HENNEPIN COUNTY
MINNESOTA

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Contracting Guide

Standards and policies for Health and Human Services contracted providers

Health and Human Services - Contract Management Services
300 South Sixth Street
Minneapolis, MN 55487
612-348-4071
hennepin.us/hhspartners

Contents

Purpose

This contracting guide is for providers who are contracting with or are interested in contracting with Hennepin County Health and Human Services. (You may also see Health and Human Services referred to as Human Services and Public Health.) This guide will help providers understand the processes and procedures Health and Human Services (HHS) uses when writing contracts and overseeing contracted relationships. The guide also helps providers understand what is required from them when a contract is being developed. Should anything in this guide conflict with the specific terms and conditions in a provider's contract, the contract supersedes this guide.

Providers are strongly encouraged to review this guide to keep current with contract requirements. Providers can find the most current copy of this guide on the Hennepin County website by visiting the partners in health and human services page.

Contract types

Agreement types used by Health and Human Services

Health and Human Services uses several types of contracts. The type of contract used depends on the service being purchased. HHS has sole discretion to determine the appropriate form of contract to be used in each situation. The types of contracts are briefly described below:

Human service agreements

Human service agreements (HSAs) are contracts used for the purchase of client-based human services and public health services. Human service agreements (HSAs) are the most common agreement type HHS uses. HSAs are used to purchase client-based human services and public health services. A majority of these services are for the provision of direct client services. HSAs include client protection language in the contract as well as performance measurements and other reporting requirements.

Personal/professional service agreements

Personal/professional service agreements (PSAs) are used for contracts with individuals or other organizations to purchase a product, deliverable, or other non-client service such as consultant or training services. PSAs typically do not include performance measures or other reporting requirements.

Subrecipient agreements

In some instances, federal funds awarded to HHS are passed directly to a provider via a subrecipient agreement. In instances such as these, the subrecipient that spends the funds has the responsibility for administering the program.

Special agreements

Some contracts do not fall into the more common categories that have already been described. These situations have unique circumstances, and your contract manager will work with you to help you understand the terms of your contract.

Contract Type - Payment Methods

Health and Human Services uses four primary payment methods in its contracts. HHS will determine the appropriate payment method to be used for each agreement.

Unit rate (fixed price)

When using this method of payment, a rate is established for a pre-determined and defined service unit. The provider receives payment for each service unit provided, based on the negotiated or pre-determined rate. Per contract specifications, the provider is responsible for invoicing HHS after the service has been delivered and documented.

Cost reimbursement – Invoice

With this payment method, the provider is only paid for actual expenses incurred. The provider is reimbursed for all actual allowable expenditures, as agreed upon in the contract. The provider is responsible

for submitting an itemized invoice (typically monthly) to HHS. All expenditures and revenues are governed by the contracted budget. All payments for contracted services are subject to financial review by HHS.

Cost reimbursement – Settle up

This version of a cost reimbursement contract is used only in rare instances, when the county deems it acceptable or necessary to issue payments to the provider before expenses are actually incurred. With the cost reimbursement—settle up payment method, pre-determined, fixed-amount payments are invoiced by the provider based on anticipated and agreed upon costs. All expenditures are governed by the approved budget, as described in the contract. While HHS pays an agreed upon amount, only allowable expenses may be reimbursed. Therefore, at the end of the contract budget period, reconciliation or "settle up" may be needed. During this settle up, HHS will review the provider's expenses in order to ensure that the contracted provider's actual eligible expenses match that total of the payments made by HHS. This settle up might require the provider to refund money to HHS in those instances when payments have exceeded the provider's actual eligible expenses.

Deliverable

With this method of payment, the provider is paid upon the completion or delivery of a clearly defined product or service. Payment for the specific deliverable can be made at an agreed upon price or for costs incurred. Deliverables are used for some personal/professional service agreements (PSAs) but are not appropriate for client service contracts.

Getting a contract

Provider selection

HHS awards contracts to agencies through an open and competitive selection process. The frequency and criteria of the selection process may vary depending on the services and/or funding source. The department has developed processes which support that practice. A variety of methods are used to solicit proposals for new or existing services:

Request for proposal (RFP)

An RFP is used to collect information on services available and make recommendations to a service area regarding the service providers that seem most likely to be able to deliver a desired service. In many instances, the service providers that submit proposals during an RFP are competing for a specific amount of resources that will be used to develop contracts. Depending on the needs of the service area, one or more service providers may be invited to enter into contract negotiations after an RFP has concluded. However, HHS reserves the right to reject any and all submissions received during an RFP process.

Request for qualifications (RFQ)

An RFQ establishes a qualified provider list or panel from which the County may purchase services. Contracts awarded to qualified agencies are often contracts that enable the County to purchase services but do not commit the County to a specific funding level.

Request for information (RFI)

An RFI is a provider selection method used when HHS is not certain about the exact nature of the service that is needed. An RFI typically originates with a specific target population that has some identified need. The proposals that are recommended to the service area following an RFI are those that appear to be best able to meet the needs of the identified population. An RFI is seldom the final step and sometimes will result in a subsequent RFP.

