Self Determination Program: Self Directed Supports (099)

SCLARC Vendor Checklist

Below are the required documents you will need to submit to do business with SCLARC for providing self-directed supports under service code 099 for individuals enrolling in the Self-Determination Program. Please contact vendocs@sclarc.org for questions on any of the below items.

- ☐ Proof of office in South Central Los Angeles Regional Center's (SCLARC) catchment area. (Title 17, §54302(58))
- ☐ Copy of Valid and current identification such as a driver's License, California state ID, or passport (Title 17, §54310)
- ☐ *General Liability Insurance (required to do business with SCLARC, per SCLARC Board policy)
- ☐ Zero Tolerance Policy
- ☐ Whistleblower Policy
- ☐ Business License (if applicable)
- ☐ Articles of incorporation / ownership statement (if applicable)
- ☐ Independent Facilitator Certificate / Proof of completion of Self Determination Program training course (experience requirements per DDS)
- ☐ Service Provider Insurance Policy

SELF-DETERMINATION PROGRAM: Self-Directed Supports (099)

DDS Vendor Packet Checklist

Below are the required documents you will need to submit to your regional center to complete the vendorization process to provide self-directed supports under service code 099 for individuals enrolling in the Self-Determination Program. Please contact your regional center Community Services liaison for questions on any of the below items.

☐ Qualifications and Agreement Form:

- ☐ General SD Supports
  and/or
- ☐ FMS SD Supports

☐ DS1890: Vendor Application

☐ DS1891: Applicant/Vendor Disclosure Statement

☐ Conflict of Interest Form

☐ Business Associate Agreement / HIPAA Form

☐ Home and Community Based-Services Provider Agreement Form

☐ W-9: Request for Taxpayer Identification Number and Certification

☐ Contact your regional center for eBilling instructions and any other documentation required to set up payment for services

SELF-DETERMINATION PROGRAM: General Self-Directed Supports (099)

Qualifications and Agreement Form

Applicant Name: _____

Email: _____ Phone: _____

Statement of Written Qualifications

Individuals seeking to provide vendored General Self-Directed Supports must submit a written qualification statement indicating their knowledge and/or experience in each of the following areas. **Please provide a brief statement about how you meet each of these qualifications.**

1. Knowledge of people with developmental disabilities, through lived experience, and/or one year of formal paid experience.

2. Completion of a training course about the self-determination program; and,

3. Knowledge of the Lanterman Developmental Disabilities Services Act, including SDP requirements.

Service Agreement

As a service provider for general support needed during a participant's enrollment into the Self-Determination Program (SDP), I agree that I will assist in the areas listed below, as appropriate for each participant and/or family I assist:

1. Individual program planning
    a. Coordination with an individual who provided the Initial Person-Centered Plan
    b. Assistance at the individual program planning meeting to identify the potential SDP participant's needs, goals and services in the SDP

2. Coordinating how services and supports are provided
    a. Finding and hiring qualified staff or an agency provider
    b. Negotiating staff pay or provider rate

c. Understanding the process for obtaining criminal background checks for staff, if applicable
d. Basic information about who can provide services (e.g., qualifications, rules on who may or may not be paid)
e. Basic information about how to manage staff (e.g., setting expectations and hours of work, timely submission and claiming for hours worked)
f. Coaching on all aspects of onboarding and training staff

3. Managing the 12-month SDP individual budget through the spending plan
a. Education about generic sources of funding to maximize use of SDP funds
b. Understanding the process/assistance to obtain a certified 12-month budget, understanding how an SDP individual budget is developed and reviewing/developing the individual spending plan
c. Learning and developing basic skills in budgeting and tracking monthly expenditures
d. Basic information about the use of SDP funds (e.g., as required in state or federal law and regulations)
e. Assistance with establishing communication and coordination between the regional center, FMS provider, and staff

Printed Name: _____

Signature: _____ Date: _____

SELF-DETERMINATION PROGRAM: FMS Self-Directed Supports (099)

Qualifications and Agreement Form

Applicant Name: _____

Email: _____ Phone: _____

Statement of Written Qualifications

Individuals seeking to provide vendored FMS Self-Directed Supports must submit a written qualification statement. To provide FMS Self-Directed Supports you currently must be a regional center FMS for Self-Determination Program participants. **Please provide the following:**

1. My FMS vendor number for providing services to SDP participants is: _____
2. The vendoring regional center is: _____

Please provide a brief statement about your ability to provide each of the following:

1. Education and coaching/training about employment laws; responsibility for reviewing monthly budget reports, budget expenditures, adjustments to budgets and spending plans and eligible goods and services.

2. Assistance with criminal background checks, verification of proposed services compliance with HCBS, and review and assistance in adjusting individual spending plans to ensure expenditures are based on a sound methodology.

3. Discussions with regional centers about inclusion of spending plan and service authorizations in ebilling and other financial and billing requirements and other topics as need to support a smooth transition.

Service Agreement

As a service provider for FMS Self-Directed Supports needed during a participant's enrollment into the Self-Determination Program (SDP), I agree that I will assist and

provide coaching and/or training in the areas listed below, as appropriate for each participant and/or family I assist:

1. Education and coaching about:

    a. Employment laws, overtime rules, timesheet requirements and responsibilities, insurance requirements.

    b. Reviewing the monthly budget report provided by the FMS and responsibilities for reviewing the individual budget expenditures; requirements for adjustments to the individual budget and spending planning and FMS processes for these.

    c. Eligible goods and services requirements.

2. Process for and assistance with:

    a. Obtaining criminal background checks.

    b. Verification that the proposed services are compliant with Home and Community-Based Services settings requirements.

    c. Review of and assistance in adjusting the individual spending plan to ensure the method for calculating the proposed expenditures are based on reliable costs and service utilization and adjustments, as needed.

3. Discussions with the regional center about:

    a. Inclusion of the spending plan and service authorizations in the ebilling system and other financial and billing requirements, POS processes and regional center processes to support a successful transition into the SDP.

    b. Other topics, as needed, to support a smooth transition into the SDP.

Printed Name: _____

Signature:: _____

Date: _____

State of California—Health and Human Services Agency

Department of Developmental Services

VENDOR APPLICATION

DS 1890 (Rev. 07/2011) (Electronic Version)

Reset Form | Save As

Applicant Name	Federal Tax ID or SSN *

Name of Governing Body or Management Organization

Mailing Address	(Street)	(City)	(State)	(Zip)	(County)

Service Address *(If different than mailing address)*	(Street)	(City)	(State)	(Zip)	(County)

Applicant *(owner or executive director)*	Telephone number ( )

Type of Service to be Provided	Facility Capacity

Identification of the type of consultants, subcontractors and community resources to be used by the vendor as part of its service

CERTIFICATION

I hereby certify to the best of my knowledge and belief, this information is true, correct, and complies with Title 17, Section 54310(a).

Applicant's Signature	Date
▶	

INSTRUCTIONS

Please read the Department of Developmental Services California Code of Regulations, available from the regional centers, prior to completing this form. Type or print this form. Mail to the regional center serving your area.

Attach applicable information outlined in Title 17, Section 54310(a)(10)

(A) Any license, credential, registration or permit required for the performance of the service or operation of the program, or proof of application for such document;

(B) Any academic degree required for performance or operation of the service;

(C) Any waiver from licensure, registration, certification, credential, or permit from the responsible controlling agency;

(D) The proposed or existing program design as required in Section 56712 and Section 56762, if applicable, for applicants seeking vendorization as community-based day programs;

(E) The proposed or existing staff qualifications and duty statements as required in Sections 56722 and 56724 for applicants seeking vendorization as community-based day programs;

(F) The proposed or existing design as required in Section 56780 for applicants seeking vendorization as in-home respite services agencies;

(G) The proposed or existing staff qualifications and duty statements as required in Section 56792 for applicants seeking vendorization as in-home respite services agencies;

(H) The signed Home and Community-Based Services Provider Agreement with the Department of Health Services, if required.

** "Except for the Federal Tax ID or Social Security Number, all information provided by you on this form may be released to a member of the public pursuant to the Public Records Act, Section 6250 et seq. of the California Government Code."*

State of California—Health and Human Services Agency

Department of Developmental Services

VENDOR APPLICATION

DS 1890 (Rev. 07/2011) (Electronic Version)

Reset Form | Save As

Applicant Name	Federal Tax ID or SSN *

Name of Governing Body or Management Organization

Mailing Address	(Street)	(City)	(State)	(Zip)	(County)

Service Address *(If different than mailing address)*	(Street)	(City)	(State)	(Zip)	(County)

Applicant *(owner or executive director)*	Telephone number ( )

Type of Service to be Provided	Facility Capacity

You can put general or FMS, depending on the type of supports you plan to provide.

Identification of the type of consultants, subcontractors and community resources to be used by the vendor as part of its service

You can leave this blank.

If you plan to have other work with you to provide these supports, specify here.

CERTIFICATION

I hereby certify to the best of my knowledge and belief, this information is true, correct, and complies with Title 17, Section 54310(a).

Applicant's Signature ▶	Date
John Smith	

INSTRUCTIONS

Please read the Department of Developmental Services California Code of Regulations, available from the regional centers, prior to completing this form. Type or print this form. Mail to the regional center serving your area.

Attach applicable information outlined in Title 17, Section 54310(a)(10)

(A) Any license, credential, registration or permit required for the performance of the service or operation of the program, or proof of application for such document;

(B) Any academic degree required for performance or operation of the service;

(C) Any waiver from licensure, registration, certification, credential, or permit from the responsible controlling agency;

(D) The proposed or existing program design as required in Section 56712 and Section 56762, if applicable, for applicants seeking vendorization as community-based day programs;

(E) The proposed or existing staff qualifications and duty statements as required in Sections 56722 and 56724 for applicants seeking vendorization as community-based day programs;

(F) The proposed or existing design as required in Section 56780 for applicants seeking vendorization as in-home respite services agencies;

(G) The proposed or existing staff qualifications and duty statements as required in Section 56792 for applicants seeking vendorization as in-home respite services agencies;

(H) The signed Home and Community-Based Services Provider Agreement with the Department of Health Services, if required.

