

Review of the Fund for a Healthy Maine: Healthy Maine Partnerships

Melissa Fochesato, Director, Access Health

Jamie Comstock, Director, Bangor Public Health

Senator Brakey, Representative Gattine, and members of the Joint Standing Committee on Health and Human Services.

My name is Melissa Fochesato, Director of Access Health and with me is Jamie Comstock, Director of Bangor Public Health HMP, two of the state's 28 Healthy Maine Partnerships (HMPs). Access Health serves all of Sagadahoc County and the communities of Brunswick and Harpswell in Cumberland County. Bangor Public Health serves 13 towns in the Greater Bangor Region.

Thank you for the opportunity to share the funding, services, costs, people served and outcomes of the Healthy Maine Partnerships, who are implementing programs and strategies to reduce tobacco use, obesity and substance abuse across the State of Maine with support from the Fund for a Healthy Maine.

HMPs have a contract with Maine Center for Disease Control (MeCDC) and Maine Substance Abuse and Mental Health Services (SAMHS) to deliver tobacco, obesity and substance abuse prevention programming across the state of Maine, which we understand accounts for approximately 10 percent of the Fund for a Healthy Maine. This system, created by MeCDC in 2001, assures that each community in Maine is served by public health professionals, and allows all communities to have equal access to MeCDC and SAMHS tobacco use, substance abuse and obesity prevention programming. The system also includes community oversight. Each HMP is required to be governed by a Community Advisory Board. Advisory Board membership is submitted annually to MeCDC to ensure that they are representative of the communities served by the HMP.

Funding

The Healthy Maine Partnership Program receives approximately \$5 million per year from the Fund for a Healthy Maine. For the past three years, each HMP has annually received:

- \$120,000 for Tobacco and Obesity programming, overseen by MeCDC and
- \$15,000 for Substance Abuse Prevention programming, overseen by the Office of Substance Abuse and Mental Health Services (SAMHS)
- In addition, \$134,605 is awarded to one HMP in each of the eight Public Health Districts to support the Public Health District infrastructure, overseen by eight District Liaisons

Oversight and Accountability

In 2011, the first year of the current HMP contract, each HMP created a five-year plan that included long-term goals.

Each year, we submit detailed annual budgets and work plans proposing strategies and activities to meet these five-year goals. Before annual contracts are signed, budgets must be reviewed and approved by the Maine DHHS Division of Contract Management, SAMHS, and MeCDC

Program Managers to ensure they meet the grant guidelines. Work plans are also annually reviewed and approved by MeCDC and SAMHS Project Officers, as well as a Public Health District Liaison, to ensure plans meet the requirements and expectations of the funding.

Progress is monitored on a quarterly basis. Financial reports are submitted to the Division of Contract Management. Progress reports are submitted via a statewide web-based reporting system that is then accessed by our Project Officers. Financial and program progress reports are submitted by each HMP within 30 days of the quarter's end. Our project officers review the quarterly reports and provide feedback and technical assistance as needed.

We've included a copy of our contract in your packets today which outline annual expectations and reporting deadlines.

Services Provided

HMPs were developed, and continue to be an extension of MeCDC and SAMHS offices. MeCDC provides a menu of strategies that we use to create our work plans. Work plans are a balance of required strategies that are implemented statewide, and optional strategies that our Community Advisory Boards, based on data and local knowledge, can decide to implement. For example, we all offer free retail trainings to stores selling tobacco. In Sagadahoc County, we also decided to work with our towns to create smoke-free events (such as the Topsham Fair, Highland Games, and Bath Heritage Days) and parks - Topsham, Bath, Bowdoinham, and Brunswick have all adopted smoke-free ordinances and resolutions since we began five years ago. Bangor has worked to create tobacco-free campuses at the University of Maine, Dorothea Dix Psychiatric Center, and Husson University to name a few. Other HMPs may focus on beaches, multi-unit buildings, or schools that need extra assistance creating or implementing tobacco policies.

It is important to share that these work plans have become smaller as our budgets have shrunk. Since 2011, year one of our current contract, our menu of strategy choices has decreased. For example, we can no longer provide: early childhood staff trainings on promoting healthy eating and physical activity, social service staff trainings on talking to and coaching parents on tobacco use, cessation and protecting children from second hand smoke, assistance to restaurants who want to label healthy food offerings or increasing access to chronic disease screenings such as blood pressure and cholesterol screenings. Additionally, the School Health Coordinator program was cut, reducing HMPs ability to impact the lives of young people statewide.

Responsiveness and Flexibility

The flexibility of Healthy Maine Partnerships makes us unique and invaluable assets to Maine's public health system. If the State decides they need to change focus, this structure allows a quick change that can reach every town in Maine efficiently and effectively. For example, we are seeing a spike in e-cigarette use among teens. MeCDC can create an intervention and direct the HMPs to deliver it – in schools, in community settings, in worksites. If there is a flu epidemic, HMPs can assist public health nursing to organize clinics and communicate logistics. When there was a bath salt epidemic four years ago we were able to support our local law enforcement agencies by coordinating community forums that allowed them to educate the public and answer questions. In many states, this is the role of local County Health Departments. The HMP structure was created in 2001 to fill this void in our state.

Outcomes and effectiveness

The HMP structure is recognized as an effective best practice nationally. The University of New England uses this structure to implement SNAP education, funding each HMP to deliver nutrition education classes to SNAP eligible recipients in their county. SAMHS uses the structure to distribute federal substance abuse prevention funds, increasing each HMP's substance abuse prevention funding by \$48,160.

Thanks to community advisory board oversight, local data, and local public health expertise Access Health recently received two important federal Substance Abuse and Mental Health Services Administration (SAMHSA) grants – one for substance abuse prevention, and one to provide Youth Mental Health First Aid Training throughout our community.

We know HMPs have contributed to the plunge in Maine's youth tobacco and underage drinking rates, as measured by the National Youth Risk Behavior Survey (YRBS), administered by the US Centers for Disease Control and Prevention since 1995. According to the YRBS, Maine High School:

- Cigarette smoking has dropped from 39.2 percent in 1997 to 12.8 percent in 2013, and is now better than national average of 15.7 percent
- Smokeless tobacco use had decreased from 7.9 percent to 6 percent
- Youth under 18 who report buying cigarettes from stores is lower than the national average, 7.6 percent in Maine vs 18.1 percent nationally
- Underage drinking rates have dropped from 51.3 percent in 1997 to 26.6 percent in 2013, now better than the national average of 34.9 percent

In addition to the decrease in tobacco and substance use, after years of increase, Maine's youth obesity and overweight rates have remained steady.

We realize that these positive outcomes are not solely due to 28 HMPs with two to three health educators each. It is due to community and statewide coordination and collaboration, which is often the result of local HMP efforts.

In the Bangor area for example, HMP-organized collaboration led to a successful community response to bath salts. These relationships remain in place today and have been leveraged to address addiction issues in the region with the development of an 18-point plan to end substance abuse. Significant work on the plan has already been accomplished. I've mentioned Access Health's recent SAMHSA mental health awareness grant, which was a result of community concern about our higher than average youth depression and suicide contemplation rates and willingness of partners to support local community trainings. Our three year goal is to partner with Maine's National Alliance on Mental Illness (NAMI) to train 1,000 local adults in Youth Mental Health First Aid and decrease barriers to accessing care.

Though the work mentioned here is focused on substance abuse and mental health, it is an example of how relationships created through the Healthy Maine Partnership Initiative have much broader reach into the fabric and health of our communities.

Conclusion

Having a statewide HMP infrastructure to deliver evidence based public health strategies uses Maine's tobacco settlement funds as intended and is making Maine a healthier state. It is efficient, flexible, and has allowed communities across Maine to leverage millions of supplemental dollars to address local health needs and concerns.

Thank you.

Encumbrance #:
DHHS Agreement #:
Vendor/Customer #:

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CDC-16-342
VC1000065011

STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Agreement to Purchase Services

THIS AGREEMENT, made this 1st day of July, 2015, is by and between the State of Maine, Department of Health and Human Services, hereinafter called "Department," and Mid Coast Hospital - Addiction Resource Center, address 123 Medical Center Drive, Brunswick, ME 04011, hereinafter called "Provider", for the period of 7/1/15 to 6/30/16.

WITNESSETH, that for and in consideration of the payments and agreements hereinafter mentioned, to be made and performed by the Department, the Provider hereby agrees with the Department to furnish all qualified personnel, facilities, materials and services and in consultation with the Department, to perform the services, study or projects described in Rider A, and under the terms of this Agreement.

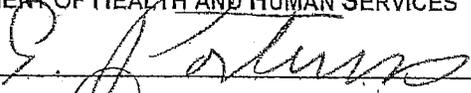
The following Riders and Attachments are hereby incorporated into this Agreement and made part of it by reference:

- Rider A - Specifications of Work to be Performed
- Rider B - Payment and Other Provisions
- Rider D - Additional Requirements
- Rider F - Budget; F-1 Agreement Settlement Form; F-2 Agreement Compliance Form
- Rider G - Identification of Country In Which Contracted Work Will Be Performed
- Rider I - Assurance of Compliance
- Rider - Exceptions
- Appendix A - Revised Programming Matrix
- Appendix B - Required Language for Support HMP Subcontracts
- Appendix C - District-wide HMP Infrastructure & Capacity Workplan
- Appendix D - Substance Abuse Prevention Strategy Matrix
- Appendix E - Guide to Assessment, Planning & Evaluation

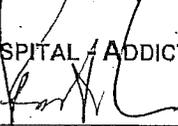
WITNESSETH, that this Agreement is consistent with Executive Order 01 FY 11/12 or a superseding Executive Order, and complies with its requirements.

IN WITNESS WHEREOF, the Department and the Provider, by their representatives duly authorized, have executed this agreement in one original copy.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

By: 
Alexander Porteous, Deputy Commissioner of Finance

MID COAST HOSPITAL / ADDICTION RESOURCE CENTER

By: 
Robert Mccue, Vice President of Finance

Total Agreement Amount: \$722,941.00

Approved: _____

Chair, State Procurement Review Committee

RIDER A

SPECIFICATIONS OF WORK TO BE PERFORMED

I. TABLE OF CONTENTS

Definitions
Introduction
Deliverables
Performance Measures
Reporting

II. DEFINITIONS

Alcohol Use/Abuse Prevention Services – Community-level evidenced-based prevention activities targeting underage drinking and high risk drinking that are implemented within Maine's cities and towns.

District Coordinating Councils – A representative districtwide body of local public health stakeholders established in M.S.R.A. 22 § 411 that works toward collaborative public health planning and coordination to ensure effectiveness and efficiencies in the public health system. District Coordinating Councils:

- a. Participate as appropriate in District-Level activities to help ensure the State public health system in each district is ready and maintained for accreditation; and
- b. Ensure that the essential public health services and resources are provided for in each district in the most efficient, effective and evidence-based manner possible

District Support Team – Composed of the District Project Officer, the District Liaison, the Substance Abuse Project Officer, and program specific staff providing oversight of the local Healthy Maine Partnership (HMP) program implementation and reporting.

Evidenced-Based Substance Abuse Prevention Strategies – Strategies that have been determined through national research and data analysis to be the most effective approaches in reducing substance use and abuse. These strategies are broken up into five (5) approaches: Environmental, Information Dissemination, Education, Problem Identification, and Referral, Community Based Process (see **Appendix D**).

Healthy Maine Partnership (HMP) – A comprehensive community health coalition, funded with special revenue dollars, that assists local agencies and organizations to develop and enact environmental changes which are intended to improve the health outcomes affected by tobacco, obesity, physical activity, nutrition, and substance abuse.

IMPACT® – A performance based reporting tool that is part of the Suite of Grants Management Software Services® through the Mosaix Company®. IMPACT is configured to allow the Department to comply with Federal reporting requirements, but

also to collect additional information necessary to monitor progress of Community-level implementation of prevention programs.

Lead Healthy Maine Partnership (HMP) – Identified as the Provider in this Agreement. Each of the Department's identified Public Health Districts has one (1) Lead HMP. In addition to meeting the programmatic requirements expected of all HMPs, Lead HMP's administer Agreement funding to the Support Healthy Maine Partnerships (Support HMPs) and are expected to serve as an exemplary HMP within their District, providing leadership to Support HMPs.

No Buts! Initiative – The Partnership For Tobacco Free Maine's training program for stores licensed to sell tobacco products; designed to prevent tobacco sales to underage youth. No Buts! is intended to increase awareness of tobacco retail personnel on State law regarding the sale of tobacco products and train them on asking customers for proof of age.

Public Health Infrastructure – The systems, competencies, frameworks, relationships, and resources that enable public health agencies to perform their core functions and essential services. Infrastructure categories encompass human, organizational, informational, legal, policy, and fiscal resources.

Star Store Initiative – The Partnership for Tobacco Free Maine's program designed to help licensed tobacco retailers reduce in-store tobacco product advertising that may appeal to youth.

Strategic Prevention Framework (SPF) Guide to Assessment – A document and resource guide created for community coalitions to complete their Community-Level Assessment, an assessment of conditions, health data, and partners related to substance abuse prevention, in preparation for selecting those activities best suited for addressing substance abuse prevention in their community. See <http://www.maine.gov/dhhs/samhs/osa/prevention/provider/index.htm> (**Appendix E**) for the most recent version of this tool.

Support Healthy Maine Partnership (HMP) – An HMP receiving funding through the Lead HMP via a subcontract. Support HMPs are required to meet the same programmatic requirements as Lead HMPs with some minor differences.

Tribal Health District – The Public Health District that includes all of Maine's Tribal nations. Also referred to as the Wabanaki Public Health District.

III. INTRODUCTION/OVERVIEW

This Agreement is for the purpose of providing health promotion, education and prevention services to support public health along with conducting activities in support of the public health infrastructure (as described in the Revised Programming Matrix (**Appendix A**) and accompanied by guidance issued by the Department). The Provider is being issued funds to conduct prevention work and to distribute them through subcontracts to Support HMPs so that they may also meet the requirements for the

expected deliverables. The Provider shall engage in three (3) programmatic areas: 1) Activities in support of infrastructure (see **Appendix C**); 2) Activities of substance abuse prevention (see **Appendix D & E**); and 3) activities in support of tobacco related prevention, healthy nutrition and increased physical activity (see **Appendix B**).

IV. DELIVERABLES

The Provider shall submit an approved workplan by August 15, 2015 that meets the following requirements:

SECTION 1: INFRASTRUCTURE SUPPORT AND CAPACITY DEVELOPMENT
<ul style="list-style-type: none"> A Section 1 Workplan that will be completely developed by August 31, 2015 (see Appendix C).
SECTION 2: SUBSTANCE ABUSE
<ul style="list-style-type: none"> Implement a minimum of four (4) evidenced-based prevention activities (see Appendix D) within the municipalities that make up the service area of the HMP, and which specifically focus on alcohol use/abuse prevention. The activities shall include: <ul style="list-style-type: none"> Two (2) environmental activities (See Appendix D, Pg. 2); and Two (2) activities from Appendix D of the Coalition's choice based on the Provider's assessment. <i>- Provided by Kristina [unclear], SAMHS</i>
SECTION 3: TOBACCO
<ul style="list-style-type: none"> From Appendix A implement Objective PTM 1 and Objective PTM 2, and a choice of Objective PTM 3, or Objective PTM 4 for a total of three (3) tobacco-related non-school objectives. Implement a minimum of two (2) strategies from each selected objective annually, for a minimum total of six (6) strategies.
SECTION 4: OBESITY
<ul style="list-style-type: none"> From Appendix A implement Objectives OB 1 and a choice of Objective OB 2, or Objective OB 3, for a total of two (2) obesity-related, non-school objectives. Implement Strategy OB 1.1: Increase by <u>X</u> the number of municipalities completing the Rural Active Living Assessment (RALA), an evidence-based tool designed to identify characteristics of a community that encourage physical activity. Implement a minimum of two (2) strategies from each selected community focused objective annually, for a minimum total of four (4) strategies.
SECTION 6: SCHOOL ADMINISTRATIVE UNITS (SAU)
<ul style="list-style-type: none"> From Appendix A implement all school objectives at the Maine Department of Education defined School Administrative Unit-level Select a new School Administrative Unit (SAU) each year to work with. Where work has not been completed in a SAU selected for the previous year, work must continue with that SAU in addition to work in the SAU newly selected. Where the Provider has less than three (3) SAUs in their local service area, the requirement is that the Provider work in all SAUs.

*→ Kristina
Finney
8/5/15 email
Old
work
P102*

The Provider also shall:

1. Divide funding for the work defined in **Appendix C** amongst all HMPs within the Health District in accordance with the **Appendix C** workplan guidance

issued by the Department's District Liaison assigned to the Provider's Public Health District.

