.

To notify the designated Privacy Official of the PROVIDER of any use or disclosure of PHI by VENDOR not permitted by this Agreement, any Security Incident involving electronic PHI, and any Breach of Unsecured Protected Health Information within five (5) business days as required under 45 CFR § 164.410.

VENDOR shall provide the following information to the PROVIDER within ten (10) business days of discovery of a breach, except when, despite all reasonable efforts by the VENDOR to obtain the information required, circumstances beyond the control of the VENDOR necessitate additional time. Under such circumstances VENDOR shall provide PROVIDER the following information as soon as possible and without unreasonable delay, but in no event later than thirty (30) calendar days from the date of discovery of a breach:

(a) the date of the breach;
(b) the date of the discovery of the breach;
(c) a description of the types of unsecured PHI involved;
(d) identification of each individual whose unsecured PHI has been, or is reasonably believed to have been assessed, acquired, or disclosed; and
(e) Any other details necessary to complete an assessment of the risk of harm to the individual.

VENDOR agrees to establish procedures to investigate the breach, mitigate losses, and protect against any future breaches, and to provide a description of these procedures and the specific findings of the investigation to the PROVIDER in the time and manner reasonably requested by the PROVIDER.

VENDOR will maintain a log of breaches of unsecured PHI with respect to PROVIDER and will submit the log to PROVIDER within thirty (30) calendar days following the end of each calendar year and will report breaches to the Secretary in accordance with 45 CFR § 164.408.

The parties agree that this section satisfies any notices necessary by the VENDOR to the PROVIDER of the ongoing existence and occurrence of attempted but unsuccessful Security Incidents for which no additional notice to the PROVIDER shall be required, so long as no such incident results in unauthorized access, use or disclosure of electronic PHI.

VENDOR will keep accurate records of its use and disclosure of PHI, and make its internal practices, books, and records available, upon request, to PROVIDER or to the Secretary at the request of the PROVIDER, for purposes of determining compliance with the HIPAA Rules.

To the extent that VENDOR is to carry out one or more of PROVIDER’s obligations under 45 CFR Part 164 subpart E (the "Privacy Rule"), VENDOR agrees to comply with the requirements of the Privacy Rule that apply to the PROVIDER in the performance of such obligation(s).

To make available PHI in accordance with 45 CFR § 164.524.
2.15 To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526.

3 PROVIDER'S OBLIGATIONS

PROVIDER Agrees:

3.1 To maintain policies, procedures and documentation necessary to establish its continued compliance with the HIPAA Regulations and the HITECH Act, as well as other applicable federal and state laws regarding the maintenance, use and disclosure of PHI and its right to provide VENDOR with PHI within its possession and control.

3.2 To provide VENDOR, upon reasonable request, with copies of policies and procedures of PROVIDER which have been developed and implemented as part of PROVIDER's HIPAA and HITECH Act compliance effort and to provide VENDOR with adequate access to information regarding its electronic transmission and storage systems and capabilities as is necessary to enable VENDOR to comply with its obligations under this Agreement.

3.3 To notify VENDOR of any limitation(s) in the Notice of Privacy Practices of PROVIDER in accordance with 45 CFR § 164.520, to the extent that such limitation may affect VENDOR's use or disclosure of PHI. VENDOR will give timely effect to such limitations.

3.4 To notify VENDOR of any changes in or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect VENDOR's use or disclosure of PHI. VENDOR will give timely effect to such changes or revocations.

3.5 To notify VENDOR of any restriction to the use or disclosure of PHI that PROVIDER has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect VENDOR's use or disclosure of PHI. VENDOR will give timely effect to such restrictions.

4 TERM AND TERMINATION

4.1 **Term** The initial Term of this Agreement shall be for one (1) year commencing on the effective date of this Agreement and thereafter, shall automatically renew for successive one (1) year terms until such time as the parties may terminate or otherwise end their relationship.

4.2 **Termination on Notice for Default.** In the event either party shall give written notice to the other that such other party has substantially defaulted in the performance of any obligation under this Agreement and such default is not cured or reasonable steps are not taken to effect such cure within thirty (30) days following the giving of such notice, the non-breaching party shall be entitled to all remedies available under this Agreement and shall further have the right to terminate this Agreement, to the extent such right of termination also exists under any related agreement for services between the parties and the non-breaching party so terminates the agreement. If the non-breaching party does not have a right of termination under a related agreement for services between the parties, it shall not have a right of termination under this Agreement.

4.3 **Termination due to Violation of HIPAA.** If VENDOR \ PROVIDER becomes aware that the PROVIDER \ VENDOR with whom it has contracted has engaged in a pattern or practice that constitutes a material violation of certain of HIPAA and HITECH Act requirements, and if the PROVIDER \ VENDOR does not take steps to cure the violation, then the VENDOR \ PROVIDER must terminate the contract and report the violation to the Department of Health and Human Services.

4.4 **Legislation; Actual or Threatened Actions.** Upon either party having received a written opinion of reasonably qualified or experienced legal counsel, or written notice of proposed adverse action by a governmental agency concluding that the Agreement is likely to violate federal or state statutes or regulations, and upon the other party having been provided a written copy of same, and unless the parties can agree, within sixty (60) days, to adequate revision or
amendment of this Agreement and their relationship, such that the parties are no longer at risk, this Agreement shall immediately terminate.

4.5 **Obligations Surviving Termination.** Irrespective of whether the Agreement is terminated as provided for herein or expires without renewal, the parties agree that with respect to any PHI provided to VENDOR during the term of the Agreement, VENDOR shall continue to maintain, use and disclose said PHI in accordance with the provisions of this Agreement, unless said PHI is otherwise appropriately destroyed or returned to the PROVIDER, to the extent required by law.

4.6 **Effect of Multiple Parties.** In the event there are more than two parties to this Agreement, the termination of this Agreement with respect to any one party shall not automatically terminate this Agreement with respect to the remaining parties.

5 **MISCELLANEOUS COVENANTS**

5.1 **Assignment.** This Agreement shall not be assignable by any party hereto without the written consent of the other party.

5.2 **Federal Government Access to Books and Records.** To the extent required by the Social Security Act (and any regulations promulgated there under), until the expiration of four (4) years after the termination of this Agreement, the parties shall make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States, or any of their authorized representatives, this Agreement and all books, documents and records that are necessary to certify the nature and extent of the financial relationships and obligations, use or disclosure of PHI called for with respect to this Agreement. Each party shall promptly notify the other, in writing, of any such request and provide the other with access to the same books, documents and records as are made available to the requester.

5.3 **Confidentiality of Information.** The business affairs and information of the parties including, without limitation, this Agreement, are confidential and neither party will discuss such matters with or disclose the contents of this Agreement to anyone who is not a trustee, officer, agent, or a fiduciary of either party having a need to know such information in performance of his/her duties under this Agreement, all of whom shall be subject to these provisions concerning confidentiality.

5.4 ** Entire Agreement.** This Agreement and the exhibits attached to it supersedes all previous contracts and commitments and constitutes the entire Agreement between the parties with respect to the uses and disclosures of PHI and the services specified and agreed upon in this Agreement. Neither party shall be entitled to benefits other than those specified herein. No oral statements or prior written material not specifically incorporated herein shall be of any force and effect and no changes in or additions to this Agreement shall be recognized unless incorporated herein by amendment as provided herein, such amendment(s) to become effective on the date stipulated in such amendment(s). The parties specifically acknowledge that in entering into and executing this Agreement each is relying solely upon the representations and terms contained in this Agreement and no others.

5.5 **Amendment.** None of the terms and provisions of this Agreement and the exhibits and schedules attached (if any) may be modified or amended in any way except by an instrument in writing executed, on behalf of VENDOR, by any official of VENDOR appropriately authorized with respect to such execution, and on behalf of PROVIDER, by an official of the PROVIDER specifically authorized by its Board of Directors with respect to such execution.

5.6 **Waiver.** The failure by either party at any time to require the performance by the other party or to claim a breach of any provision of this Agreement will not be construed as a waiver of any subsequent breach nor affect the validity and operation of this Agreement nor prejudice either party with regard to any subsequent action.

5.7 **Notices.** Any notice or other communication required or permitted under this Agreement shall be provided to the following parties at the following locations, and shall be sufficiently given if in
writing and delivered personally or sent by telex, telecopy or other wire transmission (with request for assurance in a manner typical with respective communications of that type), registered or certified mail (postage prepaid with return receipt requested):

VENDOR: Osceola County Commission on Aging  
PO BOX 594  
Evart, Michigan 49631

PROVIDER: Reliance Community Care Partners  
2100 Raybrook Street SE  
Suite 203  
Grand Rapids, MI 49546

The parties may change the address for notices, payments or statements by giving written notice of such address change in the manner described herein. Notices shall be deemed received: (i) on the date delivered, if delivered personally or by wire transmission; (ii) on the next business day after deposit with an overnight courier; or (iii) three (3) business days after being sent by registered or certified mail.