** "Except for the Federal Tax ID or Social Security Number, all information provided by you on this form may be released to a member of the public pursuant to the Public Records Act, Section 6250 et seq. of the California Government Code."*

Vendor Appeals FAQ

These FAQs provide you with very basic information about vendor appeals. For additional information about vendor appeals, please read the vendor appeal information on DDS' website.

Q. What Can I Do If Regional Center Denies My Request for Vendorization?

A. Applicants who want to be a vendor may appeal any denial of a vendor application by following the below steps:

Step 1: An appeal is filed with the director of the regional center. You must file your appeal within 30 days of receiving the written denial. You will need to include specific information with your appeal – further details can be found on the DDS web page linked above.

The regional center director will issue a decision within 60 days of receiving your complete appeal package.

Step 2: If you are not satisfied with the regional center director's decision, you may appeal the decision to the Director of the Department of Developmental Services (DDS).

You file this appeal with the director of the regional center. You must file your appeal within 15 days of receipt of the regional center's decision. You will need to include specific information with your appeal – further details can be found on the DDS web page linked above. The regional center forwards the appeal to DDS within 15 days of receiving the appeal.

The DDS Director issues a decision within 60 days of receiving your appeal and all the information. A copy of the decision will be sent to you and the regional center within 15 days.

APPLICANT/VENDOR DISCLOSURE STATEMENT

GENERAL INSTRUCTIONS

Every applicant or vendor must complete and submit a current Applicant/Vendor Disclosure Statement, DS 1891 (disclosure statement) as part of a complete application packet for vendorization or upon request of the vendoring regional center. The following instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. See 42 CFR 455.101 for additional definitions.

Overall Authority: Code of Federal Regulations (CFR), Title 42, Part 455; California Code of Regulations, Title 17, Section 54311. Welfare and Institutions Code, Section 4648.12.

Important:

- **IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.**
- ***Parents and consumers of Vouchers, Participant-Directed Services, or Purchase Reimbursements:*** Complete Part 1 on page 2 and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date.
- Failure to disclose complete and accurate information will result in a denial of enrollment and/or may be cause for termination of vendorization.
- Read ***ALL*** instructions when completing the disclosure statement.
- Type or print clearly in ink.
- If applicant or vendor must make corrections, please line through, date, and initial in ink. Do not use correction fluid.
- Answer all questions as of the current date.
- If additional space is needed, attach a sheet referencing the part and question being completed.
- Return this completed statement with the complete application package to the regional center to which you are applying.

Part 1: Identifying Information

A. Specify name of the applicant or vendor, agency, facility or organization, vendor number and service code, business address, and telephone number of applicant or vendor submitting the vendor application.
B. Specify in what capacity the applicant or vendor is doing business. For example: The name of the corporation under which they are doing business. This name must match the license name, if applicable.
C. List the National Provider Identifier, of the applicant or vendor, if any.
D. List the Social Security Number, Date of Birth, and/or the Federal Employer Identification Number (EIN) of the applicant or vendor, if any. Enter Vendor's nine-digit EIN assigned by the IRS in the following format: XX-XXXXXXX.

- An EIN is used to identify the accounts of employers and certain others who have no employees.
- For more information about an EIN, please check http://www.irs.gov for "Employer Identification Numbers" or "EIN". Whenever this Disclosure Statement requests an EIN about an individual or entity, it has the same meaning.

E. Check the entity type that best describes the structure of your organization.

Part 2: Ownership and Control Interests. Use the following definitions to identify the individuals you should enter in A, B and C of this section. See 42 CFR 455.101 for additional definitions.

- "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in the applicant or vendor. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or vendor;
- "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, agency or business entity;
- "Ownership Interest" means the possession of equity in the capital, the stock, or the profits of the applicant or vendor.
- "Person with an Ownership or Control Interest" means a person or corporation that:
  - A) Has an ownership interest totaling 5 percent or more in an applicant or vendor;
  - B) Has an indirect ownership interest equal to 5 percent or more of an applicant or vendor;
  - C) Has a combination of direct or indirect ownership interests equal to 5 percent or more in an applicant or vendor;
  - D) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or vendor if that interest equals at least 5 percent of the value of the property or assets of the applicant or vendor;
  - E) Is an officer or director of an applicant or vendor that is organized as a corporation; or
  - F) Is a partner in an applicant or vendor that is organized as a partnership.
- "Significant Business Transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of an applicant or vendor's total operating expenses.

- "Subcontractor" means an individual, agency, or organization to which an applicant or vendor has contracted or delegated some of the management functions or responsibilities of providing services.
- "Wholly Owned Supplier" means a supplier whose total ownership interest is held by an applicant or vendor or by a person, persons, or other entity with an ownership or control interest in an applicant or vendor.

Part 3: Excluded Individuals or Entities. ***(See page 3. Must be disclosed if applicable.)***

"Excluded Individuals or Entities" means those individuals and entities that have been placed on either the U.S. Department of Health and Human Services Office of Inspectors' General (OIG) List of Excluded Individuals/Entities or the Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible Provider List of persons, or individuals and entities that have been convicted of a criminal offense related to involvement in any program under Medicare, Medicaid or the Title XX services program, or those individuals and entities that meet the criteria included in Title 17, Section 54311(a)(6).

Title 17, California Code of Regulations, Section 54311(a)(6)
(Criteria for Excluded Individuals or Entities)

The name, title and address of any person(s) who, as applicant or vendor, or who has ownership or control interest in the applicant or vendor, or is an agent, director, members of the board of directors, officer, or managing employee of the applicant or vendor, has within the previous ten years:
(A) Been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of an elder or dependent adult or child, or in any connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse; or
(B) Been found liable any civil proceeding for fraud or abuse involving any government program; or
(C) Entered into a settlement in lieu of conviction involving fraud or abuse in any government program.

PLEASE FILL OUT

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Part 1. Applicant/Vendor Information

A. Name of applicant or vendor, entity, agency, facility, or organization as reported to IRS:

Vendor Number and Service Code:

Business Address:

Telephone number (with area code):

B. Name registered with California Secretary of State, if any:

C. National Provider Identifier (NPI), if any:

D. Social Security Number (SSN), Date of Birth (DOB), and/or Federal Employer Identification Number (EIN), if any:

E. Check the entity type that best describes the structure of the applicant or vendor individual, business entity, agency, facility or organization: Check **only one** box:

- ◯ **Parent or Consumer *for Vouchers, Participant-Directed Services, or Purchase Reimbursements*** (Complete Part 1 above and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date).
- ◯ **Sole Proprietor (Unincorporated)**
- ◯ **General Partnership** ◯ **Limited Partnership** ◯ **Limited Liability Partnership**
- ◯ **Limited Liability Company: State of formation: _____**
- ◯ **Governmental**
- ◯ **Corporation: Corporate number: _____ State incorporated: _____**
- ◯ **Nonprofit – Check One:** ◯ **Unincorporated Association** ◯ **Religious/Charitable**
  ◯ **Corporation** ◯ **Other (specify): _____**

Part 2. Ownership, indirect ownership, and managing employee interests (If not applicable, please indicate.)

A. List the name(s), title(s), address(es), SSNs, and DOBs of individuals for organizations having direct or indirect ownership interests, and/or managing employees in the applicant/vendor (see instructions for definitions). Also list all members of a group practice. Attach additional pages as necessary to list all officers, owners, management and ownership individuals and entities.

Name	Title	Address	SSN	DOB

B. List those persons named in **'A'** above or **'Part 4. A'** below, that are related to each other as spouse, parent, child, or sibling.

Name	Relationship	Address

C. List the name, address, vendor number and service code, SSN, NPI and/or EIN of any other applicant or vendor in which a person with an ownership or controlling interest in the applicant or vendor also has an ownership or control interest of at least 5 percent or more. For example: Are any owners of the applicant or vendor also owners of Medicare or Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.)

Name	Address	Vendor Number and Service Code	SSN, NPI and/or EIN

Part 3. Excluded Individuals or Entities (If not applicable, please indicate.)

List the name, title, and address of any person, as applicant or vendor, or entity with an ownership or control interest, any agent, director, officer, or managing employee of the applicant or vendor who is an excluded individual or entity, as defined on page 2.

Name	Title	Address

Part 4. Subcontractor (If not applicable, please indicate.)

A. List the name, title, address, SSN, NPI and/or EIN of each person or entity with an ownership or control interest **in any subcontractor** in which the applicant or vendor has direct or indirect ownership of 5 percent or more. State percentage.

Name	Title	Address	Percentage	SSN, NPI and/or EIN

B. List the name, title, address, SSN, NPI and/or EIN of each **subcontractor or wholly owned supplier** in which the applicant or vendor has had any significant business transactions within 5 years of the application or request.

Name	Title	Address	SSN, NPI, and/or EIN

APPLICANT/VENDOR SIGNATURE

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become vendored, or if the service provider already is vendored, a termination of its vendorization.

By signing this disclosure statement, you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform the vendoring Regional Center, in writing, within 30 days of any changes or if additional information becomes available.

Name of Applicant/Vendor or Authorized Representative **Title**

Signature **Date**

Recordkeeping and Access to Records

Subject to the provisions of Title 17, California Code of Regulations, Section 54311 and Code of Federal Regulations, Title 42, Part 455.105, an applicant or vendored provider agrees to provide access for the review of any and all ownership disclosure information and/or documentation upon written request by the vendoring regional center, the Department of Developmental Services, the State Medicaid Agency, Department of Health Care Services, any State survey team, the Secretary of the United States Department of Health and Human Services, or any duly authorized representatives of the above named entities.