2. Develop and implement subcontracts following according to Section 10 of Rider D, and using the language provided in **Appendix B** for each Support HMP for their own programmatic work in support of the health promotion, education, and prevention services defined in **Appendix A** to be delivered.
3. Use the Lead and Support HMP Strategic Prevention Framework Assessments from Spring 2015 (which includes data analysis) to assist each HMP in identifying needs and capacity that will allow each community to target its resources and maximize its impact on substance use/abuse.
4. Ensure that each HMP will deliver tobacco, substance abuse, physical activity and nutrition services to all communities within its service area. HMPs are expected to coordinate these services, assuring the most efficient use of funds and effective application of programming.
5. Coordinate with District Liaisons and the Department's Project Officers to assure that guidance and technical assistance necessary to meet all Agreement expectations is available to Support HMPs.
6. Notify the Department's Project Officer in writing if and when potential or real issues arise that have the potential to adversely affect the initiative in the District. This may include the actions of Support HMPs.
7. Work closely and cooperatively with the District Support Team, the SAMHS Prevention Manager and the Senior Program Manager for Community Based Prevention to review and correct problematic situations.
8. Work closely and cooperatively with the Department in the event that actions become necessary to address underperformance of a Support HMP.
9. Continue to maintain all subcontracts for Support HMPs except in the event of dissolution of a Support HMP, or with the explicit permission of Department's HMP Sr. Program Manager to release the contract.
10. Use sound fiscal management practices in monitoring the performance of subcontracting HMPs.
11. Include in subcontracts for the Support HMPs a requirement that Support HMPs provide the Lead HMP access codes to the IMPACT Monitoring System in order to be able to monitor the presence of quarterly and other reporting.

HMPs are required to:

1. Meet expected deliverables and milestones within the approved timelines identified in this Agreement, make use of technical assistance as necessary, and implement any plan of correction developed to remediate underperformance.
2. Maintain an HMP Governance or Advisory Board comprised of local stakeholders, which as a body directs and oversees the work of the paid staff, and whose members are identified in the Coalition Characteristics reporting section of the IMPACT monitoring system, that is representative of their local service area and that includes at least two (2) individuals representing populations with health disparities. Board members representing populations with health disparities should be members of that specific population; in the lieu of meeting this condition, representatives may be drawn from agencies that provide significant services to such populations. This Governance or Advisory Board must maintain an Advocacy Committee, charged with identifying the health needs of the HMP service area and working to assure

they are met, and a Board Development Committee, charged with identifying new potential members of the Board and recruiting them. It is the Department's requirement that this Governance or Advisory Board be distinct from paid staff, and that this Governance or Advisory Board oversees and directs the strategic direction of the HMP and the implementation of the HMP's work plan. The Department expects HMP Directors to keep the Governance or Advisory Board informed of their progress on deliverables, for example by providing quarterly updates regarding overall progress on Agreement deliverables, and on deliverables that are not met or behind schedule.

3. Maintain a mutual agreement identified as a Memoranda of Understanding (MOU) that defines the relationship between the agency that holds the contract for HMPs not incorporated as a 501-c(3) (fiscal agent) and the HMP Advisory Board. Wherever possible, the fiscal agent shall participate in the work of the HMP and hold membership on the District Coordinating Council (DCC).
4. Complete a Community-level Assessment to determine for the HMP service area community what contributing factors of alcohol abuse are of greatest concern in the community (ex. access, availability, etc.). In order to do so, the Provider shall utilize the SPF Guide to Assessment (Appendix E) as a resource for this assessment and complete an Assessment Summary capturing the key points found through the assessment, a Logic Model illustrating the resources, short, intermediate, and long term outcomes, and the intended impact of the work, and Strategy Selection Matrix identifying the strategies selected by the HMP to address substance abuse, to help them determine how they will implement alcohol use/abuse prevention services in their community.
5. Participate in Statewide communication campaigns and other initiatives developed by the State partners of the HMP.
6. Talk directly with schools about participating in the Department's Maine Integrated Youth Health Survey, the primary data collection instrument used to assess the health of Maine youth.
7. Work with the Department's contracted evaluators to complete evaluation activities that apply to services performed under this Agreement. This includes, but is not limited to, participating in evaluation activities such as site visits, complying with requests for program documentation, participation in surveys, and telephone interviews.
8. Use appropriate State logo and credits on all publications/brochures/marketing materials used to meet the terms of this Agreement in accordance with the Department's requirements to be disseminated in guidance issued by the Department.
9. Immediately notify the Department Project Officer in writing if there are any changes in key staff such as the Partnership Director or Substance Abuse lead.

V. PERFORMANCE MEASURES

Note: Performance Deliverables are determined using the average expected change for one year. Baseline is defined as the number of target settings in which the expected change had already been accomplished at the beginning of the grant period.

I. Required Standards:	II. Information Used to Track/Monitor Completion of Column I.:	III. Source of Information of Column II. (e.g. Name of report, on-site visit, data extraction from particular database, Department-obtained report 3 rd party (such as APS), etc.):
5 percent over Baseline of active retail settings that are enrolled in the Department's No Butts! Initiative.	Number of licensed tobacco retailers enrolled in No Butts!	PTM No Butts! database
39 percent over Baseline of retail settings that newly enroll in the Department's Star Store Initiative.	Number of licensed tobacco retailers enrolled in Star Store	PTM Star Store database
6 percent over Baseline of multi-unit residential settings that enact new smoke free policies or revise existing policies.	Number of multi-unit residential buildings that enact smoke free policies	IMPACT report
18 percent over Baseline of municipalities that enact policies and/or ordinances that address smoking in municipally sponsored open air events.	Number of municipalities that enact policies and/or ordinances that address smoking at open air events	IMPACT report
39 percent over Baseline of municipalities that have policies, plans and/or ordinances that promote healthy living in the built environment (the built environment includes all of the physical parts of where people live and work; e.g., homes, buildings, streets, open spaces, and infrastructure).	Number of municipalities that enact policies that address healthy living in the built environment.	IMPACT report
36 percent over baseline of sites that newly offer free access to physical activity opportunities	Number of sites that newly pass policies or cooperative agreements that allow physical activity	IMPACT report
62 percent over baseline of municipalities that	Number of municipalities that enact policies that increase	IMPACT report

newly increase access to healthy food options at municipally run venues	access to healthy food options at municipally run venues	
8 percent of schools over baseline that newly implement comprehensive tobacco policies that meet PTM criteria	Number of schools over baseline that implement comprehensive tobacco policies	IMPACT report
13 percent of schools over baseline that implement comprehensive Wellness policies	Number of schools over baseline that implement comprehensive Wellness policies	IMPACT report
Department staff receives from the Provider a final SPF assessment and Substance Abuse Prevention Services workplan by August 15, 2015.	Completed FINAL Substance Abuse Prevention Services community assessment and work plan regarding alcohol use by August 15, 2015.	Completed FINAL Substance Abuse Prevention Services community assessment and work plan regarding alcohol use by August 15, 2015.

VI. REPORTS

HMPs shall comply with all data and reporting requirements utilizing the identified HMP monitoring tool and any complementary reporting tools developed by the Department, meeting the deadlines provided.

Name of Report or On-Site Visit:	Description or Appendix #:
1. Quarterly Fiscal Report	1. Located at: http://www.maine.gov/dhhs/contracts/contract-2016/index.html
2. Monthly Prevention Performance Measure IMPACT Report	2. Monthly IMPACT report
3. Quarterly Prevention Performance Measure IMPACT Report	3. Quarterly IMPACT Summary
4. Agreement Closeout Report	3. DHHS Closeout report Located at: http://www.maine.gov/dhhs/contracts/contract-2016/index.html

A. Reporting Schedule

The Provider shall submit reports in accordance with the specifications of the Department, according to the following schedule:

Name of Report or On-Site Visit:	Schedule:
1. Quarterly Fiscal Report	1. Due Thirty (30) days following last day of each quarter; October 30, 2015, January 30, 2016, April 30, 2016, July 30, 2016.
2. Quarterly Prevention Performance Measure IMPACT Report	2. Due thirty (30) days following last day of each quarter; October 30, 2015, January 30, 2016, April 30, 2016, July 30, 2016.
3. Agreement Closeout Report *	3. Sixty (60) days following the close of the Agreement period.

* The original copy of the Final Agreement Closeout Report along with a check payable to Treasurer, State of Maine for any surplus balance must be sent to: DHHS Service Center, 221 State Street SHS#11, 3rd Floor – SSC-ACR, Augusta, ME 04333-0011.

The Provider understands that the reports are due within the timeframes established and that the Department will not make subsequent payment installments under this Agreement until such reports are received, reviewed and accepted.

The Provider further agrees to submit such other data and reports as may be requested by the Agreement Administrator. The Provider shall submit all data and reports to the Department in accordance with Section 6 of Rider B of this Agreement.

The Provider further agrees that any final budget revision shall be submitted no later than sixty (60) days prior to the agreement end date.

RIDER B

PAYMENT AND OTHER PROVISIONS

1. AGREEMENT AMOUNT: \$722,941.00

The sources of funds and compliance requirements for this Agreement follow:

A. Dedicated/Special Revenue \$642,941.00

B. Federal Funds \$80,000.00

CFDA# & Description (CFDA Title, award name, award no., federal awarding agency): 93.959, 2B08TI010025-14. \$20,000.00

CFDA# & Description (CFDA Title, award name, award no., federal awarding agency): 93.959, 2B08TI010025-15. \$60,000.00

2. INVOICES AND PAYMENT. The Department will pay the Provider as follows:

The Provider shall divide funding for the work defined in **Appendix C** amongst all HMPs within the health District in accordance with the **Appendix C** workplan guidance issued by the Department's District Liaison assigned to the Provider's district.

The Provider shall divide the substance abuse prevention funds equally among all HMPs within the district.

The Provider shall not reduce funding amounts provided for subcontracts for Support HMPs in order to pay indirect costs; the Provider is being issued funds to cover costs associated with administering subcontracts with Support HMPs. The Provider is prohibited from charging additional overhead costs to Support HMPs. Any proposed reduction in funds to Support HMPs must have approval in writing from the Department's Sr. Program Manager for Community Based Prevention.

The Department shall pay the Provider twelve monthly payments; the total amount of the payments will not exceed the Agreement amount. Payments may be adjusted on a quarterly basis, based upon the level of expenditures as reported on the quarterly financial reports as indicated in Rider A.

Payments may be delayed or adjusted when:

- A. The Provider has not submitted required program and fiscal reports.
- B. There is an under expenditure of budgeted funds or under delivery of services amounting to the lesser of:
 - a. 10% or more of the total Agreement for 3 consecutive months
 - b. \$50,000 or more.
- C. Services have been provided to ineligible recipients.
- D. An audit finding shows that the Provider holds an overpayment from a prior Agreement.
- E. The Provider has not met obligations for prior agreements for which this is a renewal.

- F. Other circumstances where, in the judgment of the Agreement Administrator, delay or reduction of payment is appropriate.

Payments are subject to the Provider's compliance with all items set forth in this Agreement and subject to the availability of funds.

3. **BENEFITS AND DEDUCTIONS**. If the Provider is an individual, the Provider understands and agrees that he/she is an independent contractor for whom no Federal or State Income Tax will be deducted by the Department, and for whom no retirement benefits, survivor benefit insurance, group life insurance, vacation and sick leave, and similar benefits available to State employees will accrue. The Provider further understands that annual information returns, as required by the Internal Revenue Code or State of Maine Income Tax Law, will be filed by the State Controller with the Internal Revenue Service and the State of Maine Bureau of Revenue Services, copies of which will be furnished to the Provider for his/her Income Tax records.

4. **INDEPENDENT CAPACITY**. In the performance of this Agreement, the parties hereto agree that the Provider, and any agents and employees of the Provider, shall act in the capacity of an independent contractor and not as officers or employees or agents of the State.

5. **DEPARTMENT'S REPRESENTATIVE**. The Agreement Administrator shall be the Department's representative during the period of this Agreement. He/she has authority to curtail services if necessary to ensure proper execution. He/she shall certify to the Department when payments under the Agreement are due and the amounts to be paid. He/she shall make decisions on all claims of the Provider, subject to the approval of the Commissioner of the Department.

6. **AGREEMENT ADMINISTRATOR**. All progress reports, correspondence and related submissions from the Provider shall be submitted to:

Name and Title: Stacy McCurdy, Contract Administrator
Address: 11 SHS, 211 State Street
Augusta, ME 04333-0011
Telephone: 207-287-6414
E-mail Address: Stacy.J.McCurdy@maine.gov

who is designated as the Agreement Administrator on behalf of the Department for this Agreement, except where specified otherwise in this Agreement.

The following is designated as the Program Administrator for this Agreement and shall be responsible for oversight of the programmatic aspects of this Agreement.

Name and Title: Andrew Finch Sr. Program manager
Maine Center for Disease Control and
Prevention
Address: 286 Water St, Key Bank Bldg, SHS #11
Augusta ME 04333-0011
Telephone: 207-287-3886
E-mail Address: Andrew.Finch@maine.gov

7. **CHANGES IN THE WORK**. The Department may order changes in the work, the Agreement Amount being adjusted accordingly. Any monetary adjustment or any substantive change in the

work shall be in the form of an amendment, signed by both parties and approved by the State Purchases Review Committee. Said amendment must be effective prior to execution of the work.

8. **SUB-AGREEMENTS**. Unless provided for in this Agreement, no arrangement shall be made by the Provider with any other party for furnishing any of the services herein contracted for without the consent and approval of the Agreement Administrator. Any sub-agreement hereunder entered into subsequent to the execution of this Agreement must be annotated "approved" by the Agreement Administrator before it is reimbursable hereunder. This provision will not be taken as requiring the approval of contracts of employment between the Provider and its employees assigned for services thereunder.

9. **SUBLETTING, ASSIGNMENT OR TRANSFER**. The Provider shall not sublet, sell, transfer, assign or otherwise dispose of this Agreement or any portion thereof, or of its right, title or interest therein, without written request to and written consent of the Agreement Administrator. No subcontracts or transfer of agreement shall in any case release the Provider of its liability under this Agreement.

10. **EQUAL EMPLOYMENT OPPORTUNITY**. During the performance of this Agreement, the Provider agrees as follows:

- a. The Provider shall not discriminate against any employee or applicant for employment relating to this Agreement because of race, color, religious creed, sex, national origin, ancestry, age, physical or mental disability, or sexual orientation, unless related to a bona fide occupational qualification. The Provider shall take affirmative action to ensure that applicants are employed and employees are treated during employment, without regard to their race, color, religion, sex, age, national origin, physical or mental disability, or sexual orientation.

Such action shall include but not be limited to the following: employment, upgrading, demotions, or transfers; recruitment or recruitment advertising; layoffs or terminations; rates of pay or other forms of compensation; and selection for training including apprenticeship. The Provider agrees to post in conspicuous places available to employees and applicants for employment notices setting forth the provisions of this nondiscrimination clause.

- b. The Provider shall, in all solicitations or advertising for employees placed by or on behalf of the Provider relating to this Agreement, state that all qualified applicants shall receive consideration for employment without regard to race, color, religious creed, sex, national origin, ancestry, age, physical or mental disability, or sexual orientation.
- c. The Provider shall send to each labor union or representative of the workers with which it has a collective bargaining agreement, or other agreement or understanding, whereby it is furnished with labor for the performance of this Agreement a notice to be provided by the contracting agency, advising the said labor union or workers' representative of the Provider's commitment under this section and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
- d. The Provider shall inform the contracting Department's Equal Employment Opportunity Coordinator of any discrimination complaints brought to an external regulatory body (Maine Human Rights Commission, EEOC, Office of Civil Rights) against their agency by any individual as well as any lawsuit regarding alleged discriminatory practice.
- e. The Provider shall comply with all aspects of the Americans with Disabilities Act (ADA) in employment and in the provision of service to include accessibility and reasonable accommodations for employees and clients.

- f. Providers and subcontractors with Agreements in excess of \$50,000 shall also pursue in good faith affirmative action programs.
- g. The Provider shall cause the foregoing provisions to be inserted in any subcontract for any work covered by this Agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

11. **EMPLOYMENT AND PERSONNEL.** The Provider shall not engage any person in the employ of any State Department or Agency in a position that would constitute a violation of 5 M.R.S.A. § 18 or 17 M.R.S.A. § 3104. The Provider shall not engage on a full-time, part-time or other basis during the period of this Agreement, any other personnel who are or have been at any time during the period of this Agreement in the employ of any State Department or Agency, except regularly retired employees, without the written consent of the State Purchases Review Committee. Further, the Provider shall not engage on this project on a full-time, part-time or other basis during the period of this Agreement any retired employee of the Department who has not been retired for at least one year, without the written consent of the State Purchases Review Committee. The Provider shall cause the foregoing provisions to be inserted in any subcontract for any work covered by this Agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

12. **STATE EMPLOYEES NOT TO BENEFIT.** No individual employed by the State at the time this Agreement is executed or any time thereafter shall be admitted to any share or part of this Agreement or to any benefit that might arise there from directly or indirectly that would constitute a violation of 5 M.R.S.A. § 18 or 17 M.R.S.A. § 3104. No other individual employed by the State at the time this Agreement is executed or any time thereafter shall be admitted to any share or part of this Agreement or to any benefit that might arise there from directly or indirectly due to his employment by or financial interest in the Provider or any affiliate of the Provider, without the written consent of the State Purchases Review Committee. The Provider shall cause the foregoing provisions to be inserted in any subcontract for any work covered by this Agreement so that such provisions shall be binding upon each subcontractor, provided that the foregoing provisions shall not apply to contracts or subcontracts for standard commercial supplies or raw materials.

13. **WARRANTY.** The Provider warrants that it has not employed or contracted with any company or person, other than for assistance with the normal study and preparation of a proposal, to solicit or secure this Agreement and that it has not paid, or agreed to pay, any company or person, other than a bona fide employee working solely for the Provider, any fee, commission, percentage, brokerage fee, gifts, or any other consideration, contingent upon, or resulting from the award for making this Agreement. For breach or violation of this warranty, the Department shall have the right to annul this Agreement without liability or, in its discretion to otherwise recover the full amount of such fee, commission, percentage, brokerage fee, gift, or contingent fee.

