



**State of Rhode Island  
Department of Human Services  
Office of Rehabilitation Services**

40 Fountain Street ~ Providence, RI 02903  
401-421-7005 ~ 401-222-3574 FAX  
Spanish (401) 462-7791

**REQUEST FOR APPROVAL TO PROVIDE VOCATIONAL  
REHABILITATION SERVICES UNDER FEE FOR SERVICE**

**EXPLANATION OF APPROVAL PROCESS**

*The mission of the Office of Rehabilitation Services is “to empower individuals with disabilities to choose, prepare for, obtain, and maintain employment, economic self sufficiency, independence, and integration into society”.*

*The outcome expected from the provision of all vocational rehabilitation services, including supported employment, is integrated competitive employment in the community at or above the prevailing wage.*

*The Office of Rehabilitation Services provides services to eligible individuals through a fee for service individual authorization process. Any services initiated by a provider without an authorization may not be reimbursable. Fees for particular services are determined by the state agency with significant input from providers of services.*

*ORS approves programs/services based on the provider’s ability to provide services through appropriately qualified staff and a commitment of the provider agency to assist individuals with disabilities to reach community integrated employment goals consistent with the Individualized Plan for Employment.*

**PLEASE PROVIDE THE INFORMATION REQUESTED ON THE ATTACHED SHEETS.  
SEND ONE HARD COPY TO MIKE MONTANARO, COMMUNITY REHABILITATION  
PROGRAM SPECIALIST, OFFICE OF REHABILITATION SERVICES, 40 FOUNTAIN  
STREET, PROVIDENCE, RI 02903.**

**IF YOU HAVE ANY QUESTIONS, CONTACT MICHAEL MONTANARO AT 787-0564 OR  
VIA EMAIL AT MICHAEL.MONTANARO@ORS.RI.GOV.**

**YOU WILL RECEIVE EITHER A WRITTEN RESPONSE OR REQUEST  
FOR A MEETING REGARDING YOUR APPLICATION WITHIN 4 WEEKS  
OF RECEIPT OF THE INFORMATION.**

**Please complete information requested on attached sheets  
(Do not attach separate documents)**



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**VENDOR APPROVAL APPLICATION**

**NAME OF ORGANIZATION:** \_\_\_\_\_

**CONTACT PERSON:** \_\_\_\_\_ **FEIN NUMBER:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE NUMBER:** \_\_\_\_\_ **FAX NUMBER:** \_\_\_\_\_

**E-MAIL ADDRESS:** \_\_\_\_\_  
 \_\_\_\_\_

**Certification of State Employment**

**Are you currently a RI State Employee?** Yes  No

**Are you currently receiving retirement benefits from the State or RI?** Yes  No

**Are you currently a consultant with the State of RI?** Yes  No

**Are you currently a vendor/service provider with the State of RI?** Yes  No

**In the event of future employment with State of RI, I acknowledge my responsibility to promptly notify the Office of Rehabilitation Services.**

**Please describe/explain any "Yes" answers:** \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_  
**Name (Print or Type) / Signature** **Date**

**SERVICE(S) WHICH YOU OR YOUR ORGANIZATION IS REQUESTING TO PROVIDE THROUGH FEE FOR SERVICE:**

- Evaluations/Testings (Physical, Psychological, Vocational)
- Situational Assessments in the Community
- Supported Employment Services/Long Term Supports
- Job Preparation Services

- Rehabilitation/Assistive Technology Services
- Specific Skill Training Programs
- Job Development and Placement
- Time Limited Supports
- Other (Please describe): \_\_\_\_\_



- 6. The status of licensure (if applicable) with other state agencies (such as DHS, BHDDH) and your status in providing Medicaid funded services.**
- 7. Federal and state requirements for ORS funding requires that your community rehabilitation program meet the standards as described in the attached policy for community rehabilitation programs and other providers of services.**
- Please check here that you have reviewed the standards and meet all requirements.
  - Please check here if all requirements are not met.
  - Please explain and provide a description of an action plan to comply.
  - Please review and sign the attached Business Associate Agreement.
- 8. How many ORS clients do you feel can be serviced through your program in one year?**  
\_\_\_\_\_
- 9. Are you currently an Employment Network (EN) through COGNOSANTE/Social Security?If not what is your plan for becoming an EN?**