VENDOR agrees to indemnify and hold harmless PROVIDER from any and all liability, damages, costs (including reasonable attorney fees and costs), and expenses incurred by, imposed on, or asserted against PROVIDER arising out of any claims, demands, awards, settlements, fines, or judgments relating to VENDOR's access, use, or disclosure of PHI in violation of this Agreement. In turn, PROVIDER agrees to indemnify and hold harmless VENDOR from any and all liability, damages, costs (including reasonable attorney fees and costs), and expenses incurred by, imposed on, or asserted against VENDOR arising out of any claims, demands, awards, settlements, fines, judgments relating to PROVIDER's access, use, or disclosure of PHI in violation of this Agreement.

5.8 Governing Law. This Agreement shall be interpreted and enforced under the laws of the State of Michigan applicable to contracts made and to be performed entirely within this state without giving effect to choice of law principles of such state. The parties irrevocably consent to the jurisdiction of the courts of Michigan to determine all issues which may arise under this Agreement.

5.9 Severability. If any one or more of the provisions of this Agreement should be deemed invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions contained in this Agreement shall not in any way be affected, impaired or prejudiced.

5.10 Force Majeure. Neither party shall be liable to the other for any loss of business or any other damages caused by an interruption of this Agreement, when such interruption is due to: war; rebellion or insurrection; an act of god; fires; government statute, or regulation prohibiting the performance of this Agreement; strikes; labor stoppages; lock-outs or labor disputes to the extent such occurrences are not caused by the actions of the parties seeking relief under this Section; or any other causes beyond the reasonable control or anticipation of the parties.

5.11 Interpretation. As used in this Agreement, the masculine, feminine or neuter gender, and the singular and plural number, shall be deemed to include the others whenever the context so indicates. This Agreement shall be construed as a whole in accordance with its fair meaning. This Agreement shall not be construed against the party because that party or that party's legal representative drafted this Agreement or any provision or portion of it. With regard to performance, time shall be of the essence.

5.12 Section Headings. The section headings of this Agreement are for convenience of the parties only. They in no way alter, modify, amend, limit or restrict contractual obligations of the parties.

5.13 Counterparts. This Agreement and any amendments to it may be executed in one or more counterparts, each of which shall be deemed to be an original, but all of which shall constitute one and the same Agreement.
5.14 **Cooperation.** The provisions of this Agreement shall be self-operative and shall not require further agreement except as may be provided specifically herein to the contrary. However, each party shall, upon reasonable request, execute and deliver such other further documents and records as may be necessary to properly effectuate this Agreement, in accordance with its terms.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year herein above written.

**Osceola County Commission on Aging**

By: ____________________________

Date: ____________________________

**Reliance Community Care Partners**

By: ____________________________

Date: ____________________________
CONDITIONS SUMMARIZED

Condition 1. Agency Structure

The provider must be a formally organized business or service agency that is operating in the community at the point of application.

Condition 2. Legal Adherence

The provider must comply with and adhere to all required Federal, State and Local laws and regulations as listed in the Purchase of Service Agreement and Minimum Operating Standards for MI Choice Waiver Program Services.

Condition 3. Physical Facility

The provider must have a physical facility from which to conduct business.

Condition 4. Administrative Policies

The provider must have written policies and procedures supporting the operation of business and service.

Condition 5. Personnel Policies

The provider must have written personnel policies that are in compliance with State and Federal employee practice regulations.

Condition 6. Service Delivery

The provider must deliver services in compliance with service specifications and in accordance with the person-centered plan developed and authorized by the MI Choice Waiver Program, Kent County Senior Millage or other Reliance programs.

Condition 7. Compliance

The provider must comply with all contract requirements, Conditions of Participation, relevant standards and monitoring and reporting requirements of Reliance programs.

Condition 8. Billing

The provider must submit timely invoices for authorized services rendered using established procedures and in compliance with outlined requirements.

Condition 9. Grievances and Severability

The provider must provide notice of termination of the contractual agreement and participate in Reliance’s provider dispute resolution procedure.
EXHIBIT 2

Condition 1. Agency Structure

The provider must be a formally organized business or service agency that is operating in the community at the point of application.

Required Elements:

1.1 The provider must disclose ownership and have a written statement defining the purpose of their business or service agency.

1.2 The provider shall employ competent personnel sufficient to provide services pursuant to the contractual agreement and must have a written table of organization that clearly defines lines of administrative authority and responsibility to the direct care level.

1.3 The provider must have a written statement of policies and directives or bylaws or articles of incorporation.

Condition 2. Legal Adherence

Provider must comply with and adhere to all required Federal, State and Local laws and regulations as listed in the Purchase of Service Agreement and Minimum Operating Standards for MI Choice Waiver Program Services. These include, but are not limited to: Pro-Children Act, Hatch Political Activity Act and Intergovernmental Personnel Act, Equal Employment Opportunity Act, Clean Air Act and Federal Water Pollution Control Act, Federal Civil Rights Act, Drug Free Workplace Act, Americans with Disabilities Act, Health Insurance Portability and Accountability Act (HIPAA), Conflict of Interest and the Byrd Anti-Lobbying Amendment.

Required Elements:

2.1 The provider must have a written statement supporting compliance with non-discrimination laws, federal wage and hour laws and Workers' Compensation Laws in the recruitment and employment of individuals.

2.2 The provider must have written attestation supporting compliance with non-discrimination laws in service delivery.

2.3 The provider must have a written statement supporting compliance with Drug Free Workplace laws. The State of Michigan prohibits the unlawful manufacture, distribution, dispensing, possession, or use of controlled substances in the provider's workplace.

2.4 The provider must operate in compliance with the Americans with Disabilities Act (PL 101-136).

2.5 The provider must not be excluded from receiving federal contracts, certain subcontracts, and from certain types of federal financial and non-financial assistance and benefits. Exclusion records will be checked using the System for Award Management (SAM) site for all employees.

Condition 3. Physical Facility

The provider must have a physical facility from which to conduct business.

Required Elements:

3.1 The provider must have a telephone, internet access/computer access, and a method to receive faxes.
EXHIBIT 2

3.2 The provider must designate and utilize a locked storage space for the maintenance of all non-electronic Reliance participant records.

Condition 4. Administrative Policies

The provider must have written policies and procedures supporting the operation of business and service.

Required Elements:

4.1 The provider must maintain administrative policies and procedures to support daily operations.

4.2 The provider must establish accessible record systems to verify all programmatic and fiscal information is reported and make such records available for review by Reliance staff, Michigan Department of Health and Human Services (MDHHS), and/or Centers for Medicare & Medicaid Services (CMS).

4.3 The provider must have documentation of reviewing these Conditions of Participation with applicable staff.

4.4 The provider must have a written procedure for reporting and documenting all incidents that affect a participant's physical or emotional well-being.

4.4.1 The provider must notify the Reliance Case Manager of any critical incidents as defined by MDHHS MI Choice Waiver Program including at a minimum no-shows, medication errors, abuse, neglect and exploitation, theft and death within one (1) business day of occurrence and document the notification.

4.4.2 The provider shall be prepared to bring to the attention of appropriate officials for follow up, conditions or circumstances that place the participant, or the household of the participant, in imminent danger.

4.4.3 The provider shall have a training program on critical incidents.

4.5 The provider must have written policies and procedures to assure the availability of services in emergency situations. The provider must evaluate the occupational exposure of employees to blood or other potentially infectious materials that may result from the employee's performance of duties. The provider must establish the following:

4.5.1 Appropriate universal precautions based upon the potential exposure to blood or infectious materials.

4.5.2 An exposure control plan which complies with the Federal regulations implementing the Occupation Safety and Health Act (OSHA).

4.5.3 A training program on Universal Precautions.

4.6 The provider must maintain comprehensive and complete participant records. Refer to the MI Choice Minimum Operating Standards and Definitions for each service for further detail. Files shall be made available to authorized representatives of Reliance, MDHHS, or CMS. At a minimum the participant record shall contain:

4.6.1 A copy of or have access to Reliance's assessment summary on the Case Logic Provider Site.

4.6.2 A copy of or have acknowledged the approved authorizations and corresponding service adjustments for the participant on the Case Logic Provider Site.

Revised August 2019
4.6.3 A way of identifying the participant as a Reliance participant.

4.6.5 Separate and specific progress notes in response to participant, family, and other contacts pertaining to the agency's provision of service to each participant.

4.6.6 A copy of a signed release of information form to disclose personal information about the participant.

4.6.7 Documentation of services delivered and billed to Reliance. Failure to produce complete documentation upon request will result in recoupment of unverifiable units of service billed to and paid by Reliance.

4.6.8 Documentation of incident reports as applicable

4.6.9 Documentation of termination reason as applicable

4.7 The provider must maintain signed and dated documentation of each participant contact. Documentation of services provided in the home must include the participant name, date of service, start time, stop time, tasks completed, provider staff signature and participant/Reliance approved delegate signature. Electronic Visit Verification systems may take the place of this requirement as long as verification is available to Reliance upon request. If it is not provided, then claims payment will be held.

