DISTRICT SCHOOL BOARD OF PASCO COUNTY
Kurt S. Browning, Superintendent of Schools

7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638

Purchasing Services
Nicole Westmoreland, MBA, Purchasing Agent
813/ 794-2221 Fax: 813/ 794-2111
727/ 774-2221 TDD: 813/794-2484
352/ 524-2221 e-mail: nwestmor@pasco.k12.fl.us

July 22, 2014

MEMORANDUM

TO: Honorable School Board Members

FROM: Nicole Westmoreland, Purchasing Agent

SUBJECT: Florida Department of Health
Contract #2015000028

Early Childhood Programs is requesting approval of the attached agreement with the Florida Department of Health to cover health services for the 2014 - 2015 school year. The anticipated annual expenditure is $25,000, using Head Start/Early Head Start Federal Grant. Please reference the attached memo from Angela Porterfield, Director, Early Childhood Programs. The agreement has been previously approved by the District School Board's Attorney, Ms. Nancy Alfonso, on May 30, 2013.

Should you have any questions regarding this matter, please contact Debra Reaves, Purchasing Services, at your earliest convenience.

NW/dr

Attachments

Date/Time: July 15, 2014 10:43:00

DISTRICT SCHOOL BOARD OF PASCO COUNTY
Kurt S. Browning, Superintendent of Schools
7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638

Memo # ECP-002-14-15
Contact: Angela Porterfield aap
Ext. # 42730

DATE: July 22, 2014

TO: HONORABLE SCHOOL BOARD MEMBERS

FROM: Kurt S. Browning, Superintendent of Schools
Amelia Van Name Larson, Assistant Superintendent for Student Achievement

SUBJECT: Partnership Agreement- Pasco County Health Department

Introduction
The Head Start and Early Head Start Programs must partner with existing community agencies to deliver necessary health services to enrolled families. The agreement will facilitate necessary health services for Head Start and Early Head Start enrollees.

Description
The 2014-15 agreement was reviewed and updated to address most current practices and requirements. The Head Start/Early Head Start federal grant will be used to fund this agreement.

Strategic Focus: Engage Families, Communities, and Business
Strategic Goal: The district and schools will communicate with and engage all stakeholders in the educational process.

Action Requested
Approval of the updated Pasco County Health Department Partnership Agreement is needed in order to satisfy health services requirements.

Conclusion
The staff respectfully requests the approval of the Pasco County Health Department Partnership Agreement for the 2014-15 school year.

Contract #20150000026

RECEIVED 6/30/2014

District School Board of Pasco County
Pasco County Early Childhood Programs Head Start/Early Head Start and Florida Department of Health Partnership Agreement
2014-2015 Fiscal School Year

The District School Board of Pasco County, Pasco County Early Childhood Programs and the Florida Department of Health in Pasco County, hereinafter referred to as DOH, agree to work together and share information in providing Child Health Check Up (EPSDT physicals), dental services, WIC, and prenatal/postpartum health care for enrolled expectant/postpartum (up to six weeks after delivery) women, infants, toddlers and preschool children in Pasco County Head Start/Early Head Start during the 2014-2015 fiscal school year. **THOUGH APPOINTMENTS CAN BE MADE PRIOR TO AUGUST 1, 2014, THEY CANNOT TAKE PLACE BEFORE AUGUST 1, 2014, AND NO TREATMENTS CAN BE PERFORMED AFTER AUGUST 1, 2015.**

Funds to reimburse services are provided by the Federal Head Start/Early Head Start grants to those expectant/postpartum women, infants, toddlers and preschool children who do not have current Medicaid eligibility or other health insurance. Reimbursement for dental services shall be billed at the rate of $120.00 per visit. Reimbursement for medical services shall be on a per visit basis at the published Cost Based Reimbursement rate in effect at the time of the visit. In addition, the DOH will perform lead blood tests for Head Start/Early Head Start children at the rate of $15.00 and hemoglobin tests (finger stick) at the rate of $5.00 for approved Head Start/Early Head Start children if the physician who performed the initial EPSDT failed to perform either of these required blood tests.

