MEDICAID WAIVER SERVICES AGREEMENT

This Agreement is entered into between the Florida Agency for Persons with Disabilities, hereinafter referred to as "APD," and **Levy Cnty board of Cnty Commisione** hereinafter referred to as the "Provider." Pursuant to the terms and conditions of this Agreement, APD authorizes the Provider to furnish I Budget Home and Community-Based Services (HCBS) Medicaid waiver services to eligible APD clients, and to receive payment for such services. Services may be authorized by multiple Region offices for multiple service types and service locations within the respective region pursuant to the standards specified in Florida's HCBS waivers. The services that may be provided in any APD region or location within a region are limited to the services that the respective Region office has authorized.

I. AGREEMENT DOCUMENTS:

A. The Medicaid Waiver Services Agreement consists of the terms and conditions specified in this Agreement, any attachments, and the following documents, which are incorporated by reference:

1. ***The Developmental Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitations Handbook***, dated September 2015 and any updates or replacements thereto. The Handbook can be found at the Medicaid fiscal agent's Web Portal: **http://www.mymedicaid-florida.com/**. Click on Public Information for Providers, then on Provider Support, and then on Provider Handbooks. The Handbook provides the terms and conditions by which the provider of Developmental Disabilities Individual Budgeting HCBS waiver services agrees to be bound.
2. ***Attachment*** N/A **,** providing individually negotiated unit rates of payment for services not already established and available on APD's Web site: http://www.apdcares.org, as referenced in II.E., and any other service or data requirements, as applicable.

B. Prior to executing this Agreement and furnishing any waiver services, the Provider must have executed a Medicaid Provider Agreement with the Agency for Health Care Administration (AHCA) and be issued a Medicaid provider number by AHCA. The Provider must at all times during the term of this Agreement, maintain a current and valid Medicaid Provider Agreement with AHCA, and comply with the terms and conditions of the Medicaid Provider Agreement.

II. THE PROVIDER AGREES:

To comply with all of the terms and conditions contained within this Agreement, including all documents incorporated by reference and any attachments.

A. Monitoring, Audits, Inspections, and Investigations

To permit persons duly authorized by APD, the Agency for Health Care Administration (AHCA), or representatives of either, to monitor, audit, inspect, and investigate any recipient records, payroll and expenditure records (including electronic storage media), papers, documents, facilities, goods and services of the Provider which are relevant to this Agreement, and to interview any recipients receiving services and employees of the Provider to assure APD of the satisfactory performance of the terms and conditions of this Agreement.

1. Following such monitoring, audit, inspection, or investigation, APD or its authorized representative, will furnish to the Provider a written report of its findings and, if deficiencies are found, request for development, by the Provider, a Plan of Remediation for needed corrections. The Provider hereby agrees to correct all noted deficiencies identified by APD, AHCA, or their authorized representatives within the specified period of time identified within the report documentation. Failure to correct noted deficiencies within stated time frames may result in termination of this Agreement.
2. Upon demand, and at no additional cost to the APD, AHCA, or their authorized representatives, the Provider will facilitate the duplication and transfer of any records or documents (including electronic storage media), during the required retention period of six years after termination of the Agreement, or if an audit has been initiated and audit findings have not been resolved at the end of six years, the records shall be retained until resolution of the audit findings or any litigation which may be based on the terms of this Agreement, at no additional cost to APD.
3. To comply and cooperate immediately with APD requests for information, records, reports, and documents deemed necessary to review the rate setting process to ensure that provider rates are based on accurate information and reflect the existing operational requirements of each service.

Any individual who knowingly misrepresents the information required in rate setting commits a felony of the third degree, punishable as provided in sections 775.082 and 775.083, F.S.

4. To comply and cooperate immediately with any inspections, reviews, investigations, or audits deemed necessary by APD's Office of the Inspector General pursuant to section 20.055, F.S.

5. To include the aforementioned audit, inspections, investigations and record keeping requirements in all subcontracts and assignments.

B. Confidentiality of Client Information

Not to use or disclose any information concerning a client receiving services under this Agreement for any purpose prohibited by state or federal law or regulation, except with the written consent of a person legally authorized to give that consent or when authorized by law. This includes compliance with the Health Insurance Portability and Accountability Act of 1996,42 U.S.C. 1320d and all applicable regulations provided in 45 CFR Parts 160, 162, and 164; and 42 CFR, Part 431, Subpart F, relating to the disclosure of information concerning Medicaid applicants and recipients.