**THANK YOU**

**Current Revision: 7/2014  
Last revision:10/2011**

**State of Rhode Island**  
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40 Fountain Street ~ Providence, RI 02903  
(401) 421-7005 ~ (401) 222-3574 FAX  
TDD (401) 421-7016 ~ Spanish (401) 462-7791

Please be advised that before providing any services to clients of the RI Office of Rehabilitation Services (ORS), you must comply with the following requirements:

1. You must have a **printed AUTHORIZATION TO PROVIDE RI ORS SERVICES.** This is an authorization letter from RI ORS to you/your company that designates:
  - ♦ name of the client who will receive services from you/your company
  - ♦ description of service to be provided
  - ♦ fee charged for the service
  - ♦ time period within which the service is to be provided
2. You must be an active vendor within the State of RI vendor system and maintain that status during the dates of service covered on the AUTHORIZATION described above until payment for said services is processed.

Attached is the State of Rhode Island, Payer's Request for Taxpayer Identification Number and Certification (Form W-9-rev. 3/7/11). Any new vendors must complete this form in its entirety and submit the form with the Vendor Application to me.

Current active vendors must notify me if you or anyone in your company is currently an employee of the State of Rhode Island or currently collecting a pension from the State of Rhode Island.

3. Should you or any of your employees provide any services without a hard copy of an authorization; ORS cannot guarantee that you will be reimbursed for any service that you provide.

If you have any questions, please contact Michael Montanaro, CRP Supervisor, at 462-7817.

STATE OF RHODE ISLAND  
FORM W-9 PAYER'S REQUEST FOR TAXPAYER  
IDENTIFICATION NUMBER AND CERTIFICATION



THE IRS REQUIRES THAT YOU FURNISH YOUR TAXPAYER IDENTIFICATION NUMBER TO US. FAILURE TO PROVIDE THIS INFORMATION CAN RESULT IN A \$50 PENALTY BY THE IRS. IF YOU ARE AN INDIVIDUAL, PLEASE PROVIDE US WITH YOUR SOCIAL SECURITY NUMBER (SSN) IN THE SPACE INDICATED BELOW. IF YOU ARE A COMPANY OR A CORPORATION, PLEASE PROVIDE US WITH YOUR EMPLOYER IDENTIFICATION NUMBER (EIN) WHERE INDICATED.

**Taxpayer Identification Number (T.I.N.)**

Enter your taxpayer identification number in the appropriate box. For most individuals, this is your social security number.

Social Security No. (SSN)

Employer ID No. (EIN)

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**NAME**

**ADDRESS**

**CITY, STATE AND ZIP CODE**

**PAYMENT REMITTANCE ADDRESS, IF DIFFERENT FROM THE ADDRESS ABOVE**

**ADDRESS**

**CITY, STATE AND ZIP CODE**

**CERTIFICATION:** Under penalties of perjury, I certify that:

- (1) The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), **and**
- (2) I am not subject to backup withholding because either: (A) I am exempt from backup withholding, or (B) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (C) the IRS has notified me that I am no longer subject to backup withholding.
- (3) I am a U.S. citizen or other U.S. person (as defined by the IRS).

**Certification Instructions** -- You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item (2) does not apply.

*Please sign here and provide title, date and telephone number:*

SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ DATE \_\_\_\_\_ TEL NO \_\_\_\_\_  
*Original Signature Required (Digital Signature Not Acceptable)*

**BUSINESS DESIGNATION:**

- Please Check One:* Individual  Corporation  Trust/Estate  Government/Nonprofit Corporation   
Partnership  Medical Services Corporation  Legal Services Corporation   
LLC Tax Classification: Single Member (Individual)  Partnership  Corporation

**TIPS:**

**NAME:** Be sure to enter your full and correct legal name as shown on your income tax return for the SSN or EIN provided.

**ADDRESS, CITY, STATE AND ZIP CODE:** If you operate a business at more than one location, adhere to the following:

- 1) Same EIN with more than one location -- attach a list of location addresses with remittance address for each location and indicate to which location the year-end tax information return should be mailed.
- 2) Different EIN for each different location -- submit a completed W-9 form for each EIN and location. (One year-end tax information return will be reported for each EIN and remittance address.)