4.7.1 Tasks completed must correspond to the tasks ordered on the authorization.

4.7.2 Participants must not be asked to sign blank time sheets.

4.7.3 Timesheets must not be prefilled with dates, times, signatures or tasks.

4.8 The provider must keep all participant records (written, electronic, or other) confidential and in controlled access files for at least ten (10) years following the date of participant service termination.

4.8.1 The provider must adhere to requirements as specified in the Reliance Business Associate Agreement and maintain an agreement with all subcontractors assuring adherence to the same requirements.

4.8.2 The provider must have established procedures to protect confidential information about participants collected in the conduct of its responsibilities. No information will be disclosed without the prior informed consent of an individual or his/her legal representative. Disclosure may be allowed by court order, or for program monitoring by authorized federal, state, or local agencies (which are bound to protect the confidentiality of participant information) so long as access is in conformity with the Privacy Act of 1974. This applies to all information whether written, electronic, or oral.

4.8.3 The provider must maintain the security and privacy of all Protected Health Information (PHI) in a manner consistent with all applicable State and Federal laws and regulations.

4.9 The provider must notify each participant, in writing, at the time service is initiated of his or her right to comment about service provision or appeal the termination of services. Such notice must advise the participant that he/she may file complaints of discrimination with Reliance, MDHHS Field Office, Office of Civil Rights, or Michigan Department of Civil Rights.

4.10 The provider must establish a written termination policy that documents the reason for the termination of the participant's services.

HOME BASED SERVICE PROVIDERS

Revised August 2019
Condition 5. Personnel Policies

The provider must have written personnel policies that are in compliance with State and Federal employee practice regulations.

5.1 The provider shall have written procedures governing, recruiting, training, and supervision. Personnel policies must apply to all individuals involved in the direct delivery of services. This includes paid and volunteer staff regardless of the relationship to the participant.

5.2 The provider must have written job descriptions or statements of job responsibilities that include qualifications (as applicable to service) for each position involved in direct delivery of service.

5.3 The provider must have a written policy to conduct and document annual performance appraisals for all individuals involved in the direct delivery of services.

5.4 Service providers must conduct in-home supervision of each staff at least twice per each fiscal year. A qualified professional must conduct the supervisory visit. Staff providing hands-on care must receive supervisory visits from a Registered Nurse. Documentation of all supervisory visits must be maintained in the employee record. Supervision documentation must include the name and title of the supervisor, the staff receiving supervision and the location of the supervision.

5.5 The provider must have a supervisor available to direct care workers at all times while the worker is furnishing services to participants.

5.6 The provider must have documentation signed and dated by staff members that indicates completion of an orientation prior to rendering services to a Reliance participant that includes:

5.6.1 The provider's purpose, policies, and procedures including but not limited to:

   1. Employee position description/expectations
   2. Agency personnel policies
   3. Reporting procedures and policies
   4. Agency organizational chart
   5. Lines of communication

5.6.2 Training which includes at a minimum, the following topics:

   1. Introduction to MI Choice Waiver
   2. Aging Network
   3. Documentation required and maintenance of records and files
   4. The Aging Process
   5. Working with disabled individuals
   6. Ethics, specifically:
      Acceptable work ethics
      Honoring the participants' dignity
      Respect of the participant and their property
      Prevention of theft of the participant's belongings
   7. Emergency Procedures
   8. HIPAA and IIHI (Individually Identifiable Health Information)
   9. Assessment and observation skills
   10. Person Centered Planning
   11. Universal Precautions

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EXHIBIT 2

5.7 The provider must have written policy to assure that all participant information remains confidential whether written, oral, or electronic.

5.8 The provider must have a written procedure defining the process by which a staff member can register a complaint or grievance.

5.9 The provider must maintain a personnel file on every staff member (including volunteers and contract workers) who provides services. This file must include:

- 5.9.1 A resume or application for employment that includes work history
- 5.9.2 Documentation of provider attempts to confirm employee previous work experience, training, and employment.
- 5.9.3 Documentation of a thorough check of references prior to entering the home of a participant. Documentation is to include successful and unsuccessful attempts to check references.
- 5.9.4 Written verification of required licensure/certification.
- 5.9.5 A copy of annual performance appraisals signed/dated by the staff member and supervisor.
- 5.9.6 A copy of all signed/dated supervisory visits conducted.
- 5.9.7 A copy of the Criminal History Screening (initial and most current).

5.10 Each provider staff person, paid or volunteer, who enters a participant’s home shall display proper identification, either an agency picture identification card or a Michigan driver’s license and some other form of agency identification.

5.11 The provider must conduct a criminal history screening for staff members that provide, either directly or indirectly, services for Reliance participants. Criminal history screenings must be conducted prior to initial delivery of service to participants, and no less than every three (3) years thereafter.

<table>
<thead>
<tr>
<th>Length of Time Barred from Working</th>
<th>Types of Conviction</th>
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</table>
| Lifetime Ban                      | Felony related to manufacture, distribution, prescription or dispensing of a controlled substance. (Felony must have occurred after August 21, 1996)  
                                      Felony or misdemeanor related to delivery of item or service under any state or federally funded health care program.  
                                      Felony of health care fraud (Felony must have occurred after August 21, 1996).  
                                      Felony or misdemeanor patient abuse.  
                                      Felony for abuse, neglect, assault, battery, criminal sexual conduct (1st, 2nd, or 3rd degree), fraud or theft against a minor or vulnerable adult.  
                                      More than one felony conviction  
                                      Felony involving cruelty or torture                                                                 |
| Fifteen Years After Completion of Parole or Probation | Felonies involving the use of a firearm or dangerous weapon.  
                                                      Felonies involving cruelty or torture  
                                                      Any conviction relating to the abuse of or fraud against a vulnerable adult.  
                                                      Felony involving abuse or neglect  
                                                      Felony involving criminal sexual conduct  
                                                      Felony that involves the intent to, or results in, death or serious impairment of a body |
### EXHIBIT 2

<table>
<thead>
<tr>
<th>Function</th>
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<tbody>
<tr>
<td>Felonies involving the diversion or adulteration of a prescription drug or other medications.</td>
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<tr>
<td>Felonies involving the use or threat of violence.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Ten Years After Completion of Parole or Probation</th>
<th>Any other felony</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ten Years From the Date of Conviction</td>
<td>Misdemeanors involving the use or threat of violence.</td>
</tr>
<tr>
<td></td>
<td>Misdemeanors involving the use of a firearm or dangerous weapon.</td>
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<td></td>
<td>Misdemeanors involving abuse or neglect.</td>
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<tr>
<td></td>
<td>Misdemeanor related to delivery of item or service under any state or federally funded medical insurance program.</td>
</tr>
<tr>
<td></td>
<td>Misdemeanor related to submission of falsified records or reports to a state licensing authority or the interference of an individual attempting to submit a report to a state licensing authority.</td>
</tr>
<tr>
<td></td>
<td>Misdemeanor involving cruelty or torture.</td>
</tr>
<tr>
<td></td>
<td>Misdemeanor involving sexual conduct (4th degree)</td>
</tr>
</tbody>
</table>

| Five Years From the Date of Conviction              | Misdemeanor cruelty if committed by an individual who is less than 16 years of age |
|                                                   | Misdemeanor home invasion |
|                                                   | Misdemeanor embezzlement |
|                                                   | Misdemeanor negligent homicide |
|                                                   | Misdemeanor involving a moving violation that causes serious impairment of a body function to another person |
|                                                   | Misdemeanor larceny |
|                                                   | Misdemeanor second degree retail fraud |
|                                                   | Any other misdemeanor involving assault, fraud, theft, or possession or delivery of a controlled substance. |

| Three Years From the Date of Conviction             | Misdemeanor assault without use of firearm or dangerous weapon and no intent to commit murder or inflict great bodily injury |
|                                                   | Misdemeanor third degree retail fraud |
|                                                   | Misdemeanor involving the creation, delivery or possession with intent to manufacture or deliver a controlled substance. |

| One Year From the Date of Conviction                | Misdemeanor involving the creation, delivery, or possession with intent to manufacture or deliver a controlled substance by an individual who is less than 18 years of age. |

5.12 The provider will review the positive results on any criminal history screening and take action relative to the findings. Reliance will not reimburse provider for services provided by a staff whose criminal history screening identified findings that excluded them as described in the grid above.

5.12.1 New employees cannot be utilized to provide care for Reliance participants.
5.12.2 New employees that are being considered for hire to provide care to a family member, the agency will notify Reliance. These employees continue to be ineligible to provide care to Reliance participants.
5.12.3 Current employees with a positive result must be immediately removed from providing care to Reliance participants.
5.12.4 The Provider must notify Reliance of current employees with a positive result and the action taken within one day of the issue.
5.12.5 If the current employee is a paid family caregiver, it is recommended that the provider conduct an investigation and follow up with Adult Protective Services and/or the police to ensure the health, welfare and safety of the participant.