14. **ACCESS TO RECORDS.** As a condition of accepting an Agreement for services under this section, a Provider must agree to treat all records, other than proprietary information, relating to personal services work performed under the Agreement as public records under the freedom of access laws to the same extent as if the work were performed directly by the Department or agency. For the purposes of this subsection, "proprietary information" means information that is a trade secret or commercial or financial information, the disclosure of which would impair the competitive position of the Provider and would make available information not otherwise publicly available. Information relating to wages and benefits of the employees performing the personal services work under the Agreement and information concerning employee and Agreement

oversight and accountability procedures and systems are not proprietary information. The Provider shall maintain all books, documents, payrolls, papers, accounting records and other evidence pertaining to this Agreement and make such materials available at its offices at all reasonable times during the period of this Agreement and for such subsequent period as specified under Maine Uniform Accounting and Auditing Practices for Community Agencies (MAAP) rules. The Provider shall allow inspection of pertinent documents by the Department or any authorized representative of the State of Maine or Federal Government, and shall furnish copies thereof, if requested. This subsection applies to contracts, contract extensions and contract amendments executed on or after October 1, 2009.

15. **TERMINATION**. The performance of work under the Agreement may be terminated by the Department in whole, or in part, whenever for any reason the Agreement Administrator shall determine that such termination is in the best interest of the Department. Any such termination shall be effected by delivery to the Provider of a Notice of Termination specifying the extent to which performance of the work under the Agreement is terminated and the date on which such termination becomes effective. The Agreement shall be equitably adjusted to compensate for such termination, and modified accordingly.

16. **GOVERNMENTAL REQUIREMENTS**. The Provider warrants and represents that it will comply with all governmental ordinances, laws and regulations.

17. **GOVERNING LAW**. This Agreement shall be governed in all respects by the laws, statutes, and regulations of the United States of America and of the State of Maine. Any legal proceeding against the State regarding this Agreement shall be brought in State of Maine administrative or judicial forums. The Provider consents to personal jurisdiction in the State of Maine.

18. **STATE HELD HARMLESS**. The Provider agrees to indemnify, defend and save harmless the State, its officers, agents and employees from any and all claims, costs, expenses, injuries, liabilities, losses and damages of every kind and description (hereinafter in this paragraph referred to as "claims") resulting from or arising out of the performance of this Agreement by the Provider, its employees, agents, or subcontractors. Claims to which this indemnification applies include, without limitation, the following: (i) claims suffered or incurred by any Provider, subcontractor, materialman, laborer and any other person, firm, corporation or other legal entity (hereinafter in this paragraph referred to as "person") providing work, services, materials, equipment or supplies in connection with the performance of this Agreement; (ii) claims arising out of a violation or infringement of any proprietary right, copyright, trademark, right of privacy or other right arising out of publication, translation, development, reproduction, delivery, use, or disposition of any data, information or other matter furnished or used in connection with this Agreement; (iii) claims arising out of a libelous or other unlawful matter used or developed in connection with this Agreement; (iv) claims suffered or incurred by any person who may be otherwise injured or damaged in the performance of this Agreement; and (v) all legal costs and other expenses of defense against any asserted claims to which this indemnification applies. This indemnification does not extend to a claim that results solely and directly from (i) the Department's negligence or unlawful act, or (ii) action by the Provider taken in reasonable reliance upon an instruction or direction given by an authorized person acting on behalf of the Department in accordance with this Agreement.

19. **NOTICE OF CLAIMS**. The Provider shall give the Agreement Administrator immediate notice in writing of any legal action or suit filed that is related in any way to the Agreement or which may affect the performance of duties under the Agreement, and prompt notice of any claim made against the Provider by any subcontractor which may result in litigation related in any way to the Agreement or which may affect the performance of duties under the Agreement.

20. **APPROVAL.** This Agreement must have the approval of the State Controller and the State Purchases Review Committee before it can be considered a valid, enforceable document.

21. **LIABILITY INSURANCE.** The Provider shall keep in force a liability policy issued by a company fully licensed or designated as an eligible surplus line insurer to do business in this State by the Maine Department of Professional & Financial Regulation, Bureau of Insurance, which policy includes the activity to be covered by this Agreement with adequate liability coverage to protect itself and the Department from suits. Providers insured through a "risk retention group" insurer prior to July 1, 1991, may continue under that arrangement. Prior to or upon execution of this Agreement, the Provider shall furnish the Department with written or photocopied verification of the existence of such liability insurance policy.

22. **NON-APPROPRIATION.** Notwithstanding any other provision of this Agreement, if the State does not receive sufficient funds to fund this Agreement and other obligations of the State, if funds are de-appropriated, or if the State does not receive legal authority to expend funds from the Maine State Legislature or Maine courts, then the State is not obligated to make payment under this Agreement.

23. **SEVERABILITY.** The invalidity or unenforceability of any particular provision, or part thereof, of this Agreement shall not affect the remainder of said provision or any other provisions, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision or part thereof had been omitted.

24. **INTEGRATION.** All terms of this Agreement are to be interpreted in such a way as to be consistent at all times with the terms of Rider B (except for expressed exceptions to Rider B included in the Exceptions Rider), followed in precedence by Rider A, and any remaining Riders in alphabetical order.

25. **FORCE MAJEURE.** The Department may, at its discretion, excuse the performance of an obligation by a party under this Agreement in the event that performance of that obligation by that party is prevented by an act of God, act of war, riot, fire, explosion, flood or other catastrophe, sabotage, severe shortage of fuel, power or raw materials, change in law, court order, national defense requirement, or strike or labor dispute, provided that any such event and the delay caused thereby is beyond the control of, and could not reasonably be avoided by, that party. The Department may, at its discretion, extend the time period for performance of the obligation excused under this section by the period of the excused delay together with a reasonable period to reinstate compliance with the terms of this Agreement.

26. **SET-OFF RIGHTS.** The State shall have all of its common law, equitable and statutory rights of set-off. These rights shall include, but not be limited to, the State's option to withhold for the purposes of set-off any monies due to the Provider under this Agreement up to any amounts due and owing to the State with regard to this Agreement, any other Agreement, any other Agreement with any State department or agency, including any Agreement for a term commencing prior to the term of this Agreement, plus any amounts due and owing to the State for any other reason including, without limitation, tax delinquencies, fee delinquencies or monetary penalties relative thereto. The State shall exercise its set-off rights in accordance with normal State practices including, in cases of set-off pursuant to an audit, the finalization of such audit by the State agency, its representatives, or the State Controller.

27. **ENTIRE AGREEMENT.** This document contains the entire Agreement of the parties, and neither party shall be bound by any statement or representation not contained herein. No waiver shall be deemed to have been made by any of the parties unless expressed in writing and signed by the waiving party. The parties expressly agree that they shall not assert in any action

relating to the Agreement that any implied waiver occurred between the parties, which is not expressed in writing. The failure of any party to insist in any one or more instances upon strict performance of any of the terms or provisions of the Agreement, or to exercise an option or election under the Agreement, shall not be construed as a waiver or relinquishment for the future of such terms, provisions, option or election, but the same shall continue in full force and effect, and no waiver by any party of any one or more of its rights or remedies under the Agreement shall be deemed to be a waiver of any prior or subsequent rights or remedy under the Agreement or at law.

Rider D
Additional Requirements

- 1) **Confidentiality.** To the extent that the services carried out under this Agreement involve the use, disclosure, access to, acquisition or maintenance of information that actually or reasonably could identify an individual or consumer receiving benefits or services from or through the Department ("Protected Information"), the Provider agrees to a) maintain the confidentiality and security of such Protected Information as required by applicable state and federal laws, rules, regulations and Department policy, b) contact the Department within 24 hours of a privacy or security incident that actually or potentially could be a breach of Protected Information and c) cooperate with the Department in its investigation and any required reporting and notification of individuals regarding such incident involving Protected Information. To the extent that a breach of Protected Information is caused by the Provider or one of its subcontractors or agents, the Provider agrees to pay the cost of notification, as well as any financial costs and/or penalties incurred by the Department as a result of such breach."

To the extent the Provider under this Agreement is considered a Business Associate under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA) and its updates and associated regulatory requirements, rules and standards, including those issued under the Health Information Technology for Economic and Clinical Care Act (HITECH), the Provider shall execute the Department's Business Associate Agreement template (BA Agreement). The terms of the BA Agreement shall be incorporated into this Agreement by reference. Provider agrees that failure of Provider to execute and deliver such BA Agreement to the Department or to adhere to the terms of the BA Agreement shall result in breach of the underlying Agreement, and that remedies available to the Department for breach of the Agreement apply hereto.

- 2) **Lobbying.** No Federal or State appropriated funds shall be expended by the Provider for influencing or attempting to influence, as prohibited by state or federal law, an officer or employee of any Federal or State agency, a member of Congress or a State Legislature, or an officer or employee of Congress or a State Legislature in connection with any of the following covered actions: the awarding of any Agreement; the making of any grant; the entering into of any cooperative agreement; or the extension, continuation, renewal, amendment, or modification of any Agreement, grant, or cooperative agreement. The signing of this Agreement fulfills the requirement that providers receiving over \$100,000 in Federal or State funds file with the Department with respect to this provision. If any other funds have been or will be paid to any person in connection with any of the covered actions specified in this provision, the Provider shall complete and submit a "Disclosure of Lobbying Activities" form available at: <http://www.whitehouse.gov/omb/grants/#forms>.
- 3) **Drug-Free Workplace.** By signing this Agreement, the Provider certifies that it shall provide a drug-free workplace by: publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the Provider's workplace and specifying the actions that will be taken against employees for violation of such prohibition; establishing a drug-free awareness program to inform employees about the dangers of drug abuse in the workplace, the Provider's policy of maintaining a drug-free workplace, available drug counseling and rehabilitation programs, employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations occurring in the workplace; providing a copy of the drug-free workplace statement to each employee to be engaged in the performance of this Agreement; notifying the employees that as a condition of employment under the Agreement the employee will

abide by the terms of the statement and notify the employer of any criminal drug conviction for a violation occurring in the workplace no later than five days after such conviction.

The Provider shall notify the state agency within ten days after receiving notice of criminal drug convictions occurring in the workplace from an employee, or otherwise receiving actual notice of such conviction, and will take one of the following actions within 30 days of receiving such notice with respect to any employee who is so convicted: take appropriate personnel action against the employee, up to and including termination, or requiring the employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency.

- 4) **Debarment and Suspension.** By signing this Agreement, the Provider certifies to the best of its knowledge and belief that it and all persons associated with the Agreement, including persons or corporations who have critical influence on or control over the Agreement, are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation by any federal department or agency.

The Provider further agrees that the Debarment and Suspension Provision shall be included, without modification, in all sub-agreements.

- 5) **Environment Tobacco Smoke.** By signing this Agreement, the Provider certifies that it shall comply with the Pro-Children Act of 1994, P.L. 103-227, Part C, which requires that smoking not be permitted in any portion of any indoor facility owned, leased, or contracted for by an entity and used routinely or regularly for the provision of health, day care, education, or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments by Federal grant, Agreement, loan, or loan guarantee. The law does not apply to children's services provided in private residences, facilities funded solely by Medicare or MaineCare funds, and portions of facilities used for inpatient drug or alcohol treatment. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 per day and/or the imposition of an administrative compliance order on the responsible entity.

Also, the Provider of foster care services agrees that it will comply with Resolve 2003, c. 134, which prohibits smoking in the homes and vehicles operated by foster parents.

- 6) **Medicare and MaineCare Anti-Kickback.** By signing this Agreement, the Provider agrees that it shall comply with the dictates of 42 U.S.C. 1320a-7b(b), which prohibits the solicitation or receipt of any direct or indirect remuneration in return for referring or arranging for the referral of an individual to a Provider of goods or services that may be paid for with Medicare, MaineCare, or state health program funds. <http://www.gpoaccess.gov/uscode/index.html>
- 7) **Publications.** When issuing reports, brochures, or other documents describing programs funded in whole or in part with funds provided through this Agreement, the Provider agrees to clearly acknowledge the participation of the Department of Health and Human Services in the program. In addition, when issuing press releases and requests for proposals, the Provider shall clearly state the percentage of the total cost of the project or program to be financed with Agreement funds and the dollar amount of Agreement funds for the project or program.
- 8) **Ownership.** All notebooks, plans, working papers, or other work produced in the performance of this Agreement, which are related to specific deliverables under this

Agreement, are the property of the Department and upon request shall be turned over to the Department.

- 9) **Software Ownership.** Upon request, the State and all appropriate federal agencies shall receive a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, or otherwise use, and to authorize others to do so, all application software produced in the performance of this Agreement, including, but not limited to, all source, object, and executable code, data files, and job control language, or other system instructions. This requirement applies only to software that is a specific deliverable under this Agreement, or is integral to the program or service funded under this Agreement, and is primarily financed with funding provided under this Agreement.
- 10) **Provider Responsibilities / Sub Agreements.** The Provider is solely responsible for fulfillment of this Agreement with the Department. The Provider assumes responsibility for all services offered and products to be delivered whether or not the Provider is the manufacturer or producer of said services.
- a) Sub-agreements.
- i) All sub-agreements must contain the assurances of Rider B and Rider D of this Agreement;
- ii) All sub-agreements must be signed and delivered to the Department's Agreement Administrator within five (5) business days following the execution date of the sub-agreement.
- iii) See Rider B Section 8.
- b) Relationship between Provider, Subcontractor and Department. The Provider shall be wholly responsible for performance of the entire Agreement whether or not subcontractors are used. Any sub-agreement into which the Provider enters with respect to performance under this Agreement shall not relieve the Provider in any way of responsibility for performance of its duties. Further, the Department will consider the Provider to be the sole point of contact with regard to any matters related to this Agreement, including payment of any and all charges resulting from this Agreement. The Department shall bear no liability for paying the claims of any subcontractors, whether or not those claims are valid. The Provider is responsible for ensuring that all staff, employees, subcontractors, or other individuals or entities providing any services on behalf of the Provider clearly explain, verbally and in writing, to clients and families their relationship to the Provider and the Provider's relationship to the Department.
- c) Liability to Subcontractor. The requirement of prior approval of any sub-agreement under this Agreement shall not make the Department a party to any sub-agreement or create any right, claim or interest in the subcontractor or proposed subcontractor against the Department. The Provider agrees to defend (subject to the approval of the Attorney General) and indemnify and hold harmless the Department against any claim, loss, damage, or liability against the Department based upon the requirements of Rider B, Section 18.
- 11) **Renewals.** This Agreement may be renewed at the discretion of the Department:
- 12) **No Rule of Construction.** The parties acknowledge that this Agreement was initially prepared by the Department solely as a convenience and that all parties hereto, and their

counsel, have read and fully negotiated all the language used in the Agreement. The parties acknowledge that, because all parties and their counsel participated in negotiating and drafting this Agreement, no rule of construction shall apply to this Agreement that construes ambiguous or unclear language in favor of or against any party because such party drafted this Agreement.

13) **Conflict of Interest.** The Provider covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Provider further covenants that in the performance of this Agreement, no person having any such known interests shall be employed. [See also Rider B, #11 and #12]

14) **Whistleblower Protection.**

a) This Agreement and employees working on this Agreement will be subject to the whistleblower rights and remedies in the pilot program on employee whistleblower protections established at 41 U.S.C. 4712 by section 828 of the National Defense Authorization Act for Fiscal Year 2013 (Pub. L. 112-239) and FAR 3.908.

b) The Provider shall inform its employees in writing, in the predominant language of the workforce, of employee whistleblower rights and protections under 41 U.S.C. 4712, as described in section 3.908 of the Federal Acquisition Regulation.

c) The Provider shall insert the substance of this clause, including this paragraph (c), in all subcontracts over the simplified acquisition threshold.

15) **Funding Sources Reduced.** Notwithstanding any other provision of this Agreement, if the United States Government or any department of the United States Government, has de-appropriated or suspended funds for this Agreement, or where the Governor of the State of Maine has curtailed funds for this Agreement then the Department is not obligated to make payment under this Agreement to the extent of such de-appropriation, suspension or curtailment of funds. In the event of such de-appropriation, suspension or curtailment of funds, the Agreement shall be modified accordingly.

16) **Change of Operations**

The Provider shall report to the Agreement Administrator and Program Administrator any anticipated changes of the Provider's operations, including but not limited to mergers, acquisitions, or closings, at the earliest possible date and no later than sixty (60) days prior to the anticipated closure date, with the exception of reasonably unforeseen circumstance.

17) **Termination or Change of Work Performance.**

In addition to the requirements of Rider D, Section 16, the written communication shall be specific and also include, and not be limited to, the date of expected closure, description of any and all programs affected, number of clients projected to be impacted, plans for addressing needs of the clients affected, and the name and contact information of the person(s) responsible for the care of clients affected and their records. The Provider shall assist the client and the client's case manager or other supports in obtaining services from another provider.

a) The Provider shall report to the Program Administrator all major programming and structural changes in programs funded, seeded, or licensed by the Department within the timeframe noted above. Any changes that add, alter, or eliminate existing services must be negotiated and approved by the Program Administrator prior to implementation. Major program changes include, but are not limited to, the following: (1) The addition of new

services or deletion of existing services; (2) Serving a population not served by the agency previously; (3) Significant increases or decreases in service capacity as defined by the governing body; (4) Significant changes in the organizational structure as defined by the governing body; (5) Changes in the executive director or name or ownership of the agency; or 6) Relocation of services. For MaineCare funded services, the Provider shall give due process notification as required by MaineCare regulations, Chapter I, §1.03-4 of the MaineCare Benefits Manual. In addition to MaineCare Benefits Manual Chapter I, §1.03-4, the following shall apply:

- i) If a provider provides services under this Agreement and chooses to voluntarily terminate participation in MaineCare or voluntarily terminates State funded services funded in whole or part by this agreement, the provider must inform the Program Administrator of the intent. This notice should be concurrent with the notice to MaineCare as required in Chapter I. The provider is expected to work cooperatively with the Department on the planning the transition to replacement services for the affected members. In order to facilitate continuity of services for the member(s), the Department reserves the right to require that the provider continue to provide necessary services until appropriate replacement services are secured for the member(s).
- ii) If a provider chooses to terminate services to a specific member or group of members, the provider must request permission to do so from the Program Administrator. Such a request must be in writing and with a minimum of 30 days advance notice. The written request must state that the provider will agree to work with the member, the Department and any potential replacement provider on the transition of services. In order to facilitate continuity of services for the member(s), the Department reserves the right to request that the provider continue to provide necessary services until appropriate replacement services are secured for the member(s).