Privacy Statement

All information requested on the application and the disclosure statement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department of Developmental Services pursuant to 26 USC 6041. This information is required by the authority of Welfare and Institutions Code, Section 4648.12 and Title 17, California Code of Regulations, Section 54311. The consequences of not supplying the mandatory information requested are denial of vendorization as a regional center vendor or termination of vendorization. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, or licensing programs in other states.

This form will need to be completed every 2 years.

APPLICANT/VENDOR DISCLOSURE STATEMENT

GENERAL INSTRUCTIONS

Every applicant or vendor must complete and submit a current Applicant/Vendor Disclosure Statement, DS 1891 (disclosure statement) as part of a complete application packet for vendorization or upon request of the vendoring regional center. The following instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. See 42 CFR 455.101 for additional definitions.

Overall Authority: Code of Federal Regulations (CFR), Title 42, Part 455; California Code of Regulations, Title 17, Section 54311. Welfare and Institutions Code, Section 4648.12.

Important:

- **IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.**
- ***Parents and consumers of Vouchers, Participant-Directed Services, or Purchase Reimbursements:*** Complete Part 1 on page 2 and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date.
- Failure to disclose complete and accurate information will result in a denial of enrollment and/or may be cause for termination of vendorization.
- Read ***ALL*** instructions when completing the disclosure statement.
- Type or print clearly in ink.
- If applicant or vendor must make corrections, please line through, date, and initial in ink. Do not use correction fluid.
- Answer all questions as of the current date.
- If additional space is needed, attach a sheet referencing the part and question being completed.
- Return this completed statement with the complete application package to the regional center to which you are applying.

Part 1: Identifying Information

A. Specify name of the applicant or vendor, agency, facility or organization, vendor number and service code, business address, and telephone number of applicant or vendor submitting the vendor application.

B. Specify in what capacity the applicant or vendor is doing business. For example: The name of the corporation under which they are doing business. This name must match the license name, if applicable.

C. List the National Provider Identifier, of the applicant or vendor, if any.

D. List the Social Security Number, Date of Birth, and/or the Federal Employer Identification Number (EIN) of the applicant or vendor, if any. Enter Vendor's nine-digit EIN assigned by the IRS in the following format: XX-XXXXXXX.

- An EIN is used to identify the accounts of employers and certain others who have no employees.
- For more information about an EIN, please check http://www.irs.gov for "Employer Identification Numbers" or "EIN". Whenever this Disclosure Statement requests an EIN about an individual or entity, it has the same meaning.

E. Check the entity type that best describes the structure of your organization.

Part 2: Ownership and Control Interests. Use the following definitions to identify the individuals you should enter in A, B and C of this section. See 42 CFR 455.101 for additional definitions.

- "Indirect Ownership Interest" means an ownership interest in an entity that has an ownership interest in the applicant or vendor. This term includes an ownership interest in any entity that has an indirect ownership interest in the applicant or vendor;
- "Managing Employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, agency or business entity;
- "Ownership Interest" means the possession of equity in the capital, the stock, or the profits of the applicant or vendor.
- "Person with an Ownership or Control Interest" means a person or corporation that:
  - A) Has an ownership interest totaling 5 percent or more in an applicant or vendor;
  - B) Has an indirect ownership interest equal to 5 percent or more of an applicant or vendor;
  - C) Has a combination of direct or indirect ownership interests equal to 5 percent or more in an applicant or vendor;
  - D) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the applicant or vendor if that interest equals at least 5 percent of the value of the property or assets of the applicant or vendor;
  - E) Is an officer or director of an applicant or vendor that is organized as a corporation; or
  - F) Is a partner in an applicant or vendor that is organized as a partnership.
- "Significant Business Transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of an applicant or vendor's total operating expenses.

- "Subcontractor" means an individual, agency, or organization to which an applicant or vendor has contracted or delegated some of the management functions or responsibilities of providing services.
- "Wholly Owned Supplier" means a supplier whose total ownership interest is held by an applicant or vendor or by a person, persons, or other entity with an ownership or control interest in an applicant or vendor.

Part 3: Excluded Individuals or Entities. ***(See page 3. Must be disclosed if applicable.)***

"Excluded Individuals or Entities" means those individuals and entities that have been placed on either the U.S. Department of Health and Human Services Office of Inspectors' General (OIG) List of Excluded Individuals/Entities or the Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible Provider List of persons, or individuals and entities that have been convicted of a criminal offense related to involvement in any program under Medicare, Medicaid or the Title XX services program, or those individuals and entities that meet the criteria included in Title 17, Section 54311(a)(6).

Title 17, California Code of Regulations, Section 54311(a)(6)
(Criteria for Excluded Individuals or Entities)

The name, title and address of any person(s) who, as applicant or vendor, or who has ownership or control interest in the applicant or vendor, or is an agent, director, members of the board of directors, officer, or managing employee of the applicant or vendor, has within the previous ten years:
(A) Been convicted of any felony or misdemeanor involving fraud or abuse in any government program, or related to neglect or abuse of an elder or dependent adult or child, or in any connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse; or
(B) Been found liable any civil proceeding for fraud or abuse involving any government program; or
(C) Entered into a settlement in lieu of conviction involving fraud or abuse in any government program.

PLEASE FILL OUT

Save Form Reset Form

Part 1. Applicant/Vendor Information

A. Name of applicant or vendor, entity, agency, facility, or organization as reported to IRS:

Vendor Number and Service Code:

You will not have a vendor number. You can leave this blank.

Business Address:

Telephone number (with area code):

This will apply if you are a registered business entity such as an LLC or corporation.

B. Name registered with California Secretary of State, if any:

C. National Provider Identifier (NPI), if any:

This applies to healthcare providers registered with CMS. You can leave this blank.

D. Social Security Number (SSN), Date of Birth (DOB), and/or Federal Employer Identification Number (EIN), if any:

E. Check the entity type that best describes the structure of the applicant or vendor individual, business entity, agency, facility or organization: Check **only one** box:

Check the box that best describes you or your business.

- ◯ **Parent or Consumer *for Vouchers, Participant-Directed Services, or Purchase Reimbursements*** (Complete Part 1 above and Part 3 on page 3, then proceed to **Applicant/Vendor Signature** on page 4 to sign and date).
- ◯ **Sole Proprietor (Unincorporated)**
- ◯ **General Partnership** ◯ **Limited Partnership** ◯ **Limited Liability Partnership**
- ◯ **Limited Liability Company: State of formation: _____**
- ◯ **Governmental**
- ◯ **Corporation: Corporate number: _____ State incorporated: _____**
- ◯ **Nonprofit – Check One:** ◯ **Unincorporated Association** ◯ **Religious/Charitable**
  ◯ **Corporation** ◯ **Other (specify): _____**

Part 2 through 4 may not apply to you. Please read through carefully and complete if applicable.

Part 2. Ownership, indirect ownership, and managing employee interests (If not applicable, please indicate.)

A. List the name(s), title(s), address(es), SSNs, and DOBs of individuals for organizations having direct or indirect ownership interests, and/or managing employees in the applicant/vendor (see instructions for definitions). Also list all members of a group practice. Attach additional pages as necessary to list all officers, owners, management and ownership individuals and entities.

Name	Title	Address	SSN	DOB

B. List those persons named in **'A'** above or **'Part 4. A'** below, that are related to each other as spouse, parent, child, or sibling.

Name	Relationship	Address

C. List the name, address, vendor number and service code, SSN, NPI and/or EIN of any other applicant or vendor in which a person with an ownership or controlling interest in the applicant or vendor also has an ownership or control interest of at least 5 percent or more. For example: Are any owners of the applicant or vendor also owners of Medicare or Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.)

Name	Address	Vendor Number and Service Code	SSN, NPI and/or EIN

Part 3. Excluded Individuals or Entities (If not applicable, please indicate.)

List the name, title, and address of any person, as applicant or vendor, or entity with an ownership or control interest, any agent, director, officer, or managing employee of the applicant or vendor who is an excluded individual or entity, as defined on page 2.

Name	Title	Address

Part 4. Subcontractor (If not applicable, please indicate.)

A. List the name, title, address, SSN, NPI and/or EIN of each person or entity with an ownership or control interest **in any subcontractor** in which the applicant or vendor has direct or indirect ownership of 5 percent or more. State percentage.

Name	Title	Address	Percentage	SSN, NPI and/or EIN

B. List the name, title, address, SSN, NPI and/or EIN of each **subcontractor or wholly owned supplier** in which the applicant or vendor has had any significant business transactions within 5 years of the application or request.

Name	Title	Address	SSN, NPI, and/or EIN

APPLICANT/VENDOR SIGNATURE

Knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become vendored, or if the service provider already is vendored, a termination of its vendorization.

By signing this disclosure statement, you hereby certify and swear under penalty of perjury that (a) you have knowledge concerning the information above, and (b) the information above is true and accurate. You agree to inform the vendoring Regional Center, in writing, within 30 days of any changes or if additional information becomes available.

Name of Applicant/Vendor or Authorized Representative **Title**

John Smith

Signature **Date**

Recordkeeping and Access to Records

Subject to the provisions of Title 17, California Code of Regulations, Section 54311 and Code of Federal Regulations, Title 42, Part 455.105, an applicant or vendored provider agrees to provide access for the review of any and all ownership disclosure information and/or documentation upon written request by the vendoring regional center, the Department of Developmental Services, the State Medicaid Agency, Department of Health Care Services, any State survey team, the Secretary of the United States Department of Health and Human Services, or any duly authorized representatives of the above named entities.