5.13 The provider will mandate that employees report any charges, pleas, or convictions of felonies or misdemeanors. Provider policy must state if the employee does not report such incidence to employer...
they may be terminated immediately. Provider is still responsible and will not be paid for any service(s) that is performed by an excluded staff member. If payment has already occurred, the provider may choose to reimburse Reliance with a check or have the amount withheld from future payments.

5.13.1 The provider may not employ in the delivery of service to Reliance participant any staff member that has been subject of a substantiated finding of neglect, abuse or misappropriation of property by a state or federal agency pursuant to an investigation conducted in a skilled nursing or nursing facility at which the staff member was employed.

5.13.2 The provider may not employ in the delivery of service to an Reliance participant any staff member that becomes or has been the subject of an order or disposition finding of not guilty by reason of insanity.

5.14 Conduct an internet check of the following registries for each employee or volunteer who works directly with or has access to participant information. The check must be completed prior to providing service to participants or having access to participants' records.
1. Michigan Public Sex Offender Registry: [http://mipsor.state.mi.us](http://mipsor.state.mi.us)
3. Central Registry: [http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_48330---,00.html](http://www.michigan.gov/mdhhs/0,5885,7-339-73971_7119_50648_48330---,00.html)

5.15 Both volunteer and paid staff of in-home care, and home delivered meal providers must receive in-service training at least twice each fiscal year (October 1 – September 30) which is specifically designed to increase their knowledge and understanding of the program and participant and to improve their skills at tasks performed in the provision of service. Comprehensive records identifying dates of training and topics covered are to be maintained in each employee's personnel file. An individualized in-service training plan should be developed for each staff person when a performance evaluation indicates a need.

5.16 No paid or volunteer staff person may solicit contributions from participants for services paid for by Reliance, offer for sale any type of merchandise or service, or seek to encourage the acceptance of any particular belief or philosophy by any participant.

5.17 The provider must have procedures in place for obtaining participant signatures on the time sheets (or similar document) of direct care workers to verify that the worker provided the services ordered by Reliance. In the event, the participant is unable to sign, the provider must coordinate with Reliance and document who can provide an authorized signature. Electronic Visit Verification systems may take the place of this requirement as long as verification is available to Reliance upon request. If it is not provided and payment has already occurred, the provider may choose to reimburse Reliance with a check or have the amount withheld from future payments.

5.18 The provider must establish a policy prohibiting direct care workers from smoking in participant's home (or during the delivery of service).

5.19 The provider must establish a policy prohibiting direct care workers from threatening or coercing the participants in any way. The policy needs to assure the health, welfare, and safety of the participant and notification to the proper authorities. Failure to establish and enforce this policy is grounds for immediate termination of the contract.

5.20 The provider must immediately report any conflict of interest that exists between the staff and/or volunteers and the Reliance program participant to the Case Manager.

5.21 The provider must report, in good faith, any incidence of false claim fraud, waste or abuse of public funding to Reliance.
EXHIBIT 2

5.22 The provider must have entered all new and currently employed staff into the CHAMPS system by the assigned date.

Condition 6 Service Delivery

The provider must deliver services in compliance with service specifications and in accordance with the person-centered plan developed and authorized by the Reliance program staff.

Required Elements:

6.1 The provider must acknowledge acceptance of the participant referral for consideration of service within one (1) working day of the Reliance request.

6.2 The provider must collaborate with the Reliance programs regarding issues of service delivery and participant status. The provider must immediately notify Reliance if there is a change in the participant status, location or admission to an institution.

6.3 The provider must designate a contact person with whom Reliance staff can discuss referrals, authorizations, and service delivery schedules or problems.

6.4 The provider must have available staff and be able to begin services within two (2) business days upon accepting a Reliance referral.

6.5 The provider must not increase or decrease units of participant service or change a schedule without prior approval by Reliance Case Management staff. Increases without prior authorization shall not be reimbursed by Reliance, the State of Michigan, nor are they billable to the participant.

6.6 The provider must make all reasonable efforts to deliver services as authorized.

6.6.1 The provider shall not change authorized days of service except as required to meet the participant's needs and at the participant's request.

1. No one participant should have the service time or day of service changed more than one time a week without prior authorization from the Reliance Case Manager.

2. Permanent changes to service schedules require prior authorization from the Reliance Case Manager.

3. Units of service from multiple dates of service may not be combined within a single date of service unless explicitly authorized, in writing, by Reliance.

6.6.2 The provider shall be prepared to make arrangements for availability of services to participants in weather related emergencies, as appropriate.

6.6.3 In the event of a staff member absence, the provider must furnish a substitute to deliver the services as authorized.

6.6.4 Provider is required to ensure the client receives services in accordance with the Service Level assigned by Reliance. Refer to Exhibit 4 for further definition.

1. Documented failure to meet schedule obligations of a service authorization may result in contract termination.

2. If the schedule obligations of a service authorization cannot be met, the provider must immediately report this by telephone to Reliance and initiate the emergency back up plan.

3. The provider is responsible for assuring that all participants receive services as authorized by Reliance.
EXHIBIT 2

6.6.5 The provider shall not use the Service Priority Classification to determine that a participant may receive fewer hours of service in one week than authorized by Reliance. The total number of service hours one participant receives should never be reduced to serve another participant.

6.6.6 In situations of potential participant and/or provider staff jeopardy, the provider must participate with Reliance in good faith towards problem resolution in order to promote continuing service delivery.
   1. Providers are not expected to deliver services to any participant if the delivery of service would pose a significant risk of harm to the providers' staff.
   2. Such events must be reported to Reliance within one (1) business day of occurrence.

6.6.7 Services ordered may not be subcontracted to another entity without prior written authorization from Reliance.

6.6.8 The provider must notify the participant, who is to receive a new caregiver or a change in service appointment time prior to implementing the change.

6.6 The provider cannot be reimbursed for time spent traveling to a participant's home. The provider cannot be reimbursed if no service is provided.

6.7 Services provided under the Reliance Purchase of Service Agreement must not duplicate services available under Medicare, Medicaid or other third party resources for which the provider may be enrolled.

6.8 The provider shall employ a registered nurse (RN) to supervise direct care staff and is available to staff when they are in the participant's home.

6.9 Each provider contracted to either administer or set-up medications is required to maintain a verified, current and comprehensive medication list.

   6.9.1 Medication lists shall be verified with prescribing physicians prior to rendering any medication assistance.

   6.9.2 Medication lists shall be reconciled, at a minimum, every three (3) months or more frequently as needed to ensure accuracy of medication lists.

   6.9.3 Medications being administered by trained medication technicians (residential settings only) or licensed health professionals must be dispensed from labeled prescription bottles or labeled packages prepared by a licensed pharmacist and in accordance with provider policies and procedures.

6.10 The provider will submit all notes for Private Duty Nursing and Nursing services at the time of invoicing.

6.11 The participant service plan shall be reviewed with each care provider prior to his/her initial delivery of service.

6.12 The provider must notify each participant, in writing, at the time service is initiated of his or her right to comment about service provisions or to appeal the denial, reduction, suspension, or termination of services.

6.13 The provider must give a minimum of seven (7) days notice prior to terminating the services for an individual participant.

6.14 The provider must attempt to maintain an in-home journal that contains the minimum requirements of the date of service provided, start times, stop times, a written summary of tasks performed, pertinent
EXHIBIT 2

Information regarding the participant, changes, problems and signatures from the caregiver and the participant.

6.15 Personal Emergency Response System providers must submit the UL certificate for all equipment at the time of contracting and for all new equipment as necessary.

Condition 7 Compliance

The provider must comply with all contract requirements, Conditions of Participation, relevant standards and monitoring and reporting requirements of Reliance programs.

Required Elements:

7.1 The provider must furnish documentation demonstrating that all requirements outlined in the applicable service standards have been met.

7.2 The provider must have sufficient insurance to indemnify loss of federal, state and local resources, due to casualty or fraud, and to cover the fair market value of the asset at the time of the loss.

7.2.1 Insurance coverage requirements for the provider are:
- General Liability
- Worker’s Compensation
- Unemployment
- Property and Theft
- No-fault vehicle insurance (for provider owned vehicles)
- Fidelity Bonding (for persons handling cash) or written attestation that the agency does not handle participant cash

7.2.2 Insurance coverage recommendations are:
- Insurance to protect the provider from claims against provider drivers and/or passengers
- Errors and Omissions Insurance for board members and officers
- Professional Liability
- Umbrella Liability
- Special Multi-peril

7.3 The provider must maintain insurance coverage as required in the MI Choice Minimum Standards and conditions of participation.

7.3.1 Initially, a copy of the entire policy must be provided to Reliance.

7.3.2 The provider must provide continued proof of coverage for each required insurance and name Reliance as a certificate holder as applicable.

7.3.3 The provider must notify Reliance immediately of any changes in coverage, changes in the need for coverage or the termination of coverage. The provider will not be reimbursed for services provided if the provider does not maintain the required insurance coverage.

7.3.4 If the provider is not required to maintain Worker’s Compensation and Unemployment due to established laws, the provider agrees that they cannot file a claim for either against Reliance or MDHHS.