If HHS is going to solicit services through an RFP, RFQ or RFI, the provider selection information is posted on the Supplier Portal webpage. Contracted agencies and potential providers are strongly encouraged to establish an account with the Supplier Portal to receive announcement of posted provider selection processes.

As necessary, HHS may use sole source contracting for vendor selection. Sole source contracting might be used if a vendor possesses a unique performance capability or is the single source of services proposed, an immediate action is required, when federal or state regulations require the County to have a contract for a specific service, when a disruption of service would be overly difficult for persons receiving that service, or under other circumstances when HHS determines that a sole source agreement is in its best interest.

Required materials for HHS contracts

Prior to any contract being completed, a provider must submit all requested documentation and/or information to their contract manager. Failure to submit documentation may prevent Contract Management Services (CMS) from

being able to finalize a contract. Your contract manager will prepare a contract documentation checklist that will list all the information you are required to provide.

Some information that is requested, such as verification of insurance, is standard for all contracted services. Other requested items, such as a copy of a license, relate specifically to the contracted service. Agencies should be prepared to submit all documentation required for their specific contract.

Programmatic requirements

A clear and concise written description of the service being purchased is required in every contract. This information is used as the foundation for developing the contract and is typically included in Exhibit A of the contract. This description may be written by the provider or HHS may provide it. Refer to your contract documentation checklist to determine what information you will need to provide.

Exhibit A of the contract may include any or all the following:

- Description of the specific services to be provided
- Target population
- Admission and discharge criteria and process
- Details regarding client progression through the program
- Coordination, consultation, and other community involvement

Providers may be asked to provide the following supporting documentation during contract development:

- Quality assurance efforts
- List of planned activities for the program
- Staffing pattern for the program and job descriptions for each position

Additional resources:

- Instructions for preparing information that may be requested for Exhibit A or during contract development

Performance measurement

Most client service contracts are required to contain performance measures. Performance measures track the contracted provider's efficiency and effectiveness in delivering contracted services.

All contracted agencies are required to maintain records and submit periodic reports showing actual results for their contract performance measures. Such records may include, but are not limited to, individual eligible recipient case files and program plans; demographic information; enrollment, attendance, and/or utilization

information; and information about the type and amount of service provided, such as output and outcome information.

Hennepin County considers performance measures to be a critical component of an effective service delivery system and expects your provider's service results to be consistent with the performance measures contained in the contract agreement. Performance achievement will be factored into contracting decisions by Hennepin County.

Additional resources:

- Information about developing performance measures during contract development

Financial requirements

Most contracts require the provider to submit some financial information to CMS.

Items typically required from the provider are:

- Independent audit reports and AU-265 management letters from the last two years
- Revenue and expense statements from two prior years
- Agency-wide and program specific budgets with administrative cost allocation and salary schedules for the anticipated funding period for the contract

Your contract manager will indicate which financial information is required for your contract in the contract documentation checklist.

Additional resources

- Guidance for preparing financial information

Administrative requirements

Agencies are required to submit certain types of administrative documentation. The required documentation often includes the following:

- Completed Provider Fact Sheet showing pertinent information about the organization and contact persons. The Provider Fact Sheet form can be found on the hennepin.us/hhspartners web page.
- Current list of the board of directors
- Board directive showing who has been given authorization to sign contracts
- Affirmative action information (If required. This depends on agency size).
- Verification that insurance coverage is in place at the required levels
- Copies of current city, state, or federal licenses (if required for the contracted service)

Additional resources:

- Guidance for preparing administrative information

Contract term

HHS contracts generally run for a term of one to four years. A multi-year contract with HHS that has been approved by the Hennepin County Board of Commissioners does not imply a continued funding commitment by the County during the entire term of the contract. Funding may be determined as the County budget is determined and approved annually.

Fully executed contract

Any contract offered for signature to a potential provider is not a commitment by the County to enter into the agreement. The contract document must be signed by all responsible parties before it is considered a fully executed document.

Hennepin County purchasing rules require that the provider sign the contract prior to it being authorized by the Hennepin County Board of Commissioners. After the contracted provider's signature is obtained, contract documents are then signed by the assistant county attorney and the County Administrator, and then approved by the Hennepin County Board of Commissioners or their delegated authority. Once the process has been completed, the electronic contract-management system will send a copy of the fully executed agreement via email to the provider's authorized signer.

The County's purchasing rules require the contract to be approved and fully executed prior to service being authorized or paid.

Renewing contracts

Contracts can span a term of one to four years. Prior to the expiration of a contract, HHS evaluates the continued need for the contracted service. If the department decides to continue to contract for a service, decisions are made about whether to renew any or all existing contracts or begin a new provider selection process. The process for renewing a contract is similar to establishing a new contract. Please review the Getting a contract section of this guide for additional details.

If it is determined that your contract will be renewed, any changes or updates to the contract that are requested by the provider will be considered during the contract renewal period.

Reporting

Agencies are required to routinely submit reports to CMS as part of the contract monitoring process. Failure to submit reports as required can result in termination of a contract.

