SERVICES AGREEMENT BETWEEN COLLIN COUNTY HEALTH CARE FOUNDATION AND COLLIN COUNTY ADULT CLINIC - WEST

This Agreement is made January 1, 2012 by and between the Collin County Health Care Foundation, 825 N. McDonald Street, McKinney, Texas 75069 and Collin County Adult Clinic - West Clinic (FIN 20-2868837), 2520 Avenue K, Suite 100, Plano, Texas 75074.

Whereas, Collin County Health Care Foundation, hereinafter referred to as "CCHCF", wishes to provide assistance to the most vulnerable, low income United States Citizens and Resident Aliens of Collin County, Texas, who are at or below 100% of the Federal Poverty Level, needing primary health care; and

Whereas, Collin County Adult Clinic – West Side Clinic, hereinafter referred to as "Provider", provides low cost primary and preventive health care to low income, uninsured citizens of Collin County, Texas.

NOW THEREFORE, this agreement is made and entered into by the Collin County Health Care Foundation and Collin County Adult Clinic - West.

1. **Term of Agreement.** This agreement shall be effective as of January 1, 2012 and ends on December 31, 2012.

2. **Scope of Work.** Provider shall perform the following during the term of this agreement:

   a. Provider shall provide limited primary health care to U.S. Citizens and Resident Aliens with more than 40 working quarters of U.S. residency, of Collin County, Texas, who are 18 years of age or older.
   b. This agreement will not pay for individuals who are enrolled in Medicaid, Medicare, the Collin County Indigent Health Care program, have private insurance or any other payor.
   c. Provider is required to use due diligence in determining patient eligibility as condition of payment from CCHCF. Patients eligible for payment under this agreement are those individuals who are U.S. Citizens and Resident Aliens residing and domiciled in Collin County, Texas, 18 years or older and who are at or below 100% of the current published Federal Poverty Level, to pay for primary health care services provided by Provider.
   d. Provider will be paid on a fee-for-service basis of $54.00 per patient visit. Patients must be domiciled and reside in Collin County, Texas. Well patient visits will not be reimbursed.
   e. Payment from CCHCF to Provider shall be contingent upon the completion of the invoice in the format provided and attached as Exhibit "A". (See Exhibit "A"). All data fields contained in Exhibit "A" must be completed in electronic format and submitted to CCHCF before any payment will be paid to Provider. CCHCF reserves the right to reject any claim for payment for incomplete or unverifiable data submitted by Provider.

f. CCHCF will only pay for patient visits between January 1, 2012 and December 31, 2012.
g. A prearranged site visit may be conducted on behalf of CCHCF by the Manager, Collin County Health Care Services, her designee or the Collin County Auditors Office. CCHCF reserves the right to audit records for financial accuracy and contractual compliance for any and all claims made for payment for services rendered under this agreement.
h. Any revision to this scope of work, including the use of funds, must be mutually approved in writing prior to the implementation of the revision, by both the Manager of the Collin County Health Care Services and Provider.

3. **Payment of Services.** The total amount of this agreement shall not exceed $33,750. Provider shall submit all invoices in an electronic, Microsoft Excel format on a quarterly basis. The payment will be on an after-the-fact, fee-for-service basis. A separate invoice shall be submitted each quarter for the West Clinic. No more than $54.00 will be paid for each patient visit.

i. The first invoice shall be submitted no later than April 20, 2012 for the period January 1, 2012 - March 31, 2012.
ii. The second invoice shall be submitted no later than July 20, 2012 for the period April 1, 2012 – June 30, 2012.
iii. The third invoice shall be submitted no later than October 20, 2012 for the period July 1, 2012 – September 30, 2012.
iv. The final invoice shall be submitted not later than January 15, 2013 for the period October 1, 2012 – December 31, 2012.

The Collin County Health Care Foundation reserves the right to adjust the payments based on incomplete or unverifiable data. Invoices shall be submitted in a Microsoft Excel format by e-mail to Delia Mason at dmason@co.collin.tx.us or by disk to Delia Mason, Collin County Health Care Foundation, 825 N. McDonald St, McKinney, Texas, 75069.

4. **Indemnification.** To the extent allowed by law, each party agrees to release, defend, indemnify, and hold harmless the other (and its officers, agents, and employees) from and against all claims or causes of action for injuries (including death), property damages (including loss of use), and any other losses, demands, suits, judgments and costs, including reasonable attorneys' fees and expenses, in any way arising out of, related to, or resulting from performance under this agreement, or caused by its negligent acts or omissions (or those of its respective officers, agents, employees, or any other third parties for whom it is legally responsible) in connection with performing this agreement. Provider expressly agrees to indemnify and defend CCHCF for any medical malpractice claim, or related claim, brought against Provider in which CCHCF is made a party.

5. **Provider Licensure and Insurance.** Provider warrants that it is in legal compliance with all state and federal medical licensure requirements. Provider is licensed to provide medical care. Provider agrees to notify CCHCF of any suspension, revocation, or disciplinary action by any state or federal licensing body related to Provider's ability to provide health care. Provider has a current malpractice insurance policy which covers the services contemplated by this agreement. Provider agrees to maintain licensure and insurance for the term of this agreement.

6. **Venue.** The laws of the State of Texas shall govern the interpretation, validity, performance and enforcement of this agreement. The parties agree that this agreement is performable in Collin County, Texas and that exclusive venue shall lie in Collin County, Texas.

7. **Confidentiality of Protected Health Information.** Provider is required to comply with state and federal laws relating to the privacy and confidentiality of patient and client records that contain protected health information, or other health information made confidential by law.