7.4 The provider must successfully maintain Reliance program certification and Medicaid provider enrollment.

7.4.1 The following documents and forms must be completed and up-to-date in the Reliance files:

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EXHIBIT 2

1. Michigan Medicaid Provider Enrollment Agreement
2. Purchase of Service Agreement
3. Business Associate Agreement
4. Conditions of Participation Acknowledgement
5. MI Choice Minimum Standards Assurance

7.5 The provider must agree to receive reimbursement for services rendered at the unit rate agreed upon with Reliance as payment in full.

7.6 The provider recognizes that Reliance will assume responsibility for determining participant eligibility.

7.7 When a corrective action plan has been requested by Reliance, a formal written plan of correction shall be submitted by the provider by the deadline established in the request.

7.7.1 Approved plans of correction must be implemented by the provider within the timeline established by the corrective action, or by the date specified in the plan of correction.
7.7.2 Failure to submit an acceptable plan of correction or implement approved plans of correction by established deadlines may result in contract termination.

7.8 The provider must have written policies and/or procedures related to the following:

7.8.1 Participant confidentiality
7.8.2 Participant appeals and grievances
7.8.3 Participant feedback/evaluation
7.8.4 Participant rights and responsibilities
7.8.5 Reporting suspected abuse, neglect, exploitation and other critical incidents
7.8.6 Emergencies in the participants’ home
7.8.7 Personnel policies including recruitment, training and supervision

7.9 If the provider has a complaint, it is to be submitted in writing and can be sent directly to the CQI Department at cqi@relianceccp.org. The CQI Department will work with the Provider Network Department to ensure received complaints are addressed within (30) days of receipt. This is the only complaint process for providers and there is no appeal process available.

7.10 Provider compliance will be reviewed periodically through participation in provider monitoring visits. These visits will review general standards, policies and procedures, employee record reviews, participant record reviews, and billing compliance and accuracy. The Provider will receive a compliance percentage based on the findings. Compliance percentages falling below the threshold will result in a probationary status for the Provider. If a Provider is on probation, Reliance will continue to pay for services for current participants but will not refer any new participants to the Provider until there is an accepted corrective action plan and the probationary status has been removed.

Condition 8 Billing

The provider must submit timely invoices for authorized services rendered using established procedures and in compliance with outlined requirements.

Required Elements:

8.1 The provider must submit complete and accurate monthly invoices for services rendered during the prior month.

8.1.1 The invoices must cover a full month period and be complete upon submission.

8.1.2 Invoices may not be submitted that include dates of service from more than one month. Invoices...
EXHIBIT 2

must be separated by month.

8.1.3 The provider invoices, by date of service, for only those units of service authorized and delivered and have dated documentation for each unit of service delivered. (Documentation must include date and time of service provided, services provided, date of signature, signature of caregiver and the signature of the participant.)

8.1.4 Invoices must include the Reliance participant ID number, date of service, units of service, type of service, diagnosis code and total cost for each date of service. A unit of service is defined in each service standard. Do not use the participant’s Social Security Number as the participant ID number.

8.1.5 Partial units are not billable and cannot be rounded up. Units must be rounded down to the nearest full unit for the service provided.

8.1.6 The provider must submit and/or resubmit all invoices for services within ninety (90) days of the date of service.

8.1.7 Reliance shall have and exercise at its discretion the following rights:
   1. To reject invoices submitted that are inaccurate or are incomplete
   2. To process original invoices on a first-in, first-out basis.
   3. To pend invoices for processing that are missing any required verification documents.
   4. To reject invoices, in whole or in part, that is missing required verification documents.
   5. To reject invoices that are submitted more than ninety (90) days following the latest date of service billed.
   7. To pay the invoice as billed if the unit amount billed is less than the contracted rate. Invoices that have been adjudicated for payment that were not billed at the contracted rate may not be resubmitted at a later date with a new rate being billed.

8.2 If payment is made for services that do not meet the compliance requirements, the provider may choose to reimburse Reliance with a check or have the amount withheld from future payments.

Condition 9  Grievances and Severability

The provider must provide notice of termination of the contractual agreement and participate in Reliance’s provider dispute resolution procedure.

9.1 The initial term of the Agreement with Reliance shall begin on the Effective Date, and shall, until terminated as provided herein, continue in effect for a period of one (1) year. The Agreement shall automatically renew for one (1) additional one (1) year period unless either party provides the other party termination notice. The Agreement will be reviewed annually and amended, as necessary.

9.2 This agreement may be terminated without cause and without reason by either party with 60 days prior written notice.

9.3 The provider agrees to submit, within thirty (30) days of the date of termination, all reports, records, and invoices necessary for the reimbursement of outstanding invoices and to complete final reporting.

9.4 In the event that either party substantially fails to perform any of its material obligations under this Agreement, the other party may give written notice to the non-performing party specifying the obligation(s) not performed and demanding performance within thirty (30) days. If at the end of the thirty (30) day period the non-performing party has not performed the specified obligation(s), the party giving notice may terminate this Agreement immediately in writing. Each party is responsible for its own legal fees and costs incurred.

13 Revised August 2019

HOME BASED SERVICE PROVIDERS
9.5 Whenever contract suspension, termination, revocation, or cancellation, is considered by Reliance, Reliance shall first make a determination as to whether the noncompliance, although substantial, is amenable to correction. When the cause for contract suspension, termination, revocation, or cancellation is considered by Reliance to be substantial but subject to correction, Reliance Community Care Partners shall notify the Provider of the specific deficiency and shall request that the Provider develop and submit a plan of correction within ten (10) working days following receipt of a formal notice of deficiency. If approved by Reliance, the plan of correction shall be an amendment to the contract. Failure to meet or continue to meet the plan's requirement(s) shall constitute a substantial failure to comply with the contract and will result in an immediate suspension, termination, revocation, or cancellation of the contract.

9.6 Should either party or any of its employees be debarred or excluded from participating in any federal or state health care program, failure to attain and/or retain licensure, appropriate insurance, a prerequisite and ongoing prerequisite condition of the contract, or demonstrates a lack of quality of care that may adversely affect the health or safety of participants, then said failure may immediately cause this contract to be canceled.
FRAUD WASTE AND ABUSE PROVIDER TRAINING INFORMATION

**Fraud Definition:** Fraud is knowingly billing for a service that is known by the individual to be fraudulent OR not reporting a fraudulent activity when you know it is fraudulent.

**What is Fraud**

Most Providers who commit Medicaid Fraud fall into one or more of these categories
1. Billing for people do did not really receive services (signing a blank or incorrect timesheet is a red flag)
2. Billing for an individual when they are not working with the provider
3. Billing for days when an individual is in the hospital or nursing facility (this would be an incorrect time sheet as providers coming in the home can’t bill when the individual is not in the home.)
4. Billing for a service and/or equipment that was never provided
5. Billing for items and services the individual no longer needs
6. Overcharging for equipment or services
7. Billing for lengthy counseling sessions when only short ones were provided
8. A provider being paid for a referral to another provider
9. Billing more then once for the same service
10. Billing for medical services that were actually provided by unlicensed or excluded staff
11. Using false credentials such as diplomas, licenses or certifications

**Reporting Suspected or Potential Fraud**

There is no harm in an employee or a provider reporting something that the employee believes to be potential fraud. There is more harm in not reporting fraudulent activities.

Contact Reliance Community Care Partners

**Compliance Hotline at 616-643-2555**

An anonymous message can be left, however it is difficult to investigate without having enough information and/or someone to contact with questions.

You may also report the issue to the
**State of Michigan at 855-643-7283**

False Claims Act (FCA) Overview:

The False Claims Act (FCA) is a Federal law that establishes criminal and civil liability when any covered person or covered entity improperly receives reimbursement from or avoids payments to the Federal government. The act specifically excludes tax fraud, which is covered by other status. Due to its role in processing payments from the Medicaid program (and State General Funds), individuals and entities that do business with Reliance Community Care Partners are covered entities. In particular, the FCA prohibits:

- Knowingly presenting, or causing to be presented, a false claim for payment;
- Knowingly making, using or causing to be made or used, a false record or statement to get a false claim paid or approved;
- Conspiring to defraud by getting a false claim allowed or paid;
- Certifying receipt of property on a document without completely knowing that the information is true and correct;
- Knowingly buying government property from an unauthorized office of the government and;
- Knowingly making, using or causing to be made or used a false record to avoid, or decrease an obligation to pay or transmit property to the government.

The FCA includes a “qui tam” provision, literally “Who sues on behalf of the king as well as for himself.” This provision allows a private citizen to file a suit in the name of the U.S. Government charging fraud by government contractors and other entities that receive or use government funds. The filer of the suit may share in any money received.

In the event that a Provider receives improper reimbursement as defined by State and/or Federal regulations, Reliance Community Care Partners will recover the money from the provider.

Provider Policy

SCOPE

This policy applies to all contracted providers rendering services on behalf of Reliance Community Care Partners (Reliance CCP).