Privacy Statement

All information requested on the application and the disclosure statement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department of Developmental Services pursuant to 26 USC 6041. This information is required by the authority of Welfare and Institutions Code, Section 4648.12 and Title 17, California Code of Regulations, Section 54311. The consequences of not supplying the mandatory information requested are denial of vendorization as a regional center vendor or termination of vendorization. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, or licensing programs in other states.

Conflict of Interest FAQs

Q. Why do I need to sign a conflict of interest form?

A. A conflict of interest form is signed by anyone who wants to be a regional center vendor. If you provide Self-Directed Services, you will be a regional center vendor and must complete the conflict of interest Form.

Q. What is a conflict of interest?

A. A conflict is a financial interest or a professional or personal relationship that makes it hard for a person to perform their duties in an impartial manner. The State has identified financial and professional or personal relationships that are a conflict of interest. These conflicts are listed on the conflict of interest Form. This form applies to any conflicts you or an immediate family member may have.

Q. Who is an immediate family member for purposes of the conflict of interest form?

A. An immediate family member includes your spouse, domestic partner, parents, stepparents, grandparents, siblings, stepsiblings, children, stepchildren, grandchildren, parents-in-law, brothers-in-law, sisters-in-law, sons-in-law, and daughters-in-law.

Q. How do I complete the conflict of interest form?

A. To complete the form, you must answer the questions that list possible conflicts of interest. If you check a box indicating a conflict you must provide more information. The completed form will help the regional center understand if you or your immediate family have any conflicts of interest.

After you answer the questions, you must certify that you: 1) reviewed the conflict of interest requirements, 2) have no conflicts or have disclosed any possible conflicts; and 3) understand the conflict of interest statements. You then sign the form and include it in your vendor packet.

Q. What happens after I submit the conflict of interest form?

A. The regional center will review the form. They will tell you if there are any conflicts of interest. They may ask you for more information. The regional center may also give you information about how you can resolve a conflict of interest. If you have a conflict and it cannot be resolved, you will not be able to be a vendor.

Q. Where can I get more information?

A. You can ask your regional center liaison if you have questions or need more information. The applicable conflict of interest rules are found in Title 17 of the California Code of Regulations Sections 54314 and Sections 54500-54535. They may be found here.

SELF-DETERMINATION PROGRAM: General Self-Directed Supports (099)

Conflict of Interest Form

Name:
Business Name (if applicable):
Address:
Phone:
Email:

Have you ever been vendored (i.e., been issued a vendor number) by this or any other Regional Center?

☐ Yes
Name:
Vendor Number:
Regional Center:
☐ No

Conflict of Interest Statement:
Section 54314 of California's Title 17 Regulations, prohibits individuals from being a vendor if you or a member of your or your immediate family meet one of the below criteria. If you are unsure whether your employment or other position creates a conflict, please consult with your regional center liaison.

a. An officer or employee of the State of California;
b. Any applicant in which an officer or employee of the State of California has a financial interest (as defined in the Government Code, Section 87103) in your business providing General Self-Directed Supports;
c. An employee or board member of any regional center and there is a conflict of interest pursuant to Title 17, Sections 54500 through 54535;
d. An individual or entity in which the regional center employee or board member has a relationship that creates a conflict of interest pursuant to Title 17, Sections 54500 through 5425.

Please complete the below questions to identify any conflicts of interest you may have:

1. Are you or any members of your immediate family an employee, on leave of absence, or an officer or employee of the following?
   ☐ State of California
   ☐ Department of Developmental Services
   ☐ Regional Center
   ☐ Regional Center Board of Directors
   ☐ State Developmental Center
   If you checked any of the above options, please provide name, relationship to applicant, and any other information relevant to above selection.

2. Does any officer or employee of the State of California have a financial interest in your business providing General Self-Directed Supports for individuals entering the Self-Determination Program?

   ☐ Yes

   ☐ No

   If you checked yes, please provide additional information:

3. Are there any relationships between you or an immediate family member and a regional center employee or board member that create a conflict of interest?

   ☐ Yes

   ☐ No

   If you checked yes, please provide additional information:

4. Are there any other circumstances or relationships for you or an immediate family member that you believe would create a conflict of interest in your provision of General Self-Directed Supports to a regional center consumer?

   ☐ Yes

   ☐ No

   If you checked yes, please provide additional information:

CERTIFICATION:

I have read the CCR Title 17 Regulations at dds.ca.gov, Sections 54500 through 54535, and certify that I either have no conflicts or have identified any possible conflicts above. I also certify that I understand the Conflict of Interest statement.

Applicant's Signature: Date:

OFFICE USE ONLY:

Applicants signature and affirmation indicate there does not appear to be a conflict of interest per CCR Title 17 Regulations:

Signature: Date:

Vendor #:

Business Associate Agreement FAQs

Q. What is the Business Associate Agreement?

A. This is an agreement between you and the regional center. It is about how you must protect and keep confidential records you receive or develop when providing Self-Directed Supports. You must comply with federal and state laws, including the federal Health Insurance Portability and Accountability Act (HIPPA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). These FAQs provide basic information about these requirements. Resources to obtain additional information is found at the end of this document.

Q. What Is Protected Health Information?

A. HIPAA defines Protected Health Information (PHI) as individually identifiable health information you created or received that relates to the past, present or future health needs of an individual. Regional center records that include information about the individual's disability are one example of PHI.

Health information is individually identifiable when it includes a unique identifier that matches a particular individual. Unique identifiers include, but are not limited to: date of birth, unique identification number, address, phone number or email.

Protected health information can be provided in writing, electronically or through a verbal communication. The same requirements to protect PHI apply regardless of how it is shared.

Q. If I provide Self-Directed Supports what are my responsibilities to protect PHI?

A. Your responsibilities fall into three broad categories:

1. You may not use or disclose a consumer's PHI except as allowed by your agreement with the regional center or required by law.

2. You must use appropriate safeguards to prevent the disclosure of a consumer's PHI, including electronic PHI.

3. You must notify the regional center and the Department of Development Services (DDS) of any privacy or security breach.

Q. When can I use or share protected health information?

A. You may only use or share PHI to perform the services you are providing as a Self-Directed Supports vendor. For example, you can share information when a regional center consumer or their legal representative signs a written authorization allowing the information to be shared. Under the Business Associate Agreement, you may also share information with the regional center.

Q. How do I safeguard PHI?

A. You must use appropriate safeguards to protect PHI. Examples of some ways to safeguard information are:

- Records with PHI must be maintained in a secured location;
- PHI can only be used to provide Self-Directed Support services;
- Discussions about PHI should only occur in a secure area, or in a low tone of voice so others do not overhear the discussion;
- Computers and fax machines must be located in a private location.

Q. What are my responsibilities if there is a disclosure of PHI that does not comply with the Business Associate Agreement?

A. You must provide a written notice to the regional center and DDS of any non-compliant disclosure of PHI. The notice must be made without unreasonable delay, and, in no event later than 24 hours after the discovery of the incident.

Q. Where can I get additional information about HIPAA?

To view the entire Security Rule, and for other additional helpful information, see the Centers for Medicare & Medicaid Services (CMS) website.

To view the entire Privacy Rule, and for other additional helpful information, see the Office for Civil Rights (OCR) website.

Vendor Name

Vendor Number

SELF-DETERMINATION PROGRAM: General Self-Directed Supports (099)

BUSINESS ASSOCIATE AGREEMENT / HIPAA

This Business Associate Agreement / HIPAA - Contractor ("**Agreement**"), effective as of 01/01/01 , is entered into by Enter name of regional center ("**RC**") and _____ ("**Contractor**"). Contractor and the RC are each referred to herein as a "**Party**," and collectively, the "**Parties**." The Parties enter into this Agreement in accordance with the following facts:

A. RC arranges for the provision of services to individuals with developmental disabilities ("**Consumers**"). In providing its services, RC acts as a Business Associate of the California Department of Developmental Services ("**Covered Entity**"). As a necessary part of arranging services to Consumers served by Covered Entity, RC may have access to Protected Health Information ("**PHI**") as such term is defined in the Health Insurance Portability and Accountability Act of 1996, as amended ("**HIPAA**"), and its Privacy and Security Rules.

B. Contractor is, or desires to be, vendored by RC to provide services to or for the benefit of RC's Consumers. Once Contractor is vendored, RC may elect to enter into one or more agreements with Contractor (each, a "**Service Provider Agreement**") to provide specific services to or for the benefit of specific Consumers.

C. Under each Service Provider Agreement, it is anticipated that Contractor may receive and use PHI from and related to RC's Consumers.

D. The purpose of this Agreement is to comply with the requirements of HIPAA, its associated regulations (45 CFR Parts 160-164), and the Health Information Technology for Economic and Clinical Health Act (the "**HITECH Act**"), Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (Pub.L. 111-5), as these laws may be amended, as well as any state law(s) or regulation(s) governing the privacy and security protections of confidential information created or received by Contractor pursuant to each Service Provider Agreement.

In consideration of the following mutual covenants, the Parties therefore agree as follows:

1. **DEFINITIONS**. Except as otherwise defined herein, any and all capitalized terms in this Agreement shall have the definitions set forth in HIPAA and its Privacy and Security Rules.

2. **OBLIGATIONS AND DUTIES OF CONTRACTOR**.

2.1 General. Contractor agrees not to use or disclose any Consumer's PHI other than as permitted or required by this Agreement or by applicable law.

2.2 Safeguard. In accordance with 45 CFR Part 164, Subpart C and 45 CFR §164.314(a)(2)(i)(A)&(B), Contractor agrees to use appropriate administrative, physical and technical safeguards to prevent the use or disclosure of any Consumer's PHI, including Electronic PHI other than as provided for by this Agreement.