Annual financial reporting

The County requires agencies to submit financial reports at least annually. The type of financial report submitted will depend upon each provider's financial standing.

Independent external audit

The County requires nonprofit agencies to hire certified public accountants to conduct annual independent external audits of financial statements, if a provider's total annual revenues for the prior year meet or exceed $750,000.

Agencies that meet the criteria for an audit shall provide a copy of it their audit report to CMS with a full set of audited financial statements containing all disclosures required by generally accepted accounting principles (GAAP) and a copy of the AU-265 management letter (report on internal controls) from the independent auditors. The management letter is a document that is issued by the external auditors that is addressed to the provider and states the findings (if any) that were noted during the audit. The AU-265 management letter will have definitions for material weakness or significant deficiency.

Financial statement review or compilation requirement

If a provider does not have an independent audit performed, but has total receipts arising out of all HHS contracts for the preceding calendar year of $200,000 or more, the County requires the provider to hire an external accountant to perform a compilation or review of their financial statements.

Compilations or reviews must include a review of the provider's statement of financial position, revenue and expense statement, statements of cash flows, and all other disclosures required by GAAP. A copy of the compilation or review must be submitted within thirty (30) days of completion, but not later than 180 days after the end of provider's accounting year.

Minimal financial reporting

If agencies do not meet the criteria for an audit, review, or compilation, the County requires an unaudited financial report containing a provider wide balance sheet and revenue and expense statement prepared by the provider's internal accountant. These statements must be submitted within ninety (90) days of the end of the provider's accounting year.

In no instance will a balance sheet and revenue and expense statement prepared as part of a provider's income tax return or IRS Form 990 meet the County's financial reporting requirements.

Additional reporting requirements

Financial reports

Agencies are required to submit annual agency-wide and program-specific line item revenue and expense statements and administrative allocation schedules, including methodology used, within thirty (30) days after the end of the reporting period, unless otherwise indicated in writing by the County.

Performance measurements

Most contracts require the provider to submit regular performance measurement reports to the county. The standard format and frequency of submission of the reports is governed by the terms of the contract.

Insurance

The County requires agencies to carry insurance coverage in accordance with the tort liability limits under Minnesota Statutes, Chapter 466 during the entire term of their contract.

Providers must have the appropriate level of insurance in place in order to enter into a county contract. This level of insurance must be maintained throughout the entire contract term. As proof of coverage, contractors must ensure the Certificate of Insurance is on file with the county prior to the contract being fully executed. In addition to meeting the coverage amounts, Hennepin County must be listed as an "Additional Certificate Holder" on the insurance certificate.

Licensing

For contracted services that require a city, state, or federal license or certification, a current copy of the licensing document must be on file with the county

Organizational changes

Significant organizational changes within a provider or a contracted program must be reported in writing to the County in a timely manner in accordance with the contract. Examples include changes to key staff, Executive Director contact information, membership of the Board of Directors, organization's name, business address, or ownership structure.

Financial standards

Fiscal capacity standards

Agencies that hold human service contracts with HHS must have fiscal capability and financial stability. A fiscally capable provider must remain in compliance with the following requirements:

- Have an accounting system that is appropriate to the size and nature of the organization and complies with generally accepted accounting principles (GAAP) and governmental regulations
- Issue regular financial statements that conform to GAAP standards
- Comply with applicable federal requirements and County financial procedures as identified in this manual and its contract(s)
- Maintain and routinely review an annual organizational budget that is clear, arithmetically accurate, and appropriately detailed; this detail includes cost centers (service elements) and revenue and expense line items appropriate for the size and nature of the organization
- Have documented financial policies and procedures that are appropriate to the size, nature and needs of the organization and comply with GAAP and contract requirements; these policies and procedures are to be reviewed regularly by the provider's governing body
- Provide its governing body with timely and appropriate fiscal information which must be reviewed at least annually at a meeting of the governing body
- Be on stable financial footing, as indicated by a lack of excessive recurring losses, significant liabilities, and/or insufficient working capital as determined by the County

OMB Uniform Guidance requirements

Federal single audit requirement

Agencies must comply with all applicable single audit requirements, as outlined in the OMB Compliance Supplement. Compliance Supplement means Appendix XI to Title 2, U.S. Code of Federal Regulations, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit requirements for Federal Awards (Uniform Guidance). Under the requirements of this circular, any non-profit organization receiving federal funds must determine what level, if any, of federal compliance audit to perform. Subrecipients of federal funds will be notified by the County of their status. A subrecipient is subject to the requirements of OMB Uniform Guidance; a provider is not.

Determination of federal funds

If federal funds are a part of the funding for a human services contract, the County will give the provider information concerning the amount of federal funds and Catalog of Federal Domestic Assistance (CFDA) number for each service element as soon as this information is available. It is the provider's responsibility to forward this information to their auditors for determination of federal audit requirements.

Responsibility for determining federal audit requirements

It is the provider's sole responsibility for determining compliance with federal audit requirements. The County can only provide information about federal dollars contained in a provider's contracts and the related CFDA number(s). However, because organizations may receive federal dollars from sources other than the County, they should not depend solely upon receiving information from the County in determining their own compliance with federal requirements.