18) **Audit.** Funds provided under this Agreement to community agencies for social services are subject to the audit requirements contained in the Maine Uniform Accounting and Auditing Practices for Community Agencies (MAAP), Federal OMB Circular A-110, and may further be subject to audit by authorized representatives of the Federal Government, according to the Agreement Settlement Form (pro forma) contained in Rider F, if applicable. Agencies that expend \$500,000 or more in a year in Federal Awards shall have a single or program-specific audit conducted for that year in accordance with Federal Circular OMB A-133, Audits of States, Local Governments, and Non-Profit Organizations.

Please see <http://www.maine.gov/dhhs/audit/social-services/rules.shtml> for details on this requirement.

The Department's Agreement Administrator may approve Provider submissions, but has no authority to relieve the Provider from being audited according to MAAP and Federal regulations in cases where this approval may be counter to the MAAP and Federal regulations.

19) **Motor Vehicle Check.** The Provider shall complete a check with the Bureau of Motor Vehicles on all of Provider's staff and volunteers who transport clients or who may transport clients. This check must be completed before the Provider allows the staff person or volunteer to transport clients, and at least every two years thereafter. If the record of a staff member or volunteer contains an arrest or conviction for Operating under the Influence or any other violations which, in the judgment of the Provider, indicate an unsafe driving history

within the previous three (3) years, the Provider shall not permit the staff member or volunteer to transport clients. The Provider shall implement appropriate procedures to ensure compliance with the requirements of this section.

20) Exceptions to OMB Circulars for Non-Federally-Funded Activities.

- a) Travel. The reimbursement rate for mileage charged to Department funded programs cannot exceed the reimbursement rate allowed for state employees. (5 M.R.S.A. §1541(13)(A)).
- b) Any other exceptions to OMB Circular A-122 are allowable only with prior written approval from the Department and must be offset against identified unrestricted non-Federal revenue.

21) **MaineCare Regulations.** Providers who receive MaineCare funds will assure that their programmatic and financial management policies and procedures are in accordance with applicable MaineCare regulations and that their staff members are familiar with the requirements of the applicable MaineCare service they are providing. Providers will ensure that they are in compliance with the applicable MaineCare regulation prior to billing for the service.

22) **Revenue Maximization.** The Provider shall conduct its services in such a way as to maximize revenues from MaineCare and other third-party sources such as private insurance as may be available to reduce the need for funds from the Department. Agreement funds may not be used to pay for services that are reimbursable by other third party sources, such as private health insurance and MaineCare, under any circumstances. It is the Provider's obligation to seek and obtain reimbursement from other third party sources for any reimbursable services provided to covered individuals.

23) **Illegal Aliens Ineligible for State and Local Public Benefits.** Notwithstanding any other provision of this Agreement, if this Agreement is for the provision of any State or local public benefit, the Provider certifies that it shall comply with the requirements of 8 U.S.C. § 1621 regarding the ineligibility of illegal aliens for any State or local public benefits.

24) **Background Checks.** The Provider agrees to conduct background checks on all prospective employees, persons contracted or hired, consultants, volunteers, students, and other persons who may provide services under this Agreement. Background checks on persons professionally licensed by the State of Maine will include a confirmation that the licensee is in good standing with the appropriate licensing board or entity. The Provider shall not hire or retain in any capacity any person who may directly provide services to a client under this Agreement if that person has a record of:

- a) any criminal conviction that involves client abuse, neglect or exploitation;
- b) any criminal conviction in connection to intentional or knowing conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person;
- c) any criminal conviction resulting from a sexual act, contact, touching or solicitation in connection to any victim; or
- d) any other criminal conviction, classified as Class A, B or C or the equivalent of any of these, or any reckless conduct that caused, threatened, solicited or created the substantial risk of bodily injury to another person within the preceding two years.

Employment of persons with records of such convictions more than two years ago is a matter within the Provider's discretion after consideration of the individual's criminal record in relation to the nature of the position.

The Provider shall contact child protective services units within State government to obtain any record of substantiated allegations of abuse, neglect or exploitation against an employment applicant before hiring the same. In the case of a child protective services investigation substantiating abuse, neglect or exploitation by a prospective employee of the Provider, it is the Provider's responsibility to decide what hiring action to take in response to that substantiation, while acting in accordance with licensing standards.

Providers are not required to obtain records from child protective services for employees who (a) do not provide services to children, and (b) work in settings where there is on-site supervision at all times.

- 25) **Notification and Reporting.** The Provider shall follow all policies, procedures, and protocols developed by the Department, including procedures and protocols for tracking and reporting to the Program Administrator (i) reportable events; (ii) critical incidents; including all incidents of abuse and neglect or children and adults. The Provider shall develop the capacity to transmit identified uniform data elements in accordance with specifications established by the office of the Program Administrator.

Insofar as the Provider serves members of the class outlined in the "Community Consent Decree", Consumer Advisory Board v. DHHS Commissioner, No. 91-321-P-C (D. Ct. Me.), all terms and conditions of the Community Consent Decree are applicable to this Agreement. All Providers must pay particular attention to the Grievance process available to persons with developmental disabilities served by the Provider, and ensure that notice of the process is regularly provided to persons served by the Provider. Providing notice includes ensuring that written notice of the grievance process is provided to the person and/or their guardian at any planning meeting; posting notice of the grievance process in an appropriate common area of all facilities operated by the Provider; and posting notice of the grievance process on any website maintained by the Provider. In addition, the Provider must ensure that all new staff is trained in the grievance process and that it is available to all persons served by the Department. The Provider is also responsible for ensuring that all staff, employees, subcontractors, or other individuals or entities providing any services on behalf of the Provider clearly explain verbally and in writing to clients and families their relationship to the Provider and their roles and responsibilities and include, in writing, contact information for the individual(s) responsible for responding to complaints or grievances on behalf of the Provider.

RIDER G

IDENTIFICATION OF COUNTRY
IN WHICH CONTRACTED WORK WILL BE PERFORMED

Please identify the country in which the services purchased through this Agreement will be performed:

- United States. Please identify state: Maine
- Other. Please identify country: _____

Notification of Changes to the Information

The Provider agrees to notify the Division of Purchases of any changes to the information provided above.

RIDER I
MAINE STATE DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLES VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, THE CODE OF FAIR PRACTICES AND AFFIRMATIVE ACTION AND STATE OF MAINE EXECUTIVE ORDER 17/FY 04/05.

The Provider/Contractor provides this assurance in consideration of and for the purpose of obtaining Federal/State grants, loans, contracts, property, discounts or other Federal/State financial assistance from the U.S./State Departments of Health and Human Services.

By signing this contract, Rider I Assurance of Compliance is by agreement fully incorporated into the contract.

THE PROVIDER/CONTRACTOR HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Titles VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Service (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States, shall on the grounds of race, color or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Provider/Contractor receives Federal/State financial assistance from the Department. Specifically, providers of client services shall develop clear, written communication plans, provide and document training in order to ensure that staff can communicate meaningfully with applicants/clients and/or family members who are limited English proficient (LEP); determine the primary language of applicants/clients and/or family members, and ensure that bi-lingual workers or qualified interpreters will be provided at no cost to the applicant/client.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap be excluded from participation in, be denied the benefits of, or subjected to discrimination under any program or activity for which the Provider/Contractor receives Federal/State financial assistance from the Department. Specifically, providers shall develop clear, written communication plans, provide and document training in order to ensure that staff can communicate meaningfully with applicants/clients and/or family members who are deaf, hard or hearing, late deafened, speech impaired and/or nonverbal. The Provider will provide visible or tactile alarms for safety and privacy, telecommunications device for the deaf (TTY), amplified phone or fax machine, and train staff in the use of adaptive equipment. The Provider shall obtain the services of a qualified, licensed sign language interpreter or other adaptive service such as CART or C-Print at no expense to the applicant/client or family member.
3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by for pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of /or be otherwise subjected to discrimination under any education program or activity for which the Provider/Contractor receives Federal/State financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in or be subjected to discrimination under any program or activity for which the Provider/Contractor receives Federal/State financial assistance from the Department.
5. The Code of Fair Practices and Affirmative Action, 5 M.R.S.A. § 781 *et. seq.*, to the end that, in accordance with the Code of Fair Practices and Affirmative Action, no state or state related agency contractor, subcontractor, or labor union or representative of the workers with which the contractor has an agreement will discriminate because of race, color, religious creed, sex, national origin, ancestry, age, physical or mental disability while providing any function or service to the public, in enforcing any regulation, or in any education, counseling, vocational guidance, apprenticeship and on the job training programs, unless based upon a bona fide occupational qualification. During the performance of this contract, the Provider/Contractor agrees as follows:
 - A. That it will not discriminate against any employee or applicant for employment because of race, color, religious creed, sex, national origin, ancestry, age physical or mental disability. Such action shall include, but not be limited to the following: Employment, upgrading, demotions, transfers, recruitment or recruitment advertising; layoffs or terminations; rates of pay or other forms of compensation; and selection for training, including apprenticeship.
 - B. The Provider/Contractor will, in all solicitations or advertisements for employees place by or on behalf of the Provider/Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religious creed, sex, national origin, ancestry, age, physical or mental disability.
 - C. The Provider/Contractor will send to each labor union or representative of the workers with which it has a collective or bargaining agreement, or other contract or understanding, whereby he is furnished with labor for the performances of his contract, a notice, to be provided by the contracting department or agency, advising the said labor union or workers' representative of the contractor's commitment under this section and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
 - D. The Provider/Contractor will cause the foregoing provisions to be inserted in all contracts for any work covered by this agreement so that such provisions will be binding upon each subcontractor.
 - E. Provider/Contractors and subcontractors with contracts in excess of \$50,000 will also pursue in good faith affirmative action programs.
6. State of Maine Executive Order 17 FY 04/05 which provides that all contractors entering into contracts for services to be provided to or on behalf of the State of Maine not discriminate against any employee or applicant for employment because of that employee's or applicant's sexual orientation. Solicitations or advertisements for employment by the contractor or subcontractor shall state that all qualified applicants will receive consideration for employment without regard to sexual orientation. Contractor will notify each labor union or workers' representative of the contractor's obligations under State of Maine Executive Order 17 FY 04/05 and post such notice in conspicuous places available to employees and applicants for employment. The contractor will cause the requirement of State of Maine Executive Order 17 FY 04/05 to be inserted in all contracts for work covered by a State contract for services such that the requirements will be binding on any and all subcontractors. The Provider further stipulates that services will be provided in a culturally sensitive and age appropriate manner.

The Provider/Contractor agrees that compliance with this assurance constitutes a condition of continued receipt of Federal/State financial assistance, and that it is binding upon the Provider/Contractor, its successors, transferees and assignees for the period during which such

assistance is provided. The Provider/Contractor also agrees that the Department may withhold financial assistance to any recipient found to be in violation of the Maine Human Rights Act, 5 M.R.S.A. § 4551 *et. seq.* or the Federal Civil Rights Act, 42 U.S.C. § 1981 *et. seq.* in accordance with 5 M.R.S.A. § 783. If any real property or structure thereon is provided or improved with the aid of Federal/State financial assistance extended to the Provider/Contractor by the Department, this assurance shall obligate the Provider/Contractor, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal/State financial assistance is extended or for another purpose involving the provision of similar service or benefits. If any personal property is so provided, this assurance shall obligate the Provider/Contractor for the period during which it retains ownership or possession of the property. The Provider/Contractor further recognizes and agrees that the United States shall have the right to seek judicial enforcement of the assurance.

* Technical assistance and information relating to the requirements associated with sections 1 through 5 can be found at U.S. Health and Human Services Website: www.hhs.gov/ocr/pregrant/indexpg.html. Technical assistance and information regarding section 1 can also be found at the U.S. Equal Employment Opportunity Commission website: www.eeoc.gov. Technical assistance and information relating to the requirements associated with section 6 can be found at www.state.me.us/mhrc/laws.htm . For technical assistance and information relating to section 6 above, please refer to www.jan.wvu.edu/links/adalinks.html. Information relating to section 6 can be found at <http://janus.state.me.us/legis/statutes/search.asp>.

EXCEPTIONS TO AGREEMENT

There are no exceptions to State Riders in this agreement.

Appendix A:

I. REVISED PROGRAMMING MATRIX

The revised Programming Matrix contains a list of key objectives and evidence based strategies to achieve the HMP outcomes in both community and school settings. The Matrix is based on the one developed for the 2010 RFP which was established through a formal priority setting process conducted individually and collectively by the state programs partnering on this RFP as well as forums held at the HMP Leadership Council meetings.

Criteria used to develop this Matrix: This Matrix was developed from the previous HMP Programming Matrix in order to reflect changes in the HMP initiative funding and structure. Several key principles guided these changes. These were: 1.) HMP work should be focused on having the greatest possible impact; 2.) HMPs should continue to address the key contributors to the leading causes of death and disability; 3.) HMPs should continue to work with schools as well as the greater community; and 4.) This work should provide continuation of the basic principles underlying the previous Programming Matrix as much as possible.

Process and Outcomes: Aspirational goals defined by the x % change, for each objective is intended to be reached by the close of the grant cycle, June 30, 2016. The goal for each objective chosen by a HMP will be established in cooperation with DHHS staff and, where possible, be informed by the HMP-specific settings spreadsheet developed by the HMP Evaluation Team earlier this year. Strategies are intended to be enacted on an annual basis but may be repeated from year to year. HMPs should carefully consider how they intend to meet the goals of their chosen objectives, and adjust their strategies to changes in local conditions through thinking strategically about their choice of strategies, where they will be implemented, and how local stakeholders can be engaged to achieve the maximum progress towards reaching the objective goals.

With the exception of Section 1, the milestones that indicate progress to fulfilling the strategy on an annual basis must be renewed and revised annually, and must follow the guidance issued by DHHS for their development, composition, and format.

The Matrix

The revised Matrix consists of six (6) sections, each of which reflects a portion of the overarching goals of the HMP Initiative.

SECTIONS

Section 1: INFRASTRUCTURE SUPPORT AND CAPACITY DEVELOPMENT

Section 2: SUBSTANCE ABUSE

Section 3: TOBACCO

Section 4: OBESITY

Section 5: WORKSITES

Section 6: SCHOOL ADMINISTRATIVE UNITS

Symbols are used in the Matrix to assist the applicants in identifying appropriate objectives and strategies.

	<p>The milestone is only applicable to Lead HMPs.</p>
	<p>The objective or strategy is required by all HMPs</p>
<p>SECTION I</p> <p>OBJECTIVE 1: Provide support for and increase capacity of the public health infrastructure.</p>	
<p>Strategies</p>	<p>Measures</p>
<p>1.1 Lead HMP will provide meeting support for DCC Quarterly Meetings</p> <p>1.2 Assure exchange of information related to the HMP and its local service area among local, district and state partner</p> <p>1.3 Participate in MCDC requests for assistance in public health emergencies and/or calls to action. Participate in District Public Health Improvement Plan (DPHIP)</p> <p>1.4 A minimum of one (1) HMP will serve at the DCC Executive/Steering committee level</p> <p>1.5 Chair/lead/ participate and/or otherwise contribute to the implementation of a minimum of one (1) DPHIP objective</p>	<p>1.1 Timely Minutes Associated Budget Attendance at DCC meeting, DCC Steering Committee, and Subcommittee</p> <p>1.2 Number of HMP service area originated communications that are shared with identified partners Number of HMP related communications initiated by the HMP Number of requests made to HMP by DCC/DL Number of dissemination partners who receive communications</p> <p>1.3 Number of requests made by Maine CDC for HMP assistance</p> <p>1.4 DCC Executive/Steering Committee roster DCC Executive/Steering Committee meeting attendance list</p> <p>1.6 Brief quarterly update of specific activity undertaken by HMP on DPHIP objective for use by DL, DCC, and SCC</p>

Objective 2: Increase effectiveness through building CCHC core competencies	
Strategies	Measures
1.6 Adopt and build CCHC core competencies (FY 2015-2016 focus 1,2,3,4,5 and 9)	<p><u>Governance Core Competency:</u> HMP membership roster HMP minutes indicating member and associated sector attendance Membership gap analysis and description of action taken to recruit vacancies</p> <p><u>Funding Core Competency:</u> 100% HMP financial and activity reports are submitted by deadlines.</p> <p><u>Management and Administrative Core Competency:</u> Job vacancy postings Updated Staffing plan and / or organization chart Copy of contracts drafted for the provision of service for which the HMP is held ultimately accountable.</p> <p><u>Leadership Core Competency:</u> Adobe and/or other training attendance rosters</p> <p><u>Convening and Mobilizing Core Competency:</u> Identify staff member assigned to serve on District Engagement Subcommittee Attendance at District Engagement Subcommittee meetings # contacts provided # sectors represented # of sectors representing populations experiencing health disparities</p>

SECTION 2: SUBSTANCE ABUSE

Instructions:

- The HMP must select a minimum of two (2) objectives and implement a minimum of two (2) strategies from each selected community focus objective annually. (See below for SA workplace and school objectives)

OBJECTIVE 1:

Engage a minimum of x% of liquor licensees to participate in two or more strategies that lead to responsible retailing as defined by SAMHS guidelines.