Head Start/Early Head Start funds may be used for professional medical and dental services when no other source of funding is available. DOH will obtain prior approval from Early Childhood Programs for medical services other than well baby check, dental, hemoglobin, lead, or prenatal/postpartum health care. DOH will verify Medicaid or other insurance coverage when services are provided to ensure that Head Start/Early Head Start is the payor of last resort. DOH will verify that any infants, toddlers and preschool children requesting treatment are currently enrolled in the Head Start/Early Head Start program before services are provided. Parent/Guardian will provide a copy of their program orientation letter as verification (Exhibit B).

Purchase orders will be issued in favor of DOH and reimbursement will be made upon receipt of an invoice, which includes the patient's name and the services provided. Purchase orders will expire at the end of the Head Start/Early Head Start Fiscal year on July 31, 2015. Payment will not be made for services provided after that date, and all invoices must be submitted no later than August 31, 2015.

Pasco County Early Childhood Programs agrees to provide services as outlined:

- Receive referrals from DOH for expectant/postpartum women, infants, toddlers and preschool children who may be eligible for the program.
- Recruit, enroll and serve eligible expectant/postpartum women, infants and toddlers, age 0 to 36 months, and preschool children, age 36 months to 72 months.
- Provide screening, using the Ages and Stages Questionnaire, for all enrolled infants and toddlers within 45 days of entry into the program for developmental, sensory and behavior concerns.
- Provide an infant and toddler assessment on an ongoing basis for enrolled infant and toddlers.

CONTRACT REVIEWED AND APPROVED: mw/dam 7/8/14

- Implement "Partners for a Healthy Baby" home visiting curriculum.
- Refer expectant/postpartum women, infants, toddlers and preschool children for medical, dental and nutritional services care.
- Assist expectant/postpartum women and families with scheduling transportation for all medical, dental and nutrition care appointments.
- Work closely with other community agencies in order to provide comprehensive services to expectant/postpartum women, infants, toddlers and preschool children in order to build on pre-existing plans.
- Provide individualized services to all expectant/postpartum women, infants, toddlers and preschool Medicaid Physician Evaluation and Management Services Fee Schedule.
- Develop family partnership agreements that build on pre-existing plans with all enrolled families.
- Develop and implement transition plans that support expectant/postpartum women, infants, toddlers and preschool children as they enter and exit into different program options.
- Be available to provide training and consultation to the staff at DOH on an as needed basis.

DOH agrees to provide services for referred eligible Early Head Start expectant/postpartum women, infants, and toddlers, and for Head Start children as follows:

Prenatal and Postpartum care
Child Health Check Ups (EPSDT)
Lead Blood Testing/Hemoglobin for children whose PCPs do not provide this test
Dental procedures as outlined on Dental Treatment Guidelines for infants 12 months of age or older (Exhibit A)

DOH agrees to make referrals for such Early Head Start expectant/postpartum women, infants, and toddlers, and for Head Start children referenced above as follows as follows:

Fetal Development
Smoking cessation
Alcohol and drug exposure
Environmental Hazards
Child Birth Classes
Parenting Classes
Family Planning
Miscarriage Support
SIDS
Grief Counselling Referrals
Infant Toddler First Aid CPR Training
How to Apply for Medicaid and Florida Kid Care
Identification of Nutritional Needs
Nutrition Counselling & Intervention

CONTRACT REVIEWED AND APPROVED:
7/8/14

Breast Feeding Support
Food Budgeting/ Menu Planning
Attachment and Bonding

- The parties will maintain confidentiality of all data, files and client records related to the services provided pursuant to the agreement and shall comply with all State and Federal laws including, but n limited to, Sections 384.29, 381.004, 392.65 and 456.057 Florida Statutes. Both parties shall assure compliance with HIPAA as well as all regulations promulgated there under (45 CFR parts 160, 162, and 164).

- A referral form mutually agreed upon by both partners will be used to document the need for services, the treatment recommended and services received. A sample referral form is attached hereto (Exhibit D).

- An Authorization to Disclose Confidential Information, which has been mutually agreed upon by both partners, will be used to document that confidentiality procedures have been followed (Exhibit E and F).

- A representative from DOH will participate as a member of the Head Start Health Advisory Committee.

- A representative from DOH will be available at appointment times to provide information to parents on health related topics mentioned in this agreement.

- DOH will train their office/clinic staff to be knowledgeable of the partnership agreement/procedures.

I have read the above and agree to provide Child Health Check Up (EPSDT physicals), WIC, and prenatal/postpartum health care to expectant/postpartum women, infants, toddlers and preschool children enrolled in Pasco County Early childhood Programs (Head Start/Early Head Start) as outlined herein.

