EAST CENTRAL KANSAS AREA AGENCY ON AGING, ECKAAA CDDO, BUSINESS AGREEMENT
FISCAL YEAR 2025

This agreement made this _____ day of _____ , 2024/25 by and between East Central Kansas Area Agency on Aging, ECKAAA CDDO and _____ of _____, for provision of product services funded under State Aid Emergent/Flex Funds. The Contractor shall provide product services as indicated and agreed upon on the State Aid Emergent/Flex Funds Request Form.

COUNTIES SERVED: County of service will be Coffey, Franklin and/or Osage.

SERVICE(S) TO BE PROVIDED:

RESPONSE TIME: Contractor will begin process within seven (7) calendar days of approval.

TERM AND TERMINATION: Unless sooner terminated in accordance with these terms, this Business Agreement shall be in effect July 1, 2024 and ending June 30, 2025 (the State Fiscal Year).

a. Either party may terminate the business agreement participation at any time by giving the other party written notice of termination at least ninety (90) calendar days prior to the termination date identified in the written notice;
b. Either party may terminate the Contractor's participation in this contract at any time for the other party's failure to perform in accordance with any provision in this contract by giving the other party written notice of termination at least fifteen (15) calendar days prior to the termination date identified in the written notice; or
c. The ECKAAA CDDO may terminate the Contractor's participation at any time without prior written notice if the ECKAAA CDDO first determines that termination is necessary to avoid harm to members of the public, to prevent fraud or abuse, to protect public funds, or pursuant to federal funds being available.
d. The ECKAAA CDDO requires the *Statement of Usage of State Aid Funded Services* form to be included in all state aid requests, which allows the ECKAAA CDDO to terminate the business agreement after thirty (30) days of non-usage.
e. Reimbursement by ECKAAA CDDO to contractor is based on the ability of the state to provide funding to the ECKAAA CDDO.

***AUTHORIZED REIMBURSEMENT*: Service fee will be reimbursed to contractor by ECKAAA on submission of invoice which includes customer name, address, date of service, type of service and/or product purchased.** **ONLY** charges approved by the ECKAAA CDDO on the State Aid Emergent/Flex Funds Request Form **BEFORE** services are provided may be submitted for reimbursement. **NO** charges exceeding what is approved by ECKAAA CDDO reflected on the State Aid Emergent/Flex Funds Request Form will be accepted or paid. Service to be provided will be defined on said form. Rate and county of service will be approved by ECKAAA CDDO after request for service is received.

Request for payment for service must be received by the 7th of the month following service provision. No retroactive financial adjustment will be made for late submissions. Contractor's inability to meet billing deadline of 7th of month due to natural disaster or health related staffing emergencies requires notice to and pre-approval by the ECKAAA Executive Director by the 7th of the month in order for a contingency plan to be made.

a. Payment by the ECKAAA CDDO to provider will be made within 30 days of the 7th of the month in which billing is received.
b. When applicable an insurance company will be first payor.
c. ECKAAA will not pay for services provided over the amount approved by ECKAAA CDDO
d. When appropriate proof of liability insurance and workman's comp certificates will be provided to ECKAAA.

HIPAA: Contractor acknowledges that certain information received in the performance of this may constitute Protected Health Information or other confidential information. Contractor will establish and maintain procedures and controls as required in the Underlying Agreement for the protection of confidential information. Contractor agrees to enter into a Business Agreement with Contractor in the form as provided by the Kansas Department of Aging and Disability Services (KDADS).

CONFIDENTIALITY: The Contractor may have access to private or confidential data maintained by State to the extent necessary to carry out its responsibilities under this agreement. Contractor must comply with all the requirements of the Kansas Open Records Act (K.S.A. 42-215 *et seq.*) in providing services under this contract. Contractor shall accept full responsibility for providing adequate supervision and training to its agents and employees to ensure compliance with the Act. No private or confidential data collected, maintained or used in the course of performance of this contract shall be disseminated by either party except as authorized by the State promptly at the request of State in whatever form it is maintained by Contractor. On the termination or expiration of this contract, Contractor will not use any of such data or any material derived from the data for any purpose and, where so instructed by State, will destroy or render it unreadable.

- **I understand that this authorization will be honored unless revoked verbally or in writing and that it will be my responsibility to revoke any authorizations no longer relevant. Revocation may be made at any time except to the extent that the information has already been released; or the program which is to make the disclosure has already taken action in reliance on it.**
- To revoke an authorization, it will be my responsibility to contact the Medical Records Director or my clinician to obtain appropriate forms to be completed (i.e., the Revocation of Authorization Form) and I will forward the completed form to Medical Records Director of Crosswinds or my clinician. (KAR 30-60-47(b)(7), AAPS guidelines, Chapter 7, 1.a. (7), and 42 C.F.R. Part 2 Regulations)
- I understand that under state and federal confidentiality provisions, only the information specified can be released to only the specified person or agency. (42 C.F.R. Part 2 Regulations, KAR 30-60-47(b)(5), AAPS Guidelines, Chapter 7)
- The persons or organizations receiving any disclosure of the information referenced herein will generally be prohibited by law from re-disclosing any information received based upon this consent and will be notified of that fact in every health informational exchange disclosure. I understand that if the person or organization authorized to receive this information is not a health care provider, health plan, or is not otherwise covered under the federal privacy regulations, the released information may be re-disclosed and will no longer be protected by federal privacy laws. I understand that certain persons or organizations may not re-disclose substance abuse treatment information. (42 C.F.R. Part 2 Regulations)
- **I understand that this authorization will expire 1 year from the signature date or immediately upon revocation.**
- I understand that this authorization waives the community mental health center-patient privilege described in K.S.A. 65-5601 *et seq.*
- I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
- I verify that this authorization is voluntary; and that I have asked and received answers to my questions.

Client Signature _____ Date _____

Parent/Guardian/Legal Rep. Signature _____ Printed Name _____ Date _____ Relationship to Client _____

(Complete the following information if address is DIFFERENT from Client)

Address _____ City _____ State _____ Zip Code _____

Telephone # _____

*Witness Signature _____ Date _____

"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Signature Page