STRATEGIES

REF #	DESCRIPTION
SA 1.1	Plan, coordinate, advertise, and/or host in-person <i>Responsible Beverage Server/ Service (RBS)</i> trainings.
SA 1.2	Engage liquor licensees to participate in the <i>Card ME</i> Program.
SA 1.3	Encourage Law Enforcement to partner with HMP in working with local licensees.
SA 1.4	Engage retailers to participate in the <i>Sticker Shock</i> Program.
SA 1.5	Assess and educate on-premise liquor licensees on pricing and promotion practices, using the SAMHS “Environmental Assessment: Pricing and Promotion” and “Alcohol Pricing and Promotions: Protect Your Business” guides.
SA 1.6	Assess and educate off-premise liquor licensees on pricing and promotion practices, using the SAMHS “Environmental Assessment: Pricing and Promotion” and “Alcohol Pricing and Promotions: Protect Your Business” guides.

OBJECTIVE 2:

Engage a local area Underage Drinking Enforcement Task Force to participate in two or more strategies that lead to the increased perception among youth that they would be caught using alcohol.

STRATEGIES

REF #	DESCRIPTION
SA 2.1	Work with law enforcement agencies to ensure participation on an active Task Force which is representative of key stakeholders in the community.

SA 2.2	Collaborate with law enforcement to increase the enforcement of underage drinking laws.
SA 2.3	Work with law enforcement to increase communication about enforcement efforts and community supports.
SA 2.4	Work with Higher Education Alcohol Prevention Partnership (HEAPP) and local colleges/universities to coordinate enforcement efforts to address social hosting and off-campus drinking environments for underage college students.
<p>OBJECTIVE 3: Engage a minimum of x% of partners (e.g., schools, hospitals, provider offices, service agencies, civic organizations, etc.) that promote and disseminate information about the risk of underage alcohol use and high risk drinking in young adults.</p> <p>STRATEGIES</p>	
REF #	DESCRIPTION
SA 3.1	Engage business and community organizations to assist with implementing components of <i>Table Talks</i> with parents.
SA 3.2	Engage local public gathering places (i.e., libraries, schools, health care facilities) to promote and disseminate SAMHS parent media campaign materials.
SA 3.3	Engage business and community organizations to disseminate <i>Parents Who Host, Lose the Most</i> information.
SA 3.4	Coordinate with community organizations, the promotion of www.AlcoholScreening.org/maine as a health resource for young adults.
SA 3.5	Engage business and community organizations that serve young adults (including bars and restaurants) to disseminate SAMHS <i>Party Smarter</i> campaign material.
SA 3.6	Coordinate with Higher Education Alcohol Prevention Partnership (HEAPP) and local colleges/universities to disseminate SAMHS <i>Party Smarter</i> materials in campus and off-campus settings.

SECTION 3: TOBACCO

Requirements for Community Focused Objectives:

- The HMP must implement objectives PTM 1 and PTM 2, and a choice of PTM 3, or PTM 4 for a total of three (3) tobacco-related non-school objectives.
- HMPs must implement a minimum of two (2) strategies from each selected objective annually, i.e. a minimum of six (6) strategies.

Health Disparities:

When completing the workplan in KIT, the HMP must indicate how each strategy addresses health disparities for the community focused objectives. There are four (4) approved methods by which the HMP may address health disparities at the strategy level:

1. The strategy is implemented in a manner that ensures that it, or the benefit of the strategy, is accessible to a specific population with a health disparity.
2. The strategy is implemented in a culturally appropriate manner specific to a specific population with a health disparity.
3. The strategy is implemented so that the work is focused solely on a population with health disparities.
4. The strategy is *adapted* to meet the needs of a specific population with a health disparity. (HMPs must consult with their Project Officer prior to employing this method)

OBJECTIVE 1:

Increase by x%, the number of tobacco retailers implementing the Partnership For A Tobacco-Free Maine's NO BUTS! Program.



STRATEGIES

REF #	DESCRIPTION
PTM 1.1	Recruit tobacco retailers to participate in the NO BUTS! Program.
PTM 1.2	Conduct follow up through in-person meetings, or direct phone call with tobacco retailers enrolled in NO BUTS! to assure adherence to the NO BUTS! Program standards.

OBJECTIVE 2:
 Increase by x%, the number of tobacco retailers participating in the NO BUTS! Program who also implement the Star Store Program in order to reduce the impact of tobacco advertising.



STRATEGIES	
REF #	DESCRIPTION
PTM 2.1	Enroll NO BUTS! tobacco retailers into the Star Store Program in order to reduce tobacco advertising and product placement through mobilizing youth.
PTM 2.2	Conduct ongoing follow up through in-person meetings, or direct phone call with tobacco retailers enrolled in the Star Store Program to support implementation of and assure adherence to Star Store Program standards.

OBJECTIVE 3:
 Increase by x%, the number of multi-unit residential buildings that are 100% smoke-free.

STRATEGIES	
REF #	DESCRIPTION
PTM 3.1	Guide tenants to effectively advocate for smoke-free rental units based on the negative health consequences of secondhand smoke and their right to breathe clean air.
PTM 3.2	Assist landlords, community action programs, and/or tenant associations to develop and implement smoke-free policies.
PTM 3.3	Engage local asthma educators, healthy homes practitioners, COPD educators, and persons with asthma and / or COPD to advocate for the inclusion of smoke-free policies in residential buildings.
PTM 3.4	Review and/or revise smoke-free policies to eliminate “grandfathering” of existing smoking units.
PTM 3.5	Work with owners and managers to review enforcement of newly developed smoke-free policies, revising as necessary to assure effective implementation.

OBJECTIVE 4:

Increase by x%, the number of municipalities that have policies and/or ordinances prohibiting tobacco use at public events and open-air places.

STRATEGIES

REF #	DESCRIPTION
PTM 4.1	Assist with the development of a policy and/or ordinance that increases the number of recreation areas and other venues that are smoke-free (e.g., amusement parks, piers, playgrounds, sport stadiums).
PTM 4.2	Assist with the development of a policy and/or ordinance that increases the number of recreational events that are smoke-free (e.g., celebrations, fairs, parades).
PTM 4.3	Assist with the development of a policy and/or ordinance that increases the number of municipal beaches that are smoke-free.
PTM 4.4	Assist with the development of a policy and/or ordinance that increases the number of towns that have an ordinance that specifically prohibits tobacco litter in their municipality.
PTM 4.5	Review enforcement of developed smoke-free policies, revise as necessary and elevate said policies to tobacco-free. (NOTE: applies to 4.1, 4.2, 4.3 and 4.4)

SECTION 4: OBESITY

Requirements for Community Objectives:

- The HMP must implement objectives OB 1 and a choice of OB 2, or OB 3, for a total of two (2) obesity-related, non-school objectives.
- Implementation of Strategy OB 1.1 is required of all HMPs.
- HMPs must implement a minimum of two (2) strategies from each selected community focused objective annually, i.e. a minimum of four (4) strategies.

Health Disparities:

When completing the workplan in KIT, the HMP must indicate how each strategy addresses health disparities. There are four (4) approved methods by which the HMP may address health disparities at the strategy level:

1. The strategy is implemented in a manner that ensures that it, or the benefit of the strategy, is accessible to a specific population

- with a health disparity.
2. The strategy is implemented in a culturally appropriate manner specific to a specific population with a health disparity.
 3. The strategy is implemented so that the work is focused solely on a population with health disparities.
 4. The strategy is *adapted* to meet the needs of a specific population with a health disparity. (You must consult with your Project Officer prior to employing this method)

OBJECTIVE 1:
 Increase by x%, the number of municipalities that have policies, plans and /or ordinances which promote healthy living in the built environment.

STRATEGIES	
REF #	DESCRIPTION
OB 1.1	Engage local partners and municipal officials to conduct the Rural Active Living Assessment http://www.activelivingresearch.org/node/11947 or the Irvine Minnesota Inventory https://webfiles.uci.edu/kday/public/index.html as appropriate for the municipality.
OB 1.2	Partner with municipalities and appropriate organizations to establish bicycle and pedestrian committees in each community to advocate for local, state and federal funding for trail construction and maintenance.
OB 1.3	Collaborate with municipalities and appropriate partners to develop local plans to safely connect youth and adults of all ages to neighborhoods, schools and/or recreation areas.
OB 1.4	Provide technical assistance to municipalities and local partners for development, adoption, and implementation of system-wide policies that establish built environment design standards promoting physical activity.
OB 1.5	Provide technical assistance to local planning departments and transportation authorities to adopt "Complete Streets" approaches.
OB 1.6	Work with municipalities to encourage and facilitate their membership in at least one coalition or partnership that aims for environmental and/or policy change to promote active living and/or healthy eating (excluding personal health programs such as health fairs).
OB 1.7	Work with municipalities to form or participate on a Food Policy Council that brings together stakeholders from diverse food-related areas to monitor, evaluate, and improve the performance of the municipality's food system.

OBJECTIVE 2: Increase by x%, the number of municipalities that develop and implement policies that increase access to healthy food and drink options sold at municipal-owned or managed sites.	
STRATEGIES	
REF #	DESCRIPTION
OB 2.1	Assist with the development and implementation of a relative price policy in vending machines that increase the cost of unhealthy items and/or decrease the cost of healthier items.
OB 2.2	Assist with the development and implementation of a policy that decreases the availability of unhealthy food and drink options sold at municipal-owned or managed sites
OB 2.3	Assist with the development and implementation of a policy that increases the availability of healthy food and drink options sold at municipal-owned or managed sites.
OB 2.4	Assist with the development and implementation of a policy that makes healthy food and drink options more accessible through pricing strategies at municipal-owned or managed sites.
OBJECTIVE 3: Increase by x%, the number of sites that provide free public access for physical activity.	
STRATEGIES	
REF #	DESCRIPTION
OB 3.1	Provide technical assistance to school administration for development, adoption, and implementation of policies that provide public access to indoor and / or outdoor school facilities for after-school physical activity.
OB 3.2	Provide technical assistance to school administration for the development and adoption of a collaborative use agreement to provide public access to indoor and / or outdoor school facilities for after-school physical activity.
OB 3.3	Provide technical assistance to owners, managers, and developers of private facilities (such as hospitals, colleges, large business, buildings, and malls) for development, adoption, and implementation of policies that provide free public access to indoor and / or outdoor facilities for physical activity.
OB 3.4	Provide technical assistance to owners, managers, and developers of private facilities (such as hospitals, colleges, large business, buildings, and malls) for the development, adoption, and implementation of a collaborative use agreement to provide public access to indoor and/or outdoor facilities for physical activity.

SECTION 5: WORKSITES

The WORKSITE Objective is optional but encouraged for all HMPs. The WORKSITE objective may be implemented focusing on Tobacco, Obesity, Substance Abuse, or all three. For maximum effectiveness in the worksite setting, it is recommended that the HMP implement a minimum of two (2) strategies from the objective when this objective is chosen. Where the WORKSITE Objective is chosen for multiple focus areas, the milestones marking progress of the chosen strategies should be written to show the separate focus areas.

Worksites are defined as any organization or entity employing 5+ people that are either paid or work voluntarily with alternative compensation. Worksites include hospitals, colleges, private employers, schools, and municipalities.

Health Disparities:

When completing the workplan in KIT, the HMP must indicate how each strategy addresses health disparities for the community focused objectives. There are four (4) approved methods by which the HMP may address health disparities at the strategy level:

1. The strategy is implemented in a manner that ensures that it, or the benefit of the strategy, is accessible to a specific population with a health disparity.
2. The strategy is implemented in a culturally appropriate manner specific to a specific population with a health disparity.
3. The strategy is implemented so that the work is focused solely on a population with health disparities.
4. The strategy is *adapted* to meet the needs of a specific population with a health disparity. (You must consult with your Project Officer prior to employing this method)

OBJECTIVE 1:

Engage a minimum of x% of local worksites that develop and implement policies and plans which promote healthy lifestyles

STRATEGIES

REF #	DESCRIPTION
WS 1.1	Using the Healthy Maine Works Framework, offer technical assistance and resources to worksites to assist in the creation of a workplan focused on <i>healthy lifestyle promotion and education</i> .
WS 1.2	Using the Healthy Maine Works Framework, offer technical assistance and resources to worksites to assist in the creation of a workplan focused on <i>environmental change, policies and / or procedures</i> .

WS 1.3	Offer technical assistance and resources (such as Good Works!) to worksites to assist employers in implementing a written <i>smoking or tobacco use policy</i> that meets and / or exceeds current Maine state law.
WS 1.4	Using the Healthy Maine Works Framework, offer technical assistance and resources to worksites to develop and implement policies promoting a <i>drug-free</i> workplace.
WS 1.5	Using the Healthy Maine Works Framework, offer technical assistance and resources to worksites to promote and enable mothers to breastfeed or express breast milk at the workplace.
WS 1.6	Enlist worksites to make available and promote access to the KeepMEWell website for their employees.

SECTION 6: SCHOOL ADMINISTRATIVE UNITS

Requirements for School Objectives:

- All School Objectives must be implemented.
- Because the school objectives focus on policy development, the HMP will be implementing these objectives at the SAU level and not the individual school level.
- By the end of the grant period (June 2016), the HMP must have worked with a minimum of three (3) SAUs in their local service area. Where the HMP has less than three (3) SAUs in their local service area, the requirement is that the HMP will work in all SAUs.

OBJECTIVE 1: Increase by x%, the number of SAUs that implement a comprehensive Tobacco-free Policy that meet PTM criteria.	
	
STRATEGIES	
REF #	DESCRIPTION
SAU 1.1	Provide SAUs with guidance to review and compare tobacco-free policies with PTM criteria.
SAU 1.2	Engage SAUs in revising tobacco-free policies to meet PTM criteria for a comprehensive tobacco-free policy.
SAU 1.3	Provide SAUs with technical assistance and/or guidance in the implementation of a comprehensive tobacco-free

	policy following an administration-approved plan with a monitoring and accountability component.
SAU 1.4	Provide SAUs with guidance in creating and implementing a communication plan for the comprehensive tobacco-free policy.
	
OBJECTIVE 2: Increase by x%, the number of SAUs that implement a comprehensive local Wellness Policy.	
STRATEGIES	
REF #	DESCRIPTION
SAU 2.1	Provide SAUs with technical assistance and/or guidance for reviewing and enhancing the local Wellness Policy and insuring compliance with new requirements resulting from the Healthy Hunger Free Kids Act of 2010.
SAU 2.2	Engage SAUs in prioritizing strategies and creating a timeline for Wellness Policy implementation.
SAU 2.3	Provide SAUs with guidance, resources and tools for developing and executing the Wellness Policy Implementation Plan.
	
OBJECTIVE 3: Increase by x%, the number of SAUs that implement a Substance Abuse Policy that meets SAMHS guidelines.	
STRATEGIES	
REF #	DESCRIPTION
SAU 3.1	Provide SAUs with guidance for reviewing, comparing, and revising school substance abuse policies according to SAMHS guidelines (using "Your Substance Abuse Policy: A Comprehensive Guide for Schools").
SAU 3.2	Provide guidance to SAUs on how to engage appropriate SAU committees to develop a Substance Abuse Policy Implementation Plan with a monitoring component (Refer to "A Comprehensive Guide for Schools" for a list of who should be involved).
SAU 3.3	Provide SAUs with guidance and support to engage parent organizations to support and promote the development and implementation of a school Substance Abuse Policy.

Appendix B: Required Subcontract language for Support HMPs

I. INTRODUCTION/OVERVIEW

This Agreement is for the purpose of providing health promotion, education and prevention services to support public health along with conducting activities in support of the public health infrastructure (as described in the Revised Programming Matrix (**Appendix A**) and accompanied by guidance issued by the Department). The Provider is being issued funds to conduct prevention work and to distribute them through subcontracts to Support HMPs so that they may also meet the requirements for the expected deliverables. The Provider shall engage in three (3) programmatic areas: 1) Activities in support of infrastructure (see **Appendix C**); 2) Activities of substance abuse prevention (see **Appendix D & E**); and 3) activities in support of tobacco related prevention, healthy nutrition and increased physical activity (see **Appendix B**).