2.3 Standard Transactions. Under HIPAA, the US Department of Health and Human Services has adopted certain standard transactions for the electronic exchange of health care data ("**Standard Transactions**"). If Contractor conducts any Standard Transactions on behalf of Covered Entity or RC, Contractor shall comply with the applicable requirements of 45 C.F.R. Parts 160-162. Contractor acknowledges that as of the effective date of this Agreement it may be civilly and/or criminally liable for failure to comply with the safeguards, policies, and procedure requirements, or any of the use and disclosure requirements, established by law.

2.4 Mitigation. Contractor agrees to mitigate, to the extent practicable and appropriate, any harmful effect that is known to Contractor of a use or disclosure of PHI by Contractor in violation of the requirements of this Agreement.

2.5 Agents; Subcontractors. Contractor agrees to ensure that its agents, including any subcontractor, to whom it provides PHI received from, or created or received by Contractor on behalf of Covered Entity or RC, agrees to the same restrictions and conditions applicable to Contractor with respect to such information.

2.6 Access to PHI by Covered Entity, RC or Consumer. Consumers have a right to access their PHI in a designated record set. A "**Designated Record Set**" is defined at 45 CFR 164.501 as a group of records maintained by or for a Covered Entity that comprises the (i) medical records and billing records about Consumers maintained by or for a Covered Entity, (ii) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan, or (iii) other records that are used, in whole or in part, by or for the Covered Entity to make decisions about Consumers. The term "**record**" means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for a Covered Entity. If applicable, and upon request by Covered Entity or RC, Contractor agrees to provide access to Covered Entity, RC or to a Consumer as directed by Covered Entity or RC, the PHI in a Designated Record Set within fifteen (15) days in order to meet the requirements under 45 C.F.R. section 164.524. In addition, as of the effective date of this Agreement, with respect to information contained in an Electronic Health Record, Contractor will provide access to such records in electronic format.

2.7 Amendments to PHI. If applicable, Contractor agrees to make any amendment(s) to PHI in a Designated Record Set as directed or agreed to by Covered Entity or RC pursuant to 45 C.F.R. section 164.526, and as requested by the Covered Entity, RC or a Consumer, within fifteen (15) days of receipt of a request. Any denials,

in whole or in part, of requested amendments shall be made by Contractor in accordance with 45 C.F.R. section 164.526.

2.8 Audit. Contractor agrees that the Secretary of the Department of Health and Human Services (the "**Secretary**") shall have the right to audit Contractor's internal records, books, policies, and practices relating to the use and disclosure of PHI received from, or created or received by Contractor on behalf of Covered Entity or RC, in a time and manner agreed to by the Parties, or as otherwise designated by the Secretary, for purposes of the Secretary determining compliance with the HIPAA Privacy Rule.

2.9 Documentation of Disclosed Information. Contractor agrees to document disclosures of PHI, and information related to such disclosures (collectively, "**Disclosed Information**"), as would be required for Covered Entity or RC to respond to a request by Consumer for an accounting of disclosures of PHI in accordance with 45 C.F.R. section 164.528, as amended from time to time. Contractor hereby agrees to take reasonable steps to enable it to comply with the requirements of this section and to notify RC of any such requests. Contractor shall promptly notify RC of the existence of any Disclosed Information.

2.10 Disclosure Accounting; Retention. Contractor agrees to provide Disclosed Information to Covered Entity, RC or to Consumer at Covered Entity's or RC's request, within fifteen (15) days of such request, in order to permit Covered Entity to meet its obligations in accordance with 45 CFR section 164.528. Contractor shall maintain Disclosed Information for six (6) years following the date of the event or incident to which such information relates.

2.11 Privacy or Security Breach.

2.11.1 In accordance with applicable law, Contractor agrees to give written notice (an "**Incident Notice**") to Covered Entity and RC of any (a) use or disclosure of PHI that is not in compliance with the terms of this Agreement, of which it becomes aware ("**Breach**") and (b) attempted or actual Security Incident (collectively with a Breach, an "**Incident**"). An Incident Notice shall be made without unreasonable delay and, in no event, later than twenty four (24) hours after discovery of such Incident, except where a law enforcement official determines that a notification would impede a criminal investigation or cause damage to national security as described in 45 C.F.R. § 164.412. In addition, an Incident Notice shall include (to the extent possible) the following information:

(a) identification of each Consumer whose Unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed during the Incident;

(b) the circumstances constituting and, to the extent relevant, surrounding the Incident (including, without limitation, the individual(s) causing the Incident and the person(s) receiving or accessing the PHI), the date of the Incident and date of discovery;

(c) the PHI affected or disclosed by the Incident on an individual Consumer-by-individual Consumer basis;

(d) the steps Contractor is taking to investigate and correct the Incident, mitigate harm or loss to affected Consumers, and protect against future similar Incidences,

(e) the actions which Consumers affected by the Incident should take to protect their interests; and

(f) a contact person for additional information.

2.11.2 Contractor shall cooperate with Covered Entity and RC in the investigation of the Incident, and in conducting any risk assessment necessary to determine whether notification of the Incident is required, and shall maintain, and provide at the direction of RC or Covered Entity, all reasonable and appropriate documents, files, records, or logs related to the Incident. For purposes of discovery and reporting of an Incident, Contractor agrees that it shall not be the agent of RC.

2.11.3 To the extent that any Incident involves a Breach of Unsecured PHI, and upon the request of RC or Covered Entity, Contractor shall provide notice to impacted Consumers, the media and the Secretary in the time and manner required by 42 U.S.C. § 17932 and 45 C.F.R. §§ 164.404, 164.406 and 164.408. Prior to providing any such notice, Contractor shall provide RC and Covered Entity with a reasonable opportunity to review and comment on such notice. Contractor shall maintain complete records regarding the Incident, the determination of whether notice is required and the issuance of the notice (including the recipients and content of such notice), and upon request, shall make such records available to RC and Covered Entity. Contractor shall also provide to Consumers affected by the Incident, upon the request of the Covered Entity or RC, such remedies as may be reasonably necessary or appropriate to mitigate the deleterious effects of the Incident including, without limitation, provision of credit report monitoring for a reasonable period of time. Any such remedies provided by Contractor pursuant to this section shall be at the sole expense of Contractor.

2.11.4 Notwithstanding Section 2.11.3 above, if RC or Covered Entity elects to provide the notice referenced in Section 2.11.3, Contractor shall promptly provide to RC and Covered Entity, the information required by 42 U.S.C. § 17932 and 45 C.F.R. §§ 164.404, 164.406 and 164.408, to the extent not previously provided in an Incident Notice.

2.11.5 Any annual notification to the Secretary as required under 42 U.S.C. § 17932(e) and 45 C.F.R. § 164.408(c), shall be provided by Covered Entity or RC, unless Covered Entity or RC directs Contractor to provide such notice within fifteen (15) days after the close of the calendar year. Contractor shall provide RC and Covered Entity a copy of the annual notification before it is provided to the Secretary sufficiently in advance of the due date to permit Covered Entity or RC to revise the notification as may be appropriate.

2.12 Genetic Information. Contractor shall not undertake any activity that may be considered underwriting based on genetic information, as defined by the Genetic Information Nondiscrimination Act and prohibited under the HIPAA Privacy & Security Rules.

2.13 Compliance. Contractor shall comply with all other privacy and security requirements made applicable to it by HIPAA, the HITECH Act and the HITECH Rules as promulgated by the Secretary. In addition, Contractor shall comply at all times with the requirements imposed on Covered Entity, RC and Contractor by state health information privacy laws including, without limitation, the Confidentiality of Medical Information Act (Cal. Civ. Code §56 *et seq*.) and the Lanterman-Petris-Short Act (Cal. Welfare & Inst. Code §5000 *et seq*.)

3. PERMITTED USES AND DISCLOSURES BY CONTRACTOR.

3.1 Business Relationship Activities. Except as otherwise limited in this Agreement, Contractor may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity and RC as specified in the ongoing contractual relationships among the Parties and Covered Entity, provided that such use or disclosure would not violate the HIPAA Privacy Rule or Security Rule if done by Covered Entity, nor violate the minimum necessary policies and procedures of the Covered Entity. For this purpose, the determination of what constitutes the "**minimum necessary**" amount of PHI shall be determined in accordance with 45 C.F.R. section 164.502(b), as amended by section 13405 of the HITECH Act. Without limitation of the foregoing, Contractor shall limit the use, disclosure, or request of PHI, to the extent practicable, to the Limited Data Set (as defined in 45 C.F.R. §164.514(e)(2)) or, if needed by Contractor, to the minimum necessary amount of PHI to satisfy the requirements of each applicable Service Provider Agreement.

3.2 Management and Administration of Contractor. Except as otherwise limited in this Agreement, Contractor may disclose PHI for the proper management and administration of Contractor, provided that disclosures are Required by Law, or Contractor obtains reasonable assurances from the person to whom the information is disclosed that such PHI will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person agrees to notify Contractor and RC within one (1) day of discovery of any Incident.

3.3 Data Aggregation. Except as otherwise limited by this Agreement, Contractor may disclose PHI to provide Data Aggregation services to Covered Entity or RC as permitted by 45 CFR 164.504(e)(2)(i)(B). Any aggregated data will be de-identified in compliance with 45 C.F.R. 164.502(d) before it is disclosed. Contractor agrees that it will not disclose any re-identification key or other mechanism to re-identify the data.

3.4 Remuneration. Contractor shall not directly or indirectly receive remuneration in exchange for any PHI unless informed by RC or Covered Entity that

Covered Entity has first obtained a valid authorization from the applicable Consumer that specifically allows PHI to be further exchanged for remuneration by the entity receiving such PHI, or the receipt of such remuneration complies with an otherwise available exception under HIPAA or the HITECH Act.