Christine Ataca for 6/13/14
Michael J. Napier, MS Date
Administrator, County Health Officer

Nicole Westmoreland (DAN) 7/8/14
Nicole Westmoreland, MBA Date
Purchasing Agent
District School Board of Pasco County

angela Porterfield 6/24/14
Angela Porterfield, Director Date
Pasco County Early Childhood Programs

PWainwright 6/30/14
Princess Addisa Wainwright, Chairman Date
Head Start/Early Head Start Policy Council

Alison Crumbley, Chairman Date
District School Board of Pasco County

Attachment A – Florida Department of Health in Pasco County (DOH-Pasco)

A) Each party agrees to be fully responsible for its own acts of negligence and its respective agents/employees' negligence when acting in the scope of employment, and agree to be liable for damages proximately caused thereby; however, nothing herein is intended to act as a waiver of sovereign immunity by the parties. Nothing herein shall be construed as consent by any party to be sued by any third party for any cause or matter arising from this agreement. The parties shall be acting at all times as independent contractors and not as the agent or employee of the other party."

B) Termination of Contract: This contract may be terminated when it is in the best interest of the District within 30 days notice. Contracts cancelled by the vendor because of non-performance may result in exclusion from participating on any other similar contracts offered by any public school in Pasco County, FL. Contracts cancelled because of non-performance will be excluded from future business with the District for the full term of the contract plus one year.

C) Venue for any and all legal action regarding or arising out of the transaction covered herein shall be solely in the appropriate Court in and for Pasco County, State of Florida.

D) This contract is governed by the laws put forth by the State of Florida.

E) The School Board normally issues payment for services within 30 days from receipt of invoices, provided the services have been received in a satisfactory and proper manner. No advance payments will be made.

F) The company and/or individual shall remain independent and not an employee or agent of the Board for the purpose of providing services not otherwise available to the Board.

G) DOH-Pasco) shall not assign, sublet, or otherwise dispose of, without first obtaining the written consent of the Board, any portion of services to be performed under this contract.

H) DOH-Pasco shall comply with all applicable laws, ordinances, codes, and statutes of any and all local, state, or national governing bodies included within this section. DOH-Pasco shall comply with the regulations of the Civil Rights Act of 1964, in which no person in the United States shall on the grounds of race, creed, color, or national origin be excluded from participation in or be denied the proceeds of, or be subject to discrimination in the performance of this Contract.

I) Children receiving treatment at DOH-Pasco will be accompanied at all times by a parent or by a level II screened employee of the District School Board of Pasco County.

Christine Alam 6/13/14

Michael J. Napier, MS Date
Administrator, County Health Officer

Nicole Westmoreland/Kdaw

Nicole Westmoreland, MBA Date 7/8/14
Purchasing Agent
District School Board of Pasco County

Angela Porterfield 6/24/14

Angela Porterfield, Director Date
Early Childhood Programs

Dental Treatment Guidelines

The dentist will provide treatment to Head Start/Early Head Start children, 12 months of age or older, assigned to him/her under the following conditions:

Covered Services:

Because of budget limitations, Head Start/Early Head Start can provide only those services, which will give the greatest long-term benefit to the participant. **Please contact the program office to discuss exceptions on a per-participant basis.**

1. Prophylaxis is allowed for all Children.
2. Fluoride treatment may be provided to all children.
3. Teeth not restored may be extracted when deemed necessary at the sole discretion of the dentist.
4. Polycarbonate crowns are not to be used.
5. Space maintainers and orthodontic appliances are not included as basic services due to the prolonged follow-up that may be required.
6. Head Start/Early Head Start cannot pay for sealants under this agreement.
7. Nitrous Oxide will be paid for by Early Childhood Programs in the following situations:
   - Head Start children that insured by a Medicaid plan that does not cover the cost at all.
   - Head Start children that are insured by a Medicaid plan that pays for a set amount of times (eg. 3 times/fiscal year). Once the set amount has been exhausted, ECP will pay if further visits are required.

Dental provider will require the Head Start family to provide them with an acceptance letter as verification of enrollment in the current program year.