II. DELIVERABLES

The Provider shall submit an approved workplan by August 15, 2015 that meets the following requirements:

SECTION 1: INFRASTRUCTURE SUPPORT AND CAPACITY DEVELOPMENT
<ul style="list-style-type: none">• A Section 1 Workplan that will be completely developed by August 31, 2015 (see Appendix C).
SECTION 2: SUBSTANCE ABUSE
<ul style="list-style-type: none">• Implement a minimum of four (4) evidenced-based prevention activities (see Appendix D) within the municipalities that make up the service area of the HMP, and which specifically focus on alcohol use/abuse prevention. The activities shall include:<ul style="list-style-type: none">○ Two (2) environmental activities (See Appendix D, Pg. 2); and○ Two (2) activities from Appendix D of the Coalition's choice based on the Provider's assessment.
SECTION 3: TOBACCO
<ul style="list-style-type: none">• From Appendix A implement Objective PTM 1 and Objective PTM 2, and a choice of Objective PTM 3, or Objective PTM 4 for a total of three (3) tobacco-related non-school objectives.• Implement a minimum of two (2) strategies from each selected objective annually, for a minimum total of six (6) strategies.
SECTION 4: OBESITY
<ul style="list-style-type: none">• From Appendix A implement Objectives OB 1 and a choice of Objective OB 2, or Objective OB 3, for a total of two (2) obesity-related, non-school objectives.• Implement Strategy OB 1.1: Increase by <u>X</u> the number of municipalities completing the Rural Active Living Assessment (RALA), an evidence-based tool designed to identify characteristics of a community that encourage physical activity.• Implement a minimum of two (2) strategies from each selected community focused objective annually, for a minimum total of four (4) strategies.

SECTION 6 SCHOOL ADMINISTRATIVE UNITS (SAU)

- From **Appendix A** implement all school objectives at the Maine Department of Education defined School Administrative Unit-level
- Select a new School Administrative Unit (SAU) each year to work with. Where work has not been completed in a SAU selected for the previous year, work must continue with that SAU in addition to work in the SAU newly selected. Where the Provider has less than three (3) SAUs in their local service area, the requirement is that the Provider work in all SAUs.

The Provider also shall:

12. Divide funding for the work defined in **Appendix C** amongst all HMPs within the health District in accordance with the **Appendix C** workplan guidance issued by the Department's District Liaison assigned to the Provider's Public Health District.
13. Develop and implement subcontracts following according to Section 10 of Rider D, and using the language provided in **Appendix B** for each Support HMP for their own programmatic work in support of the health promotion, education, and prevention services defined in **Appendix A** to be delivered.
14. Use the Lead and Support HMP Strategic Prevention Framework Assessments from Spring 2015 (which includes data analysis) to assist each HMP in identifying needs and capacity that will allow each community to target its resources and maximize its impact on substance use/abuse.
15. Ensure that each HMP will deliver tobacco, substance abuse, physical activity and nutrition services to all communities within its service area. HMPs are expected to coordinate these services, assuring the most efficient use of funds and effective application of programming.
16. Coordinate with District Liaisons and the Department's Project Officers to assure that guidance and technical assistance necessary to meet all Agreement expectations is available to Support HMPs.
17. Notify the Department's Project Officer in writing if and when potential or real issues arise that have the potential to adversely affect the initiative in the District. This may include the actions of Support HMPs.
18. Work closely and cooperatively with the District Support Team, the SAMHS Prevention Manager and the Senior Program Manager for Community Based Prevention to review and correct problematic situations.
19. Work closely and cooperatively with the Department in the event that actions become necessary to address underperformance of a Support HMP.
20. Continue to maintain all subcontracts for Support HMPs except in the event of dissolution of a Support HMP, or with the explicit permission of Department's HMP Sr. Program Manager to release the contract.
21. Use sound fiscal management practices in monitoring the performance of subcontracting HMPs.
22. Include in subcontracts for the Support HMPs a requirement that Support HMPs provide the Lead HMP access codes to the IMPACT Monitoring System in order to be able to monitor the presence of quarterly and other reporting.

HMPs are required to:

10. Meet expected deliverables and milestones within the approved timelines identified in this Agreement, make use of technical assistance as necessary, and implement

- any plan of correction developed to remediate underperformance.
11. Maintain an HMP Governance or Advisory Board comprised of local stakeholders, which as a body directs and oversees the work of the paid staff, and whose members are identified in the Coalition Characteristics reporting section of the IMPACT monitoring system, that is representative of their local service area and that includes at least two (2) individuals representing populations with health disparities. Board members representing populations with health disparities should be members of that specific population; in the lieu of meeting this condition, representatives may be drawn from agencies that provide significant services to such populations. This Governance or Advisory Board must maintain an Advocacy Committee, charged with identifying the health needs of the HMP service area and working to assure they are met, and a Board Development Committee, charged with identifying new potential members of the Board and recruiting them. It is the Department's requirement that this Governance or Advisory Board be distinct from paid staff, and that this Governance or Advisory Board oversees and directs the strategic direction of the HMP and the implementation of the HMP's work plan. The Department expects HMP Directors to keep the Governance or Advisory Board informed of their progress on deliverables, for example by providing quarterly updates regarding overall progress on Agreement deliverables, and on deliverables that are not met or behind schedule.
 12. Maintain a mutual agreement identified as a Memoranda of Understanding (MOU) that defines the relationship between the agency that holds the contract for HMPs not incorporated as a 501-c(3) (fiscal agent) and the HMP Advisory Board. Wherever possible, the fiscal agent shall participate in the work of the HMP and hold membership on the District Coordinating Council (DCC).
 13. Complete a Community-level Assessment to determine for the HMP service area community what contributing factors of alcohol abuse are of greatest concern in the community (ex. access, availability, etc.). In order to do so, the Provider shall utilize the SPF Guide to Assessment as a resource for this assessment and complete an Assessment Summary capturing the key points found through the assessment, a Logic Model illustrating the resources, short, intermediate, and long term outcomes, and the intended impact of the work, and Strategy Selection Matrix identifying the strategies selected by the HMP to address substance abuse, to help them determine how they will implement alcohol use/abuse prevention services in their community.
 14. Participate in Statewide communication campaigns and other initiatives developed by the State partners of the HMP.
 15. Talk directly with schools about participating in the Department's Maine Integrated Youth Health Survey, the primary data collection instrument used to assess the health of Maine youth.
 16. Work with the Department's contracted evaluators to complete evaluation activities that apply to services performed under this Agreement. This includes, but is not limited to, participating in evaluation activities such as site visits, complying with requests for program documentation, participation in surveys, and telephone interviews.
 17. Use appropriate State logo and credits on all publications/brochures/marketing materials used to meet the terms of this Agreement in accordance with the Department's requirements to be disseminated in guidance issued by the Department.
 18. Immediately notify the Department Project Officer in writing if there are any changes in key staff such as the Partnership Director or Substance Abuse lead.

III. PERFORMANCE MEASURES

Note: Performance Deliverables are determined using the average expected change for one year. Baseline is defined as the number of target settings in which the expected change had already been accomplished at the beginning of the grant period.

IV. Required Standards:	V. Information Used to Track/Monitor Completion of Column I.:	VI. Source of Information of Column II. (e.g. Name of report, on-site visit, data extraction from particular database, Department-obtained report 3 rd party (such as APS), etc.):
<p><i>Annual</i></p> <p>5 percent over Baseline of active retail settings that are enrolled in the Department's No Buts! Initiative.</p>	<p>Number of licensed tobacco retailers enrolled in No Buts!</p>	<p>PTM No Buts! database</p>
<p>39 percent over Baseline of retail settings that newly enroll in the Department's Star Store Initiative.</p>	<p>Number of licensed tobacco retailers enrolled in Star Store</p>	<p>PTM Star Store database</p>
<p>6 percent over Baseline of multi-unit residential settings that enact new smoke free policies or revise existing policies.</p>	<p>Number of multi-unit residential buildings that enact smoke free policies</p>	<p>IMPACT report</p>
<p>18 percent over Baseline of municipalities that enact policies and/or ordinances that address smoking in municipally sponsored open air events.</p>	<p>Number of municipalities that enact policies and/or ordinances that address smoking at open air events</p>	<p>IMPACT report</p>
<p>39 percent over Baseline of municipalities that have policies, plans and/or ordinances that</p>	<p>Number of municipalities that enact policies that address healthy living in the built environment</p>	<p>IMPACT report</p>

promote healthy living in the built environment (the built environment includes all of the physical parts of where people live and work; e.g., homes, buildings, streets, open spaces, and infrastructure).		
36 percent over baseline of sites that newly offer free access to physical activity opportunities	Number of sites that newly pass policies or cooperative agreements that allow physical activity	IMPACT report
62 percent over baseline of municipalities that newly increase access to healthy food options at municipally run venues	Number of municipalities that enact policies that increase access to healthy food options at municipally run venues	IMPACT report
8 percent of schools over baseline that newly implement comprehensive tobacco policies that meet PTM criteria	Number of schools over baseline that implement comprehensive tobacco policies	IMPACT report
13 percent of schools over baseline that implement comprehensive Wellness policies	Number of schools over baseline that implement comprehensive Wellness policies	IMPACT report
Department staff receives from the Provider a final SPF assessment and Substance Abuse Prevention Services workplan by August 15, 2015.	Completed FINAL Substance Abuse Prevention Services community assessment and work plan regarding alcohol use by August 15, 2015.	Completed FINAL Substance Abuse Prevention Services community assessment and work plan regarding alcohol use by August 15, 2015.

IV. REPORTS

HMPs shall comply with all data and reporting requirements utilizing the identified HMP monitoring tool and any complementary reporting tools developed by the Department, meeting the deadlines provided.

Name of Report or On-Site Visit:	Description or Appendix #:
1. Quarterly Fiscal Report	1. Located at: http://www.maine.gov/dhhs/contracts/contract-2016/index.html
2. Monthly Prevention Performance Measure IMPACT Report	2. Monthly IMPACT report
3. Quarterly Prevention Performance Measure IMPACT Report	3. Quarterly IMPACT Summary
4. Agreement Closeout Report	3. DHHS Closeout report Located at: http://www.maine.gov/dhhs/contracts/contract-2016/index.html

A. Reporting Schedule

The Provider shall submit reports in accordance with the specifications of the Department, according to the following schedule:

Name of Report or On-Site Visit:	Schedule:
1. Quarterly Fiscal Report	1. Due Thirty (30) days following last day of each quarter; October 30, 2015, January 30, 2016, April 30, 2016, July 30, 2016.
2. Quarterly Prevention Performance Measure IMPACT Report	2. Due thirty (30) days following last day of each quarter; October 30, 2015, January 30, 2016, April 30, 2016, July 30, 2016
3. Agreement Closeout Report	3. Sixty (60) days following the close of the Agreement period.

The Provider understands that the reports are due within the timeframes established and that the Department will not make subsequent payment installments under this Agreement until such reports are received, reviewed and accepted.

The Provider further agrees to submit such other data and reports as may be requested by the Agreement Administrator. The Provider shall submit all data and reports to the Department in accordance with Section 6 of Rider B of this Agreement.

District-wide HMP Infrastructure and Capacity (Section 1) Work plan

District Public Health

State of Maine Department of Health and
Human Services, Maine CDC
FY 2015-2016

OBJECTIVE 1:

Provide support for and increase capacity of the public health infrastructure.

IC 1.1 Actively participate on the District Coordinating Council

	<p>Lead HMP Deliverable: Insert name</p>	<p>Supporting HMP #1 Deliverable: Insert name</p>	<p>Measure</p>
<p>1.1.1 Lead HMP will provide meeting support for DCC Quarterly Meetings</p>	<p>HMP will provide staff responsible for recording minutes for the following: -Full DCC Coalition meeting -DCC Steering Committee meetings -DCC workgroup meetings</p> <p>Minutes will be submitted in typed format to the District Liaison no later than one week after the meeting</p> <p>The Lead HMP will assure that space is secured and appropriately sized to accommodate participants in advance of scheduled meetings</p> <p>The following will be provided at each DCC meeting: -printed agendas and other printed materials -Refreshments for full DCC meeting -Projector, flip charts, markers, laptop</p>	<p>Not Applicable for Support HMPs</p>	<p>Timely Minutes</p> <p>Associated Budget:</p> <ul style="list-style-type: none"> • Salary per hour x # hours necessary to record and submit minutes and prepare for meetings • In-kind contributions • Goods and Services- meeting space, food, etc... • Postage / Printing • Travel <p>Attendance at DCC meeting, DCC Steering Committee, and Subcommittee</p>

<p>1.1.2. Assure exchange of information related to the HMP, its local service area, and DCC among local, district and state partners.</p>	<p>HMP will report on / advocate for health promotion and prevention needs of their contracted local service area as requested by DCC</p>	<p>HMP will report on / advocate for health promotion and prevention needs of their contracted local service area as requested by DCC.</p>	<p>HMP will provide written documentation (such as corresponding materials, newsletters, brochures, etc.), to accompany DCC request.</p>
<p>Provide local service area (LSA) updates, input and feedback to the District Liaison, HMP Project Officer, SAMHS Project Officer.</p>	<p>Provide local service area (LSA) updates, input and feedback to the District Liaison, HMP Project Officer, SAMHS Project Officer.</p>	<p>Provide local service area (LSA) updates, input and feedback to the District Liaison, HMP Project Officer, SAMHS Project Officer.</p>	<p># HMP service area originated communications that are shared with identified partners</p>
<p>Disseminate Maine CDC and/or District communications as directed by the DCC / DL</p>	<p>Disseminate Maine CDC and/or District communications as directed by the DCC / DL</p>	<p>Disseminate Maine CDC and/or District communications as directed by the DCC / DL</p>	<p># HMP related communications initiated by the HMP</p>
<p># of requests made to HMP by DCC / DL</p>	<p># of dissemination partners who receive communications</p>	<p>Indicate format and purpose of communication</p>	<p># of requests made to HMP by DCC / DL</p>

<p>1.1.3. Participate in MCDC requests for assistance in public health emergencies and/or calls to action.</p>	<p>Respond to 100% of Maine CDC requests for assistance in public health emergencies and/or calls to action; notification and specific instruction will be made based upon event.</p>	<p># requests made by Maine CDC for HMP assistance</p> <p>List activities which occurred as a result of Maine CDC request for assistance</p>
<p>1.1.4.A. minimum of one (1) HMP will serve at the DCC Executive/Steering committee level</p>	<p>At least one HMP shall serve on the Executive/Steering committee level. Identify which HMP will assume this responsibility.</p>	<p>DCC Executive/Steering Committee roster</p> <p>DCC Executive/Steering Committee meeting attendance list</p>
<p>1.1.5. Chair/lead/ participate and/or otherwise contribute to the implementation of a minimum of one (1) DPHIP objective</p>	<p>DPHIP Objective(s):</p> <p>(1) _____</p> <p>(2) _____</p>	<p>Provide brief quarterly update of specific activity undertaken by HMP on DPHIP objective for use by DL, DCC, and SCC.</p>

IC 1.2 Adopt and build CCHC core competencies (FY 2015-2016 focus 1,2,3,4,5 and 9)

Governance Core Competency:

A CCHC has a transparent process that includes an independent advisory or governance board.
Performance standard: CCHC advisory or governance board has representatives that reflect the community, including people who represent vulnerable populations and those at increased risk.

Funding Core Competency:

A CCHC can secure resources to support its mission and its capacity.
Performance standard: CCHC responds effectively to regional, statewide, and federal requests for proposals.

Management and Administrative Core Competency:

A CCHC can maintain the management and administrative capacity necessary to carry out its functions, strategies and programs, comply with fiscal requirements, and meet performance standards.
Performance standard: CCHC recruits, hires and

The HMP will maintain a Board Development Committee which is responsible for assuring multi-sector representation on the coalition.

HMP will maintain its ability to meet any and all contract requirements of funder organizations regardless of other organizational obligation or deadline.

All HMP job ads and subsequent hiring processes will seek candidates' educated/trained with direct experience specifically in the field of community/public health.

HMP will update staffing plan with HMP Support Team members resulting from staff or proposed staff responsibility changes

The HMP will maintain a Board Development Committee which is responsible for assuring multi-sector representation on the coalition.

HMP will maintain its ability to meet any and all contract requirements of funder organizations regardless of other organizational obligations or deadlines.

All HMP job ads and subsequent hiring processes will seek candidates' educated/trained with direct experience specifically in the field of community/public health.

HMP will update staffing plan with HMP Support Team members resulting from staff or proposed staff responsibility changes

HMP membership roster
 HMP minutes indicating member and associated sector attendance

Membership gap analysis and description of action taken to recruit vacancies

100% HMP financial and activity reports are submitted by deadlines.