**Mail Completed Form To:**

**Office of Rehabilitation Services**  
**Attn: Michael Montanaro**  
**40 Fountain Street**  
**Providence RI 02903**

For State Use Only:	
IRS _____ RI SOS _____ FED _____ Other _____	
RI Supplier # _____	Approved _____
Date Entered _____	Entered By _____



*State of Rhode Island*  
*Department of Human Services*  
*Office of Rehabilitation Services*  
 40 Fountain Street Providence, RI 02903  
 (401) 421-7005 (V)  
 (401) 222-3574 (FAX) - (401) 462-7791 (Spanish)

**B.C.I. Disclaimer**

**Note: Clear copy of photo identification with date of birth must accompany this disclaimer:**

Name: \_\_\_\_\_  
 (Print or Type)

Maiden Name (if applicable): \_\_\_\_\_

Alias (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**DISCLAIMER**

I \_\_\_\_\_ hereby consent and authorize the Department of Human Services/Office of Rehabilitation Services to perform a local criminal background check.

I further agree to fully waive, release, indemnify, defend and hold harmless, the Department of Human Services, the Office of Rehabilitation Services, the State of Rhode Island, the Bureau of Criminal Identification and the Attorney General’s office, including their respective employees and agents, against any and all claims, demands, actions, or causes of action that I have, or may have, in both law and equity, of any nature or kind whatsoever arising from or in any way related to the release of my criminal record, or the results of the criminal background check, performed in accordance with this consent and authorization.

\_\_\_\_\_  
 Signature of Applicant

Sworn to before me in the City of \_\_\_\_\_ State of \_\_\_\_\_  
 \_\_\_\_\_ this \_\_\_\_ day of \_\_\_\_\_ 20\_\_.

\_\_\_\_\_  
 Notary Public

\_\_\_\_\_  
 Commission Expires



**DEPARTMENT OF HUMAN SERVICES – OFFICE OF REHABILITATION SERVICES**

**40 Fountain Street ~ Providence, RI 02903 ~ (401) 421-7005 (V) ~ 711 (TTY)**

*“Helping individuals with disabilities to choose, find and keep employment”*

**AUTHORIZATION FOR DISCLOSURE/USE OF HEALTH INFORMATION**

**DIRECTIONS: COMPLETE ALL SECTIONS, DATE, AND SIGN**

**I.** I, \_\_\_\_\_, hereby voluntarily authorize the disclosure of information from my record. *(Name of Client)*

My Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**II. My information is to be disclosed to/ provided by:**

**And is to be provided to/disclosed by:**

Office of Rehabilitation Services

Attorney General

40 Fountain Street

4 Howard Avenue

Providence, RI 02903

Cranston, RI 02920

**III. The purpose or need for this release of information is:**

- To obtain the information checked below that will assist me in vocational rehabilitation planning
- My own personal and private reasons
- Other (*specify*): Pre-Employment BCI Search

**IV. The information to be disclosed from my health record:** (*check all of the boxes that apply*)

- Vocational                       Medical                       Educational                       Social
- Financial                       Psychiatric/Psychological                       Other (*specify*): BCI Search
- Psychotherapy notes ONLY (by checking this box, I waive my psychotherapist-patient privilege)**

Specific Information Needed: BCI Search

Dates of Service: 1/1995 to Present

**I would also like the following sensitive information disclosed:** (*check the applicable box(es)*)

- Alcohol/Drug Abuse Treatment/Referral                       HIV/AIDS-related Treatment
- Sexually Transmitted Diseases

**V.** I understand that I may revoke this authorization in writing at any time to the DEPARTMENT OF HUMAN SERVICES/OFFICE OF REHABILITATION SERVICES (DHS/ORS) and that, if I do, DHS/ORS may condition my access to services on my decision to revoke. In addition, any information disclosed to DHS/ORS before I revoked this authorization, as well as any information disclosed to other parties by this authorization, may no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a]. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event on the line below. Any information released or received as a result of this consent shall not be further relayed in any way to any person or organization outside the Department of Human Services without additional written consent from me.

