Department of Health & Human Services
DHHS
NEBRASKA

Division of Public Health

Program Services Agreement

READ INSTRUCTIONS BEFORE COMPLETING. SIGNATURE REQUIRED.

By completing and signing this agreement, the Provider agrees to provide services as needed to Nebraska Department of Health and Human Services (hereinafter "DHHS") approved clients in accordance with the terms and conditions of this agreement with the Every Woman Matters and Nebraska Colon Cancer Screening Programs (hereinafter EWM/NCCP).

Section A: Type of Provider Agreement

1. **Check Type of Provider Enrollment:**
   - o New EWM/NCCP Provider or Facility
   - **X** Existing EWM/NCCP Provider or Facility
   - o Add Individuals to Provider Group

2. **Check Type of Provider:**
   - o Primary Care Setting O Hospital Setting O OB/GYN Specialty
   - o Surgery Center O Surgeon (Specialty):_____ O Anesthesiology
   - o Radiology/Mammography ***FDA Certification Required- Please include a copy.***
   - o Laboratory/Pathology CLIA#: **28D0674817**
   - **X** Other: **Public Health Clinic**

3. **Effective Dates:** The agreement shall be effective **on July 1, 2012** and shall continue in effect until **June 30, 2017** or in the event of termination or suspension.

Section B: Provider Information

4. **Federal Taxpayer Identification Name and Number (FTIN):**

   Issued to: **Lincoln-Lancaster County Health Department** Number: **47-6006256**

5. **Provider Name and Physical Address:**

   Legal Name: **City of Lincoln on behalf of the Lincoln-Lancaster County Health Department**

   Business as Name: (if applicable): **NA**

   Contract Contact Name and Title: **Andrea Haberman RN, MSN, Community Health Services Division Manager**

   Physical Street Address (P.O. Box not accepted): **3140 N Street**

   City, State, Zip + 4: **Lincoln, NE 68510-1514**

   Phone Number: **402-441-8054** *Fax Number*: **402-441-6229**

   E-Mail for Provider Contact: ahaberman@lincoln.ne.gov

Section C: Billing Information

A completed Form W-9 is required to be returned with this signed agreement. See attached form for completion.

6. **Third Party Billing Service?** O Yes **X** No

7. **Type of Billing Fee:** **X** Global Fee O Professional Fee O Technical Fee

8. **Pay to Name and Mailing Address**: (if different from 5)

   Name:

   Address:

   City, State, Zip +4:

   E-mail: Fax:

9. **Contact for Billing Related Inquiries:**

   Name: **Bernice Afuh, BSN, MS** Phone Number: **402-441-6216**

   Address: **3140 N Street**

   City, State, Zip +4: **Lincoln, NE 68510 - 1514**

   E-mail: bafuh@lincoln.ne.gov Fax: 402-441-8646

Section D: Provider Scope of Services:

10. **Primary Contact for Program Service/Client Related Questions:**

    Name: **Bernice Afuh, BSN, MS** Phone Number: **402-441-6216**

    Address: **3140 N Street**

    City, State, Zip +4: **Lincoln, NE 68510 - 1514**

    E-mail: bafuh@lincoln.ne.gov Fax: 402-441-8646

11. **Related Program Services *Performed* At This Facility:**

    X Clinical Breast Exams O Breast Biopsy O Breast Fine Needle Aspiration O Breast Ultrasound O Mammography
    X Pelvic/Pap Tests O Colposcopy **X** Laboratory O Colonoscopy O Radiology

12. ***Will Accept Referrals* For the Following Program Services:**

    X Clinical Breast Exams O Breast Biopsy O Breast Fine Needle Aspiration O Breast Ultrasound O Mammography
    X Pelvic/Pap Tests O Colposcopy **X** Laboratory O Colonoscopy O Radiology

13. **Translation Services Available?** **X** Yes O No O N/A

    X Spanish **X** Vietnamese X Other(s): **Arabic and other languages as needed**

    X On-Site Translation **X** Language Line Services

14. **Accepting New EWM/NCCP Clients?** **X** Yes O No O N/A

    * All EWM/NCCP Participating Providers Will Appear on Web-Based Listing Available to Clients Seeking Care.