Job vacancy postings

Updated Staffing plan and/or organization chart

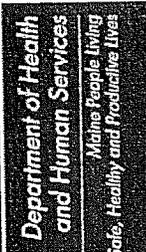
<p>supervises competent staff, and/or establishes contracts for necessary services and expert assistance.</p> <p>Leadership Core Competency: A CCHC develops and sustains competent and effective leaders.</p> <p>Performance standard: CCHC leaders participate in reviews of research, ongoing learning, and capacity-building opportunities that strengthen the coalition in carrying out its functions and meeting performance standards.</p>	<p>HMP will assure that subcontracts are appropriately awarded and monitored</p> <p>HMP will participate in at least 6 HMP Professional Development Workgroup activities / webinars / trainings</p>	<p>HMP will assure that subcontracts are appropriately awarded and monitored</p> <p>HMP will participate in at least 6 HMP Professional Development Workgroup activities / webinars / trainings</p>	<p>Copy of contracts drafted for the provision of service for which the HMP is held ultimately accountable.</p> <p>Adobe and/or other training attendance rosters</p>
<p>Convening and Mobilizing Core Competency: A CCHC can bring together individuals, organizations and agencies to align their work in the community, collaborate on community health assessments, and develop and carry out Community Health Improvement Plans.</p> <p>Performance standard: CCHC mobilizes partnerships to address community health improvement goals.</p>	<p>Participate in Shared Health Needs Assessment and Planning Process (SHNAPP) community engagement activities including membership on District Community Engagement Subcommittee</p> <p>Identify SHNAPP engagement contacts and promote inclusion of populations from the HMP local service; Distribute health needs assessment results and forum invitations as indicated by District</p>	<p>Participate in Shared Health Needs Assessment and Planning Process (SHNAPP) community engagement activities including membership on District Community Engagement Subcommittee</p> <p>Identify SHNAPP engagement contacts and promote inclusion of populations from the HMP local service; Distribute health needs assessment results and forum invitations as indicated by District</p>	<p>Identify staff member assigned to serve on District Engagement Subcommittee</p> <p>Attendance at District Engagement Subcommittee meetings</p> <p># contacts provided # sectors represented # of sectors representing populations experiencing health disparities</p>

<p><u>Evaluation Core Competency:</u> A CCHC can engage in evaluations of its functions, programs and strategies.</p> <p>Performance Standard: CCHC complies with required evaluations.</p>	<p><i>Community Engagement Subcommittee</i></p> <p>HMP will complete all necessary reports including MOSAIC system entries</p> <p>WHAT REPORTS are THE HMP REPORTING WORKGROUP PROPOSING – CONSIDER MANDATING PROGRESS NOTES</p>	<p><i>Community Engagement Subcommittee</i></p>	<p>HMP financial and activity reports are submitted by deadlines.</p>
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Appendix D:

Substance Abuse Prevention Strategy Matrix for Expanded Substance Abuse Prevention FY 16

<p>Information Dissemination: This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco, obesity, and drug use, abuse and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.</p>	
<ul style="list-style-type: none"> • Clearinghouse/information resource center(s) • Resource directories • Media campaigns • Brochures • Radio/TV public service announcements • Dissemination at venues (ex. movie theaters, real estate agencies, coasters, placemats, funeral homes, hospice, hospitals, pizza box tops, 5K, work sites, pharmacies, mental health facilities, colleges/universities, schools, laundromats.) 	<p style="text-align: center;">Suggested Activities</p> <ul style="list-style-type: none"> • Health fairs/health promotion • Information line • Newsletter Development, articles • Social media (e.g. facebook, twitter, instagram, etc.) • Web information (eg. Youtube, web pages, etc.) • Announcements at sporting events • Piggybacking on other partners mailings, events, newsletters, etc.
<p>Education: This strategy involves two-way communication and is distinguished from the <i>Information Dissemination strategy</i> by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life skills, decision-making, critical analysis, judgment abilities (i.e. Media literacy etc.) classroom and/or small group sessions (all ages)</p>	
<ul style="list-style-type: none"> • Prime For Life program in universal settings • Evidenced based curricula listed on NREPP (ex. Project Alert, Project Success, Life Skills.) • Parenting and family management classes • Peer educators • Education programs for youth groups • Education with/at venues listed in Info. Dissemination (above) 	<p style="text-align: center;">Activity</p> <ul style="list-style-type: none"> • Substance Abuse Education Sessions, such as: <ul style="list-style-type: none"> ○ safe storage ○ proper disposal of prescription pills ○ harmful effects of substance abuse ○ problem gambling ○ Responsible Beverage Server Seller



AGENCY NAME: Mid Coast Hospital
PROGRAM NAME: Access Health HMP
AGREEMENT START DATE: 7/1/2015
AGREEMENT END DATE: 6/30/2016
DHHS AGREEMENT #: CDC 16-342 LEAD BUDGET

REVENUE SUMMARY							
LINE	COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7
	REVENUE SOURCES	TOTAL PROGRAMS (this agreement)	SERVICE: PROGRAM: District Level	SERVICE: PROGRAM: HMP Programmatic	SERVICE: PROGRAM: Underage & High Risk Drinking	SERVICE: PROGRAM:	SERVICE: PROGRAM:
3	TO BE COST SHARED List by Donor or Source (Add rows as needed)*						
4	AGREEMENT FEDERAL REVENUE						
5	FEDERAL DHHS AGREEMENT FUNDS	80,000			80,000		
6	FEDERAL BLOCK GRANT AGREEMENT FUNDS						
7	AGREEMENT STATE REVENUE						
9	STATE DHHS AGREEMENT FUNDS-GF						
10	STATE DHHS AGREEMENT FUNDS-FHM	642,941	134,605	508,336			
11	STATE DHHS AGREEMENT FUNDS-OTHER						
12	RESTRICTED UNITED WAY						
13	RESTRICTED MUNICIPAL/COUNTY						
14	OTHER RESTRICTED INCOME (PROGRAM)						
15	PRIVATE CLIENT FEES						
16	AGENCY COMMITMENT TO PROGRAM						
17							
18							
19							
20	TOTAL COST SHARED REVENUE	722941	134,605	508,336	80,000		
21	NON COST SHARED (Add rows as needed)*						
22	MAINECARE						
23	OTHER RESTRICTED FEDERAL/STATE						
24	THIRD PARTY IN-KIND						
25	PROGRAM CLIENT FEES						
26	PROGRAM INCOME						
27	SUBRECIPIENT AWARD: CITY OF PORTLAND Agreement # CDC-16-468	26,745		20,000	6,745		
28							
29	RESTRICTED REVENUE (PURPOSE)						
30							
31							
32							
33							
34	TOTAL NON COST SHARED REVENUE	26745		20,000	6,745		
35	TOTAL REVENUE (Lines 19, 33)	749886	134,605	528,336	86,745		
36	TOTAL AGENCY-WIDE REVENUE	124,149,436					

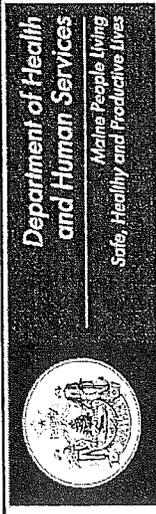
* If adding rows, please make sure cells containing formulas are copied into rows added



Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

AGENCY NAME: Mid Coast Hospital
PROGRAM NAME: Access Health HMP
AGREEMENT START DATE: 7/1/2015
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LINE	COLUMN 1 EXPENSES	COLUMN 2 TOTAL PROGRAMS (this agreement)	COLUMN 3		COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7
			SERVICE:	PROGRAM: District Level	SERVICE:	PROGRAM: HMP Programmatic	SERVICE:	PROGRAM:
3	PERSONNEL EXPENSES							
4	SALARIES/WAGES	177,864	48,406	113,308	16,150			
5	FRINGE BENEFITS	37,173	10,117	23,681	3,375			
6	THIRD PARTY IN-KIND (Match Only)							
7	TOTAL PERSONNEL EXPENSES	215,037	58,523	136,989	19,525			
8	CAPITAL EQUIPMENT PURCHASES							
9	SUB-RECIPIENT AWARDS	492,721	66,000	366,721	60,000			
10	ALL OTHER EXPENSES							
11	OCCUPANCY - DEPRECIATION							
12	OCCUPANCY - INTEREST							
13	OCCUPANCY - RENT							
14	UTILITIES/HEAT							
15	TELEPHONE							
16	MAINTENANCE/MINOR REPAIRS							
17	BONDING/INSURANCE							
18	EQUIPMENT RENTAL/LEASE							
19	MATERIALS/SUPPLIES	2,816	250	927	1,639			
20	DEPRECIATION (Non-Occupancy)							
21	FOOD							
22	CLIENT-RELATED TRAVEL							
23	OTHER TRAVEL	3,095	780	1,875	440			
24	CONSULTANTS - DIRECT SERVICE							
25	CONSULTANTS - OTHER	750			750			
26	INDEPENDENT PUBLIC ACCOUNTANTS							
27	TECHNOLOGY SERVICES/SOFTWARE							
28	THIRD PARTY IN-KIND (Match Only)							
29	SERVICE PROVIDER TAX							
30	TRAINING/EDUCATION	500		500				
31	MISCELLANEOUS	862			862			
32	SUBTOTAL - ALL OTHER EXPENSES	8,023	1,030	3,302	3,691			
33	INDIRECT ALLOCATED - G&A (Line 37 x Line 38)	33,905	9,052	21,324	3,529			
34	TOTAL ALL OTHER EXPENSES (Lines 32, 33)	41,928	10,082	24,626	7,220			
35	TOTAL EXPENSES (Lines 7, 8, 9, 34)	749,686	134,605	528,336	86,745			
36	TOTAL AGENCY-WIDE EXPENSES	127,672,435						
37	ALLOCATION BASE	223,060	59,553	140,291	23,216			
38	INDIRECT COST RATE (Form 4, Line 6)	15.20%	15.20%	15.20%	15.20%			15.20%



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THIRD PARTY IN-KIND RESOURCE DONATION

\$ _____ Of In-Kind (describe):
 Shall be furnished by:
 Explanation (how was value determined):

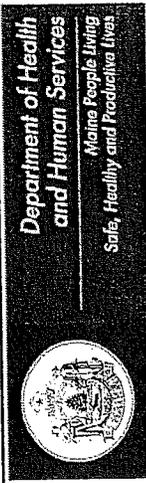
Shall be used as matching funds for (check applicable): FVPG SSBG/SPSS/CCSF CVAP
 Other (specify) _____

\$ _____ Of In-Kind (describe):
 Shall be furnished by:
 Explanation (how was value determined):

Shall be used as matching funds for (check applicable): FVPG SSBG/SPSS/CCSF CVAP
 Other (specify) _____

\$ _____ Of In-Kind (describe):
 Shall be furnished by:
 Explanation (how was value determined):

Shall be used as matching funds for (check applicable): FVPG SSBG/SPSS/CCSF CVAP
 Other (specify) _____



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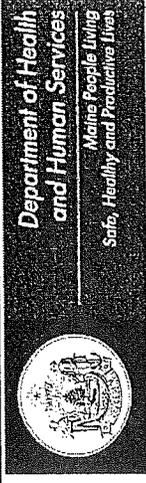
DIRECT PERSONNEL EXPENSES - DISTRICT LEVEL

LINE	COLUMN 1 PERSONNEL EXPENSES	COLUMN 2 POSITION TITLE	COLUMN 3 CREDENTIAL (eg. MHRT II, LCSW)	COLUMN 4 TOTAL ANNUAL SALARY FOR AGREEMENT PERIOD	COLUMN 5 TOTAL # ANNUAL HOURS SPENT ON PROGRAM	TOTAL DIRECT PROGRAM SALARY FOR AGREEMENT PERIOD
1	DIRECT CARE/CLINICAL STAFF					
2	Melissa Fochesato, Program Director	BS		60,008.00	1,040.00	30,807.20
3	Theresa Sherman			26,757.00	1,092.00	17,799.60
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14	TOTAL FTE	1.00			2,132.00	48,406.80

LINE	COLUMN 6 ADMINISTRATIVE STAFF (Non Indirect Allocated)	COLUMN 7 TOTAL FRINGE BENEFITS	COLUMN 8 SUMMARY
15			
16			
17			
18			
19			
20	TOTAL FTE		TOTALS
21			2,132.00
			48,406.80

LINE	COLUMN 7 TOTAL FRINGE BENEFITS	COLUMN 8 SUMMARY
22	TYPE OF BENEFIT (SPECIFY)	ITEM
23	FICA & MEDICARE TAX	% SALARY
24	UNEMPLOYMENT INSURANCE	TOTAL SALARY
25	WORKERS' COMPENSATION	TOTAL FRINGE
26	HEALTH/DENTAL	TOTAL
27	PENSION	REMARKS:
28	OTHER	10.30% Other: Life Insurance, LTD and Tuition Reimbursement. FICA rate is below 7.65% because the rate is capped after a certain salary, hence our agency wide rate averages to 6.5%
29	TOTAL FRINGE BENEFITS	20.90%

LINE	COLUMN 9 CONSULTANTS - DIRECT SERVICE	TOTAL COST
31	SERVICE	
32	NAME	
33	CREDENTIAL	
34	HOURLY RATE	
35	# ANNUAL HOURS	
	TOTAL	



AGENCY NAME: Mid Coast Hospital
 PROGRAM NAME: Access Health HMP
 AGREEMENT START DATE: 7/1/2015
 AGREEMENT END DATE: 6/30/2016
 DHHS AGREEMENT#: CDC 16-342 LEAD BUDGET

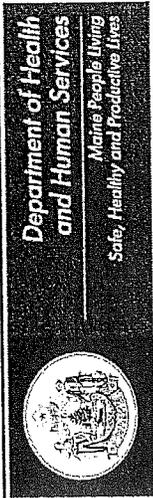
DIRECT PERSONNEL EXPENSES - HMP PROGRAMMATIC

LINE	COLUMN 1 PERSONNEL EXPENSES	COLUMN 2 CREDENTIAL (eg. MHRT II, LCSW)	COLUMN 3 TOTAL ANNUAL SALARY FOR AGREEMENT PERIOD	COLUMN 4 TOTAL # ANNUAL HOURS SPENT ON PROGRAM	COLUMN 5 TOTAL DIRECT PROGRAM SALARY FOR AGREEMENT PERIOD
1	DIRECT CARE/CLINICAL STAFF				
2	Melissa Fochesato, Program Director	BS	60,008.00	468.00	13,773.24
3	Teresa Sherman, Project Assistant	MS	26,757.00	208.00	3,390.40
4	Jannah Godo, Prevention Specialist	MS	35,006.00	676.00	15,169.44
5	Linda Christie, Prevention Specialist	BS	50,902.00	1,924.00	49,561.20
6	Colleen Fuller, Prevention Specialist	MPH	36,635.00	1,599.00	30,269.07
7	Tasha Gerken, Nutrition Educator	RD, MS	40,040.00	52.00	1,144.00
8					
9					
10					
11					
12					
13					
14	TOTAL FTE	2.40		4,927.00	113,307.35

LINE	COLUMN 7 TOTAL FRINGE BENEFITS	COLUMN 8 SUMMARY	COLUMN 9 CONSULTANTS- DIRECT SERVICE
15	ADMINISTRATIVE STAFF (Non Indirect Allocated)		
16			
17			
18			
19			
20	TOTAL FTE	TOTALS	TOTAL
21		4,927.00	113,307.35

LINE	COLUMN 7 TOTAL FRINGE BENEFITS	COLUMN 8 SUMMARY	COLUMN 9 CONSULTANTS- DIRECT SERVICE
22	TYPE OF BENEFIT (SPECIFY)	ITEM	DIRECT
23	FICA & MEDICARE TAX	6.50% TOTAL SALARY	113,307.35
24	UNEMPLOYMENT INSURANCE	0.20% TOTAL FRINGE	23,681.24
25	WORKERS' COMPENSATION	0.80% TOTAL	136,988.59
26	HEALTH/DENTAL	10.30% REMARKS:	
27	PENSION	2.70% Other: Life Insurance, LTD and Tuition Reimbursement. FICA rate is below 7.65% because the rate is capped after a certain salary, hence our agency wide rate averages to 6.5%	
28	OTHER	0.40%	
29	TOTAL FRINGE BENEFITS	20.90%	

LINE	COLUMN 9 CONSULTANTS- DIRECT SERVICE	COLUMN 8 SUMMARY	COLUMN 7 TOTAL FRINGE BENEFITS
31	SERVICE	NAME	HOURLY RATE
32			
33			
34			
35			



AGENCY NAME:	Mid Coast Hospital
PROGRAM NAME:	Access Health HMP
AGREEMENT START DATE:	7/1/2015
AGREEMENT END DATE:	6/30/2016
DHHS AGREEMENT#:	CDC 16-342 LEAD BUDGET
INDIRECT ALLOCATION (G&A) SUMMARY	

Non-profit organizations with one major function where all costs are charged to one fund/agreement typically do not have indirect costs. All costs, be they administrative or program, are charged to one agreement. Non-profit organizations with one major function that also have fundraising expenses must segregate general and administrative costs (indirect) to both program and fundraising expenses and must establish an indirect cost pool. The simplified allocation method is recommended for these agencies (See OMB A-122, Attachment A, D, 2. Simplified allocation method).

- 1 Does your agency have indirect costs? Yes No
- If NO, disregard the remainder of this Form and Forms 4A & 4B. If YES, proceed below:
- 2 Does your agency have an approved indirect cost rate? Yes No
- If NO, proceed below. If YES, enter rate here. **INCLUDE RATE LETTER** 15.20%

3 In general, there are three methods of allocating indirect costs: The simplified allocation method, the multiple allocation method, or the direct allocation method. (See OMB A-122, Attachment A, D. Allocation of Indirect Costs and Determination of Indirect Cost Rates for guidance).

What method of allocation does your agency use to spread its indirect costs?

a. Simplified Allocation Method	<input type="checkbox"/>	(Circular A-122, D, 2)
b. Multiple Allocation Method	<input type="checkbox"/>	(Circular A-122, D, 3)
c. Direct Allocation Method	<input type="checkbox"/>	(Circular A-122, D, 4)
d. Other _____	<input type="checkbox"/>	

4 Indicate your agency's distribution base and provide the amount:

a. Total Salaries	<input type="checkbox"/>	<input type="checkbox"/>	Distribution Base
b. Total Direct Costs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Other _____	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5 Total Agency-Wide Indirect Costs - Budget Form 4A, Line 26

6 Agency Indirect Cost Rate (Line 5 divided by Line 4) FALSE

Multiply the Indirect Cost Rate in Box 6, which links to Budget Form 2, Line 38, by the allocation base on Budget Form 2, Line 37 to calculate the Indirect Allocated G&A on Budget Form 2, Line 33.