POLICY STATEMENT

Contracted providers are responsible for complying with the “Conditions of Participation” along with the Michigan Department of Health and Human Services Minimum Operating Standards service specifications.

The conditions of participation outline the requirements as follows:

- Condition 1: Agency Structure-the provider must be a legally formed entity.
- Condition 2: Legal Adherence-the provider must comply with all Federal, State and local regulations.
- Condition 3: Physical facility-the provider must have a business address and a physical location to conduct business.
- Condition 4: Administrative Policies-the provider must have written policies and procedures for conducting business.
• Condition 5: Personnel Policies-the provider must have personnel policies including the hiring and training process that are in compliance with Federal and State employment regulations.
• Condition 6: Service Delivery-the provider must provide services in compliance with service specifications and the person-centered care plan developed by the RelianceCCP case manager and client.
• Condition 7: Compliance- the provider must be capable and willing to provide services in compliance with the Conditions of Participation and the Michigan Minimum Operating Standards.
• Condition 8: Billing-the provider agrees to comply with RelianceCCP billing process and comply with billing timelines.
• Condition 9: Grievances and Severability-the provider agrees to comply with termination language and to forward grievances for provider dispute resolution to RelianceCCP.

RelianceCCP holds providers responsible and accountable for:

1. Employing staff that meet the Minimum Operating Standards Service Specifications that defines qualifications along with complying with the conditions of participation.
2. Employment hiring practices include obtaining the individual’s past and current work history in the form of an employment application or resume.
3. Prior to hire the provider conducts a background check and contacts references provided.
4. Provider supports staff rendering services within client residence with training, resources and supervisory staff to respond to health, welfare and safety issues so the employee can safely complete assigned tasks.
5. Provider has supervisory and/or administrative staff available during the employee’s work hours for emergency situations and for their safety and protection.
6. Provider employees are instructed on how to file a grievance through the employer and RelianceCCP. (LTSS 6 – Element B. Factors 1-4)

Providers sign an annual attestation that the Conditions of Participation, Minimum Operating Standards, Fraud training have been reviewed and that the organization agrees to comply with the requirements.

Fraud training includes, but is not limited to:

• Definition of Fraud, Waste and Abuse
• False Claims Act
• What structure the agency is required to have to prevent, monitor and mitigate Fraud activities
• Responsibility of the agency to report Fraud
• Contract disciplinary plan
• RelianceCCP reporting requirements to Michigan Office of Inspector General when fraud is suspected.
Contract disciplinary actions for fraud, quality of care and other contractual breaches include agency probation up to contract termination for findings. Provider may appeal decision and overpayment recoupment will be assessed by RelianceCCP or the Office of Inspector General.

CQI Department works with provider network department to ensure received complaints are addressed within thirty (30) days of receipt. This is the only complaint process for providers and there is no appeal process available. (Refer to Complaint Process)

Annually providers are randomly selected for compliance audits. Providers may be placed on probation or terminated based on audit findings along with recoupment of payment when staff did not meet the qualifications or background check requirements prior to providing services to clients or other violations of the conditions of participation. Other reasons for probation are listed within the conditions of participation.

RelianceCCP conducts clinical quality audits based on service delivery complaints received and these audits evaluate the welfare and safety of clients. Providers may be terminated based on quality of care audit findings.

RelianceCCP provides training to contracted providers at least annually on conditions of participation, Federal and State regulations, Quality Improvement initiatives and other program topics in the form of attestation, webinar or in-person training.

POLICY REFERENCES

Michigan Department of Health and Human Services Attachment H: Minimum Operating Standards

Kent County Senior Millage Contract

PROCEDURES

<table>
<thead>
<tr>
<th>WHO</th>
<th>WHAT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Network Staff</td>
<td>1. Sends contract including Conditions of Participation and Minimum Operating Standards to providers at each contract renewal cycle.</td>
</tr>
<tr>
<td></td>
<td>2. Receives attestations along with signed contract from providers.</td>
</tr>
<tr>
<td></td>
<td>3. Randomly selects providers for audits each year.</td>
</tr>
<tr>
<td></td>
<td>4. Arranges and provides training to providers at least annually.</td>
</tr>
<tr>
<td></td>
<td>5. Monitors provider compliance and arranges for audits as needed.</td>
</tr>
</tbody>
</table>

Provider Policy
Page 3 of 5
FLOWCHARTS

Not applicable

DEFINITIONS

Case Manager (CM): The case management and population health programs use a Registered Nurse and Social Worker team to provide case management and population health activities.

Client: A person who is the direct or indirect recipient of the services of the organization. Depending on the context, client may be identified by different names, such as “consumer,” “member,” enrollee,” “beneficiary,” “patient,” “injured worker,” “claimant,” etc. A client relationship may exist even in cases where there is not a direct relationship between the client and RelianceCCP.

Individual: All RelianceCCP employees, Board of Directors, contractors, temporary employees, consultants, agents and all RelianceCCP visitors and business partners.

Staff: The organization’s employees, including full-time employees, part-time employees, and consultants.

COMPLIANCE & ENFORCEMENT

All management personnel are responsible for enforcing this policy. All individuals must comply with this policy. Individuals who violate this policy are subject to discipline up to and including termination from employment in accordance with RelianceCCP Disciplinary Policies.

FORMS

Not applicable

RELATED POLICIES, GUIDELINES & CRITERIA

REVIEW & APPROVAL

CQI Policy and Procedure Committee 03/31/2018
POLICY HISTORY

08/21/2014

New policy developed.

01/11/2016

The policy and procedure was updated to reflect new company name of Reliance Community Care Partners along with the removal of references to HHS, Health Options. Michigan Department of Community Health was changed to the new name Michigan Department of Health and Human Services.

1/12/2017

Removed references to URAC and added references to NCQA.

4/22/2017

Policy and procedure template revised and document migrated to new format.
Reliance Community Care Partners (Reliance) Case Management staff will establish for each participant, a priority classification ranking that will classify the need for delivery of services at exact times and on exact day/dates as authorized by the program staff. The Staff will communicate the participant's priority ranking to each provider at the time of the service referral/arrangement. This classification may also be found on the Authorization. The priority ranking will be subject to Case Manager review and possible revision on an on-going basis.

This classification ranking will assist the provider in planning for unforeseen circumstances that may interfere with delivery of services. Unforeseen circumstances may include inclement weather emergencies, disaster conditions, transportation failures, illness of staff affecting service provision to the participant, etc. The following sections detail the criteria and structure the provider's options in scheduling accordingly.

<table>
<thead>
<tr>
<th>Client Priority Classification</th>
<th>Service Priority</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Immediate - Person cannot be left alone</td>
<td>1A - This means that the participant cannot be left alone. If service are not delivered as planned, the backup plan needs to start immediately</td>
</tr>
<tr>
<td>A - No Supports are available for the person</td>
<td></td>
</tr>
<tr>
<td>1 - Immediate - Person cannot be left alone</td>
<td>1B - This means that the participant cannot be left alone. If the services are not delivered as planned, family/friends need to be contacted immediately</td>
</tr>
<tr>
<td>B - Supports are available for the person</td>
<td></td>
</tr>
<tr>
<td>1 - Immediate - Person cannot be left alone</td>
<td>1C - This means that the participant cannot be left alone. Staff at the place of residence must be available to you as planned or follow established emergency procedures</td>
</tr>
<tr>
<td>C - Lives in a supervised residential setting</td>
<td><strong>All participants living in Adult Foster Care Homes or Homes for the Aged</strong></td>
</tr>
<tr>
<td>2 - Urgent - Person can be left alone for a short time (within 12 hours)</td>
<td>2A - This means that the participant can be left alone for a short time. If the services are not delivered as planned, the backup plan needs to start within 12 hours</td>
</tr>
<tr>
<td>A - No Supports are available for the person</td>
<td></td>
</tr>
<tr>
<td>2 - Urgent - Person can be left alone for a short time (within 12 hours)</td>
<td>2B - This means the participant can be left alone for a short time. If the services are not delivered as planned, the family/friends need to be contacted within 12 hours</td>
</tr>
<tr>
<td>B - Supports are available for the person</td>
<td></td>
</tr>
<tr>
<td>2 - Urgent - Person can be left alone for a short time (within 12 hours)</td>
<td>2C - This means that you can be left alone for a short time. Staff at the place of residence must be available to you periodically each day. Follow established emergency procedures if no staff are available</td>
</tr>
<tr>
<td>C - Lives in a supervised setting</td>
<td></td>
</tr>
<tr>
<td>3 - Routine - Person can be left alone for a day or two</td>
<td>3A - This means the participant can be left alone for a day or two. If the services are not delivered as planned, your backup plan needs to start within a couple of days</td>
</tr>
<tr>
<td>A - No Supports are available for the person</td>
<td></td>
</tr>
<tr>
<td>3 - Routine - Person can be left alone for a day or two</td>
<td>3B - This means the participant can be left alone for a day or two. If the services are not delivered as planned, the family/friends need to be contacted within a couple of days</td>
</tr>
<tr>
<td>B - Supports are available for the person</td>
<td></td>
</tr>
</tbody>
</table>

**GENERAL PRINCIPLES OF USING THE PRIORITY CLASSIFICATION SYSTEM**

1. The provider is responsible for assuring that all participants receive services as authorized by the Reliance Program Staff. The priority classification system should not be used as a replacement for sound staffing planning in the acceptance of Reliance participant referrals.