Method of Payment:

1. If a participant is not covered under Medicaid or any other insurance, the program will pay for services. The dentist will be reimbursed by the District School Board of Pasco County through a purchase order.
2. A standing purchase order will be issued to the dental office by August 1 to:
   a. Cover initial dental examinations of non-Medicaid Children preparing to enter the program.
   b. Cover treatment costs of $500 per participant or less during the program year.
3. **Prior approval will be obtained for treatment costing greater than $500 and must be obtained by faxing an estimate to: ECP Health Coordinator at (727-774-5888. For cases that require immediate treatment, a separate purchase order may be needed. In any case, treatment should not begin until the dental office receives authorization.**

Documentation of Service:

1. Prior to beginning dental treatment, the dentist will provide the program with a treatment plan and cost estimate for each child. The program requests both Medicaid and non-Medicaid treatment plans. An itemized statement of completion is also required for both Medicaid and non-Medicaid children.
2. Families of enrolled children will be provided with a yellow Dental Exam Form "H108" and shall be instructed to make an appointment with the dental provider of their choice. After each visit, this completed form should be returned to the Program by the family. Head Start/Early Head Start staff may obtain the dental form from the dental provider if necessary. Head Start/Early Head staff can provide transportation and other needed assistance in order to increase compliance.

Christine Axam 6/13/14
Michael J. Napier, MS Date
Administrator, County Health Officer

CONTRACT REVIEWED AND APPROVED
7/8/14

Angela Porterfield 6/24/14
Angela Porterfield, Director Date
Pasco County Early Childhood Programs

DISTRICT SCHOOL BOARD OF PASCO COUNTY
Kurt S. Browning, Superintendent of Schools
7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638
Early Childhood Programs 813/ 794-2730 *727/ 774-2730 * 352/ 524-2730 Fax: 813/ 794-2736

2014-2015 Head Start Program
Orientation Notification

Congratulations on your child being accepted into the Pasco County Head Start Program. In order for your child to begin school, you and your child must attend Orientation at the school as follows:

School Label *Child's Label*

The purpose of Orientation is for **you and your child** to learn more about the Pre-K experience. If possible, please try to refrain from bringing other children. **Orientation will start on time and may last about 2 hours and will include:**

Meeting your child's teacher
Learning about the Head Start Program
Completing and turning in required program paperwork
Participating in Bus Transportation training
Having your child measured for a bus safety vest (If applicable)

Your child's teacher will be scheduling a home visit with your family during the first month of school. This is a requirement of your family's participation in Head Start. The purpose of the home visit is to learn more about your child's development and interests in a relaxed environment. During this home visit you will also be setting some family goals.

Families requesting Head Start enrollment in a school outside of their designated school zone WILL NOT be guaranteed enrollment in the same school for kindergarten. You must apply for school choice in February.

Please carry this letter with you to medical and dental appointments; it is your identification as an enrolled family. **If your address or telephone number changes, or if you do not intend to have your child attend this program, please notify Early Childhood Programs immediately!**

Need transportation? Transportation is provided by the District School Board of Pasco County if you live within the boundaries of the school that your child was accepted for. Parents/guardians MUST call the transportation department to arrange possible transportation, please see the back of this letter for more information.

We look forward to seeing you and your child at Orientation.

CONTRACT REVIEWED AND APPROVED:
2/18/14

Rev. AR6/5/13

DISTRICT SCHOOL BOARD OF PASCO COUNTY
Kurt S. Browning, Superintendent of Schools
7227 Land O' Lakes Boulevard • Land O' Lakes, Florida 34638

Early Childhood Programs
Angela Porterfield, Director
813/ 794-2730 727/ 774-2730
352/ 524-2730 Fax: 813/ 794-2736
e-mail: aanglinp@pasco.k12.fl.us

April 1, 2014

As requested by your agency, the following people have delegation of authority to sign agreements/contracts on behalf of the Prekindergarten Services/Head Start/Early Head Start Program. Only one signature is required.

District School Board of Pasco County

Alison Crumbley, Chairman
Kurt S. Browning, Superintendent

If I can be of further assistance, please feel free to contact me.