3.5 Violations of Law. Contractor may use PHI to report violations of law to appropriate federal and state authorities, consistent with 45 CFR 164.502(j)(1).

4. OBLIGATIONS AND DUTIES OF RC.

4.1 Notice of Privacy Practices. RC shall inform Contractor of any limitation(s) in Covered Entity's or RC's notice of privacy practices in accordance with 45 C.F.R. section 164.520, to the extent that such limitation(s), if any, may affect Contractor's use or disclosure of PHI. RC may satisfy this requirement by providing Contractor with the notices of privacy practices that Covered Entity and RC delivers in accordance with 45 C.F.R. section 164.520, as well as any changes to such notice.

4.2 Notice to Consumers of Permission. RC shall notify Contractor of any changes in, or revocation of, permission by a Consumer to use or disclose PHI which RC receives from Covered Entity, to the extent that such changes may affect Contractor's use or disclosure of PHI.

4.3 Notice of Other Restrictions. RC shall notify Contractor of any restriction to the use or disclosure of PHI which RC receives from Covered Entity to which Covered Entity has agreed in accordance with 45 C.F.R. section 164.522, to the extent that such restriction may affect Contractor's use or disclosure of PHI.

4.4 Impermissible Requests. RC shall not request Contractor to use or disclose PHI in any manner that would not be permissible under the HIPAA Privacy Rule if done by RC or Covered Entity.

5. TERM AND TERMINATION.

5.1 General. This Agreement shall remain in effect for so long as RC and Contractor are parties to one or more Service Provider Agreements and shall terminate when all of the PHI provided to Contractor, or created or received by Contractor, is destroyed or returned to RC or Covered Entity. If it is infeasible to return or destroy PHI as set forth above, the terms of this Agreement shall be extended to such PHI in perpetuity, in accordance with the termination provisions set forth below.

5.2 Termination for Cause. RC may terminate this Agreement for cause upon discovery of a material breach by Contractor as follows:

5.2.1 RC shall provide an opportunity for Contractor to cure the breach within ten (10) days from the date RC provides Contractor notice of the breach, or such longer period as may be agreed to by the Parties. If Contractor does not cure the breach within the cure period, then RC may immediately terminate this Agreement and any related Service Provider Agreement(s) in place between the Parties; or

5.2.2 RC may immediately terminate this Agreement, and any related Service Provider Agreement(s) in place between the Parties, if Contractor has breached a material term of this Agreement and cure is not possible; or

5.2.3 If neither termination nor cure is feasible, RC shall report the violation to Covered Entity and the Secretary.

5.3 Return of PHI. Upon termination:

5.3.1 Except as provided in paragraph 5.3.2 of this section, upon termination of this Agreement for any reason, Contractor shall return or destroy all PHI received from Covered Entity or RC, or created or received by Contractor on behalf of Covered Entity or RC. This provision shall apply to PHI that is in the possession of subcontractors or agents of Contractor. Contractor shall retain no copies of the PHI.

5.3.2 If Contractor determines that returning or destroying the PHI is not feasible or practicable, Contractor shall provide to Covered Entity and RC notification of the conditions that make return or destruction impossible or impracticable. Upon such notification, Contractor shall extend the protections of this Agreement to any retained PHI received hereunder and limit any further uses and disclosures to those purposes that make the return or destruction of the information impossible or impracticable for so long as Contractor maintains such PHI.

6. **GENERAL PROVISIONS**.

6.1 Notice. All notices, requests, and other communications given under this Agreement, shall be in writing and deemed duly given: (a) when delivered personally to the recipient; (b) one (1) business day after being sent to the recipient by reputable overnight courier service (charges prepaid); or (c) five (5) business days after being sent by U.S. certified mail (charges prepaid). Except as otherwise provided herein, all notices, requests or communications under this Agreement shall be addressed to the intended recipient as set forth below:

To RC:

RC Name:
RC Address:

To Contractor:

_____
Attention:
_____
_____

6.2 Regulatory References. A reference in this Agreement to any section in the HIPAA Privacy Rule or Security Rule, or the HITECH Act, means the section as presently in effect or as amended.

6.3 Amendment. The Parties agree to take reasonable action to amend this Agreement from time to time as is necessary for all Parties to comply with

the requirements of HIPAA, the HITECH Act, and all related, applicable state and federal laws.

6.4 Survival. The respective rights and obligations of Contractor under Sections 5 and 6 of this Agreement shall survive termination of this Agreement.

6.5 Interpretation. Any ambiguity in this Agreement shall be resolved to permit compliance with the HIPAA Privacy Rule and Security Rule, and the HITECH Act. If there is an inconsistency between the provisions of this Agreement and mandatory provisions of these statutes, the applicable statutory language shall control. Where provisions of this Agreement are different than those mandated by the applicable statutes, but are nonetheless permitted under the law, the provisions of this Agreement shall prevail.

6.6 Rights. Except as expressly stated herein, or the Parties to this Agreement do not intend to create any rights in any third parties, unless such rights are otherwise irrevocably established under HIPAA, or any other applicable law.

6.7 Assignment. No Party may assign its rights and obligations under this Agreement without the prior written consent of the other Party, except both Parties may assign this Agreement to any successors in interest, provided the assignor promptly notifies the other Party of such assignment.

6.8 Independent Parties. Contractor and its agents and employees, in performance of this Agreement, shall act in an independent capacity in the performance of this Agreement and not as officers or employees or agents of RC or Covered Entity. Contractor shall be wholly responsible for the manner in which Contractor and its employees perform the services required of Contractor by the terms of this Agreement. Contractor shall not be, or in any manner represent, imply or hold itself out to be an agent, partner or representative of RC. Contractor has no right or authority to assume or create in writing or otherwise any obligation of any kind, express or implied, for or on behalf of RC. The only relationship between Contractor and RC is that of independent contractors and neither shall be responsible for any obligations, liabilities, or expenses of the other, or any act or omission of the other, except as expressly set forth herein.

6.9 Indemnity. Contractor agrees to indemnify, defend and hold harmless RC and Covered Entity, and their respective employees, directors, officers, agents, subcontractors, or other members of their workforce (collectively, "**Indemnitees**") against all claims, demands, losses, damages or liability of any type or kind whatsoever, arising from or in connection with any breach of this Agreement or of any warranty hereunder or from any negligence or wrongful acts or omissions, including failure to perform its obligations under the Privacy Rule, the Standard Transactions and Code Sets Regulations, the Security Rule, HITECH or other state or federal health information privacy laws by Contractor. Accordingly, on demand, (i) Contractor at his own expense and risk, shall defend any suit, claim, action, legal proceeding, arbitration, or other mediation proceeding (each, an "**Action**"), that may be brought against the Indemnitees or any of them on any such claim or demand as set forth above (the Indemnitees need not have first paid any such claim in order to be so indemnified) and (ii) Contractor shall reimburse Indemnitees for any and all losses, liabilities, lost profits,

fines, penalties, costs or expenses (including reasonable attorneys' fees) that may for any reason be imposed upon Indemnitees as a result of any Action, with counsel reasonably satisfactory to RC. This Section shall survive the expiration or termination of this Agreement for any reason.

6.10 Interpretation; Venue; Jurisdiction. This Agreement shall be construed to comply with the requirements of the HIPAA Rules, and any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA Rules. All other aspects of this Agreement shall be governed under the laws of the State of California. All actions between the Parties shall be venued in the state or district courts of the .

6.11 Waiver. No change, waiver, or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, nor shall such action prohibit enforcement of any obligation on any other occasion.

6.12 Severability. If any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall remain in full force and effect. In addition, if either Party believes in good faith that any provision of this Agreement fails to comply with the then-current requirements of the HIPAA Privacy Rule or Security Rule, or the HITECH Act, such Party shall notify the other in writing. For a period of up to thirty (30) days, the Parties shall engage in good faith discussions about such concern and, if necessary, amend the terms of this Agreement so that it complies with the law. If the Parties are unable to agree upon the need for amendment, or the amendment itself, then either Party has the right to terminate this Agreement upon 30 days' written notice to the other Party.

6.13 Counterparts; Electronic Copies. This Agreement may be executed in counterparts, each which shall be deemed an original and all of which shall constitute a single instrument. Signed copies of this Agreement delivered by fax or in a PDF email file shall be deemed the same as originals.

Executed at , California, as of the date first set forth above.

RC:

RC Name:
RC Address:

CONTRACTOR:

_____

_____

[*State of Formation and Type of Entity*]

By: _____

Name: _____

Title: _____

Regional Center Executive
Director or Designee Signature:

HOME AND COMMUNITY BASED-SERVICES PROVIDER AGREEMENT

Name of Service Provider *(Please type or print)*

Address

Telephone	Vendor Number	Service Code

CERTIFICATION STATEMENT

The Provider agrees and shall certify under penalty of perjury that all claims for services provided to regional center clients have been provided to the clients by the Provider. The services were, to the best of the Provider's knowledge, provided in accordance with the client's written Individual Program Plan. The Provider shall also certify that all information submitted to the regional center is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

THE PROVIDER AGREES TO INCLUDE WITH EACH CLAIM SUBMITTED TO THE REGIONAL CENTER A CERTIFICATION STATEMENT TO THE ABOVE TERMS AND CONDITIONS WHICH SHALL BE PRINTED ON THE REVERSE SIDE OF EACH PROVIDER OF CARE CLAIM FORM.

I certify that the undersigned will be A PARTICIPATING provider of Medi-Cal home and community-based services upon SUBMISSION OF THIS AGREEMENT TO THE REGIONAL CENTER and satisfaction of all vendorization requirements pursuant to Title 17, California Code of Regulations, and compliance with the requirements for providers of service set out in Welfare and Institutions Code, Division 9, Part 3, and in California Code of Regulations, Title 22.