Independent external audits

Depending on an organization's total revenues and on the total amount of service that organization has contracted to deliver for the County, agencies may be required to have an external certified public accountant perform a full-scale, organization-wide financial audit. All agencies receiving federal funds must comply with OMB Uniform Guidance, as applicable.

Audits must be conducted by certified public accountants who satisfy the independence requirements outlined in the rules of the American Institute of Certified Public Accountants (AICPA) and (Rule 101 of the AICPA Code of Professional conduct, and related interpretation and rulings), the Minnesota State Board of Accountancy, the independence requirements contained within Government Auditing Standards (1994 Revision), and rules promulgated by other federal, state, and local government agencies with jurisdiction over the organization. Those rules require that the certified public accountant be independent in thought and action with respect to organizations that engage them to express an opinion on financial statements or to perform other services that require independence.

If required per contract specifications, financial statement audits are due 180 days after the end of a provider's fiscal year. Single audits are due 30 days after receipt of the auditor's report or nine months after the end of the audit period, whichever occurs first. Agencies must also submit a copy of the AU-265 management letter provided to the organization, if one exists, or a letter from the audit firm stating that no AU-265 management letter was issued.

Important Note: Federal and/or state requirements do not relieve agencies of specific HHS contract requirements.

Organizations requesting an extension of a report submission deadline must submit a written request to their contract manager via email at least two weeks before the deadline, clearly stating the reason for the request.

The provider must establish and maintain systematic written methods to assure timely and appropriate resolution of audit/review findings and recommendations.

Non-conforming or sub-standard independent audits or reviews

If the County determines that a provider's independent audit is non-conforming, written notice will be provided to the provider's executive director. Corrections to the audit report must be made and submitted to the CMS contract manager within six months of the date of notification. Failure to comply with this requirement may result in corrective actions (no further client referrals, payment holds, etc.) up to and including contract termination.

Agencies may appeal the determination of non-conformity by sending a written request their contract manager via email or by mailing a request to:

HHS Chief Financial Officer
Hennepin County Government Center, A-165
300 South Sixth Street
Minneapolis, MN 55487-0134

If the appeal is not upheld, corrections must still be made within six months of the date of original notification.

Allocation of administrative and overhead costs

The provider is required to file an administrative cost allocation schedule) with their anticipated budget for the contracted service period. The administrative cost allocation schedule will be reviewed by HHS as part of the contract budget approval process. The intent of all service contracts is to maximize the level of service given to clients; therefore, to the greatest extent possible, administrative and overhead costs charged to contracts with HHS must be minimal. HHS's policy is that the allocation of the provider's administrative and allocated direct costs must meet the following standards:

- Be made in a reasonable and consistent manner across all the provider's program services
- Be verifiable
- Ensure that the County's share be proportionate to the total program cost
- Not include any unallowable costs
- Should not be based on budgeted amounts

The following items show examples of costs that are not allowed to be charged to the County:

- Advertising, except for personnel recruitment
- Alcohol
- Bad debts
- Contingency reserve
- Depreciation, if County funds were used to acquire the asset
- Donations made by the provider to others, including cash and goods
- Entertainment costs for employees, donors or other related parties (e.g., tickets to shows, sporting events, meals)
- Federal, state or local (including Hennepin County) lobbying
- Goods and services, including housing, provided to the provider's employees, donors, or other related parties

- Legal and associated expenses related to any administrative, civil or criminal proceeding
- Penalties and interest from the Internal Revenue Service, Minnesota Department of Revenue, or other state or federal provider
- Personal use of automobiles provided by, or paid for by, the provider (e.g., a car allowance)

The following definitions guide the implementation of the administrative costs policy:

- Administrative costs: The costs incurred for the provision of management and general administration and indirect costs.
- Direct costs: The costs incurred in the provision of program services that can be identified as being solely related to one program or functional activity.
- Fundraising: An organization's activities, including conducting special fundraising campaigns, preparing fundraising manuals, instructions or materials, and conducting other activities involved with soliciting contributions from individuals, foundations, government agencies, and others.
- Indirect costs: Those costs that were incurred for more than one direct service or supporting function (fundraising or administrative) and that cannot be attributed solely to a single direct service such as utilities, insurance, and rent costs. Since all programs and functions benefit from a shared space and utilities, all programs and functions must carry their proportionate share of these costs.
- Management and general administration: The activities related to organizational oversight, business management, general recordkeeping, budgeting, financing, and related administrative activities, and all management and administration except for direct provision of program services or fundraising activities.
- Program services: The activities that result in goods and/or services being distributed to beneficiaries, customers, or members that fulfill the purposes or mission for which the organization exists.

In the event the County is using federal, state, or other outside funder to pay for the services in a specific contract, and that funder's policy on the allocation of overhead and administrative costs is different than the County's, that policy will supersede the County's policy.

Contract monitoring

In order to ensure high quality and effective services are being delivered to our clients, all contracts are monitored on a routine basis to ensure compliance with the contract terms. The level and degree of monitoring is based upon the complexity of the contract.