AGENCY NAME: Mid Coast Hospital
PROGRAM NAME: Access Health HIMP
AGREEMENT START DATE: 7/1/2015
AGREEMENT END DATE: 6/30/2016
DHHS AGREEMENT#: CDC 16-342 LEAD BUDGET

AGENCY-WIDE INDIRECT EXPENSE SUMMARY

LINE	COLUMN 1	AGENCY TOTAL	MULTIPLE ALLOCATION METHOD/DIRECT ALLOCATION			
			COST POOL ADMIN	COST POOL FACILITIES	COST POOL NAME?	COST POOL NAME?
1	INDIRECT EXPENSES					
2	INDIRECT PERSONNEL EXPENSES					
3	SALARIES/WAGES (Form 4B, Line 26)					
4	FRINGE BENEFITS					
5	TOTAL INDIRECT PERSONNEL EXPENSES					
6	INDIRECT OTHER EXPENSES					
7	OCCUPANCY - DEPRECIATION					
8	OCCUPANCY - INTEREST					
9	OCCUPANCY - RENT					
10	UTILITIES/HEAT					
11	TELEPHONE					
12	MAINTENANCE/MINOR REPAIRS					
13	BONDING/INSURANCE					
14	EQUIPMENT RENTAL/LEASE					
15	MATERIALS/SUPPLIES					
16	DEPRECIATION (Non-occupancy)					
17	FOOD					
18	CLIENT-RELATED TRAVEL					
19	OTHER TRAVEL					
20	CONSULTANTS - DIRECT SERVICE					
21	CONSULTANTS - OTHER					
22	INDEPENDENT PUBLIC ACCOUNTANTS					
23	TECHNOLOGY SERVICES/SOFTWARE					
24	MISCELLANEOUS					
25	TOTAL INDIRECT OTHER EXPENSES					
26	TOTAL INDIRECT EXPENSES					

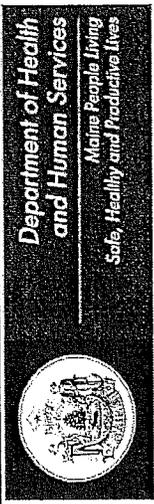


**Department of Health
and Human Services**
*Making People Living
Safe, Healthy and Productive Lives*

AGENCY NAME: Mid Coast Hospital
PROGRAM NAME: Access Health HMP
AGREEMENT START DATE: 7/1/2015
AGREEMENT END DATE: 6/30/2016
DHHS AGREEMENT#: CDC 16-342 LEAD BUDGET

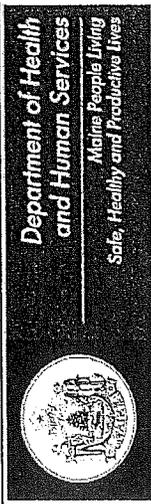
AGENCY WIDE INDIRECT PERSONNEL EXPENSE SUMMARY

LINE	POSITION/TITLE	TOTAL INDIRECT SALARIES	MULIPLE ALLOCATION METHOD/DIRECT ALLOCATION			
			COST POOL ADMIN	COST POOL FACILITIES	COST POOL NAME?	COST POOL NAME?
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						
21						
22						
23						
24						
25						
26	TOTAL INDIRECT PERSONNEL EXPENSES					



AGENCY NAME: Mid Coast Hospital
PROGRAM NAME: Access Health HMP
AGREEMENT START DATE: 7/1/2015
AGREEMENT END DATE: 6/30/2016
DHHS AGREEMENT#: CDC 16-342 LEAD BUDGET

EXPENSE/DETAILS/DISTRICT-LEVEL	
COLUMN 1	COLUMN 2
LINE	AMOUNT (from Form 2)
NAME OF LINE ITEM	DETAIL (Use Form 5A if this space is insufficient for required information)
8	CAPITAL EQUIPMENT PURCHASES (provide your agency's capitalization policy)
9	SUB-RECIPIENT AWARDS (provide detailed list) 66,000
11	OCCUPANCY - DEPRECIATION (provide depreciation schedule)
12	OCCUPANCY - INTEREST
13	OCCUPANCY - RENT (provide name of landlord and physical address)
14	UTILITIES/HEAT
15	TELEPHONE
16	MAINTENANCE/MINOR REPAIRS
17	BONDING/INSURANCE
18	EQUIPMENT RENTAL/LEASE
19	MATERIALS/SUPPLIES 250
20	DEPRECIATION - NON-OCCUPANCY (provide depreciation schedule)
21	FOOD
22	CLIENT-RELATED TRAVEL (State Rate \$0.44 per mile) Indicate your rate in Column 3
23	OTHER TRAVEL (State Rate \$0.44 per mile) Indicate your rate in Column 3 780
25	CONSULTANTS - OTHER (provide detailed information)
26	INDEPENDENT PUBLIC ACCOUNTANTS
27	TECHNOLOGY SERVICES/SOFTWARE
30	TRAINING/EDUCATION
31	MISCELLANEOUS (should be less than \$1,000; use Form 5A for additional details)



AGENCY NAME: Mid Coast Hospital
PROGRAM NAME: Access Health HMP
AGREEMENT START DATE: 7/1/2015
AGREEMENT END DATE: 6/30/2016
DHHS AGREEMENT#: CDC-16-342 LEAD BUDGET

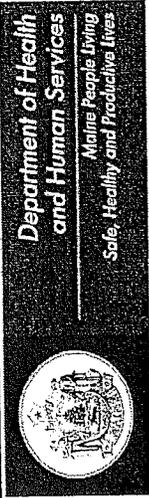
EXPENSE DETAILS HMP PROGRAMMATIC	
COLUMN 1	COLUMN 2
LINE	AMOUNT (from Form 2)
NAME OF LINE ITEM	DETAIL (Use Form 5A if this space is insufficient for required information)
8 CAPITAL EQUIPMENT PURCHASES (provide your agency's capitalization policy)	
9 SUB-RECIPIENT AWARDS (provide detailed list)	366,721
11 OCCUPANCY - DEPRECIATION (provide depreciation schedule)	
12 OCCUPANCY - INTEREST	
13 OCCUPANCY - RENT (provide name of landlord and physical address)	
14 UTILITIES/HEAT	
15 TELEPHONE	
16 MAINTENANCE/MINOR REPAIRS	
17 BONDING/INSURANCE	
18 EQUIPMENT RENTAL/LEASE	
19 MATERIALS/SUPPLIES	927
20 DEPRECIATION - NON-OCCUPANCY (provide depreciation schedule)	
21 FOOD	
22 CLIENT-RELATED TRAVEL (State Rate \$0.44 per mile) Indicate your rate in Column 3	
23 OTHER TRAVEL (State Rate \$0.44 per mile) Indicate your rate in Column 3	1,875
25 CONSULTANTS - OTHER (provide detailed information)	
26 INDEPENDENT PUBLIC ACCOUNTANTS	
27 TECHNOLOGY SERVICES/SOFTWARE	
30 TRAINING/EDUCATION	500
31 MISCELLANEOUS (should be less than \$1,000; use Form 5A for additional details)	

\$120,000 each to Medical Care Development, Penobscot Bay YMCA and Waldo General Hospital to implement HMP workplan in Lincoln, Knox and Waldo Counties. \$6721 to Healthy Communities of the Capital Area to implement HMP work in Richmond

Office supplies to support program and program materials to connect residents to low cost physical activity and promote smoke free parks and housing, TBD by Advisory Board.

Mileage at .44/mile to attend community and state meetings, plus mileage and parking

In state training registration fees for CHIP (connecting to low cost, local food) and HMP priorities (MPHA, MNHC education fees)



AGENCY NAME: Mid Coast Hospital
PROGRAM NAME: Access Health HMP
AGREEMENT START DATE: 7/1/2015
AGREEMENT END DATE: 6/30/2016
DHHS AGREEMENT#: CDC 16-342 LEAD BUDGET

EXPENSE DETAILS UNDERAGE & HIGH-RISK DRINKING	
LINE	DETAIL
COLUMN 1	COLUMN 3
NAME OF LINE ITEM	AMOUNT (from Form 2)
8	CAPITAL EQUIPMENT PURCHASES (provide your agency's capitalization policy)
9	SUB-RECIPIENT AWARDS (provide detailed list)
11	OCCUPANCY - DEPRECIATION (provide depreciation schedule)
12	OCCUPANCY - INTEREST
13	OCCUPANCY - RENT (provide name of landlord and physical address)
14	UTILITIES/HEAT
15	TELEPHONE
16	MAINTENANCE/MINOR REPAIRS
17	BONDING/INSURANCE
18	EQUIPMENT RENTAL/LEASE
19	MATERIALS/SUPPLIES
20	DEPRECIATION - NON-OCCUPANCY (provide depreciation schedule)
21	FOOD
22	CLIENT-RELATED TRAVEL (State Rate \$0.44 per mile) Indicate your rate in Column 3
23	OTHER TRAVEL (State Rate \$0.44 per mile) Indicate your rate in Column 3
25	CONSULTANTS - OTHER (provide detailed information)
26	INDEPENDENT PUBLIC ACCOUNTANTS
27	TECHNOLOGY SERVICES/SOFTWARE
30	TRAINING/EDUCATION
31	MISCELLANEOUS (should be less than \$1,000; use Form 5A for additional details)

(Use Form 5A if this space is insufficient for required information)
 \$20,000 each to Medical Care Development, Penobscot Bay YMCA and Waldo General Hospital to implement underage and high risk drinking workshop in Lincoln, Knox and Waldo Counties.
 60,000
 1,639
 440
 750
 862

Office supplies and materials to support programming, including: eTip promotional items (posters, magnets), licensee Card ME and RBS training supplies, and parental monitoring campaign promotion (rack cards, magnets, etc)
 In state travel to community and state meetings at .44/mile
 To BC Consultants (Frank Lyons) to support 2 RBS trainings, extra cost supported by registration fee of \$10/pp
 Advertising costs for FB boosts and ads for eTip and parental monitoring campaign: 8 campaigns @ \$100 per campaign (week long, multiple ads); 5 "boosts" at \$10/boost, 1 @ \$12/boost



**RIDER F-1
PRO FORMA**

(see instructions and MAAP IV)

PRO FORMA

AGENCY NAME:	Mid Coast Hospital
FISCAL YEAR END:	6/30/2016
FUNDING DEPARTMENT:	MeCDC
DHHS AGREEMENT#:	CDC 16-342 LEAD BUDGET
AGREEMENT START DATE:	7/1/2015
AGREEMENT END DATE:	6/30/2016
AGREEMENT AMOUNT:	\$134,605.00
PROGRAM NAME:	Access Health HMP

	PART I: AGREEMENT TOTALS	DISTRICT LEVEL		
		REVENUE	EXPENSE	BALANCE
1	PER AGREEMENT BUDGET	134,605	134,605	
	AGREEMENT ADJUSTMENTS			
2	Subrecipient Penobscot Bay YMCA, KCHC HMP	22,000	22,000	
3	Subrecipient Medical Care Development, HLC HMP	22,000	22,000	
4	Subrecipient Waldo County General Hospital, HWC HMP	22,000	22,000	
5				
6				
7				
8				
9	TOTAL ADJUSTMENTS	66,000	66,000	
10	TOTALS AVAILABLE FOR COST SHARING	68,605	68,605	

	PART II: AGREEMENT COST SHARING	% OF BUDGET	DISTRICT LEVEL		BALANCE
			REVENUE	EXPENSE	
11	AGREEMENT # (STATE FUNDS)	100.00%	68,605	68,605	
12	AGREEMENT # (FEDERAL FUNDS)				
13	ALL OTHER - UNRESTRICTED				
14	ALL OTHER - RESTRICTED (PROGRAM)				
15	TOTALS	100.00%	68,605	68,605	

NOTES TO ADJUSTMENTS
Subrecipient awards to support local public health district infrastructure work in HMP service area and support DCC and DPHIP focus areas



(see instructions and MAAP IV)

PRO FORMA

AGENCY NAME:	Mid Coast Hospital
FISCAL YEAR END:	6/30/2016
FUNDING DEPARTMENT:	MeCDC
DHHS AGREEMENT#:	CDC 16-342 LEAD BUDGET
AGREEMENT START DATE:	7/1/2015
AGREEMENT END DATE:	6/30/2016
AGREEMENT AMOUNT:	\$508,336.00
PROGRAM NAME:	Access Health HMP

PART I: AGREEMENT TOTALS		REVENUE	EXPENSE	BALANCE
1	PER AGREEMENT BUDGET	528,336	528,336	
AGREEMENT ADJUSTMENTS		HMP PROGRAMMATIC		
2	Subrecipient Penobscot Bay YMCA, KCHC HMP	120,000	120,000	
3	Subrecipient Medical Care Development, HLC HMP	120,000	120,000	
4	Subrecipient Waldo County General Hospital, HWC HMP	120,000	120,000	
5	Subrecipient Healthy Communities of the Capital Area	6,721	6,721	
6	Non cost shared revenue - City of Portland	20,000	20,000	
8				
9	TOTAL ADJUSTMENTS	386,721	386,721	
10	TOTALS AVAILABLE FOR COST SHARING	141,615	141,615	

PART II: AGREEMENT COST SHARING					
		% OF BUDGET	REVENUE	EXPENSE	BALANCE
11	AGREEMENT # (STATE FUNDS)	100.00%	141,615	141,615	
12	AGREEMENT # (FEDERAL FUNDS)				
13	ALL OTHER - UNRESTRICTED				
14	ALL OTHER - RESTRICTED (PROGRAM)				
15	TOTALS	100.00%	141,615	141,615	

NOTES TO ADJUSTMENTS

Subrecipient awards to implement HMP work in local service areas. HCCA will cover Richmond for Access Health. City of Portland funds awarded to cover HMP work in Brunswick and Harpswell for Healthy Casco Bay



**Department of Health
and Human Services**
Maine People Living
Safe, Healthy and Productive Lives

**RIDER F-1
PRO FORMA**

(see instructions and MAAP IV)

PRO FORMA

AGENCY NAME:	Mid Coast Hospital
FISCAL YEAR END:	6/30/2016
FUNDING DEPARTMENT:	SAMHS
DHHS AGREEMENT#:	CDC 16-342 LEAD BUDGET
AGREEMENT START DATE:	7/1/2015
AGREEMENT END DATE:	6/30/2016
AGREEMENT AMOUNT:	\$80,000.00
PROGRAM NAME:	Access Health HMP

PART I: AGREEMENT TOTALS		UNDERAGE & HIGH RISK DRINKING		
		REVENUE	EXPENSE	BALANCE
1	PER AGREEMENT BUDGET	86,745	86,745	
AGREEMENT ADJUSTMENTS				
2	Subrecipient Penobscot Bay YMCA, KCHC HMP	20,000	20,000	
3	Subrecipient Medical Care Development, HLC HMP	20,000	20,000	
4	Subrecipient Waldo County General Hospital, HWC HMP	20,000	20,000	
5	Subrecipient award from City of Portland	6,745	6,745	
6				
8				
9	TOTAL ADJUSTMENTS	66,745	66,745	
10	TOTALS AVAILABLE FOR COST SHARING	20,000	20,000	

PART II: AGREEMENT COST SHARING		% OF BUDGET	REVENUE	EXPENSE	BALANCE
11	AGREEMENT # (STATE FUNDS)				
12	AGREEMENT # (FEDERAL FUNDS)	100.00%	20,000	20,000	
13	ALL OTHER - UNRESTRICTED				
14	ALL OTHER - RESTRICTED (PROGRAM)				
15	TOTALS	100.00%	20,000	20,000	

NOTES TO ADJUSTMENTS
Subrecipient awards to implement SAMHS worplan in local service area. City of Portland funds received to cover SAMHS work in Brunswick and Harpswell.



AGREEMENT COMPLIANCE FORM

AGENCY NAME:	Mid Coast Hospital
PROGRAM NAME:	Access Health HMP
AGREEMENT START DATE:	7/1/2015
AGREEMENT END DATE:	6/30/2016
DHHS AGREEMENT#:	CDC 16-342 LEAD BUDGET

This section identifies compliance requirements that must be considered in audits of agreements between the Department and a Community Agency. Below is a summary of required compliance tests as well as sections within the agreement award relevant to such testing. Failure to comply with any of these areas could lead to material deficiencies.

Review the Federal compliance requirements specific to the following CFDA identifiers:

CFDA # 93.959 CFDA # _____
CFDA # _____ CFDA # _____

and review all the State compliance requirements listed below that apply to Federal Funds.

Review the State compliance requirements in applicable areas specified below:

- 1 INTERNAL CONTROL
- 2 STANDARD ADMINISTRATIVE PRACTICES
 - a. 2 CFR 200 Subpart D
 - b. Department Additions
Program Budget
- 3 ACTIVITIES ALLOWED OR UNALLOWED Rider A
- 4 ALLOWABLE COSTS/COST PRINCIPLES
 - 2 CFR 200 Subpart E
- 5 CASH MANAGEMENT _____
- 6 ELIGIBILITY Rider A
- 7 EQUIPMENT AND REAL PROPERTY MANAGEMENT _____
- 8 MATCHING, LEVEL OF EFFORT, EARMARKING _____
- 9 PERIOD OF AVAILABILITY OF FUNDS _____
- 10 PROCUREMENT AND SUSPENSION AND DEBARMENT _____
- 11 PROGRAM INCOME _____
- 12 REPORTING Rider A Section 6
- 13 SUB-RECIPIENT MONITORING _____
- 14 SPECIAL TESTS AND PROVISIONS _____
- 15 AGREEMENT SETTLEMENT METHOD
(Check all that are applicable)
 - COST SETTLED
 - FEE FOR SERVICE
 - LINE ITEM EXPENSE
- Full form review by DCM Staff