Sincerely,

Angela Porterfield

Angela Porterfield, Director
Early childhood Programs

CONTRACT REVIEWED AND APPROVED:
7/8/14

7

FLORIDA DEPARTMENT OF HEALTH

REFERRAL FORM

Please Type or Print Legibly

CLIENT AND FAMILY INFORMATION

Client's Name	Date of Birth (mm/dd/yy)	Social Security Number	Medicaid Number
Parent/Guardian Name			
Telephone Number	Mailing Address		

Referred To:
Address:

From (name of person making referral):	Title:	Telephone Number:
Agency:		
Address:		

Reason for Referral/Notes to Referral Agency:

LIST SERVICES AUTHORIZED

Rate Authorized:

☐ Applicable Medicaid Rate ☐ Up to _____ Dollars

☐ Per Contract ☐ No Payment Authorized

If on Medipass or HMO, indicate authorization number

Medipass/HMO #: _____

Expiration Date: _____

Referring Person's Signature Date

Response to Referral Originator:

Respondent's Signature Date

CONTRACT REVIEWED AND APPROVED: NW/Dam 7/8/14

DH 5065, Apr 98
(Obsoletes previous edition, which may not be used.)
Stock Number: 5744-000-5065-9)

Distribution of Copies:
WHITE & YELLOW - To Referral Source
PINK - Retained by Referring Agency

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

INFORMATION MAY BE DISCLOSED BY:

Person/Facility: _____ **Phone #:** _____

Address: _____ **Fax #:** _____

INFORMATION MAY BE DISCLOSED TO:

Person/Facility: _____ **Phone #:** _____

Address: _____ **Fax #:** _____

Other method of communication: _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Record(s), including STD and TB _____ Progress Notes _____ History and Physical Results

_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Consultations

_____ Diagnostic Test Reports (Specify Type of test(s) _____

_____ Other: (specify) _____

I specifically authorize release of information relating to: (initial selection)

_____HIV test results for non-treatment purposes _____Substance Abuse Service Provider Client Records

_____Psychiatric, Psychological or Psychotherapeutic notes _____Early Intervention _____WIC

PURPOSE OF DISCLOSURE:

_____ Continuity of Care _____ Personal Use _____ Other (specify)_____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

_____ _____

Client/Representative Signature Date

_____ _____

Printed Name Representative's Relationship to Client

_____ _____

Witness (optional) Date

CONTRACT REVIEWED AND APPROVED
11/8/14

Client Name: _____

ID#: _____

DOB: _____

DH 3203, 11/25/08 **Original:** To File **Copy:** To Client **Copy:** To Accompany Disclosure
(Stock Number: 5744-000-3203-1)

CONTRACT REVIEWED AND APPROVED:
7/8/14

AUTORIZACIÓN PARA DIVULGAR INFORMACIÓN CONFIDENCIAL

ESTA INFORMACIÓN PUEDE SER DIVULGADA POR:

Persona/Institución: _____ **Teléfono** _____

Dirección: _____ **Número de Fax:**_____

ESTA INFORMACION PUEDE SER DIVULGADA A:

Persona/Institución: _____ **Teléfono:** _____

Dirección: _____ **Número de Fax:** _____

Otro método de comunicación: _____

INFORMACION A SER DIVULGADA: (ponga sus iniciales en la selección deseada)

_____ Historial Clínico General, incluyendo ETS y TB _____ Notas de Progreso ___ Historial médico y Resultados de los Exámenes Físicos
_____ Vacunas ____ Planificación Familiar _____ Archivos Prenatales _____ Consultas Médicas
_____ Informes de Prueba Diagnóstica (Especificar el tipo de prueba) _____
_____ Otros: (Especificar) _____

Expreso aquí mi consentimiento para dar a conocer información relacionada con: (ponga sus iniciales en la selección deseada)

___Resultados de examen del VIH no hechos para propósito de tratamiento
___Expediente de Abuso de Substancia ____Notas Psiquiatrías, Psicológicas o de Psicoterapia
___Intervención Temprana ___ WIC

PROPOSITO DE LA DIVULGACIÓN:

_____ Continuar tratamiento médico _____ Uso Personal _____ Otro (especificar) _____

FECHA DE EXPIRACIÓN: Esta autorización expira (ponga fecha o acontecimiento) _____. Yo entiendo que si no especifico fecha de expiración o algún acontecimiento, esta autorización expirará en doce (12) meses a partir de la fecha en que fue firmada.

RE-DIVULGACIÓN: Entiendo que una vez que la información indicada anteriormente es revelada, ésta puede ser divulgada nuevamente por la persona/servicio que la recibió y que dicha información puede no estar protegida por las regulaciones o leyes federales de privacidad.

CONDICIONES: Yo entiendo que el llenar esta autorización es algo totalmente voluntario y me doy cuenta que el tratamiento no me será negado si yo me rehuso firmar este formulario.