2. The provider must notify the client who is to receive a new caregiver, or a change in service appointment, of the change prior to implementing the change.

3. The provider must report the change in service appointment times to the Reliance Case Manager. When disruption of service is to extend beyond one day, the provider must notify the Case Manager of the participant(s) affected, the reason why the service order is disrupted, and how subsequent service orders will be affected.

4. The provider should not change the participant's time or date of service more than one time per week without prior authorization from the Reliance Program Staff.

5. At no time should this classification be used by the provider to alter weekly service units in order to serve another client. The authorized units of service should be performed as ordered unless an unforeseen circumstance occurs. If services are disrupted, the Reliance Case Manager should be notified as soon as possible.
Exhibit 1 Demographic/Fee schedule

RELIANCE
COMMUNITY CARE PARTNERS™

Contracted Agency Demographic Information

Date: 09/06/2019  Federal Tax ID (FEIN#): 38-6004880
Legal Name of Applicant/Agency: Oceola County Board of Commissioners through Commission on Aging
Doing Business As (if applicable): 
NPI: 1205205903  MI Medicaid Provider # (if app) 
Website: 
Medicare Certified? Yes  No

P.O. Box 594  Evart MI  49631
Mailing Address  Street  City  State  Zip Code
732 W 11th St.  Evart MI  49631

Physical Location Address  Street  City  State  Zip Code
Phone: 231-734-5559  Emergency After Hours Phone: 
Fax: 231-734-6009  Email: oca@oceola.coa.org

Coverage area (please circle counties covered):
Allegan  Ionia  Kent  Lake  Mason  Mecosta
Montcalm  Muskegon  Newaygo  Oceana  Osceola  Ottawa

Please List Name and Contact Information for the Following:
Owner/CEO  Justin Halladay, Director

Administrator:

Contracts  Justin Halladay, 231-734-6000  jhalladay@oceola.coa.org
Referrals  Brenda Henry, 231-734-6004  bhenry@oceola.coa.org
Billing  Marcia Eising, 231-734-6000  meising@oceola.coa.org
Remittance Name/Address: Oceola County COA, P.O.Box 594, Evart MI 49631

Ownership: Private  Non-Profit  Charitable/Religious  Public  Government  Other
Legal Structure: Sole Proprietorship  S Corp  Partnership  Voluntary Corp  Corp  Non-Profit Corp
How do you prefer to be contacted? (Circle one) Email  Phone  Regular Mail

Updated 8/7/2019
Are you able to accept new participants? [Yes] [No]

Does your agency have the capacity to serve at least 125% of participants that you provided service for in the past year? [Yes] [No]
Can we contact you about providing back up services for those enrolled in Self Determination? [Yes] [No]
Do you have an On-Call System? [Yes] [No]

Identify your hours of operation: **Monday - Friday  9:00am - 5:00pm**

<table>
<thead>
<tr>
<th>For CLS – per unit and RN/LPN providers only:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the minimum amount of time per visit required to accept participants’ case?</td>
</tr>
<tr>
<td>CLS</td>
</tr>
<tr>
<td>Does your agency hire family members? [Yes] [No]</td>
</tr>
<tr>
<td>How many RN’s do you have on staff? □</td>
</tr>
</tbody>
</table>

What Languages do you have available? Other: English  Spanish  Russian  Bosnian  American Sign Language

**Medicaid Waiver Services in Residential Facilities (AFC/HFA) ONLY**: (Check all that Apply):
- □ Community Living Supports (H2016 per diem based on authorized amount)
- □ Respite provided out of the home (H0045 $140 per day)

**Medicaid Waiver Services Available**: (Check all that Apply)
- □ Adult Day Health ($5100 $3.55 per unit)
- □ Chore Services ($5120 $4.50 per unit)
- □ Community Health Worker (T2014 per bid)
- □ Community Living Supports (H2015 $5.00 per unit)
- □ Counseling Services (99510 $100.00 per hour)
- □ Environmental Accessibility Adaptations ($5165 Per Bid/ Per Project)
- □ Home Delivered Meals $5.75 ($5170 Per Bid)
- □ Transportation ($0.54 per mile)
- □ Nursing Services – LPN (T1003 $10.49 per unit)
- □ Nursing Services – RN (T1002 $10.80 per unit)
- □ Personal Emergency Response Units (SS160 – install; SS161 monthly fee)
  - □ Basic Unit ($22 per month)
  - □ Cellular Unit ($28 per month)
  - □ Other __________________________
- □ Private Duty Nursing – LPN (T1000 TE $10.49 per unit)
- □ Private Duty Nursing – RN (T1000 TD $10.80 per unit)
- □ Respiratory Therapist – RT (G0237, G0238, G0239 $10.49 per unit)
- □ Respite provided at home (SS150 $4.35 per unit)
- □ Specialized Medical Equipment and Supplies (80% of billed)
- □ Supplements (B4150)/Food Thickener (B4100) Please submit product pricing list

**Kent County Senior Millage Services Available**: (Check all that Apply)
- □ Community Living Supports (H2015 $4.35 per unit)
- □ Respite provided at home (SS150 $4.35 per unit)

Signature: ____________________________ Date: ____________________________

Updated 8/7/2019
INSURANCE REQUIREMENTS

Agency Name: Osceola County Commission on Aging

A recent review of your file indicates that the verification of proof of insurance that we have in our files has expired or will be expiring prior to October 1, 2019. Below is the list of Mandatory insurance coverage that needs to be in place and proof provided to Reliance per the Reliance Community Care Partners contract.

A check mark has been placed next to the coverage(s) that we are requesting updated proof of insurance from your agency. If you have not already done so, please also add RelianceCCP as a “certificate holder”. This will allow the insurance company to send us the updates without any prompting from you.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Date current</th>
<th>Proof Expired</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Worker's compensation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] Unemployment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[x] Property and Theft Coverage</td>
<td>7/1/19</td>
<td></td>
</tr>
<tr>
<td>[x] Fidelity Bonding (for persons handling cash)</td>
<td>7/1/19</td>
<td></td>
</tr>
<tr>
<td>[x] No-fault vehicle insurance (for agency vehicles)</td>
<td>7/1/19</td>
<td></td>
</tr>
<tr>
<td>[x] General Liability and hazard insurance (including facilities coverage)</td>
<td>7/1/19</td>
<td></td>
</tr>
</tbody>
</table>

[ ] Insurance proofs are up to date
<table>
<thead>
<tr>
<th>Osceola County Commission on Aging</th>
<th># of units that could be provided for MI Choice Waiver participants from 10/1/19 - 9/30/20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Living Supports</td>
<td>open</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>open</td>
</tr>
<tr>
<td>Respite - in home</td>
<td>open</td>
</tr>
</tbody>
</table>
Case Logic Users

Provider: Osceola County Commission on Aging

Below is the list of current Case Logic Provider Site Users assigned to your agency. Please review for accuracy. For removal of a current user please check the box “remove.” If a user’s information is incorrect, please check the box “update” and provide the corrected information below.

To add additional users please list their name, check the box “new” and return with a signed Terms of Use Agreement (enclosed) signed/dated by the new user. If you have any questions/concerns regarding the use of Case Logic Provider Site, please notify Vicki Holmes at Vicki.Holmes@RelianceCCP.org or (616) 954-1575.

<table>
<thead>
<tr>
<th>User Name</th>
<th>Email address</th>
<th>New</th>
<th>Remove</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marcia Eising</td>
<td><a href="mailto:meising@osceolacoa.org">meising@osceolacoa.org</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brenda Henry</td>
<td><a href="mailto:bhenry@osceolacoa.org">bhenry@osceolacoa.org</a></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Dear Provider:

We are asking that you respond to the following questions regarding your experience with Reliance Community Care Partners (Reliance). Our goal is to improve the quality of our services, so we need to understand our strengths and weaknesses as defined by our Provider Network. Please complete the following questions and submit them with your renewal packet. Your involvement in this process is much appreciated.

5-Strongly Agree  4-Agree  3-Neutral  2-Disagree  1-Strongly Disagree

Mark the box number below that represents your experience with each statement.