Most agencies can expect to have a monitoring site visit by contract managers annually. During the site visit, the following review categories will be covered:

- Administrative
- Financial
- Programmatic

Administrative review consists of ensuring all required contract documents, are current and on file with the County. For a detailed list of administrative requirements, review your contract or see the Administrative Requirements section of this guide.

Financial monitoring consists of reviews of budgets, financial reports, and audits to assess the financial status of programs and agencies. Contract managers also review supporting documentation including client files and provider expenses to ensure services were appropriately billed.

Programmatic monitoring reviews the effectiveness of services and verifies the service delivery is consistent with contract requirements. Programmatic monitoring activities may include facility and service observation, program and client file review, staffing review, performance management data verification, and overall discussion of a provider's performance.

Financial compliance reviews

All contracted agencies are subject to fiscal compliance reviews performed by the Hennepin County Internal Audit Division. These reviews are not intended to replace or duplicate an audit by a qualified external auditor, nor should it replace financial reviews by contract managers or be relied upon by the provider or its governing body as a statement on the financial condition of the provider.

The County determines the need for financial compliance reviews by an internal analysis of risk to the County. The factors the County considers include, but are not limited to:

- Total amount of funding under contract with the County
- Sources of funds used to pay the provider and any requirements of other funders
- Type of contract(s) and payment method(s)
- Results of independent audit
- Timeliness of filing of reports to the County
- Last financial compliance review
- Reports of unusual situations such as possible fraud or embezzlement

Financial compliance reviews will take place in the provider's primary business office, unless otherwise arranged in advance with the County. Agencies are responsible for ensuring that all records specified or referred to in the financial compliance review notice are available for examination by County staff on the date of the site visit. Agencies will be given the financial review notice at least two weeks in advance.

Notification of financial review findings and need for provider response

A financial review findings report will be sent to the provider generally within 30 days after the review. This report will cite findings and recommendations resulting from the review and may also restate findings from the most recent external financial or federal compliance audit. Agencies must respond in writing to any adverse finding(s), as required by the County. The provider may submit additional documentation or dispute the findings of a review by submitting a response to the County within 30 days of their receipt of the report. Should questions arise, your contract manager or internal audit staff will be available to work with you.

Invoicing and payment

Billing frequency

Invoices should be submitted for payment according to the schedule established within the contract. Invoices received after 90 calendar days from the last day of the month of service or 90 days from the date the county was determined to be the payer of last resort will not be paid without special prior approval from county administration.

Required billing information

An invoice must contain the following billing information to be used for payment of eligible expenses:

- Provider name
- Remittance address
- Provider number
- Contract number
- Purchase order (PO) number
- Description of the service for which the County is being billed
- Date(s) of service
- Specific client identifiers, if required in the contract
- Dollar amount requested to be paid, consistent with the terms of the contract
- Invoice must be signed and dated by the provider's staff member that has verified the accuracy of the invoiced amount.

Billing address

Invoices that have a purchase order number but do not contain client data should be submitted by email to OBF.Internet@hennepin.us.

Invoices that contain client data will not have a purchase order number but must have correct client and service information on them. Detailed information about preparing invoices with client data can be found on the hennepin.us/hhspartners web page. Invoices that contain client data should be submitted online through the Human Services and Public Health Invoicing web form.

Direct Deposit request forms can also be submitted by email to the following address:

OBF.Internet@hennepin.us

For billing or other payment questions, contact your contract manager.

Payment processing

It is the County's policy to make payments within 35 days of receipt. The County will not pay interest on any invoice less than 35 days old or for any invoice that was originally sent to an address other than the ones listed above.

In instances when an invoice or bill is sent back to a provider for revision or correction, the 35-day timeline will be reset. After the provider has made its revisions or corrections or any billing disputes have been resolved, a new 35-day timeline will start upon receipt of the corrected or undisputed invoice. If you have questions about payments, contact your contract manager.

Overpayment collection

As a condition of contracting with the County, agencies agree to repay all amounts that meet any of the following criteria:

- Paid to the provider in error
- Paid in excess of the contracted not-to-exceed amount
- Determined to have been incorrectly billed by the provider
- Amount due to the County if the provider has a cost reimbursement-settle-up contract and the year-end reconciliation (described below) determines that the provider did not incur costs commensurate with payments made

The provider is required to reimburse the County for the excess payments within 45 days of the invoice date.

In accordance with standard contract terms, the County may withhold from any payment due to the provider if it has been determined there is money due to the county. This withholding shall include, at least, amounts owed the County due to overpayment or, as the result of an audit, from any contract between the provider and the County.

Instructions for contract documentation

Before you compile your contract documentation, please review these instructions.

Hennepin County Health and Human Services (HHS) Contract Management Services has assembled a contract documentation checklist and these instructions to assist agencies that are or have been engaged in contract negotiations with the HHS.

The contract documentation checklist and instructions are made up of three sections: the ***contracted services*** section, the ***financial information*** section, and the ***administrative information*** section. Each section includes supporting material, detailed instructions and may include examples or sample forms.