   Provider agrees to provide certain basic data and information to CCHCF. This data and information is the same data and information requested for Exhibit "A". Provider agrees that CCHCF is authorized to request, collect and receive protected health information under this agreement. Provider agrees to have each client or legal guardian of the client treated under this agreement to sign the attached HIPAA release form, attached as Exhibit "B". This data may be used by CCHCF, but is not limited to, verify contractual compliance, statistical research, health research and awareness.

   As further condition for transmitting the data and information subject to this agreement, Provider agrees to execute the attached Business Associate Agreement. Attached as Exhibit "C".

8. **Successors and Assigns.** This agreement shall be binding upon the parties hereto, their successors, heirs, personal representatives and assigns. Neither party will assign or transfer an interest in this agreement without the written consent of the other party.

9. **Severability.** The provisions of this agreement are severable. If any paragraph, section, subdivision, sentence, clause, or phrase of this agreement is for any reason held by court of competent jurisdiction to be contrary to law or contrary to any rule or regulation having the force and effect of the law, the remaining portions of the agreement shall be enforced as if the invalid provisions have never been included.

10. **Entire Agreement.** This agreement embodies the entire agreement between the parties and may only be modified in writing executed by both parties.

11. **Immunity.** It is expressly understood and agreed that, in the execution of this agreement, neither party waives, nor shall be deemed hereby to have waived any immunity or defense that would otherwise be available to it against claims arising in the exercise of governmental powers and functions. By entering into this agreement, the parties do not create any obligations, express or implied, other than those set forth herein, and this agreement shall not create any rights in parties not signatories hereto.

12. **Termination.** This agreement may be terminated by either party for any reason after thirty (30) days written notice. The written notice shall be sent to the addresses identified in the first paragraph of this agreement. Provider shall be paid for all services provided up to the effective date of termination upon proper proof and submission of all required documentation.

Collin County Adult Clinic – West

By: _____

Name: JOHN ERNST

Title: EXECUTIVE DIRECTOR

Date: 2/24/12

Collin County Health Care Foundation

By: _____

Name: Keith Self

Title: President

Date: 3/19/12

Exhibit B
COLLIN COUNTY ADULT CLINIC

CASE INFORMATION RELEASE

Case Name: _____ **Case Number:** _____

By signing this authorization form, you are giving the Collin County Adult Clinic consent, authorization, and permission to release and discuss part of your case record (hereinafter collectively referred to as "Records") , which may also include personal health information. I authorize Collin County Adult Clinic to release my Record(s) to the person(s) or agencies listed below for the purpose(s) stated below. My information will remain available to the person(s) or agencies indicated until the expiration date stated below.

Consent and Authorization for Release of information: I understand that my Record(s) may contain protected health information (PHI), in addition to treatment, payment, health care operation, personal financial, and transportation information. I hereby consent to and authorize communication about my Records between agents and employees of Collin County Adult Clinic, and Collin County Health Care Foundation (CCHCF).

Check one of the following:

☐ Release all of my case record.

☐ Release only the following information:
Full Name, Date of Service, Address, Date of Birth (Age), Sex, Last Four Digits of Social Security Number, Diagnosis Code, HIPAA Release, Copy of Birth Certificate, Household Family Income, Number of Dependents, Federal Poverty Level, U.S. Citizenship or Resident Alien with more than 40 working quarters of U.S. residency, and designation of new or returning patient, insurance coverage including participation in the Collin County Indigent Health Care program or other payment program.

Purpose(s) of this Consent, Authorization, and Release: This consent, authorization, and release of information is to help CCHCF determine whether I qualify for financial assistance for healthcare services that may be provided to me by Collin County Adult Clinic. This consent, authorization, and release of information may also be used to assist CCHCF to participate in research and studies for health care and awareness.

Expiration of Authorization: This authorization expires in 365 days from today's date or until my eligibility for services can be determined, whichever occurs first.

Notice to Client/Applicant

- By signing this release, consent, and authorization, I acknowledge that the information used or disclosed pursuant to this release and authorization may be subject to re-disclosure by the persons, entities, or agencies whose name(s) is/are written above, and the information once disclosed will no longer be protected by the rules created in HIPAA. CCHCF is not responsible for any re-disclosure of the information by others who may receive it.
- Client/Applicant may revoke this permission and cancel this release, consent and authorization at any time. Any request for cancellation must be in writing and delivered to CCHCF attn: Delia Mason, Collin County Health Care Services, 825 N. McDonald St. Suite 130, McKinney, TX 75069.
- This release, consent, and authorization is a mandatory condition for payment of the health care services by CCHCF. However, you have a right to pay for your own services and not sign this document.
- You may receive a copy of any information obtained by CCHCF and Collin County Adult Clinic about you. You have the right to review such information and request that any information obtained in error or any information that is incorrect be corrected.

Signatures:

_____ _____
(Client/Applicant or Personal Representative's Signature) Date

☐ If you are signing for the client/applicant, please describe your authority to act for the client/applicant on the following line:

_____

Note: If the person requesting the release of case information cannot sign her/her name, two witnesses to his/her mark (X) must sign below:

Witness: _____ Date: _____

Witness: _____ Date: _____

Collin County Adult Clinic West - Exhibit A

Quarterly Report Form

Date of Service	At or Below 100% of FPL (Y/N)	US Citizen or Resident Alien (Y/N)	Last 4 digits of SSN	Signed HIPAA? (Y/N)	Name (First, Last)	Street Address	City	State	Zip Code	M/F	Age	DX Code	Amount	New/ Returning Patient (N/R)
												Total	$ -	