The computer hard drives used by APD Waiver Support Coordinators shall implement Full Disk Encryption software. For other types of electronic data storage devices that store confidential APD consumer data, such data shall be encrypted using a minimum of a 128-bit encryption algorithm.

C. Indemnification

1. To be liable for and indemnify, defend, and hold APD, AHCA and all of their officers, agents, and employees harmless from all claims, suits, judgments, or damages, including attorneys' fees and costs, arising out of any act, actions, neglect, or omissions by the Provider, its agents, employees, or subcontractors during the performance or operation of this Agreement or any subsequent modifications thereof, whether direct or indirect, and whether to any person or tangible or intangible property. The Provider shall not be liable for that portion of any loss or damages proximately caused by the negligent act or omission of APD or AHCA.

2. That its inability to evaluate its liability or its evaluation of liability shall not excuse the Provider's duty to defend and to indemnify within 7 days after notice by APD or AHCA by certified mail. After the highest appeal taken is exhausted, only an adjudication or judgment specifically finding the Provider not liable shall excuse performance of this provision. The Provider shall pay all costs and fees, including attorneys' fees related to these obligations and their enforcement by APD or AHCA. APD or AHCA's failure to notify the Provider of a claim shall not release the Provider of these duties.

3. If the provider is an agency or subdivision of the State, its obligation to indemnify, defend, and hold harmless shall be to the extent permitted by section 768.28, F.S. or other applicable law, and without waiving the limits of sovereign immunity.

D. Insurance

To obtain and maintain at all times continuous and adequate liability insurance coverage during the term of this Agreement. The Provider accepts full responsibility for identifying and determining the type and extent of liability insurance necessary to provide reasonable financial protection for the Provider and APD clients served by the Provider. At all times, the Provider shall maintain with APD a current certificate of insurance describing the types and extent of liability insurance obtained pursuant to this Agreement. The Provider shall cause APD to be named as a certificate holder under each policy of liability insurance maintained by the Provider pursuant to this Agreement. The limits of coverage under each such policy shall not be interpreted as limiting the Provider's liability and obligations under this Agreement. All insurance policies shall be through insurers authorized or eligible to write policies in Florida. Such coverage may be provided by a self-insurance program established and operating under Florida law.

E. Payment

Current rate information is available on the Medicaid fiscal agent's Web site at www.mymedicaid- florida.com. Select Public Information for Providers, Provider Support, and then select Fee Schedules. The signatories recognize that APD is limited by appropriation and acknowledge that Florida law requires AHCA and APD to make any adjustment necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act, including but not limited to adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or limiting enrollment. (See sections 393.0661, 409.906, 409.908, F.S.)

F. Return of Funds

To be responsible for the timely correction of all billing or reimbursement errors resulting in an overpayment, including reimbursement for services not properly authorized or documented. Reimbursement will be made pursuant to the Florida Medicaid Provider Reimbursement Handbook, CMS-
1500. Federal regulations 42 CFR § 433.312, require refund of overpayments within 60 days of discovery. AHCA will be the final authority regarding the timeliness of the reimbursement process.

G. Independent Status

That the Provider acts at all times in the capacity of an independent service provider and not as an officer, employee, or agent of APD, AHCA, or the State of Florida. The Provider shall not represent to others that it has the authority to bind the APD or AHCA unless specifically authorized in writing to do so. In addition to the Provider, this is also applicable to the Provider's officers, agents, employees, or subcontractors in performance of this Agreement.

H. Revocation of Licenses

In the event the Provider or any employee of the Provider is the holder of any license required to render the services that are subject to this Agreement, the Provider must immediately notify APD if any such license is suspended or revoked.

I. Change of Name or Ownership

The Provider shall notify APD and clients served of any change of name, or change, sale, or transfer of ownership at least sixty (60) days prior to the change, sale, or transfer. Prior to the change, sale, or transfer, the Provider shall complete the change of ownership process with Medicaid. Prior to, or contemporaneously with, the change, sale, or transfer, the Provider must execute a new Medicaid Waiver Services Agreement to ensure no lapse in service delivery. Clients receiving services will be given an opportunity to receive services from the new owner, purchaser, or transferee, or to select another provider.