Your contract manager will provide you with a contract documentation checklist. Electronic copies of blank forms needed to complete your contract documentation are provided online on the hennepin.us/hhspartners web page. If you have questions about the forms, contact your contract manager. If you do not know who is assigned to manage your contract, call 612-348-4071 to inquire.

Contract documentation should be submitted in electronic format via email and conform to the format requirements listed below.

Format requirements:

1. Submit documents in a modifiable format, such as Microsoft Word or Microsoft Excel.
2. Make sure all documents and attachments are clearly labeled. Submit documents via email and with all attachments included to your contract manager by the submission due date.

This contract documentation solicitation does not commit Hennepin County to award a contract or to pay for any costs incurred in the preparation of the documents.

If awarded a contract, you will be required to provide updates on information presented in your contract documentation. This information may include but is not limited to, budget or financial information, certificates of insurance, copies of licenses, changes in ownership/services/locations, or changes in affirmative action plans.

If you have questions about the preparation of your contract documentation call your contract manager or the reception area at (612) 348-4071 for assistance.

Contracted services information for Exhibit A

Providers may be asked to provide information that will be used in Exhibit A of the contract document.

Exhibit A contains the service narrative, or detailed information about the types of services being provided through the contract, as well as performance measures for the contract.

Exhibit A: Contracted services, narrative, section 1

Contracted services, narrative, section 1 provides details that describe the type of services covered by the contract, the people who receive those services, licensing requirements, service locations, and other details that help to provide a clear picture of the services to be delivered.

Your contract manager will prepare the service summary page, the first page of this section, based on information you provide.

Your contract manager may ask you to prepare and submit any of this additional information below. This information will also be included in the contracted services, narrative, section 1 portion of Exhibit A, following the service summary page.

Please refer to the contract documentation checklist your contract manager has shared to determine if you need to prepare and submit this information.

SERVICE DESCRIPTION – part of Exhibit A

Describe the program's services and the activities engaged in by staff and eligible persons to accomplish the program's stated performance measures. Do not include other descriptions of other programs offered by your provider. If providing any of the following, be clear and concise in your description.

- Briefly state the reason or need for services.
- Describe the type and emphasis of the service.
- Indicate the frequency of service delivery such as how often eligible persons receive the service.
- Describe the location(s) where services are delivered.
- Describe how the effectiveness of the service is determined.
- Describe how the need for ongoing service to an eligible person is determined.
- Identify the staff positions responsible for providing the service, minimum staffing levels, or levels of staffing required by license.
- Describe how a client may progress from admission to discharge through the direct service components of your system

TARGET POPULATION – required part of Exhibit A

- Provide information about the demographics of the eligible persons served (e.g. age, race, sex, etc.).
- List specific eligibility criteria for eligible persons.

ADMISSION AND DISCHARGE CRITERIA AND PROCESS – required part of Exhibit A

- Describe the referral/admission process for the program, including whether services are authorized through Hennepin County. Include follow-up methods and timelines employed to assure all referrals are responded to in a timely manner.
- List the primary sources from which you most frequently receive referrals.
- Specify any eligible person characteristics that would prohibit admission.
- Describe the criteria for successful program completion.
- Describe the criteria and types of discharge from the program and if eligible persons may be referred to program again at a later date.
- Describe when discharge planning begins for eligible persons and how it is integrated into the overall service plan. Include how the determination for discharge is made and all who participate in this process. Indicate what position is responsible for coordinating this process.

PROGRAM COORDINATION, CONSULTATION AND COMMUNITY INVOLVEMENT – required if any component of the service/program is subcontracted, or include if important/relevant to the service being delivered

- If you subcontract for any of the services purchased in the contract, indicate what services are subcontracted and who or what provider is performing those duties. All subcontractor's services are to be performed in accordance with all requirements of the contract. Submission of the subcontract is not required but should be available upon request.
- List the primary sources to which you most frequently make concurrent referrals (while the eligible person is in your program).
- Describe the joint programming or coordination efforts with other agencies. Explain the purpose or expected outcome of these efforts. Identify any written coordination agreements that have been developed with any of these agencies.
- List primary sources to which you most frequently make referrals at discharge.

- Describe ongoing staff development process.
- Describe consultation services the program intends to purchase or receive from other individuals or organizations during the contract period. For any regularly purchased clinical consultation, include the consultant's name, type of license/credentials, purpose, and frequency.

Exhibit A: Contracted services, performance measures, section 2

Contracted services, performance measures, section 2 provides details that describe the types of information that service providers will be asked to collect in order to demonstrate the effectiveness and efficiency of the contracted services. Your contract manager will work with you to develop your contract performance measures.

PERFORMANCE MEASUREMENT– Performance Measurement Grid – required

Most human service agreements will contain performance measures. You will work with HHS to develop meaningful performance measures for effectiveness and efficiency, clear descriptions, and methods to measure objectives.

Outcomes are changes to service or program participants' knowledge, skills, attitudes, values, behaviors, condition, or circumstance as a result of the service. Effectiveness performance measures, or outcomes, indicate if participants have achieved the desired service/program outcome.

Effectiveness performance measures help answer the questions of:

- Is anyone better off?
- What quantity of change for the better did we produce?
- What quality of change for the better did we produce?