Department of Health Services

Signature of Service Provider	Date

(Rev. 6/99)

HOME AND COMMUNITY BASED-SERVICES PROVIDER AGREEMENT

Name of Service Provider *(Please type or print)*

Address

Telephone	Vendor Number	Service Code

You will not have a vendor number the first time completing this form. You can leave this blank.

CERTIFICATION STATEMENT

The Provider agrees and shall certify under penalty of perjury that all claims for services pro r clients have been provided to the clients by the Provider. The services were, to the best of the P rovided in accordance with the client's written Individual Program Plan. The Provider shall also certify that all information submitted to the regional center is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. The Provider agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Developmental Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, or their duly authorized representatives. The Provider also agrees that services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

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Department of Health Services

Signature of Service Provider	Date
John Smith	

(Rev. 6/99).

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

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

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

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

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

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

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

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

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Zero Tolerance for Consumer Abuse Policy
Service Provider Certification

As a service provider vendored with South Central Los Angeles Regional Center (SCLARC), I understand that I am a mandated reporter of suspected abuse and neglect. I certify that I am committed to providing a healthy environment for the consumers I serve and support. This includes protecting these individuals from abuse and neglect.

I have established a Zero Tolerance Policy for my organization's employees, contractors, families, volunteers, and participants. All are required to adhere to this policy. Abuse and neglect of any kind will not be tolerated. This includes physical abuse, mishandling of finances, inappropriate sexual behaviors, belittling or offensive verbalizations, abandonment, isolation, abduction/or the deprivation of services of any kind.

Upon becoming aware of an allegation of abuse or neglect, my employees and I will take immediate action to ensure the health and safety of the involved consumer and all other individuals receiving services and supports. All allegations of abuse will be investigated. Any employee accused of abuse or neglect will be immediately removed from having contact with consumers. If the investigation supports the allegation, the employee will be immediately terminated.

I also understand that my employees are mandated reporters. As such, we all required to report any reasonable suspicion or known abuse or neglect to SCLARC and ALL other applicable governmental authorities. This is to be done by telephone immediately, or as soon as practically possible, and by written report sent within two working days. Failure to report abuse is a misdemeanor, and is punishable with up to six months in county jail, and/or a fine of up to $1,000.00

All employees of this organization will be fully informed upon hire and annually thereafter regarding our Zero Tolerance Policy and mandatory abuse and neglect reporting laws. Each employee will be trained on their responsibility to protect consumers from abuse and neglect, the signs of abuse and neglect, the process of reporting suspected abuse or neglect, and the consequences of failing to follow the law or the organization's Zero Tolerance Policy.

I understand that SCLARC expects all service providers and long-term health care facilities to comply with this policy and reporting laws. SCLARC will utilize all remedies available to it in statute and regulations to protect health and safety of consumers. This organization will closely monitor the Zero Tolerance Policy and report its adherence to this policy annually to SCLARC.

Program/ Facility Name: _____

Print Vendor Name and Title: _____ Vendor Number: _____

Signature: _____ Date: _____

BOARD APPROVED: OCTOBER 12, 2013

Zero Tolerance for Consumer Abuse Policy

BACKGROUND

California has adopted various laws to protect children, dependent adults, and elder adults from various types of abuse and neglect. These laws also apply to regional center consumers. This policy concerns the application of such laws to people with developmental disabilities.

PURPOSE

The purpose of this policy is to protect the interests of SCLARC's consumers and their families by:

- Educating all mandated reporters about their legal obligation to report adult and child abuse (consumer abuse).
- Requiring mandated reporters to fully comply with the adult and child reporting laws (Reporting Laws).
- Providing information to assist mandated reporters in reporting consumer abuse to the proper authorities.

POLICY

South Central Los Angeles Regional Center is committed to ensuring the health, welfare, safety, and security of the stakeholders it serves. SCLARC has a "Zero Tolerance" Policy with regard to Consumer abuse an neglect. This means that every instance of observed, reported or suspected mistreatment of any Consumer will result in an immediate investigation and action to stop it and keep it from happening again.

Pursuant to the requirements in Article 1, Section 17 of SCLARC's contract with the State Department of Developmental Services:

1. SCLARC employees
2. SCLARC service providers
3. Employees of SCLARC service providers
4. Anyone who has assumed full or intermittent responsibility for the care or custody of a SCLARC Consumer, whether or not he or she receives compensation, including administrators, supervisors, or any licensed staff of a public or private facility that provides care or services for SCLARC Consumers, or any elder or dependent adult care custodian, health practitioner, or clergy member.

Must immediately report to SCLARC observed, actual or suspected mistreatment of any Consumer. Reports must also be made to the office of Adult Protective Services for adults, to the Department of Children and Family Services for minors, and the Long Term Care Ombudsman for those Consumers in long-term care facilities, or to law enforcement.

Observed or suspected or reported mistreatment of any Consumer means the following or anything like the following:

- Hitting, slapping, pinching, pushing, pulling, biting or anything that causes fear, pain or discomfort to a Consumer. This includes Consumer to Consumer interaction.
- Unreasonable physical constraint. (Reasonable actions taken to protect a Consumer or others from a Consumer's behaviors, taken in compliance with recognized and accepted behavior protocols, are not considered abuse, but they can become abusive if the intervention is more than is required to protect the Consumer and those around him or her.)
- Sexual abuse, which includes sexual touching of any kind and inappropriate, suggestive and/or offensive sexual talk to or around a Consumer. Name calling, demeaning, tormenting, threatening, mean teasing, yelling, harassing, or any other similar treatment.
- Disciplining by withholding food, water or preferred activities or causing pain, discomfort or trauma, even if in a purported behavior modification plan. Failure to exercise a reasonable degree of care, including but not limited to, a failure to assist in personal hygiene and the provision of food, water, clothing, or shelter, or failure to provide medical care for physical and/or mental health needs, or to protect the Consumer from health and safety hazards.
- Use of physical or chemical restraint or psychotropic medication under any of the following conditions:
  (1) For punishment
  (2) For a period beyond that for which the medication was ordered pursuant to the instructions of a physician and surgeon licensed in the State of California, who is providing medical care to the Consumer at the time the instructions are given.
  (3) For any purpose not authorized by the physician and surgeon.
- Failure to exercise the degree of care that a reasonable person would exercise in the position of having the care and custody of an elder or dependent adult or child.
- Wrongfully taking anything from a Consumer, including but not limited to possessions, money, or anticipated income.
- Denying Consumer rights, except in accordance with the requirements of section 50530 – 50540 of Title 17 of the California Code of Regulations. If you observe or suspect Consumer abuse.

If it is reported to you, you must:

- Immediately do what is reasonable and necessary to stop it and to protect the health and safety of all Consumers and others who could be harmed by it.
- Immediately report it to SCLARC by phone and in writing within 24 hours. Immediately report it to Adult Protective Services, Department of Children and Family Services or the Long Term Care Ombudsman, or,
- Immediately report it to law enforcement.
- Report it to your supervisor and/or the perpetrator's supervisor, as appropriate.

SCLARC will use all remedies available to protect the health and safety of its Consumers, including, but not limited to preventing any Consumer interactions by any individual accused of and being investigated for alleged Consumer abuse or neglect of any kind, until such time as investigation clears that individual for further work with Consumers. SCLARC may notify other regional centers of incidents involving Consumer health and safety issues or issues that may impact a provider's ability to provide services, in order to prevent further incidents.

SCLARC will ensure all of its employees and consultants are fully informed upon hire and will annually review this Zero Tolerance Policy. Each employee and consultant will be made fully aware that it is his or her responsibility to protect Consumers from abuse and neglect. They will be trained on signs of abuse and neglect, the process for reporting suspected abuse or neglect, and the consequences of failing to follow the law and failing to enforce the Zero Tolerance Policy.

Going forward, this policy will be part of every agreement with every SCLARC service provider. Each service provider will have their own Zero Tolerance Policy and ensure their employees and consultants are fully informed upon hire and annually thereafter about its Zero Tolerance Policy and mandatory abuse and neglect reporting laws. Each provider, employee and consultant will be made fully aware that it is his or her responsibility to protect Consumers from abuse and neglect. They will be trained on signs of abuse and neglect, the process of reporting suspected abuse or neglect, and the consequences of failing to follow the law and failing to enforce the Zero Tolerance Policy.

South Central Los Angeles Regional Center (SCLARC)
BOARD POLICY

Policy Title:	Whistleblower Policy
Policy Number:	051909
Date Approved:	November 15, 2022

BOARD COMMITTEE RESPONSIBLE FOR THIS POLICY:

The Executive Committee

PURPOSE:

This policy is established to ensure that consumers, families, service providers, agencies, community members, and regional center staff can report suspicions, concerns, or evidence of illegal, unethical or other inappropriate activity without fear of retaliation.

POLICY:

Definition of Regional Center or Vendor/Contractor Whistleblower Complaints:

Regional Center or Vendor/Contractor Whistleblower complaints are defined as the reporting of an "improper regional center or vendor/contractor activity".

- An "improper regional center activity" means an activity by a regional center or an employee, officer, or board member of a regional center, in the conduct of regional center business, that is in a violation of a state or federal law or regulation; violation of contract provisions; fraud or fiscal malfeasance; misuse of government property; or constitutes gross misconduct, incompetency, or inefficiency.

- An "improper vendor/contractor activity" means an activity by a vendor/contractor or an employee, officer, or board member of a vendor/contractor, in the provision of the Department of Developmental Services (DDS) funded services, that is in a violation of a state or federal law or regulation; violation of contract provisions; fraud or fiscal malfeasance; misuse of government property; or constitutes gross misconduct, incompetency, or inefficiency.