ANULACIÓN: Entiendo que tengo el derecho a anular en cualquier momento esta autorización. Yo entiendo que si anulo esta autorización, ésta debe ser por escrito y presentada al departamento de historial clínico. También entiendo que esta anulación no afecta la información que ya se ha dado a conocer como respuesta a esta autorización. Yo entiendo que esta anulación no afecta la información para mi compañía de seguros, Medicaid y Medicare.

_____ _____
Firma del Cliente/Representante Legal Fecha

_____ _____
Escriba su Nombre Relación del Representante Legal con el Cliente

_____ _____
Testigo Fecha

CONTRACT REVIEWED AND APPROVED: 7/8/14

Client Name: _____

ID#: _____

DOB: _____

DH 3203, 0109
Stock Number: 5744-000-3203-1

Original to File, **Copy** to Client, **Copy** to accompany disclosure

CONTRACT REVIEWED
AND APPROVED:
7/18/14

HIPAA BUSINESS ASSOCIATE AGREEMENT

The **Florida Department of Health** and its designee, hereinafter Covered Entity, and the **District School Board of Pasco County** and **Pasco County Early Childhood Programs**, hereinafter Business Associate, agree to the following terms and conditions in addition to an existing agreement to perform services that involve the temporary possession of protected health information to develop a product for the use and possession of Business Associate. After completion of the contracted work all protected health information is returned to the Covered Entity or destroyed as directed by the Covered Entity.

Obligations and Activities of Business Associate

(a) Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as Required By Law.

(b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Agreement.

(c) Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Agreement.

(d) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to these same restrictions and conditions.

(e) Business Associate agrees to make internal practices, books, and records relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary of HHS, in a time and manner designated by the Covered Entity or the Secretary of HHS, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

(f) Business Associate agrees to document disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information.

(g) Business Associate agrees to provide to Covered Entity as disclosures of protected health information occurs information collected in accordance with Section (f) of this Agreement, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information.

CONTRACT REVIEWED AND APPROVED:
7/8/14

Obligations of Covered Entity

Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR 164.520, as well as any changes to such notice.

Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

Term and Termination

Term. The Term of this Agreement shall be effective **August 1, 2014,** or the date both parties sign this agreement which ever is later and shall terminate when all existing contracts between the parties have terminated.

Florida Department of Health

Christine Alam 6/13/14

Michael J. Napier, MS Date
Administrator, County Health Officer

Angela Porterfield

Angela Porterfield Date
Director
Pasco County Early Childhood Programs Council

Alison Crumbley Date
Chairman
District School Board of Pasco County

Provider:

Nicole Westmoreland /dam

Nicole Westmoreland, MBA 7/8/14 Date
Purchasing Agent
District School Board of Pasco County

PAWainwright 6/30/14

Princess Addisa Wainwright Date
Chairman
Head Start/Early Head Start Policy

INTEROFFICE MEMORANDUM

DATE: September 4, 2013

TO: Christine M. Abarca, Assistant Director
Kathleen Yeater, Executive Community Health Director of Nursing
Joan DeMauri, Community Program Administrator

FROM: Michael J. Napier, MS
Administrator, Florida Department of Health in Pasco County

SUBJECT: **Delegation of Authority**

EFFECTIVE: **September 4, 2013**

REFERENCE: **Section 20.05(1)(a),(b) and 20.43 Florida Statutes**

This Delegation of Authority is in accordance with the authority created in Sections 20.05(1)(a)(b) and 20.43, Florida Statutes, and vested in me as Administrator of the Florida Department of Health in Pasco County, the following staff members will act as an alternate to my delegation of authority for items listed in the State Surgeon General's Delegation of Authority dated May 4, 2011.

Christine M. Abarca, MPH, MCHES
Assistant Director

Kathleen Yeater, RN, BSN, MS, CHES
Executive Community Health Director of Nursing

Joan DeMauri, MA, RD, LDN
Community Program Administrator

CONTRACT REVIEWED AND APPROVED:
11/8/14

Florida Department of Health – Pasco County
Michael J. Napier, Administrator, Health Officer
10841 Little Road, New Port Richey, Florida 34654
PHONE: 727/861-5250 • FAX 727/862-4230

www.FloridasHealth.com
TWITTER:HealthyFLA
FACEBOOK:FLDepartmentofHealth
YOUTUBE: fldoh