Section E: Individual Professionals Part of Group

Complete for each individual professional that is part of the group provider and subject to the group service provider agreement. Attach additional pages as necessary.

1. **Name: Shirley Tachenko-Achord** **Credentials: APRN**
   License/Certification Number: 110131

2. **Name:**_____ **Credentials:**_____
   License/Certification Number:_____

3. **Name:**_____ **Credentials:**_____
   License/Certification Number:_____

4. **Name:**_____ **Credentials:**_____
   License/Certification Number:_____

5. **Name:**_____ **Credentials:**_____
   License/Certification Number:_____

6. **Name:**_____ **Credentials:**_____
   License/Certification Number:_____

Section F: Affiliated/Satellite Locations Operating Under This Contract and FTIN: NOT APPLICABLE

This section for Providers who offer Program services at multiple sites under this legal agreement and corresponding FTIN. Please complete for each site and attach additional pages as necessary.

1. **Site Name:**_____
   Address:_____
   City, State, Zip +4:_____

   Primary Contact for Program Service/Client Related Questions:
   Name:_____ Phone Number:_____
   Address:_____
   City, State, Zip +4:_____
   E-mail:_____ Fax:_____

   Contact for Billing Related Inquiries:
   Name:_____ Phone Number:_____
   Address:_____
   City, State, Zip +4:_____
   E-mail:_____ Fax:_____

Terms of Agreement:

This Agreement between DHHS and the approved service Provider governs the provision of the service(s) indicated in this Agreement.

As a Provider for the Every Woman Matters or Nebraska Colon Cancer programs specified in this Agreement, the Provider assures:

1. Compliance with the policies and procedures required by DHHS in the delivery of services and in submitting claims for payment as described in the Every Woman Matters and Nebraska Colon Cancer Program Provider Manual at http://dhhs.ne.gov/publichealth/Pages/womenshealth_ewm_ewmproviders.aspx

   The manual and its amendments are incorporated by this reference as though fully set out herein. DHHS reserves the right to amend the provider manual as needed. Authorized services and resulting charges are subject to review and approval by DHHS. Payments for services shall be in accordance with program billing guidelines in effect at the time services are provided.

2. Full compliance with all applicable Federal and Nebraska statutes and regulations.

3. Full compliance with all applicable local, state and federal statutes and regulations regarding civil rights and equal opportunity employment, including Title VI of the Civil Rights Act of 1964; the Rehabilitation Act of 1973, Public Law 93-112; the Americans with Disabilities Act of 1990, Public Law 101-336; and the Nebraska Fair Employment Practice Act, NEB. REV. STAT. §§48-1101 to 48-1125. Violation of said statutes and regulations will constitute a material breach of contract.

4. That the payment determined in accordance with the policies of the DHHS Every Woman Matters or Nebraska Colon Cancer Program will be the full and complete payment for the services provided, and the amount paid for those claims submitted by the Provider or an authorized representative will be accepted as payment in full and no additional payment will be claimed. If any additional payment is received, or will be received, from any other source, that amount will be deducted from the amount charged DHHS. Any payment received from another source after payment by DHHS shall be remitted to DHHS. Payment shall not be required or requested from clients for authorized services covered by this Agreement. The Provider shall have the right to bill clients for services not covered under this Agreement. DHHS shall not pay the co-pay portion of any public or private compensation programs in which the client is enrolled, unless so specified in the provider manual.

5. That this Agreement may be terminated at any time upon mutual written consent or by either party for any reason upon submission of written notice to the other party at least Thirty (30) days prior to the effective date of termination. DHHS may also terminate this contract, in whole or in part, in the event funding is no longer available. The Provider shall be entitled to receive just and equitable compensation for any authorized services which have been satisfactorily provided as of the termination date. If the Provider is in violation of this Agreement or any other law, rule or regulation of DHHS, the State of Nebraska, or Federal Government, this Agreement may be terminated immediately upon mailing of a written notice from DHHS. In the event of termination, the Provider shall be paid only for services provided as of the termination date.