Complaint may be filed with SCLARC staff by contacting:

1. Executive Director – South Central Los Angeles Regional Center, 2500 South Western Ave., L.A., CA 90018, (213) 744-8412 dexterh@sclarc.org, Fax (213) 744-8412
2. Chief Financial Officer, kylal@sclarc.org, (213) 744-8480, Fax (213) 744-8480
3. Director, Consumer Supports Adult– jesser@sclarc.org, (213) 744-7003, Fax (213) 744-7003
4. Director, Consumer Support Children – jenicet@sclarc.org, (213) 744-8465, Fax (213) 744-8465
5. Director, Clinical – maricelc@sclarc.org, (213) 765-3891, Fax (213) 765-3891
6. Director, Community Services and Family Supports – cheryllem@sclarc.org, (213) 744-8454, (213) 744-8454
7. Human Resources Director – karmellw@sclarc.org, (213) 744-8425, Fax (213) 744-8425
8. Fair Hearing Manager – tamis@sclarc.org, (213) 744-8899, Fax (213) 744-8899

Complaints may also be filed with DDS contacting:

- Community Operations Division - (916) 651-6309, (916) 654-3641, 1215 O Street, MS 8-20, Sacramento, CA 95814; email: DDSACPS@dds.ca.gov.
- Early Start and Health Services Section (916) 654-2773, 1215 O Street, MS 7-40, Sacramento, CA 95814; email: earlystart@dds.ca.gov.

Filing a Complaint with the Board of Directors:

A complaint may also be filed with the President of SCLRC's Board of Directors by contacting: Jesus Murillo via SCLARC's Board Liaison sclarc-executive@sclarc.org or via telephone at (213) 744-8877.

Filing a Complaint Anonymously:

An anonymous complaint may be lodged by placing the complaint in the SCLARC mailbox located in the parking lot outside of its headquarters. Address the complaint to any of SCLARC staff listed above.

1. NO RETALIATION

No individual who reports a violation of the law shall suffer harassment, retaliation or adverse consequence. A SCLARC staff member who retaliates against someone who has reported a violation is subject to discipline up to an including immediate termination of employment. This Whistleblower Policy is intended to encourage and enabled consumers, families, service providers, agencies, community members, and SCLARC staff to report serious concerns within SCLARC prior to seeking resolution outside of the agency.

2. REPORTING VIOLATIONS

SCLARC has an open door policy and suggests that board members, directors, officers, employees and parents share their questions, concerns, suggestions or complaints, or evidence of wrongdoing, with someone who can address them properly. In most cases, an employee's supervisor is in the best position to address an area of concern. However, if an employee is not comfortable speaking with his/her supervisor or the employee is not satisfied with his/her supervisor's response, he/she is encouraged to speak with someone in the Human Resources Department or anyone in management whom he/she is comfortable in approaching. Supervisors and managers are required to report suspected violations of the Code to SCLARC's Human Resources Director who will determine if referral is needed to Executive Boards Member Committee, who have specific and exclusive responsibility to investigate all reported violations. For suspected fraud, or when a person is not satisfied or uncomfortable with reporting to the aforementioned people, or following the SCLARC's open door policy, individuals should contact the SCLARC's Executive Board Member Committee directly.

3. ACCOUNTING AND AUDITING MATTERS

The Executive Committee, comprised of officers from SCLARC's board of directors, shall address all reported concerns or complaints regarding corporate accounting practices, internal controls or auditing. The Executive Committee shall immediately notify Boards of Directors of any such complaint and work until the matter is resolved.

4. CONFIDENTIALITY

SCLARC will do everything possible to maintain the confidentiality of a complainant making a whistleblower complaint if the complainant requests confidentiality. However, in the rare circumstances where SCLARC is unable to maintain confidentiality due to its statutory

responsibilities (including ensuring the health and safety of consumers and regional center contract compliance), SCLARC will attempt to inform the complainant of its need to disclose certain information prior to releasing identifying information. Additionally, the identity of the complainant may be revealed to appropriate law enforcement agencies conducting a criminal investigation. All mandatory abuse reporting requirements will remain in effect as an exception to confidentiality.

5. NOTIFICATION OF WHISTLE BLOWER POLICY

SCLARC will notify employees, board members, consumers, families, and vendor community of both SCLARC's and the State Whistleblower policy within 30 days of SCLARC's effective date and annually thereafter by the following manner:

- Employees will receive an initial e-mail with attachments of the policies. Subsequently, employees will be reminded of the policy existence at the time they sign their annual performance evaluation policy review statement.

- Board Members will receive copies of the policies in their Board Packets and they will also receive an update during SCLARC's annual board meeting.

- Clients and families will receive a hard copy by mail their annual Services Cost Statement.

- The vendor community will receive copies in their invoices. Copies will also be distributed at the Vendor Advisory Committee Meeting.

- The Whistleblower Policy will be added to SCLARC's external website located at www.sclarc.org.

6. HANDLING OF REPORTED VIOLATIONS

A SCLARC Director or Executive Committee member will notify the sender and acknowledge receipt of the reported violation or suspected violation within five business days. All reports will be promptly investigated and appropriate corrective action will be taken if warranted by the investigation.

South Central Los Angeles Regional Center, Inc., reserves the right to employ its legal counsel in order to facilitate the investigation of complaints lodged against the regional center, its vendors or its staff.

WHISTLEBLOWER POLICY RECEIPT ACKNOWLEDGEMENT

South Central Los Angeles Regional Center (SCLARC) must ensure that its vendor community receives a copy of its Whistleblower Policy on an annual basis. A copy of the Board approved policy is attached to this document. After reading the policy, please complete this acknowledgement and return it to SCLARC.

My signature serves as acknowledgement that I have received a copy of SCLARC's whistleblower policy. I will share this information with staff and maintain a copy of the policy in my file for future reference.

Program/Facility Name: _____

Print Vendor Name and Title:_____

Signature: _____

Vendor Number and Service Code: _____ Date:_____

South Central Los Angeles Regional Center (SCLARC)
BOARD POLICY

Policy Title: Service Provider Insurance Policy

Policy Number: ####

Date Approved: November 14, 2023

BOARD COMMITTEE RESPONSIBLE FOR THIS POLICY:

The Executive Committee

PURPOSE:

The purpose of the Service Provider Insurance Policy is to protect the interest of the center's consumers and their families to ensure a safe and healthful environment to all individuals with a developmental disability that are provided services by a vendor or service provider. The Service Provider Insurance Policy establishes the minimum insurance requirements for all service providers utilized by the center to serve consumers.

RESPONSIBILITY:

The Community Services & Family Support Department shall have the overall responsibility to monitor compliance of the Service Provider Insurance Policy. All service providers shall ensure that they comply with the Service Provider Insurance Policy as outlined below.

POLICY:

This policy applies to all service providers that provide direct services and supports as defined by Welfare & Institutions Code (WIC), section 4512(b) or California Code of Regulations, section 54356, have access to consumer assets, transport consumers, or have hired one (1) or more employees.

A. All service providers shall obtain and maintain insurance coverage at the level established by the regional center to which the services are provided.

B. At minimum, all service providers shall obtain and maintain General Liability insurance with at least $1 million limit of liability per occurrence and name SCLARC as "additional insured."

C. All service providers who have hired one (1) or more employees shall maintain Worker's Compensation insurance for their employees.

D. At minimum, all service providers that provide direct care services and support shall maintain Professional Liability insurance of at least $1,000,000 limit of liability per claim and name SCLARC as "additional insured."

E. All service providers that provide direct care services and supports shall maintain Abuse & Molestation Liability insurance of at least $1,000,000 limit of liability per occurence and name SCLARC as "additional insured."

F. All service providers that have access to consumer assets shall maintain Bond insurance that provides sufficient coverage for the amount of the consumer's assets the service provider has control over.

G. All service providers that own or use vehicles in the course of their operations shall maintain Auto insurance that complies with the state of California's financial responsibility law(s).

H. In accordance with WIC, section 4648.3, all service providers of transportation services to regional center consumers for the regional center, shall maintain protection against liability for damages for bodily injuries or death and for damage to or destruction of property, which may be incurred by the provider in the course of providing those services. The protection shall be maintained at the level established by the regional center to which the transportation services are provided.

I. The center may require some service providers that own or use vehicles in the course of their operations to obtain Non-Owned & Hired Auto Liability insurance of a least $1,000,000 limit of liability per accident.

J. The center may require service providers to provide a higher level of insurance coverage to ensure the health and safety of consumers.

K. All service providers whose services are paid for by vouchers, as that term is defined in Welfare and Institutions Code 4512(i), are exempt from the requirement of maintaining General Liability insurance, Professional Liability insurance, Abuse & Molestation Liability insurance, and Bond insurance.

PROCEDURES:

A. All service providers shall provide a copy of their "certificate of insurance," which demonstrates compliance with the Service Provider Insurance Policy, to the center upon request of SCLARC's Community Services & Family Support Department.

B. Upon request of the Community Services & Family Support Department, service providers shall provide a copy of their "certificate of insurance" in accordance with the terms set forth in their contract and/or agreement with SCLARC. If the service provider does not have a contract and/or agreement with SCLARC which contains a timeline for providing "certificates of insurance" to SCLARC, then the service provider shall provide a copy of their "certificate of insurance" within ten (10) business days of any such request.

DEFINITIONS:

A. "Voucher" means any authorized alternative form of service delivery in which the consumer or family member is provided with a payment, coupon, chit, or other form of authorization that enables the consumer or family member to choose his or her own service provider. Welfare and Institutions Code 4512(i).

B. "Coverage at the level established by the regional center" means coverage based on the regional center needs and the program design of the vendor. Typically, the specifics of the required coverage will be provided in a Risk Profile Agreement.