J. Public Records

The Provider shall: keep and maintain public records that ordinarily and necessarily would be required by APD in order to perform the service under this Agreement; provide the public with access to public records on the same terms and conditions that APD would provide the records, and at a cost that does not exceed the cost provided by law; ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law; and, meet all requirements for retaining public records and transfer, at no cost, to APD all public records in possession of the Provider upon termination of this Agreement, and destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements (all records
stored electronically must be provided to the public agency in a format that is compatible with the information technology systems of the public agency). If the Provider does not comply with a public records request, APD shall enforce the contract provisions in accordance with the Agreement.

III. TERMINATION:

A. Termination of Agreement Without Cause

This Agreement may be terminated by either party without cause, upon no less than 30 calendar days' notice in writing to the other party unless a lesser time is mutually agreed upon in writing by both parties. Said notice shall be delivered by certified mail, return receipt requested, or in person with proof of delivery.

B. Termination of Agreement with Cause

This Agreement may be terminated for the Provider's unacceptable performance, non-performance, or misconduct upon no less than 24 hours' notice in writing to the Provider. Waiver by either party of any breach of any term or condition of this Agreement shall not be construed as a waiver of any subsequent breach of any term or condition of this Agreement. If APD determines that the Provider is not performing in accordance with any term or condition in this Agreement, APD may, at its exclusive option, allow the Provider a period of time to achieve compliance. The provisions herein do not limit APD's right to any other remedies at law or in equity.

C. Termination of Service Regions or Service Locations

When a Provider has been authorized to provide multiple service types within a region, or to provide services in multiple regions, or at multiple locations within a region, the Provider's authorization for any individual service type, region, or location may be revoked, without cause, upon 30 days' prior written notice, without terminating this Agreement.

IV. GOVERNING LAW:

This Agreement shall be construed, performed, and enforced in all respects in accordance with all the laws and rules of the State of Florida, and any applicable federal laws and regulations.

V. AGREEMENT DURATION:

This Agreement shall be effective 12/1/2022 or the date on which it has been signed by both parties, whichever is later, and shall terminate on 11/30/2027 which is no later than five years from the effective date.

VI. OFFICIAL REPRESENTATIVES (Names, Address, Telephone Number, and E-mail Address):

1. The Provider's contact person and street address where financial and administrative records are maintained is:

Name: CONNIE CONLEY
Telephone Number: 352-486-3485
Address: NATURE COAST TRANSIT CO 970 E. HATHAWAY BRONSON FL 32621
E-mail Address: conley-connie@levycounty.org

2. The representative of the Provider responsible for administration of the services under this Agreement is:
Name: same as **above**
Telephone Number: _____
Address:
E-mail Address: _____

3. The Agency for Persons with Disabilities contact person for this Agreement is:
Name: Sandra Hill
Telephone: 904-992-2426
Address: 3631 Hodges Blvd. Jacksonville Fl.32224
E-mail Address: Sandra.hill@apdcares.org

4. Upon change of the representative's names, addresses, telephone, numbers, and e-mail addresses, by either party, notice shall be provided in writing to the other party and the notification attached to the originals of this Agreement.

VII. INTEGRATED AGREEMENT:

Only this Agreement, any attachments referenced, the Medicaid Provider Agreement, the ***Developmental Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitations Handbook***, which is incorporated into this Agreement by reference, contain all the terms and conditions agreed upon by the parties.

There are no provisions, terms, conditions, or obligations other than those contained herein, and this Agreement shall supersede all previous communications, representations, or agreements, either verbal or

written between the parties. If any term or provision of the Agreement is found to be illegal or unenforceable, the remainder of the Agreement shall remain in full force and effect and such term or provision shall be stricken.

The Provider, by signing below, attests that the Provider has received and read the entire Agreement, inclusive of its attachments and documents as referenced in Section I, A., including the service-specific requirements and for enrolled providers contained in the *Developmental Disabilities Individual Budgeting Medicaid Waiver Coverage and Limitations Handbook Waiver Services Coverage and Limitations Handbook,* and understands each section and paragraph.

IN WITNESS THEREOF, the parties hereto have caused this page Agreement to be executed by their undersigned officials as duly authorized.

PROVIDER: Levy Cnty board of Cnty Commisione	STATE OF FLORIDA, AGENCY FOR PERSONS WITH DISABILITIES
SIGNED BY:________________	SIGNED BY:________________
NAME: CONNIE CONLEY	NAME: Catherine Guiry
TITLE: ________________	TITLE: QA Regional Manager, Northeast Region
DATE:________________	DATE: ________________

MEDICAID PROVIDER ID: 440027596

(DD WAIVER)

AHCA Form 5000-3553, September 2015 (Incorporated by reference in Rule 59G-13.070)