*(Enter if different from one year after the date below)*

\_\_\_\_\_  
**Signature of Client**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Authorized Representative**

\_\_\_\_\_  
**Relationship to the Client**

\_\_\_\_\_  
**Date**



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## Instructions for Completing Form ORS-37

### AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

1. Print legibly in all fields using black ink.
2. Section I – print name of the client whose information is to be released.
3. Section II – print the name and address of the person or organization authorized to release and/or receive the information. Also, provide the name of the DHS/ORS representative, unit and address that will receive and/or release the information.
4. Section III – state the reason why the information is needed (e.g., disability claim, continuing medical care)
5. Section IV – check all of the boxes that apply.
  - a. Vocational, Medical, Educational, Social, Financial, Psychiatric/Psychological
  - b. Other (*specify*) – specific information identified by the client (e.g., billing, employee health)
  - c. Psychotherapy Notes **ONLY** – in order to authorize the use or disclosure of psychotherapy notes, only this box should be checked on this form. Authorizations for the use or disclosure of other health record information may NOT be made in conjunction with authorizations pertaining to psychotherapy notes.

Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.
  - d. Specific Information Needed – clearly identify the precise information to be disclosed.
  - e. Dates of Service – note the first and last date of service requested.
  - f. **RELEASE OF SENSITIVE INFORMATION** – check alcohol-drug abuse treatment/referral, HIV/AIDS-related treatment, sexually transmitted diseases – patient must check the appropriate box!
6. Section V – sign and date. If a different *expiration* date is desired, specify a new date.
7. Section V – Authorized Representative (e.g., parent, legal guardian, power of attorney)
8. A copy of the completed Form ORS-37 will be given to the client.

# FYI



**DEPARTMENT OF HUMAN SERVICES  
OFFICE OF REHABILITATION SERVICES**

*“Helping individuals with disabilities to choose, find and keep employment”*

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## ***Vocational Rehabilitation***

**The purpose of the Vocational Rehabilitation (VR) program is to assess, plan, develop, and provide vocational rehabilitation services to individuals with disabilities to prepare for and engage in gainful employment that is consistent with their strengths, resources, priorities, concerns, abilities, capabilities, interests and informed choice.**

**WHO IS ELIGIBLE?** You are eligible for (VR) services when:

- You have a disability, a physical or mental impairment, that results in a substantial barrier to employment;
- you must be able to benefit in terms of an employment outcome from VR services; and
- you must need vocational rehabilitation services to become employed, retain employment, or regain employment.

**HOW TO APPLY?**

- Call VR intake at (401) 421-7005 or (401) 421-7016 (TDD) for more information.
- Visit a netWORKri One-Stop Career Center and ask to see an ORS Counselor.
- Visit our website at <http://www.ors.ri.gov/PDFfiles/ApplicationORS.pdf> to obtain an application.

**DO ALL ELIGIBLE INDIVIDUALS RECEIVE VR SERVICES?**

Sometimes there are not enough resources to serve all eligible individuals. A priority system for services called the Order of Selection (OOS) is in place. Under OOS, individuals with the most significant disabilities based on their functional limitations are given priority for VR services. Those not meeting Category 1 OOS requirements are placed on a waiting list for services. SSI/SSDI recipients are subject to the same OOS category criteria as are all applicants.

**WHAT TYPES OF SERVICES MIGHT VR OFFER?**

The types of services provided by the Office of Rehabilitation are designed to develop or improve skills and abilities to enhance employment outcomes. Some examples of services the ORS offers are:

- Vocational guidance and counseling
- Vocational assessments
- Medical, social psychological and educational evaluations
- Job development
- Job placement
- Job retention
- Training for employment
- Rehabilitation evaluations
- Post employment services
- School to transition services
- Assistive technology
- Supported Employment services

***SUCCESS IS EMPLOYMENT!***

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**FYI**

## **Vocational Rehabilitation Program Regulations**

**218-RICR-50-00-1**

### **Section 1.15 Standards for Facilities and Providers of Services (Community Rehabilitation Program)**

- A. Any facility used in conjunction with the delivery of vocational rehabilitation services must meet program accessibility requirements consistent with the requirements, as applicable, of the Architectural Barriers Act of 1968 (42 U.S.C. § 4151 et seq.), the American Disabilities Act of 1990 (42 U.S.C. § 12131; 47 U.S.C. §§ 155, 201, 218, and 225) (ADA), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 701 et seq.), and the regulations implementing these laws.
- B. Providers of vocational rehabilitation services will take affirmative action to employ, and advance in employment, qualified individuals with disabilities.
- C. Providers of vocational rehabilitation services will include among their personnel, or obtain the services of, individuals able to communicate in the native languages of applicants and eligible individuals who have limited English speaking ability; and ensure that appropriate modes of communication for all applicants and eligible individuals are available.