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>My questions and phone calls are returned in a timely manner.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Reliance staff act professionally and courteously.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>I am treated respectfully by Reliance staff.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Reliance staff treat the participants with dignity and respect.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Clinical - Case Managers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Case Managers have the necessary knowledge to answer questions.</td>
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<td></td>
<td>Case Managers foster comprehensive communication with the Provider.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Case Managers provide timely documentation as requested by the Provider.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>I believe the compensation procedures are fair and reasonable.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The monetary reimbursement for services is fair and consistent.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Reimbursement for services is received in a timely manner.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The contract is easy to read and understand.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Audits are completed in a timely and helpful manner.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>If a problem or question arises, I feel confident that it will be resolved in a fair and consistent manner.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Changes in policy/procedure affecting my agency are communicated in a timely manner.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Case Logic Provider Site</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The Case Logic Provider Site (electronic record system) is easy to navigate.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>If a problem or question arises with the Provider Site, I feel confident that I will receive assistance in a timely and helpful manner.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Authorizations/Assessments/Re-Assessments are available in a timely and manner on the Provider Site.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Teamwork</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>I would recommend being a part of the Reliance Provider Network to other Providers in the community.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>I feel my agency is an integral part of the Reliance team.</td>
</tr>
</tbody>
</table>

Optional:
Name: ____________________________
Agency: ____________________________

Please answer questions on the reverse side.
1. How many referrals have you made to Reliance Community Care Partners in the last twelve months?

2. Please indicate anytrainings you would be interested in receiving

3. Please list 3 things that you like about working with Reliance Community Care Partners.

4. Please list 3 areas that you would like to see improved.
September 10, 2019

Dear Local Stakeholders:

I am pleased to report that as we near the end of the 2019 fiscal year, the Commission distributed over $80 million dollars statewide to support local funding units in providing indigent defense services consistent with the minimum standards set by the Commission.

In accordance with its statutory mandate, the Commission is currently in the process of reviewing and approving local funding unit compliance plans for fiscal year 2020. To date, the Commission has approved 93 of 124 compliance plans. The Commission’s next meeting is October 15, 2019, at the Capitol National Building at 200 N. Washington Square in downtown Lansing, where it will continue to review compliance plans at that meeting. If you are unsure of the status of your compliance plan and cost analysis, please contact your Regional Manager.

**FY20 Indigent Defense Budget and Unexpended FY19 Funds**

The legislative appropriations process, which will determine the State of Michigan’s fiscal year 2020 budget, is ongoing. We will update you when more information about the state’s indigent defense budget is known.

At its August meeting, the Commission acknowledged the need to provide for uninterrupted indigent defense services in the case where a funding unit may not have a signed FY20 grant contract in place by October 1, 2020. In order to achieve this, the Commission authorized the opportunity for local funding units to amend the FY19 grant contract to enable them to continue to spend unexpended FY19 grant funds into FY20—consistent with the FY19 grant contract.

If you wish to continue spending FY19 funds as you wait for your FY20 grant contract, please sign the attached contract amendment and return it to LARA-MIDC-Info@michigan.gov no later than Monday, September 25, 2019. You should include your Regional Manager on this email.

**Fourth Quarter Reporting**

All systems with current grant contracts will be required to submit fourth quarter reports in October per the grant contract. The following information should be submitted by local funding units:

- A quarterly program report detailing progress on implementation of compliance;
- A financial status report with information about spending during the reporting period;
- A list of the attorneys providing services.
As part of its fourth quarter reporting, each local funding unit must report identified unexpended FY19 grant funds to MIDC no later than October 31, 2019. MCL 780.993(15). Local funding units will receive specific directions for submitting this information.

The MIDC website contains helpful information, checklists, templates, and links to the above items, as well as answers to questions regarding reporting. Our grants page is accessible here: www.michiganidc.gov/grants. In addition, MIDC staff will host an informational webinar to provide additional guidance and instructions regarding fourth quarter reporting.

Local Share

As we near the end of the FY19 grant year, please keep in mind that each funding unit is required under MCL 780.993(7) to maintain its local share. The total local share is reflected on the cover page of the current grant contract.

FY20 Grant Contract

The MIDC continues to work in partnership with local stakeholders to finalize a master contract for distribution of indigent defense grant funds in fiscal year 2020. We have done so with an eye on streamlining progress and financial reporting to make it easier for everyone.

Important Upcoming Dates

Please note the following important dates:

- **September 25, 2019:** Due date for signed amendment to FY19 grant contract allowing for continued expenditures into FY20;
- **October 2019:** Each funding unit is required to submit its fourth quarter reporting and supporting documentation in October pursuant to its grant contract.
- **October 31, 2019:** Deadline by which all systems are required to report FY19 grant balances as of September 30th to the MIDC. “Identified unexpended grant funds must be reported by indigent criminal defense systems on or before October 31 of each year.” MCL 780.993(15).
- **December 31, 2019:** Deadline for any attorney receiving appointments in indigent defense cases to complete training required under Standard 1.

Please do not hesitate to contact me if you have any feedback, or your Regional Manager if you have questions about implementation or planning. We encourage you to continue to check our website, where you can find information regarding the time and location of the Commission’s meetings, as well as other updated information.

Sincerely,

s/Loren Khogali

Loren Khogali, Executive Director
Michigan Indigent Defense Commission
Phone: (517) 275-2845/Email: khogalil@michigan.gov
AMENDMENT TO ALLOW FOR EXPENDITURE OF FISCAL YEAR 2019 UNEXPENDED FUNDS

Subject to the terms and conditions below, the State of Michigan, the Michigan Indigent Defense Commission (MIDC), and the Department of Licensing and Regulatory Affairs (LARA) (collectively “Grantor”) and ________________ (“Grantee”) enter into this Agreement to allow Grantee to use funds remaining from Grant No. ______________ after September 30, 2019.

BACKGROUND

In June 2018, the Michigan Legislature appropriated funds to cover the cost of indigent defense services under the Michigan Indigent Defense Commission Act. Funding for fiscal year 2019 was distributed to funding units pursuant to a grant contract executed between each funding unit and Grantor. The funds distributed under these grant contracts included the state grant amount and the local share. The amount of the grants included funding for a full fiscal year—October 1, 2018, through September 30, 2019.

Pursuant to the MIDC Act, all indigent defense grant funds are required to be held in a restricted fund. MCL 780.993(14)(b). The MIDC Act also provides that unexpended funds in a system’s restricted fund (not subject to MCL 780.993(11)) will be included in the system’s subsequent fiscal year’s expenditures through the subsequent year’s compliance plan and cost analysis.

The Parties are unable to execute a new grant contract for fiscal year 2020 on or before October 1, 2019. The Parties agree, however, that Grantee should make indigent defense-related expenditures with unexpended funds from fiscal year 2019 in order to ensure the uninterrupted provision of indigent defense services.

TERMS

1. Scope of Authority: This agreement incorporates by reference the fiscal year 2019 grant contract and associated fiscal year 2019 compliance plan and cost analysis. If Grantee received a budget adjustment during fiscal year 2019, it should continue spending funds in accordance with the budget adjustment. Any funds used pursuant to this agreement shall be used consistent with the FY 19 approved compliance plan and cost analysis and shall not be used for any other purpose.

2. Variation from Fiscal Year 2019 Spending: Any variation in Grantee’s spending requires prior written approval from the MIDC. Grantee must follow MIDC policy and procedure when applying for approval. The MIDC’s approval of Grantee’s fiscal year 2020 plan and/or cost analysis does not qualify as approval to deviate from Grantee’s fiscal year 19 spending.

3. Offset: The state grant for fiscal year 2020 will be offset by the amount of unexpended funds (not subject to MCL 780.993(11)) remaining on September 30, 2019.

4. Fund Balance Reporting: Michigan Compiled Laws 780.993(15) requires Grantee to report all unexpended funds as of September 30th by October 31, 2019, to the MIDC.
5. **Incorporation:** All terms and conditions of the Parties’ fiscal year 2019 grant agreement (including attachments) are incorporated into this Agreement. But if there is a conflict between the terms and conditions of the fiscal year 19 grant agreement and this Agreement, this Agreement prevails.

**MISCELLANEOUS PROVISIONS**

6. **Local Share:** Nothing in this agreement affects the calculation of the local share pursuant to the MIDC Act. That share is adjusted on an annual basis.

7. **Modification:** This Agreement, and all documents incorporated hereto, constitute the Parties’ entire Agreement. This Agreement can only be modified by the Parties’ written agreement.

8. **Waiver:** Failure to enforce any provision of this Agreement shall not constitute a waiver.

9. **Severability:** If any court of competent jurisdiction finds any part of this Agreement to be invalid or unenforceable, that part will be deemed deleted from this Agreement. The severed part will be replaced with a mutually agreeable provision that achieves the same or similar objectives. The remaining Agreement will continue in full force and effect.

10. **Headings:** The use of headings in this Agreement is for convenience only. Headings shall not affect the interpretation of any provision of this Agreement or any of the rights or obligations of the Parties.

11. **Termination:** This agreement shall terminate on December 31, 2019, or the date that the parties sign their FY 20 grant contract—whichever date is earlier. Expenditures made under this Agreement, however, shall be included and supported with documentation in the first report required under the FY20 grant contract.

12. **Signatories:** The signatories warrant that they are empowered to enter into this Agreement and agree to be bound by it.

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LeAnn Droste, Director  
Bureau of Finance and Administrative Services  
Department of Licensing and Regulatory Affairs  
State of Michigan  

Date:


Loren Khogali, Executive Director  
Michigan Indigent Defense Commission  
Department of Licensing and Regulatory Affairs  

Date: