EMPLOYMENT & FAMILY SERVICES

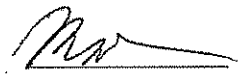
PURCHASE OF SERVICE CONTRACT
WITH
CATHOLIC CHARITIES SERVICES CORPORATION

THIS CONTRACT made and entered into this 10th day of June, **2011** by and between the County of Cuyahoga, Ohio (the "County"), on behalf of the Employment & Family Services ("Agency") and **Catholic Charities Services Corporation** with principal offices located at **3135 Euclid Avenue, Suite 202, Cleveland, Ohio 44115**, (the "Provider").

I. TERM

This contract will be effective from **July 1, 2011 through June 30, 2012** inclusive, unless otherwise terminated or extended by formal amendment. The Agency reserves the right to exercise the option, subject to the agreement of both parties, to extend the length of this contract based upon the Agency's program needs, the Provider's performance, and the availability of funds.

The Provider is a vendor of a Federal Award from the Department of Health and Human Services, Temporary Assistance for Needy Families (TANF), CFDA number: 93.558. The Provider is aware that funding for the services under this contract will not be continued after June 30, 2012. Acknowledgment for funding this contract and its deadline is shown by the initials of the Provider on the line below.

Provider Representative Initials. 

The total amount of the contract cannot exceed **$460,000.00** over the life of this contract. If the amount of the invoices exceeds the amount of the contract, the Provider realizes that no additional funds will be paid over and above the total amount of the contract, under any circumstances, even if additional services are provided.

II. PURCHASE OF SERVICE

Subject to the terms and conditions set forth in this contract and the attached EXHIBITS (such EXHIBITS are deemed to be a part of this contract as fully as set forth herein), the Provider agrees to provide Intensive Case Management services for OWF/FAET/DFA cash recipients with barriers to employment at the Virgil E. Brown Building as described in Exhibit I, (Statement of Work) and Exhibit I-A (Provider Program Design).

The Provider agrees to acknowledge the financial support of the County on any publications, promotional brochures, media releases, or other publicity materials

produced with resources from this contract. This acknowledgement should be displayed in a prominent location.

III. RECORDS AND REPORTING

The Agency reserves the right to request additional reports pertaining to the specific program during the contract period. It is the responsibility of the Provider to furnish the Agency with reports as requested. The Agency may exercise this right without a contract amendment. The Agency reserves the right to withhold payment until such time as the requested and/or required reports to the satisfaction of the Agency are received.

IV. BILLING AND PAYMENT

Billing and Payment – The Provider will submit an invoice following service, with accompanying reports to the Agency as outlined in the Exhibits and Attachments. The Agency will review such invoices for completeness/correctness and any information necessary before making payment within thirty (30) calendar days after receipt of an accurate invoice. The Agency shall not make invoice payments for any services invoiced later than 60 days after the end of the service month without prior Agency approval. The Agency reserves the right to withhold payment until such time as requested and/or required reports are received.

The Provider will indicate on their invoices, the contract number, type of service being rendered, dates service was rendered, and the contract period. The invoice should also show the contract amount minus the invoice amount to reflect the remaining balance on the contract in order to obtain reimbursement.

The Provider warrants that the following unallowable costs were not included in determining the rate of payment and that these costs will not be included in an invoice submitted for payment. For this project, unallowable costs are: bad debt, bonding costs, contingencies, contributions or donations, entertainment costs, costs of alcoholic beverages, goods or services for personal use, fines, penalties and mischarging costs, gains and losses on disposition or impairment of depreciable or capital assets, losses on other contracts, organization costs, costs related to legal and other proceedings, goodwill, asset valuations resulting from business combinations, and legislative lobbying costs.

The Provider warrants that a separate General Ledger account has been established and will be maintained for the revenue and expenses of this contracted program in accordance with the requirements of Section IX.

V. MONITORING, EVALUATION, AND QUALITY IMPROVEMENT

The effectiveness of the Provider services shall be measured by the achievement of

performance measures and outcomes as identified in the Statement of Work and the Program Design, utilization as defined in the contract budget, and compliance with the terms and conditions of the contract.

The Agency will determine the overall performance of contracted services and programs through monthly monitoring activities and the Comprehensive Program Assessment (CPA).

Monitoring activities may consist of, but are not limited to:

- Reviewing required reports and other submissions
- Reviewing required invoicing documentation and protocol
- Reviewing monthly activities such as referrals, enrollments and terminations
- Quality Improvement interventions needed to address and remedy issues discovered through the monitoring activities

The CPA consists of a series of coordinated activities designed to support, assess, and document program implementation, performance, and compliance. CPA activities may consist of, but are not limited to:

- Provider site visits to observe program activities, participant engagement, and facilities;
- Provider presentations and meetings to discuss program features, progress, adjustments, or other notable program results;
- Case File Reviews conducted by the Agency to ensure compliance with case file requirements and documentation of services rendered;
- Surveys and other methods to gauge participant feedback;
- Review of program outcomes; and
- Program enhancements and updates based on Agency feedback with regards to services and performance.

Findings based on any of the aforementioned activities will be communicated to the Provider in writing. In the event of negative findings resulting in areas in need of improvement or noncompliance, the Provider will respond in writing detailing an improvement plan and/or a corrective action plan for each issue.

The CPA and monitoring are on-going and evolving processes. The Agency reserves the right to modify the processes, activities, and products during the contract period in order to most effectively meet the monitoring and compliance needs of the Agency.

Failure to achieve performance goals or to comply with the terms of this contract will be cause for or result in reduction of funding, recuperation of funds paid, or termination of this agreement in part or in whole.

VI. ELIGIBILITY FOR SERVICES

Eligibility of individuals to receive purchased services shall be determined, and units of service authorized, by the County Department of Jobs and Family Services (CDJFS), through Employment & Family Services (EFS), in accordance with the policies and procedures established by the Ohio Department of Jobs and Family Services (ODJFS) in Section 5101.80 of the Ohio Revised Code.

VII. AVAILABILITY OF FUNDS

This contract is conditional upon the availability of federal, state, or local funds that are appropriated or allocated for payment of this contract. If funds are not allocated and available for the continuance of the function performed by the Provider hereunder, the products or services directly involved in the performance of that function may be terminated by the Agency at the end of the period for which funds are available. The Agency will notify the Provider at the earliest possible time of any products or services that will or may be affected by a shortage of funds. No penalty shall accrue to the Agency in the event this provision is exercised, and the Agency shall not be obligated or liable for any future payments due or for any damages as a result of termination under this section.

VIII. DUPLICATE BILLING

The Provider warrants that claims made to the Agency for payment for services provided shall be for actual services rendered to eligible individuals and do not duplicate claims made by the Provider to other sources of public or private funds for the same service.

IX. AVAILABILITY AND RETENTION OF RECORDS

All records relating to the service provided and supporting documentation for invoices submitted to the Agency by the Provider shall be retained and made available by the Provider for audit by the Agency, the State of Ohio (including, but not limited to, ODJFS, the Auditor of the State of Ohio, Inspector General or duly appointed law enforcement officials) and agencies of the United States government for a minimum of three (3) years after payment under this contract. If an audit is initiated during this time period, the Provider shall retain such records until the audit is concluded and all issues resolved.

X. CONFLICT OF INTEREST

This contract in no way precludes, prevents, or restricts the Provider from obtaining and working under an additional contractual arrangement(s) with other parties aside from the Agency, assuming that the contractual work in no way impedes the Provider's ability to perform the services required under this contract. The Provider

warrants that at the time of entering into this contract, it has no interest in nor shall it acquire any interest, direct or indirect, in any contract that which will impede its ability to perform the services under this contract.

The Provider further agrees that there is no financial interest involved on the part of any Agency officers, the County or employees of the county involved in the development of the specifications or the negotiation of this contract. The Provider has no knowledge of any situation that would be a conflict of interest. It is understood that a conflict of interest occurs when an Agency or County employee will gain financially or receive personal favors as a result of the signing or implementation of this contract.

The Provider will report the discovery of any potential conflict of interest to the Agency, and/or the County. Should a conflict of interest be discovered during the term of this contract, the Agency and/or the County may exercise any right under the contract including termination of the contract.

XI. ASSIGNMENTS

The parties expressly agree that the contract shall not be assigned to another Provider without the prior written approval of the Agency.

The Provider may not subcontract any of the services agreed to in this contract without the express written consent of the Agency. All subcontracts are subject to the same terms, conditions, and covenants contained within this contract. The Provider is responsible for making direct payment to all subcontractors for any and all services provided by such contractor.

XII. GOVERNING LAW; VENUE

This contract and any modifications, amendments, or alterations, shall be governed, construed, and enforced under the laws of Ohio in the state courts located in Cuyahoga County.

XIII. INTEGRATION AND MODIFICATION

This instrument with exhibits embodies the entire contract of the parties. There are no promises, terms, conditions or obligations other than those contained herein; and this contract shall supersede all previous communications, representations or contracts, either written or oral, between the parties to this contract.

Also, this contract shall not be modified in any manner except by an instrument, in writing, executed by the parties to this contract.

XIV. SEVERABILITY

If any term or provision of this contract or the application thereof to any person or circumstance shall, to any extent be held invalid or unenforceable, the remainder of this contract or the application of such term or provision to persons or circumstances other than those as to which it is held invalid or unenforceable, shall not be affected thereby and each term and provision of this contract shall be valid and enforced to the fullest extent permitted by law.

XV. TERMINATION

The Agency may terminate this contract, for any reason, upon 30 day written notice delivered to the Provider. The Provider may terminate this contract upon 30 day written notice delivered to the Agency, subject to the following:

Provider agrees that it will be considered a material breach of this contract on Provider's part if Provider terminates service on this contract without cause, which is defined as:

- The Agency failing to meet the terms and conditions specified in the contract, or

- The Agency, through action or inaction on the Agency's part, rendering performance by the provider impossible.

The notice should be sent to the attention of the Contract Manager at 1641 Payne Avenue, Room 510, Cleveland, Ohio 44114. The Agency and the Provider shall agree on a reasonable phase-out of the program as a condition of the termination.

The parties further agree that should the Provider become unable to provide the services agreed to in this contract for any reason or otherwise materially breach this contract, such service as the Provider has provided upon the date of its inability to continue the terms of this contract shall be eligible to be billed and paid according to the provisions of Section IV – Billing and Payment.

The parties further agree that should the Provider become unable to complete the services requested in this contract for any reason, such work as the Provider has completed upon the date of its inability to continue the terms of this contract shall become the property of the Agency.

Neither the Agency nor the County shall be liable to pay to the Provider any further compensation after the date of the Provider's inability to complete the terms hereof, or the date of termination of this agreement whichever is later, unless extended upon an agreement of the parties. It is agreed that even if the Provider renders services for which payments are due, that no payments will be made after the termination of this agreement, either as a result of a default in the

terms hereof or the day of termination of the contract, unless extended by an agreement of the parties. Notwithstanding the above, the Provider shall not be relieved of liability to the Agency for damages sustained by virtue of any breach of the contract by the Provider. The Agency may withhold any compensation to the Provider for the purpose of off-set until such time as the amount of damages due the Agency from the Provider is agreed upon or otherwise terminated.

XVI. COMPLIANCE

The Provider certifies that the Provider and all subcontractors who provide direct or indirect services under this contract will comply with all requirements of federal laws and regulations, applicable OMB circulars, state statutes and Ohio Administrative Code rules in the conduct of work hereunder. The Provider accepts full responsibility for payment of any and all unemployment compensation premiums, all income tax deductions, pension deductions, and any and all other taxes or payroll deductions required for the performance of the work by the Provider's full time employees.

XVII. NON-DISCRIMINATION

The Provider certifies it is an equal opportunity employer and shall remain in compliance with state and federal civil rights and nondiscrimination laws and regulations including, but not limited to Title VI, and Title VII of the Civil Rights Act of 1964 as amended, the Rehabilitation Act of 1973, the Americans with Disabilities Act, the Age Discrimination Act of 1975, the Age Discrimination in Employment Act, as amended, and the Ohio Civil Rights Law.

During the performance of this contract, the Provider will not discriminate against any employee, contract worker, or applicant for employment because of race, color, religion, sex, sexual orientation, national origin, ancestry, disability, Vietnam-era veteran status, age, political belief or place of birth. The Provider will take affirmative action to ensure that during employment, all employees are treated without regard to race, color, religion, sex, sexual orientation, national origin, ancestry, disability, Vietnam-era veteran status, age, political belief or place of birth. These provisions apply also to contract workers. Such action shall include, but is not limited to, the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising, layoff, or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship.
The Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices stating that the Provider complies with all applicable federal and state non-discrimination laws.

The Provider, or any person claiming through the Provider, agrees not to establish or knowingly permit any such practice or practices of discrimination or segregation in

reference to anything relating to this contract, or in reference to any contractors or subcontractors of said Provider.

XVIII. INDEMNIFICATION

The Provider agrees to protect, defend, indemnify and hold the Agency, the County, their officers, employees and agents, free, clear and harmless from and against any and all losses, penalties, damages, settlements, costs or liabilities of every kind and character arising out of or in connection with any acts or omissions of the Provider, negligent or otherwise, and its employees officers, agents, or independent contractors. The Provider agrees to pay all damages, costs and expenses of the Agency, officers, agents, employees and County in defending any action arising out of the aforementioned acts or omissions.

XIX. RELATIONSHIP

Nothing in this contract is intended to, or shall be deemed to constitute a partnership, association or joint venture with the Provider in the conduct of the provisions of this contract. The Provider shall at all times have the status of an independent contractor without the right or authority to impose tort, contractual or any other liability on the Agency or the County.

XX. DISCLOSURE

The Provider hereby covenants that it has disclosed any information that it possesses about any business relationship or financial interest that said Provider has with a county employee, employee's business, or any business relationship or financial interest that a county employee has with the Provider or in the Provider's business.

XXI. INSURANCE

The Provider shall at times during the terms of this contract subscribe to and comply with the Worker's Compensation Laws of the State of Ohio and pay such premiums as may be required there-under, and shall save the County harmless from any and all liability arising from or under said act. The Provider shall also furnish prior to the onset and delivery of said services and at such other times as may be requested, a copy of the official certificate or receipt showing the payments hereinbefore referenced.

The Provider shall further purchase and maintain during the life of this contract to cover any loss, liability or damage alleged to have been committed by the Provider, the Provider's employees, agents, servants, volunteers, or assigns, Employment Practices Liability insurance coverage, Professional Liability insurance, and Commercial General Liability (CGL) insurance coverage, wherein the County is named as an additional insured or co-insured, as herein specified by the County. It is

understood that said CGL coverage is to include, but not be limited to standard provisions for sexual and physical abuse, broad form property damage, personal injury, advertising injury, completed operations, product liability and firm damage. Exact copies of Certificates of Liability delineating such coverage shall be deposited with the County prior to commencement of services under this Contract. The amounts of said insurance shall be as follows:

- Commercial General Liability coverage with limits of at least $1,000,000 per claim and $3,000,000 annual aggregate.
- Employment Practices Liability coverage with limits of at least $1,000,000 per claim and $1,000,000 annual aggregate.
- Professional Liability coverage with limits of at least $1,000,000 per claim and $3,000,000 annual aggregate (where applicable).

The policies for each of the requisite insurance coverage hereinabove specified shall contain the following provision: The Provider agrees that thirty (30) days prior to cancellation or reduction of the insurance afforded by this policy, with respect to the Contract involved, written notice shall be mailed to Employment & Family Services, 1641 Payne Avenue, Room 510, Cleveland, Ohio 44114.

Cancellation of insurance will constitute a default, which if not remedied within the stated thirty (30) day notice period shall cause immediate termination of this contract by the County.

XXII. CONFIDENTIALITY

The Provider agrees to comply with all federal and state laws applicable to the Agency and/or consumers of the Agency concerning the confidentiality of the Agency's consumers. The Provider understands that any access to the identities of any Agency consumers shall only be as necessary for the purpose of performing its responsibilities under this contract. The Provider agrees that the use or disclosure of information concerning the Agency consumers for any purpose not directly related to the administration of this contract is prohibited.

Client Data Confidentiality

By receiving client data in any form whatsoever from the Agency all parties to this agreement shall protect the confidentiality of said data as per the requirements of Ohio Administrative Code 5101:1-1-03, the regulations promulgated by the United States Department of Health and Human Services, the provisions of HIPAA, specifically 45 CFR 164.501, any amendments thereto, and as detailed below.

Definition- "Client data" is any information that is, or can be, related to an individual client including all personal health information (PHI) as defined at 45 CFR 164.501.

Permitted Uses and Disclosures- The Provider and its agents and subcontractors shall not use or disclose client data except as specifically stated in this agreement.

Safeguards- The Provider shall use appropriate safeguards to protect against use or disclosure not provided for in this agreement.

Reporting of Disclosure- The Provider shall promptly report to the Agency any knowledge of uses or disclosures of client data that are not in accordance with this Agreement or applicable law. In addition, Provider shall mitigate any adverse effects of such a breach to the extent possible.

Agents and Subcontractors – The Provider ensures that all its agents and subcontractors that receive client data from or on behalf of the Agency agree to the same restrictions and conditions that apply to Provider with respect to the use or disclosure of the client data.

Accessibility of Information – The Provider shall make available to the Agency such information as the Agency may require to fulfill the Agency's obligations to provide access to, provide a copy of, and account for disclosures with respect to client data pursuant to HIPAA and regulations promulgated by the United States Department of Health and Human Services, including, but not limited to, 45 CFR 164.154 and 164.528 and any amendments thereto.

Amendments of Information – The Provider shall make client data available to the Agency in order for the Agency to fulfill its obligations pursuant to HIPAA to amend the information and shall, as directed by the Agency, incorporate any amendments into the information held by the Provider and ensure incorporation of any such amendments into information held by its agents or subcontractors.

Disclosure – The Provider shall make available its internal practices, books and records relating to use and disclosure of client data received from the Agency, or created or received by the Provider on behalf of the Agency, to the Agency and to the Secretary of the U.S. Department or Health and Human Services for the purposes of determining the Agency's compliance with HIPAA and the regulations promulgated by the U.S. Department of Health and Human services and any amendments thereto.

Portable Storage Devices- Inclusive to these terms are any form of client data stored on all portable/mobile devices (laptops/notebooks, any form of portable media, electronic communications, hard copy documentation, cell phones and PDAs) and non-portable storage and processing devices. The Provider must exercise appropriate safeguards to ensure confidentiality, integrity, and availability of all client data consistent with the Provider's Business Continuity and/or Risk Management plans

and protocol. The Agency must be notified, immediately, upon breech of any portion of this section.

Material Breach - In the event of a material breach of Provider's obligation under this section, the Agency may at its option terminate this agreement. Termination of this agreement shall not effect any provision of this agreement which, by its wording or its nature, is intended to remain effective and to continue to operate in the event of termination.

Return or Destruction of Information - Upon termination of this Agreement, the provider, at the Agency's option, shall return to the Agency, or destroy, all client data in its possession, and keep no copies of the information except as requested by the Agency or required by law. If Provider or its agents or subcontractors destroy any client data then the Provider will provide to the Agency documentation evidencing such destruction. Any client data maintained by Provider shall continue to be extended the same protections set forth in this Agreement for as long as it is maintained.

XXIII. BUSINESS CONTINUITY

The Provider shall maintain and make available to the Agency its Business Continuity Plan (BCP) relating to electronic files, application access, data back-up and computer/system equipment recovery due to a disaster or system failure. The BCP at a minimum should address:

- Recovery and restoration of critical systems and information within a specified time period after a disruption;
- Data Backup and restoration protocols in the event of a data loss;
- Hardware and systems restoration strategies; and
- Full and partial business restoration schedules.

XXIV. AUDIT RESPONSIBILITY

OMB Circular A-133

The Provider acknowledges that they are a vendor as defined in Office of Management and Budget (OMB) Circular A-133; Subject: Audits of States, Local Governments and Non-Profit Organizations. The Provider agrees to comply with all relevant requirements of OMB Circular A-133 and is advised that a full text copy of the circular is available at **www.whitehouse.gov/omb/**

The Provider further acknowledges responsibility for obtaining an annual single or program specific external audit, to include an assessment of the degree of compliance with the requirements contained in OMB Circular A-133 for Federal funding in excess of $500,000.00 in a fiscal year.

The Provider agrees to provide a copy of this audit to the Agency each year within 30 days of receipt.

The Agency reserves the right to withhold payment of the final contract invoice, or subsequent invoices in the event of a contract amendment, pending receipt of the annual audit.

The Provider acknowledges that they are subject to vendor program monitoring, as defined in OMB Circular A-133 and as implemented by the Ohio Department of Jobs and Family Services (ODJFS) OAC Rule: 5101:9-1-88; Subject: Subrecipient Annual Risk Assessment Review and Subrecipient Monitoring Process.

These monitoring activities include, but are not limited to:

- An on-site or desk review of Provider records to:
    - Verify that services being provided are within the scope of the funding being received.
    - Provide reasonable assurance that the cost of goods, services and property are allowable and that expenditures appear to be within the budget submitted.
    - Provide reasonable assurance that the Provider has acquired goods and services in accordance with applicable local, state and federal regulations.
    - Provide reasonable assurance that reports are supported by underlying accounting or performance records and are submitted in accordance with provisions of the contract.
    - Ensure that, when applicable, appropriate cash management practices are in place; that program income is correctly earned, recorded and used; and that required audits are obtained and the Provider is in compliance with any resulting corrective action plan.

Other Audits and Reviews

The Provider agrees to accept responsibility for receiving, replying to and/or complying with any audit exception or finding resulting from any appropriate federal, state or local audit or review related to the provisions of this contract.

Audits and reviews will be conducted using a "sampling" method. Depending on the type of audit or review conducted, the areas to be reviewed using the sample method may include but are not limited to; months, expenses, total units, and billable units. If errors are found, the error rate of the sample period may be applied to the entire audit period or other appropriate methods may be utilized.

The Provider agrees to repay the Agency amounts due that result from any audit or review finding with monetary implications contained in an audit or review conducted by any appropriate federal, state or local government entity.

The Provider agrees to repay the Agency the full amount of payment received for duplicate billings, erroneous billings, or false or deceptive claims.

When an overpayment is identified and the overpayment cannot be repaid in one month, the Provider will be required and hereby agrees to sign a Repayment of Funds Agreement. The Provider recognizes and agrees that the Agency may withhold any money due and recover through any appropriate method any money erroneously paid under this contract if evidence exists of less than full compliance with this contract. If payments are not made according to the agreed upon terms, future checks will be held until the repayment of funds is current. Checks held more than 60 days will be canceled and will not be reissued.

The Agency also reserves the right to not increase the rate(s) of payment or the overall contract amount for services purchased under this contract if there is any outstanding or unresolved issue related to an audit finding.

The Agency may allow a change in the terms of the Repayment of Funds Agreement. Any change will require a formal amendment to the Repayment of Funds Agreement that must be signed by all parties. An amendment to the Repayment of Funds Agreement may also be processed if any additional changes or issues develop or need to be addressed.

Other Deliverables

Within 30 days of receipt, the Provider agrees to give the Agency a copy of Provider's annual independent audit report and any associated management letters.

XXV. WARRANTY

The Provider warrants that its services and/or goods shall be performed and/or provided in a professional manner in accordance with applicable professional standards.

XXVI. ACTS OF GOD

If by reason of Acts of God, the parties are unable in whole or in part to act in accordance with this contract, the parties shall not be deemed in default during the continuance of such inability provided, however, that Provider shall only be entitled to the benefit of this paragraph for fourteen (14) days if the event of force majeure does not affect the Agency's property or employees which are necessary to the Provider's ability to perform.

The term "Acts of God" as used herein shall mean without limitation: strikes or lockout; acts of public enemies; insurrections; riots; epidemics; lightening; earthquakes; fire; storms; flood; washouts; droughts; arrests; restraint of government and people; civil disturbances; and explosions.

The Provider shall, however, remedy with all reasonable dispatch any such cause to the extent within its reasonable control that which prevents the Provider from carrying out its obligations contained herein.

XXVII. COORDINATION

The Provider will advise the Agency of any significant fund raising campaigns contemplated by the Provider within Cuyahoga County for supplementary operating or capital funds during the term of this contract so that the same may be coordinated with any planned promotion of public or private funds by the Agency for the benefit of this and other agencies within the community.

XXVIII. CHILD SUPPORT ENFORCEMENT

The Provider agrees to cooperate with the Agency, ODJFS and any other Child Support Enforcement Agency in ensuring that the Provider's employees meet child support obligations established under state law. Further, by executing this contract, the Provider certifies present and future compliance with any order for the withholding of child support payments that are issued pursuant to Sections 3113.21 and 3113.214 of the Ohio Revised Code.

XXIX. PUBLIC RECORDS

Subject to Article XXII Confidentiality, this contract is a matter of public record under the laws of the State of Ohio. The Provider agrees to make copies of this contract promptly available to any requesting party. Upon request made pursuant to Ohio Law, the Agency shall make available the contract and all public records generated as a result of this contract.

By entering into this contract, the Provider acknowledges and understands that records maintained by the Provider pursuant to this contract may be deemed public record and subject to disclosure under Ohio law. Provider shall comply with the Ohio public records law.

XXX. DRUG-FREE WORKPLACE

The Provider certifies and affirms that the Provider will comply with all applicable state and federal laws regarding a drug-free workplace. The Provider will make a good faith effort to ensure that all employees performing duties or responsibilities

under this contract, while working on state, county or private property, will not purchase, transfer, use or possess illegal drugs or alcohol, or abuse prescription drugs in any way.

XXXI. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) PARTICIPANTS

Pursuant to Chapter 5107 of the Ohio Revised Code and Prevention, Retention, and Contingency Program established under Chapter 5108 of the Revised Code, the Provider agrees to not discriminate in hiring and promoting against applicants for and participants in the Ohio Works Program. The Provider also agrees to include such provision in any such contract, subcontract, grant or procedure with any other party, which will be providing services, whether directly or indirectly, to the Agency's consumers.

XXXII. AMENDMENTS

All amendments shall be in writing and executed by both parties. All amendments and changes shall be dated and become part of the original contract.

XXXIII. WAIVER

Any waiver by either party of any provision or condition of this contract shall not be construed or deemed to be a waiver of any other provision or condition of this contract, nor a waiver of a subsequent breach of the same provision or condition.

XXXIV. PROVIDER SOLICITATION OF AGENCY EMPLOYEES

The Provider warrants that for one (1) calendar year from the beginning date of this contract with the Agency, the Provider and its employees will not solicit the Agency's employees to work for the Provider. The term Provider includes all staff personnel.

XXXV. MAINTENANCE OF SERVICE

The Provider certifies the services being reimbursed are not available from the Provider on a non-reimbursable basis or for less than the unit cost and that the level of service existing prior to the contract shall be maintained. The Provider further certifies that Federal funds will not be used to supplant non-federal funds for the same service.

XXXVI. GRIEVANCE PROCESS

The Provider will notify the Agency in writing on a monthly basis of all grievances initiated by participants that involve the services provided through this contract. The

Provider shall submit any and all facts pertaining to the grievance and the resolution of the grievance to the program contact person.

The Provider will post their organizational grievance policy and procedure in a public or common area at each contracted site so all participants are aware of the process.

XXXVII. PROPERTY OF EMPLOYMENT & FAMILY SERVICES

Any item produced under this contract or with funds provided under this contract, including any documents, data, photographs and negatives, electronic reports/records, or other media, are the property of Employment & Family Services, which has an unrestricted right to reproduce, distribute, modify, maintain, and use the deliverables. The Provider will not obtain copyright, patent, or other proprietary protection for the deliverables. The Provider will not include in any deliverable any copyrighted matter in the manner provided in this contract. The Provider agrees the deliverables will be made freely available to the general public unless the Agency determines, pursuant to state or federal law, that such materials are confidential.

XXXVIII. DEBARMENT AND SUSPENSION

For contracts valued at greater than $100,000.00, the Agency may not contract with Providers on the non-procurement portion of the General Services Administration's List of Parties Excluded from Federal Procurement or Non-procurement Programs: (hereinafter known as List) in accordance with Executive Order 12549 and 12689. By signing this contract, the Provider warrants that the Provider will immediately notify the Agency if the Provider is added to the List at any time during the life of this contract. Upon receipt of notice, the Agency will issue a termination notice in accordance with the terms of the contract. If the Provider fails to notify the Agency, then the Agency reserves the right to immediately suspend payment and terminate the contract.

XXXIX. ELECTRONIC SIGNATURES

By entering into this Agreement Catholic Charities Services Corporation agrees on behalf of its officers, employees, subcontractors, subgrantees, agents or assigns, to conduct this transaction by electronic means by agreeing that all documents requiring county signatures may be executed by electronic means, and that the electronic signatures affixed by the County to said documents shall have the same legal effect as if that signature was manually affixed to a paper version of the document. Catholic Charities Services Corporation also agrees on behalf of the aforementioned entities and persons, to be bound by the provisions of the Chapters 304 and 1306 of the Ohio Revised Code as they pertain to electronic transactions, and to comply with the electronic signature policy of Cuyahoga County.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date below written.

COUNTY OF CUYAHOGA, OHIO

BY:

X _____

Edward FitzGerald, County Executive

CATHOLIC CHARITIES SERVICES CORPORATION

BY:

_____ 6-10-11

EXECUTIVE DIRECTOR **Date**

EXHIBIT I

STATEMENT OF WORK (Agency)

The Agency agrees to enter into a contract agreement with **Catholic Charities Services Corporation** hereinafter referred to as (Provider), for the period from **July 1, 2011** to **June 30, 2012**. The Provider agrees to provide Intensive Case Management services for OWF/FAET/DFA cash recipients with barriers to employment. This program will include intensive client engagement, assessment, planning, supportive services, service coordination, and barrier removal/mitigation and/or assistance with the Social Security application process as described below for OWF/FAET/DFA eligible recipients referred by the Agency.

I. Program Objectives

The Provider will manage and provide intensive case management services to two to three hundred (200-300) OWF/FAET/DFA participants referred by the Agency as described in EXHIBIT I (Statement of Work) & EXHIBIT I-A (Provider Program Design).

II. Program Activities and Descriptions

Engagement/Re-engagement is timely and persistent effort to engage participants in program activities. Initial engagement will occur within two (32) business days of receiving a referral in the Provider Gateway system or for Disability Financial Assistance (DFA) participants, a faxed referral form. Engagement and re-engagement will consist of phone calls, written correspondence, and home visits as needed.

Assessment is the initial activity conducted by the case manager in order to identify and address participant barriers to employment and/or work and training program participation. The Pre-Employment Screen, Barriers to Employment Success Inventory (BESI) and the Ohio Mental Health Consumer Outcome System Community Functioning Scales (CFS) will be used to initially assess participants. For participants identified as needing a comprehensive mental health assessment, a substance abuse assessment, or co-occurring disorder assessment, the SOQIC questionnaire will be utilized.

To assess participant progress, the CFS will be completed minimally monthly and the BESI will be completed minimally every three (3) months. For participants who are applying for social security, the case manager will utilize the online Benefits Eligibility Screening Tool (BEST) to determine potential eligibility and/or assess the status and quality of the participant's application/appeal if already completed.

Individual Service Plan (ISP) is the plan developed with the participant based on results of the assessment tools and his/her current skills/strengths. The ISP includes short and long term goals, steps to achieving stated goals, barrier removal activities, timeframes for completion, documented review of the plan and responsible parties. The ISP will be reviewed monthly at a minimum.

Service Brokerage is defined as accessing services in the community on behalf of a participant that will address barriers to employment, assist with meeting basic needs and obtaining documentation necessary for the social security application/appeal process. The case manager will assist participants with securing services when appropriate and well as monitoring follow-through. It is expected that services will accessed on a timely basis. The case manager will track and verify time participants spend in each activity.

Intensive Case Management is an activity which includes on-going, dynamic, multi-faceted interaction with participants from enrollment to discharge from service. Case management should include at a minimum:

- assessment and reassessment of participant goals and progress
- barrier identification/removal and referrals for services
- individual service planning and service coordination
- supportive services
- weekly case management sessions for the first month of participation and monthly thereafter
- monitoring participant compliance with program requirements
- regular and timely contact with the EFS Eligibility Specialist regarding client progress and participation including notification of no-shows, schedule changes, employment readiness and program terminations (including reason for termination) within five (5) days of the event
- aggressive re-engagement efforts for no-shows, including documenting attempts to contact client and notification to the EFS Eligibility Specialist of reengagement efforts
- maintaining updated case files including participant progress notes, copies of participation verification and all administered assessments.

Barrier Removal Activities are activities designed to mitigate circumstances which prevent participants from participation in employment and/or training activities and/or to improve participants' overall level of functioning as noted on the ISP. Evidence of barrier removal activities must be present in the file.

Supportive Services is immediate assistance for individuals whose barriers may not be resolved or resolved timely through service brokerage and are deemed necessary for an individual to participate in the program. Examples of supportive services may include, but are not limited to fees associated with employment readiness or social security application such as testing or evaluation; work tools or supplies, and/or emergency child care or transportation. Supportive services may be provided if they cannot be accessed through the Agency's Prevention, Retention, and Contingency (PRC) program.

Social Security Application/Appeal Assistance is defined as completing the necessary documentation for the participant's SSI/SSDI application/appeal. Evidence of completion must be contained in the file. Examples of applicable documentation may include copies of the SSI/SSDI application as well as any documentation necessary for the reconsideration and appeals process including documentation of legal assistance, if applicable.

Participant Attendance must be documented in the participant's case file and the client services management system for all program activities from enrollment up to discharge from the program. Attendance must be reported at a minimum, once a month to the Agency via the client services management system. Attendance must be entered by the 15th business day of the following month.

Attendance reports must reflect all actual hours of participation in program related activities. Attendance reported in the client services management system must be supported by, and consistent with, attendance documentation maintained in the case file. Acceptable forms of verification include but are limited to; official printout from a doctor's office or clinic, or E-mail from a social service agency. Verbal confirmation will be accepted provided the following information is documented; date of verification, agency providing verification, name of person providing the verification, number of confirmed hours, date attended and the name and signature of the party securing the verification. Failed hours are not reported in the client services management system. However, the EFS Eligibility Specialist must be notified of the failed activity via phone call, service alert or email.

III. Program Reporting and Responsibilities

Performance Outcomes that will be used to measure program success include, but may not be limited to:

- Number of participants contacted within 2 business days of initial referral
- Number of participants who complete an ISP within 30 days of intake
- Number of participants who comply with their ISP
- Number of participants who demonstrate increased functioning
- Number of participants who achieve a successful outcome, such as:
    - Number of participants who become work ready
    - Number of participants who receive a full and complete SSI application
    - Number of participants who are awarded SSI benefits
    - Number of participants who exit with supportive services in place
- Number of participants who indicate satisfaction with program services

The Provider must submit to the Agency a monthly management report of program activities for all participants active in the program and quarterly and final reports of program performance and outcomes.

The Provider must establish access to and utilize Provider Gateway, the client services management system, as the primary tool to create enrollments, accept or decline service authorizations, report attendance and progress monthly. All authorized agents of the Provider using the client services management system must consent to adhere to the Ohio Department of Job and Family Services Code of Responsibility and must participate in user training prior to authorization to use the system.

Accurate and timely use of the client services management system includes processing Service Authorizations within ten (10) business days of receiving a referral; entering attendance by the 15th day of the month following the activity; completing progress notes by the 5th day of the month following the activity; and creating Service Alerts for changes in the participant's scheduled activities (including no-shows, drop out, termination and reason for termination, and activity changes), within five (5) business days of the change.

IV. Additional Requirements

The Provider must maintain case file documentation that, at a minimum, includes:

- Completed and updated assessment information (BESI, CFS, SOQIC)
- Individual Service Plan including review dates and signatures periodically reviewed and updated with the participant when needs/issues change.
- Signed and dated release of information form that complies with state (OAC 5101) and federal HIPAA requirements
- Case notes as necessary detailing participant progress, contacts, engagement efforts, etc.
- Documentation of attendance (activity logs)
- Documentation verifying all services rendered and all participant benchmarks achieved
- Documentation of any lapse in service greater than thirty (30) days
- Other evidence of intensive case management services provided

The Provider must only serve individuals referred to them by the Agency. If a referred individual does not appear to meet the program criteria, the Provider will inform the Agency worker and refer the individual back to the Agency.

The Provider must attend periodic briefing meetings to ensure continuity of service delivery and effective program management.

The Provider must maintain an accounting system and supporting fiscal records adequate to enable the Agency to audit and otherwise verify all payments made.

EXHIBIT I-A

PROGRAM DESIGN (Provider)

Overview

Catholic Charities Services (CCS) will provide Intensive Case Management (ICM) at the Virgil E. Brown Building for Employment and Family Services' referred customers with major barriers to employment and/or work program participation. Clients referred to ICM are determined to be 1.) unable to fulfill work requirements as a recipient of Ohio Works First cash assistance, or 2.) in receipt of Disability Financial Assistance and requesting assistance navigating the social security disability system. The purpose of the program is to serve approximately 350 participants per year who have major barriers to employment, many of whom are eligible candidates for applying for Social Security Disability Insurance (SSDI). The proposed staff of five (5) case managers and a Program Director will assist the clients with the application and/or appeal processes; evaluate the barriers to employment for treatability; and through aggressive and well documented assessment, re-assessment and follow-up contacts, link them to a variety of community resources according to assessed needs and an Individualized Service Plan.

The anticipated barriers to employability include significant mental health problems, substance abuse problems, significant learning difficulties and physical disabilities. Together, case manager and lead case manager or program director will determine the intensity of services needed for each individual client at intake. If the client is awaiting approval for SSDI, for example, case management services required will be less frequent than for the client who has significant mental health problems and is not connected to any services. This level of intensity will be a factor in determining assignment to the case manager, per their specific caseload size as well as number of high intensity case management clients.

The **contact** for the program is Maureen Dee, Executive Director of Catholic Charities Services, who can be reached at 216 391 2030, ext12 or at **medee@clevelandcatholiccharities.org**.

Target Population

Both OWF and DFA recipients are appropriate for Intensive Case Management services and will be identified and referred by their EFS Eligibility Specialist.

The Intensive Case Management staff will evaluate clients referred and determine which of two service categories is most appropriate. Each category has different goals and outcomes. The categories are:

1. Customers who have been determined by a physician to be unemployable, or who are likely to be eligible for Social Security Disability, and need help navigating the social security application and/or appeal process and interpreting the system and its rules, when employment seems unrealistic.

2. Customers who have severe barriers to employment and need interventions and assistance to become "job ready." These individuals require more intensive assistance to overcome barriers such as physical or learning disabilities, substance abuse and/or mental health issues, domestic violence, or very low basic skills. Once their condition is improved or stabilized, the participant will be referred back to the JET Center to begin to participate in work activities.

Clients who are in the DFA (disability financial assistance) group will be assigned upon evaluation. More than likely they will be in the first listed SSDI application group. As noted, the DFA participant is given a choice to participate in the program, but most opt not to as their benefit application process is well under way.

Key Program Activities

Clients will be referred to ICM by JET workers and the referral will include the Catholic Charities (CCS) Pre-Employment Screen as a starting point for beginning to assess the potential intensity of client's needs. The Program Director or lead case manager will receive the referral and use the Avatar database to determine the next case manager available to receive the assignment. Outreach will begin at that point and initial contact will be made within 2 business days of service authorization in Provider Gateway. Aggressive efforts will be made to connect with difficult to reach clients. If clients cannot be reached by phone within those 2 business days, a letter will be sent after confirming client's address with JET.

The goals for the participants in the program are to:

- Successfully become a recipient of social security benefits
- Receive supportive services to ameliorate the stress
- Transition client to the services of an attorney or other authorized representative
- Remove or reduce employment barriers so that client can participate in employment or training services and/or other work activities.

Case Management staff will be trained in and employ motivational interviewing techniques and in conducting a strength-based assessment of individual need. The ICM Case Manager will be family-centered and services may occur in the home, office, or other location (such as doctor's office, court, treatment centers, benefits office, etc.). Two assessment tools will be used, in addition to the Pre-Employment Screen, for all participants enrolled in the ICM program:

1. The Barriers to Employment Success Inventory (BESI)
2. Ohio Mental Health Consumer Outcome System – Community Functioning Scales

For clients determined to require a comprehensive mental health assessment, a substance abuse assessment or a co-occurring disorder assessment (for both diagnoses), the SOQIC questionnaire will be used. This form is developed by the Ohio Department of Mental Health for AoD, MH or Co-Occurring Disorders assessments.

Re-assessment will be conducted according to the participant's level of need, but appropriate assessment tools will be re-administered at a minimum at 3, 6, 9 and 12 months, as long as the client is active in the program. On a monthly basis, staff will conduct a case review to determine if any of the ISP's require revision, ascertain the progress of the client and discuss readiness for discharge. The Community Functioning Scales will be re-administered at this time (monthly as well). The results of the assessment and re-assessment will be used to inform and revise the goals and objectives of the participant's ISP which will be updated at the same time.

ICM will be provided one-on-one and face-to-face with a frequency and duration appropriate for each participant's situation. Each ICM Case Manager will work with 20 – 30 participants who are assessed to have a medium to high level of service need. CCSC will use the assessment tools and criteria to determine service intensity levels and will assign cases based on this. Several assessment tools may be used to determine the appropriate services, intensity and likelihood of being able to work at some later date. Clients may be referred to CCS Pre-Employment Screening program to complete a comprehensive mental health or substance abuse assessment as part of this assessment process. The Program Director will be very active in this initial assessment phase to help assure that clients are being assigned appropriately as well as to assure relatively equal and manageable caseloads for each of the Case Managers, considering the varying levels of impairment among clients.

We are committed to the collection of required outcome and evaluation data in order to assure the best possible response to this need. CCSC brings together a wealth of experience in building the components of a good mental health, substance abuse and physical health screen, an extensive knowledge of resources that can be recommended, and intensive case management skills to help some of the most challenged individuals move from chemical dependence or mental illness to independence and self sufficiency.

Once the ICM case manager and client connect, client will begin the intake process. This will include a minimum of one (1) visit per week for a minimum of four (4) weeks at which time the ICM assessment of needs will be completed utilizing the Ohio Department of Mental Health (ODMH) Adult Consumer Outcomes and the Barrier to Employment Success Inventory (BESI) as well as the BEST, Social Security's on-line screen to determine if client should apply for SSI and other more general initial assessment paperwork including releases of information for current providers, etc. Full clinical assessments will be scheduled during this time if indicated. At the end of the assessment administration but within 30 days from admission or enrolment, the individualized service plan (ISP) will be completed and agreed upon with the client.

During subsequent sessions case managers will assure that clients are getting connected to all the medical and community resources that they need. This may include meeting clients in the community and attending appointments with them. Case managers are expected to see 4-7 clients per day in a mix of ongoing and intake appointments. CCS's strong relationships with community partners provide seamless and effective services will be made available through the mental health providers, such as Recovery Resources, Murtis Taylor, West Side Ecumenical Ministry, and Mental Health Services in addition to CCS's extensive programs for mental health and drug & alcohol services. A key strategy for clients becoming engaged in community resources is follow-up. Case

managers will provide frequent and ongoing follow up with participants who are referred for appointments and/or to access services.

Outcomes will be measured using two (2) tools. ODMH Adult Consumer Outcomes will be administered monthly. At least every three (3) months and more often as needed, the ISP Review will be done, along with the rescoring on the BESI instrument, all to evaluate and chart progress toward barrier removal. One measure of the BESI is a functioning scale, and scores will be documented in the electronic client record. It is a comprehensive tool which will be completed on-line with the client. It measures Personal & Financial Barriers, Emotional & Physical Barriers, Career Decision-Making and Planning Barriers, Job-Seeking Knowledge Barriers and Training & Education Barriers. Scores on this tool clearly measure level of barrier to employment. Intake scores as well as client scores after re-administration will be recorded in the client record as well as in quarterly reporting.

Engagement/Re-engagement Activities

Attempts at engagement will occur within 48 hours of receipt of referral. Persistent outreach and engagement of referred participants will increase the service utilization and build the necessary relationship to effect change. A variety of engagement strategies will be utilized, such as telephone calls, mail, home visits and other efforts, all of which will be documented in the client file.

Program participants will be contacted when they are not following through on referrals to programs or scheduled appointments. Case Managers will determine whether the client lack of participation is related to problems with functioning requiring further assistance, outreach and intervention, which will often be conducted in the community, or whether the client is expressing disinterest. Each of these challenges will determine the strategy for reengagement and further intervention, to include setting parameters, education about alternatives, and assistance to make connections if needed.

Once the OWF referral is entered into Provider Gateway (or DFA referral packet sent via interoffice mail) by the Eligibility Specialist, the referral packet will be reviewed by the Program Director who will determine the assignment. Early evaluation in intake sessions by the Case Manager will determine into which group the client will be placed. A Case Manager will be assigned based on client characteristics and Case Manager expertise to match client need, taking caseloads into consideration.

An initial phone call will be placed to the client's home on the day the referral is received by the assigned Case Manager. If the assigned Case Manager is not available on the date of the referral, the Program Director will make the initial phone call in order to ensure that the client is called on the day of the referral. If there is no answer, a message will be left for the client to call back. Follow-up calls will be made to the client's home daily until they are reached. If the client has not returned the Case Manager's call within five business days, a letter will be sent to the client requesting immediate contact. Daily calls will continue to be made and logged on a tracking system. If the client has not contacted the assigned Case Manager within seven business days of the initial letter, the assigned Case Manager will go to the client's home in an attempt to schedule a face to face appointment. If the client is not at home when the Case Manager goes out, a letter will be left requesting a phone

call. These activities will be documented on a tracking log and this log will be provided to the client's assigned OWF worker on a weekly basis.

Participant Tracking and Documentation

CCS will use its comprehensive software system called Netsmart for clinical record keeping and data management. The electronic record version of this software, called Avatar, contains a "clinical work station" component whereby the clinicians enter all their activities through Progress Notes. The notes will link the activity provided to the goals and objectives of the ISP, which is also built into the system.

CCS already has the capability to utilize this comprehensive and robust computer software application to track referrals, program participants, demographics, program characteristics, activities, outcomes and other information and transactions pertinent to the program for the detail and summary level management reports as well as data extracts as requested by EFS. Some additional fields or dictionary choices for drop down selection will be added to adapt for service tracking for the ICM program.

A monthly management report provided to EFS will show total number of clients in the program for the month according to the target groups. The report will also show number of clients who showed for their appointments as well as the number of clients who no-show. It will report date referral accepted and date of client engagement. Because information is directly entered into the Avatar system in real time by clinicians for their purposes in working with clients and evaluating progress, the data will be easily accessible from the same program for monthly and quarterly reporting purposes and will allow for a snapshot of the program at any time.

Each staff person will maintain a log of calls per participant to document efforts for engagement, and following enrollment, to verify participant follow up for outside appointments, such as doctor visits, treatment, and other services referred to. Whereas the time the case management spends verifying these will be documented in a progress note, a log of these will allow for ease with tracking and report writing. The status of the SSDI application and/or appeal process and the stage of the application will be documented in a separate database. This will include length of time for SSI approval by application phase (initial, redetermination, or ALJ (Administrative Law Judge)). Written verification from service providers will be solicited on the program's own verification forms.

CCS' Netsmart/Avatar system will be loaded on the case managers' computers and can be accessed off site through laptops. The type of information available to be gathered and pulled from the Avatar data base will include:

- Engagement strategies, such as number of phone calls and home visits. Letters sent will be copied for the file and can be tabulated as necessary.
- Client referral status, such as number of referrals, referral dates, type, reason, assignment, first contact date, admission date, refusals.
- Program activity, such as type of case management service provided, length of stay, discharge reason and dates.

- Monthly activity
  - Case management – number of sessions, types of contacts, amount of time, etc.
  - Urinalysis – number within evaluated time period and results
  - Participant activity – per participant follow up with doctor appointments, treatment activity, other appointments, etc.

- Aggregate numbers of participant referral, enrollment, refusal, currently active and discharged or closed by service type, among others.
- Client attendance and progress (toward employability or achieving SSI). This information will come from the ISP goal achievement rates and reassessment tools.

Performance Outcome	**Indicator**	**Benchmark**	**Measure**
Completed SSI Application/Appeal Documentation	An initial application or appeal documentation is completed with the assistance of CCSC case manager.	90% of participants who begin application /appeal process.	Completed application or appeal documentation.
Timely Engagement	Attempts to contact participants will occur within two business days of receipt of referral in Provider Gateway.	100% of referred participants.	Case notes in client file/Avatar.
ISP Completion	Case managers will work with participants to complete an ISP including goals, steps, review dates and signatures within 30 days of intake.	90% of referred participants.	Completed ISP in client file/Avatar.
Community Functioning Level	Participants will achieve "normal" community functioning level while in the program.	75% of participants who complete the Community Functioning Scales	Community Functioning Scales score of 33 or higher.
Successful Discharge	Participant achieves ISP goals or has demonstrated progress toward achieving ISP goals and has supportive services in place.	75% of program participants	Completed discharge summary, progress notes, and updated ISP and assessment tools.
Participant Satisfaction	Participants will respond "yes, definitely" or "yes, somewhat" to overall satisfaction with program question on satisfaction survey.	80% of program participants	Completed satisfaction survey

Continuous Quality Improvement

Quality assurance practices will be ongoing and will include supervision, case staffing, random case file reviews, use of observation to evaluate quality of interactions and Case Manager practices, professional development and data analysis of service provision (e.g. productivity).

Documentation is key to supporting program activities. Contact logs will be kept on efforts to engage the participant within 48 hours of referral and EFS workers will be made aware that the participant has been engaged in services. All assessment documentation will be contained in the case file and will be used to form the goals and objectives of the participant's individual service plan. Through the use of individualized service plans case management services will be provided to meet specific participant needs. Each plan will be reviewed by the program director or lead case manager to assure that goals are specific, measurable, achievable, realistic, and time limited and are developed with the input of the participant. Individual service plans will be updated monthly detailing progress made toward the goals. Progress notes will document all services provided the client, including referrals made. Progress notes will be reviewed by the lead case manager weekly to identify needed areas for improvement and at the minimum five charts will randomly chosen for each of the case managers be reviewed monthly for accuracy and content.

Through supervision and team meetings, specific problems that arise with participants can be addressed, such as re-engagement strategies, community resources to utilize, etc. Caseload will also be monitored by the Program Director and client progress and case closings will be discussed during supervision and team meetings. The supervisor will also be available to assist case managers with hard to engage clients or clients with barriers that are difficult to address.

Any client complaints will be addressed by the Program Director within 24 hours of there receipt. The client complaints will be documented and addressed with the staff. Repeated complaints will result in observation of the staff member and possible disciplinary action. Catholic Charities has a specific plan for disciplinary action in our Operations Manual. Disciplinary action may also be taken for failure to complete documentation in a timely manner repeated absences, etc. and will be handled by the Program Manager and Director.

Staff is evaluated yearly on performance. During this performance evaluation the staff would list their strengths and goals and objectives for the year. Positive behaviors are reinforces and areas needing improvement are addressed. Staff is also able to comment on areas they feel they need additional training. This data is used to develop trainings for Catholic Charities Staff Development Day which is held biannually.

Staff trainings will be held quarterly based on the needs that are identified by the Clinical Supervisor and Director of the program in such areas and Individual Service Plan development, Motivational Interviewing, etc.

Customer satisfaction results will be reported to the Intensive Case Management staff and to EFS quarterly. Data from the client satisfaction survey will be utilized for program improvement. CCS will also seek other methods to solicit feedback for improvement which can include surveys of the

EFS staff, Referral Satisfaction Questionnaires from the resources in the community we refer to and link clients with, and specific meetings with EFS Work First Services Management staff.

Administration and use of results of survey:

a. All programs within Catholic Charities must complete customer satisfaction surveys on participants at least annually.
b. Surveys will be administered in ICM twice per year with all active participants.
c. Satisfaction data collection is system-wide with the Quality Department that collects all surveys, tallies surveys and reports results in a report which is then used for review and analysis of trends and areas for improvement.
d. Support is provided to improve client satisfaction results with consultation from Quality Department.
e. Staff in-service training is designed based on results of satisfaction surveys and comments
f. Client satisfaction reports are required by our accrediting body (CARF) for use for service evaluation and improvement.

EXHIBIT II

BUDGET

The Agency agrees to pay the Provider for the costs described below to the degree they are determined to be fair and reasonable for the implementation of an Intensive Case Management Program for an amount not to exceed **$460,000.00**.

I. The Agency agrees to reimburse the Provider for costs incurred for salaries and fringe benefits for the following positions in the amount not to exceed **$374,346.00**

Executive Director	$ 7,074.00
Business Administrator	$ 2,750.00
Director of Information Services	$ 4,440.00
Program Director	$ 58,000.00
Lead Case Manager	$ 43,000.00
Case Managers (4 ea)	$156,000.00
Fringe Benefits	$103,082.00

A. To receive reimbursement for these costs, the Provider must submit an invoice detailing the actual expenses incurred during the billing month with the appropriate supporting documentation.

B. In order to meet the objectives of this program, the Agency agrees to allow for the shifting of dollars within this category as necessary without a formal amendment and without exceeding the approved contract amount. The Provider must submit this request in writing to the designated Contract Specialist for prior approval.

II. The Agency agrees to reimburse the Provider for Direct costs incurred for Intensive Case Management services in the amount not to exceed **$73,610.00**

Professional Services	$ 38,480.00
Travel	$ 12,070.00
Consumable Supplies	$ 1,200.00
Supportive Services (Bus Tkts)	$ 5,000.00
IT Support & Licenses	$ 7,500.00
Leased Equipment & Maintenance (Computers, Printers, Fax)	$ 9,360.00

A. To receive reimbursement for these costs, the Provider must submit an invoice detailing the actual expenses incurred during the billing month with the appropriate supporting documentation.

B. In order to meet the objectives of this program, the Agency agrees to allow for the shifting of dollars within this category as necessary without a formal amendment and without exceeding the approved contract amount. The Provider must submit this request in writing to the designated Contract Specialist for prior approval.

III. The Agency agrees to reimburse the Provider for indirect costs in an amount not to exceed **$12,044.00**.

To receive reimbursement for indirect costs, the Provider must submit an invoice for the costs incurred/allocated during the billing month.

IV. The Provider agrees that the services being contracted for are not available from the Provider on a non-reimbursable basis for less than the unit rate and that the level of service to public assistance and food stamp recipients is guaranteed.

V. The Provider understands that failure to comply with these provisions may result in Provider refunding any funds received from the Agency that were in violation of any provisions contained above.

VI. For payment processing, an invoice must be submitted by the 15th of the month directly to:

Employment & Family Services
Division of Contracting
c/o Freda Houchins, Contract Specialist
1641 Payne Ave. Room 510
Cleveland, Ohio 44114
Phone: (216) 987-8509; Fax (216) 987-7090
Email: houchf@odjfs.state.oh.us.