6. That adequate and complete fiscal and medical records will be maintained to fully document services rendered to clients under terms of this Agreement. Service records will be retained as are necessary to fully disclose the extent of the services provided to support and document all claims, for a minimum period of six years as required under HIPPA Section 164.530(j). Service records may be reviewed for program administration or audit in accordance with 45 CFR 74.20-74.24. Inspections, reviews, and audits may be conducted on site.

7. That the Provider has and will maintain the necessary qualifications and licensure, certification, or registration required by state and federal law to provide services under this Agreement.

8. That DHHS's liability is limited to the extent provided by the Nebraska Tort Claims Act, the Nebraska Contract Claims Act, the Nebraska Miscellaneous Claims Act, and any other applicable provisions of law. DHHS does not assume liability for the action of its Providers. This provision shall survive termination of the contract.

9. That the Provider is an independent contractor and neither it nor any of its employees shall be deemed employees of DHHS for any purpose.

10. That this Agreement will not be transferred to any other person or entity.

11. That the Provider certifies that it maintains a drug-free workplace environment to ensure worker safety and workplace integrity. The Provider shall provide a copy of its drug-free workplace policy at any time upon request by DHHS.

12. That in the event Provider provides health and human services to individuals on behalf of DHHS under the terms of this contract, Provider shall submit to the jurisdiction of the Public Counsel under NEB. REV. STAT. §§ 81-8,240 through 81-8,254 with respect to the provision of services under this contract. This provision shall survive termination of the contract.

13. That the Provider shall use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska. A federal immigration verification system means the electronic verification of the work authorization program authorized by the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, 8 U.S.C. § 1324a, known as the E-Verify Program, or an equivalent federal program designated by the United States Department of Homeland Security or other federal agency authorized to verify the work eligibility status of a newly hired employee.

    If the Provider is an individual or sole proprietorship, the following applies:

    a) The Provider must complete the United States Citizenship Attestation Form, available on the Department of Administrative Services website at www.das.state.ne.us.

    b) If the Provider indicates on such attestation form that he or she is a qualified alien, the Provider agrees to provide the U.S. Citizenship and Immigration Services documentation required to verify the Provider's lawful presence in the United States using the Systematic Alien Verification for Entitlements (SAVE) Program.

    c) The Provider understands and agrees that lawful presence in the United States is required and the Provider may be disqualified or the contract terminated if such lawful presence cannot be verified as required by NEB. REV. STAT. § 4-108.

My signature certifies I have read and understand the Terms of Agreement as referenced above and the information on the form is true, accurate and complete.

Authorized Signature for Provider:

Chris Beutler, Mayor of Lincoln

Printed Name and Title of Provider/ Authorized Official

Signature Name and Title of Provider/ Authorized Official **Date**

*** NOTE: It is the provider's responsibility to retain a copy of the complete agreement.**

Authorized Signatures For DHHS/EWM/NCCP:

Kathy Ward, Administrator **Date**

Office of Women's and Men's Health

Department of Health and Human Services

PROGRAM USE ONLY

O Approved O Denied

O Med It Database Entry Complete _____ (Initials) O Date:_____

Form **W-9**
(Rev. January 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)
City of Lincoln Nebraska

Business name/disregarded entity name, if different from above
Lincoln-Lancaster County Health

Check appropriate box for federal tax classification (required): ☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☑ Other (see instructions) ▶ Local Government

☑ Exempt payee

Address (number, street, and apt. or suite no.)
3140 N Street

Requester's name and address (optional)

City, state, and ZIP code
Lincoln, NE 68510

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number
			-		-				

Employer identification number
4	7	-	6	0	0	6	2	5	6

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here | **Signature of U.S. person** ▶ Logan B. Thomas | **Date** ▶ 6-28-12

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.