Outputs are the direct results of the service or program. Efficiency performance measures, or outputs, indicate what the provider or participant have done in order to achieve the desired outcome.

Efficiency performance measures help answer the questions of:

- How much service did we deliver? (quantity/frequency)
- How well did we deliver the service? (quality/intensity)

Supporting documentation during contract development

During contract development, providers may be asked to submit supporting documents. This information will be kept in your contract file. Refer to the contract documentation checklist to determine if your contract manager has asked you to provide this information.

PLANNED ACTIVITY SCHEDULE – may be requested – will be kept in contract file

Provide a list of planned activities that would normally occur throughout the course of your program. If the planned activities for your service vary throughout the year (e.g. summer schedule, school year schedule, etc.) or you have more than one service with planned activities, provide a planned activity schedule for each variation. A planned activity schedule form can be found on the hennepin.us/hhspartners web page.

STAFFING PATTERN – may be requested – will be kept in contract file

Include a Staffing Pattern form (you can find the form on the hennepin.us/hhspartners web page, or this information may be submitted in a different but equivalent format) that reflects the following points:

- State the hours and days of program operation during a typical week.
- The Staffing Pattern should show staff coverage during a typical week of operation.
- List each position title, assign a position code letter, and state the number of FTE's of each position.
- Show the hours each individual staff person is scheduled to work. This is done by putting the code letter in the appropriate boxes of the grid. Show the amount of coverage provided by each position for hours of program operation.
- Show how program coverage will be provided after regular working hours, on weekends, and holidays, as needed.
- Indicate how emergency coverage/on-call assistance, (e.g. crisis center) is provided during times when the provider/program is closed, as needed.
- Position titles and FTE allocations must be consistent with staffing information provided throughout all your organization's submitted contract documentation.

If staffing varies throughout the year (e.g. summer schedule, school year schedule etc.) or if you have more than one contracted service, please provide a Staffing Pattern for each variation.

Financial information

Provider financial statement requirements

Please submit the following financial information:

- Independent audit reports from the previous two years (this provides three years of financial information to HHS);
- Revenue and expense reports or statement of activities, from the previous two years.

Detailed information about financial statement requirements can be found in the annual financial reporting section of this guide.

Provider budget requirements

HHS requires budgets from providers to gain an understanding of the operational costs of contracted services. HHS Contract Management Services has developed a provider contract budget workbook to simplify and reduce the amount of work providers must put into budget submissions. The budget workbook is set up to accommodate budget information for multiple contracted programs held by a provider. A provider completes one workbook with required informational pages to meet the budget requirements for all their contracts. This workbook auto populates information to prevent repeated entries on multiple pages. The budget workbook can be found on the hennepin.us/hhspartners web page.

The following four budget information pages are required:

1. Allocated provider budget by program:

   This form will organize your budget by Hennepin County contracted service/program(s) and calculate your total provider budget. The program budget should include direct revenues and costs that are identified as relating specifically to the program. The total provider budget should be a consolidation of all programs operated by the provider.

2. Administrative cost allocation schedule:

   Administrative costs are allowed as a program cost only if all expenses within administrative costs are clearly identified. A method for reasonable and equitable distribution of administrative costs across all programs must be demonstrated in the administrative cost allocation schedule.

3. Provider salary schedule by program:

   The provider salary schedule reports salary detail for the Hennepin County contracted programs and for the overall provider.

4. Budget substantiation:

   The budget substantiation provides a narrative of all expense items. For each expense line item, describe the costs and components that make up the line item. The budget

substantiation will also explain how the budgeted amounts were calculated or how distribution across programs was determined. For example, if the line item involves an allocation across programs, explain the basis used to determine the cost allocation (e.g., program FTE's, or square footage).

Explanation of a line item could be presented in the following manner:

> *Occupancy cost: Rent @ $1,000 per month = $12,000.*
>
> *Utilities @ $300 per month =$3,600.*
>
> *Building & Grounds maintenance/snow plowing and lawn care @ $1,000 annually.*
>
> *Total of $16,600 is allocated to all programs.*
>
> *A percentage for each program is assigned based on each program's percentage used out of the total square footage in the building.*

Salaries are separately detailed in the provider salary schedule by program, so you do not need to provide further documentation as part of the substantiation. Be sure to provide enough detail so that your substantiation is clear.

Your contract manager may request supporting data to clarify various expense details.

The budget can be submitted using your organization's format if it contains all the content found in the four budget pages listed above. The revenue and expense categories will be reviewed by HHS to ensure they are reasonable and appropriate for the contracted services.

Administrative information

Provider fact sheet

Complete a provider fact sheet form for your organization. This form is available on the hennepin.us/hhspartners web page. The legal name of the provider should reflect the legal name registered with the Minnesota Secretary of State's Office.

Board of directors list

Provide a list of the board of directors for your provider, which includes mailing addresses, phone numbers, and titles of officers and each board member's place of employment.

When the contracted program provider is part of another corporate structure (sometimes referred to as a "parent organization"), a list of the board of directors of that corporation is required.