*State of Rhode Island*  
*Department of Human Services Office of Rehabilitation Services*

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[www.ors.ri.gov](http://www.ors.ri.gov)

## CONFIDENTIALITY AGREEMENT

As a vendor of the Department of Human Services, Office of Rehabilitation Services, I am aware that I may have access to ORS client information. I am aware that all records pertaining to the administration of rehabilitation services to clients of ORS constitute confidential governmental information. I am also aware that I, and any employee of my organization must safeguard these restricted records against unauthorized use, release or disclosure of information for any purposes not directly connected with the administration of the ORS related program. Lastly, I, and any of my employees are aware that any willful disclosure of client information for purposes other than those directly connected with the administration of the ORS program constitutes a violation of 45 C.F.R. 164.502 (e) and 164.504 (e), governing Protected Health Information and Business Associates under the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d.

Acknowledged and agreed to by:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

## ADDENDUM XIX

### BUSINESS ASSOCIATE AGREEMENT ADDENDUM

Except as otherwise provided in this Business Associate Agreement Addendum, INSERT AGENCY NAME, (hereinafter referred to as “Business Associate”), may use, access or disclose Protected Health Information to perform functions, activities or services for or on behalf of the State of Rhode Island, **Department of Human Services** (hereinafter referred to as the “Covered Entity”), as specified herein and the attached Agreement between the Business Associate and the Covered Entity (hereinafter referred to as “the Agreement”), which this addendum supplements and is made part of, provided such use, access, or disclosure does not violate the Health Insurance Portability and Accountability Act (HIPAA), 42 USC 1320d et seq., and its implementing regulations including, but not limited to, 45 CFR, parts 160, 162 and 164, hereinafter referred to as the Privacy and Security Rules and patient confidentiality regulations, and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009, Public Law 111-5 (HITECH Act) and any regulations adopted or to be adopted pursuant to the HITECH Act that relate to the obligations of business associates, Rhode Island Mental Health Law, R.I. General Laws Chapter 40.1-5-26, and Confidentiality of Health Care Communications and Information Act, R.I. General Laws Chapter 5-37.3-1 et seq. Business Associate recognizes and agrees it is obligated by law to meet the applicable provisions of the HITECH Act.

#### 1. Definitions:

##### A. Generally:

- (1) Terms used, but not otherwise defined, in this Agreement shall have the same meaning as those terms in 45 C.F.R. §§ 160.103, 164.103, and 164.304, 164.501 and 164.502.
- (2) The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA, the Privacy and Security Rules and the HITECH Act: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

##### B. Specific:

- (1) "Addendum" means this Business Associate Agreement Addendum.

- (2) "Agreement" means the contractual Agreement by and between the State of Rhode Island, **Department of Human Services** and Business Associate, awarded pursuant to State of Rhode Island’s Purchasing Law (Chapter 37-2 of the Rhode Island General Laws) and Rhode Island Department of Administration, Division of Purchases, Purchasing Rules, Regulations, and General Conditions of Purchasing.

C. "Business Associate" generally has the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean **[Insert Name of Business Associate]**.

D. "Client/Patient" means Covered Entity funded person who is a recipient and/or the client or patient of the Business Associate.

E. "Covered Entity" generally has the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean **Rhode Island Department of Human Services**.

F. "Electronic Health Record" means an electronic record of health-related information on an individual that is created, gathered, managed or consulted by authorized health care clinicians and staff.

G. "Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media as defined in the HIPA Security Regulations.

H. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

I. "HIPAA Privacy Rule" means the regulations promulgated under HIPAA by the United States Department of Health and Human Services to protect the privacy of Protected Health Information including, the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

J. "HITECH Act" means the privacy, security and security Breach notification provisions applicable to Business Associate under Subtitle D of the Health Information Technology for Economic and Clinical Health Act, which is Title XII of the American Recovery and Reinvestment Act of 2009, Public Law 111-5, and any regulations promulgated thereunder and as amended from time to time.

K. "Secured PHI" means PHI that was rendered unusable, unreadable or indecipherable to unauthorized individuals through the use of technologies or methodologies specified under or pursuant to Section 13402 (h)(2) of the HITECH Act under ARRA.

L. "Security Incident" means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information.

M. "Security Rule" means the Standards for the security of Electronic Protected Health Information found at 45 CFR Parts 160 and 162, and Part 164, Subparts A and C. The application of Security provisions Sections 164.308, 164.310, 164.312, and 164.316 of title 45, Code of Federal Regulations shall apply to Business Associate of Covered Entity in the same manner that such sections apply to the Covered Entity.



N. "Suspected breach" is a suspected acquisition, access, use or disclosure of protected health information ("PHI") in violation of HIPPA privacy rules, as referenced above, that compromises the security or privacy of PHI.

O. "Unsecured PHI" means PHI that is not secured, as defined in this section, through the use of a technology or methodology specified by the Secretary of the U.S. Department of Health and Human Services.

2. Obligations and Activities of Business Associate.

- A. Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Agreement or as required by Law, provided such use or disclosure would also be permissible by law by Covered Entity.
- B. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement. Business Associate agrees to implement Administrative Safeguards, Physical Safeguards and Technical Safeguards ("Safeguards") that reasonably and appropriately protect the confidentiality, integrity and availability of PHI as required by the "Security Rule."
- C. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement.
- D. Business Associate agrees to report to Covered Entity any use or disclosure of the PHI not provided for by this Agreement, including breaches of unsecured PHI as required by 45 C.F.R. § 164.410, and any Security Incident of which it becomes aware, within five (5) days of the incident.
- E. Business Associate agrees to ensure that any agent, including a subcontractor or vendor, to whom it provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Agreement to Business Associate with respect to such information through a contractual arrangement that complies with 45 C.F.R. § 164.314.
- F. Business Associate agrees to provide paper or electronic access, at the request of Covered Entity and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. § 164.524. If the Individual requests an electronic copy of the information, Business Associate must provide Covered Entity with the information requested in the electronic form and format requested by the Individual and/or Covered Entity if it is readily producible in such form and format; or, if not, in a readable electronic form and format as requested by Covered Entity.

- G. Business Associate agrees to make any amendment(s) to PHI in a Designated Record Set that Covered Entity directs or agrees to pursuant to 45 C.F.R. §164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity. If Business Associate receives a request for amendment to PHI directly from an Individual, Business Associate shall notify Covered Entity upon receipt of such request.
- H. Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of PHI received from, created or received by Business Associate on behalf of Covered Entity available to Covered Entity, or at the request of Covered Entity to the Secretary, in a time and manner designated by Covered Entity or the Secretary, for the purposes of the Secretary determining compliance with the Privacy Rule and Security Rule.
- I. Business Associate agrees to document such disclosures of PHI 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 PHI in accordance with 45 C.F.R. §164.528.
- J. Business Associate agrees to provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with this Agreement, to permit Covered Entity to respond to a request by an individual for an accounting of disclosures for PHI in accordance with 45 §C.F.R. 164.528.
- K. If Business Associate accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses Unsecured Protected Health Information (as defined in 45 C.F.R. § 164.402) for Covered Entity, it shall, following the discovery of a breach of such information, notify Covered Entity of such breach within a period of five (5) days after discovery of the breach. Such notice shall include: a) the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate to have been accessed, acquired or disclosed during such breach; b) a brief description of what happened, including the date of the breach and discovery of the breach; c) a description of the type of Unsecured PHI that was involved in the breach; d) a description of the investigation into the breach, mitigation of harm to the individuals and protection against further breaches; e) the results of any and all investigation performed by Business Associate related to the breach; and f) contact information of the most knowledgeable individual for Covered Entity to contact relating to the breach and its investigation into the breach.
- L. To the extent the Business Associate is carrying out an obligation of the Covered Entity's under the Privacy Rule, the Business Associate must comply with the requirements of the Privacy Rule that apply to the Covered Entity in the performance of such obligation.