Authorization to sign contracts

Attach a copy of your board resolution, or corporate by-laws, naming individuals and/or positions with authority to sign contracts. Specify the number of signers required, as well as the names/positions with authority to sign contracts. If this information is not contained in a

resolution, you may submit minutes of board meetings stating to whom the board has delegated authority to bind the provider into a contract.

Affirmative Action certification

AFFIRMATIVE ACTION CONTRACT REQUIREMENTS

For all contracts over $100,000, the county requires contractors to have an affirmative action plan in place. An affirmative action plan is a set of goal-oriented management policies and procedures to eliminate barriers to employment and increase retention of minorities, women and qualified disabled persons that are not based on specific requirements.

The county partners with the Minnesota Department of Human Rights to monitor compliance. Contractors with contracts over $100,000 must apply for a Workforce Certificate of Compliance and submit evidence of approval to the county.

In some cases, contractors may be exempt from the requirements. Contractors are exempt if:

- Their company has no facilities in AND no more than one employee operating in Hennepin County, or
- Their company employed <40 full-time benefit-earning employees during the prior 12 months.

Scenario	Required documentation
A. Provider is EXEMPT	Provider is EXEMPT if: • Your company has no facilities in AND no more than one employee operating in Hennepin County. **OR** • Your company employed <40 fulltime benefit-earning employees during the prior 12 months. **DOCUMENTATION**: Authorized official from provider must email contract manager confirming the reason for exemption.
B. Provider has a current Workforce Certificate of Compliance	The county requires providers receive a Workforce Certificate of Compliance from the Minnesota Department of Human Rights (MDHR). **DOCUMENTATION:** Provider must send contract manager a copy of their company's MDHR Certificate of Compliance.

Scenario	Required documentation
C. Provider has submitted an application for a Workforce Certificate of Compliance*	**DOCUMENTATION:** Authorized official from provider must email contract manager stating: • We attest that we sent the MDHR our complete application for a Minnesota Workforce Certificate on __/__/____, and upon receipt we will forward a copy of the certificate to Hennepin County. **And upon receipt of certificate:** Provider must send a copy of their company's MDHR Certificate of Compliance to contract manager.
* To apply for a Workforce Certificate of Compliance, provider will need to have an Affirmative Action Plan approved by the Minnesota Department of Human Rights (MDHR). In some cases, their current plan with the federal government or local Minnesota municipality may qualify. Typically, MDHR sends the business a workforce certificate within 15 days of receipt of the Affirmative Action Plan.	

Insurance certificate

All Hennepin County contracted providers must maintain insurance. A certificate of insurance from the insurance broker must be submitted. The certificate must name Hennepin County as the certificate holder and as an additional insured for the commercial general liability coverage with respect to operations covered under the contract.

The insurance requirements for non-government entities differ from the requirements for government and school providers. Following are descriptions of the requirements for each.

INSURANCE REQUIREMENTS FOR NON-GOVERNMENT AGENCIES

The required insurance amounts indicated below are standard contract language. There may be annual changes in these required amounts, or instances where amounts can be negotiated.

Insurance type	Requirements
Commercial General Liability	• $2,000,000 General Aggregate or in accordance with contract language • Written on an occurrence basis with contractual liability coverage • Hennepin County listed as an additional insured for Commercial General Liability coverage
Automobile Liability	• $2,000,000 per occurrence
Workers Compensation Liability	• In compliance with workers compensation statutory limits
Employer's Liability	Minimum requirements: • $500,000 - Each Accident

Insurance type	Requirements
	• $500,000 - Disease – Policy Limit • $500,000 - Disease – Each Employee
Employee Dishonesty	• $50,000
Cyber Insurance	• $5,000,000*
Professional Liability	Minimum requirements: • $1,500,000 per claim • $2,000,000 aggregate
Umbrella or Excess Liability	• Umbrella or excess liability policy that provides required commercial general insurance coverage

**Some contracts require a smaller amount of coverage or may be exempt. Ask your contract manager for more information.*

INSURANCE REQUIREMENTS FOR GOVERNMENT AND SCHOOLS

The insurance requirements for non-government entities differ from the requirements for government and school providers. See contract language for specific requirements for non-government entities. The difference for units of government and school are as follows:

- Each party is liable for its own acts and agrees to defend, indemnify, and hold harmless each other from any liability, claims, causes of action, judgments, damages, losses, costs or expenses, resulting directly or indirectly from any act or omission in the performance or failure to perform its obligations for the contracted services. Except for State agencies, each party's liability is governed by the provisions of Minnesota Statutes, Chapter 466 and other applicable law. The liability of State agencies is governed by the provisions of Minnesota Statutes, Section 3.736 and other applicablelaw.

- Each party warrants that it has a purchased insurance or self-insurance program.

Copy of licenses

All local, state, and federal standards for licensing must be met. Please submit a copy of all applicable licenses and certifications for the services to be provided. A contract will not be executed without proper applicable licenses and/or certificates.

If licenses or standards are not applicable to your program, please state that in your contract documentation. Please submit documentation showing that all state and local health and safety standards have been met, and that any facilities used for programs covered under this contract are in compliance with applicable building and housing codes.