- M. Business Associate agrees that it will not receive remuneration directly or indirectly in exchange for PHI without authorization unless an exception under 45 C.F.R. § 164.502(a)(5)(ii)(B)(2) applies.
- N. Business Associate agrees that it will not receive remuneration for certain communications that fall within the exceptions to the definition of Marketing under 45 C.F.R. §164.501, unless permitted by 45 C.F.R. § 164.508(a)(3)(A)-(B).
- O. If applicable, Business Associate agrees that it will not use or disclose genetic information for underwriting purposes, as that term is defined in 45 C.F.R. § 164.502.
- P. Business Associate hereby agrees to comply with state laws and rules and regulations applicable to PHI and personal information of individuals' information it receives from Covered Entity during the term of the Agreement.
  - i. Business Associate agrees to: (a) implement and maintain appropriate physical, technical and administrative security measures for the protection of personal information as required by any state law and rules and regulations; including, but not limited to: (i) encrypting all transmitted records and files containing personal information that will travel across public networks, and encryption of all data containing personal information to be transmitted wirelessly; (ii) prohibiting the transfer of personal information to any portable device unless such transfer has been approved in advance; and (iii) encrypting any personal information to be transferred to a portable device; and (b) implement and maintain a Written Information Security Program as required by any state law as applicable.
  - ii. The safeguards set forth in this Agreement shall apply equally to PHI, confidential and "personal information." Personal information means an individual's first name and last name or first initial and last name in combination with any one or more of the following data elements that relate to such resident: (a) Social Security number; (b) driver's license number or state-issued identification card number; or (c) financial account number, or credit or debit card number, with or without any required security code, access code, personal identification number or password, that would permit access to a resident's financial account; provided, however, that "personal information" shall not include information that is lawfully obtained from publicly available information, or from federal, state or local government records lawfully made available to the general public.

### 3. Permitted Uses and Disclosures by Business Associate.

- a. Except as otherwise limited to this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Service Arrangement, provided that such use or

disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of Covered Entity required by 45 C.F.R. §164.514(d).

- b. Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
- c. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.
- d. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 C.F.R. §164.504 (e)(2)(i)(B).
- e. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. §164.502(j)(1).

#### 4. Obligations of Covered Entity

- a. Covered Entity shall notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 C.F.R. § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
- b. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI to the extent that such changes may affect Business Associate's use or disclosure of PHI.
- c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. §164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

#### 5. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, provided that, to the extent permitted by the Service Arrangement, Business Associate may use or

disclose PHI for Business Associate's Data Aggregation activities or proper management and administrative activities.

6. Term and Termination.

- a. The term of this Agreement shall begin as of the effective date of the Service Arrangement and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions of this Section.
- b. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either:
  - i. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement and the Service Arrangement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity.
  - ii. Immediately terminate this Agreement and the Service arrangement if Business Associate has breached a material term of this Agreement and cure is not possible.
- c. Except as provided in paragraph (d) of this Section, upon any termination or expiration of this Agreement, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to PHI that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI. Business Associate shall ensure that its subcontractors or vendors return or destroy any of Covered Entity's PHI received from Business Associate.
- d. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon Covered Entity's written agreement that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

7. Miscellaneous.

- a. A reference in this Agreement to a section in the Privacy Rule or Security Rule means the section as in effect or as amended.
- b. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of HIPAA, the Privacy and Security Rules and HITECH.
- c. The respective rights and obligations of Business Associate under Section 6 (c) and (d) of this Agreement shall survive the termination of this Agreement.
- d. Any ambiguity in this Agreement shall be resolved to permit Covered Entity to comply with HIPAA and HITECH.
- e. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI.
- f. Nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer upon any person other than Covered Entity, Business Associate and their respective successors and assigns, any rights, remedies, obligations or liabilities whatsoever.
- g. Modification of the terms of this Agreement shall not be effective or binding upon the parties unless and until such modification is committed to writing and executed by the parties hereto.
- h. This Agreement shall be binding upon the parties hereto, and their respective legal representatives, trustees, receivers, successors and permitted assigns.
- i. Should any provision of this Agreement be found unenforceable, it shall be deemed severable and the balance of the Agreement shall continue in full force and effect as if the unenforceable provision had never been made a part hereof.
- j. This Agreement and the rights and obligations of the parties hereunder shall in all respects be governed by, and construed in accordance with, the laws of the State of Rhode Island, including all matters of construction, validity and performance.
- k. All notices and communications required or permitted to be given hereunder shall be sent by certified or regular mail, addressed to the other part as its respective address as shown on the signature page, or at such other address as such party shall from time to time designate in writing to the other party, and shall be effective from the date of mailing.

l. This Agreement, including such portions as are incorporated by reference herein, constitutes the entire agreement by, between and among the parties, and such parties acknowledge by their signature hereto that they do not rely upon any representations or undertakings by any person or party, past or future, not expressly set forth in writing herein.

m. Business Associate shall maintain or cause to be maintained sufficient insurance coverage as shall be necessary to insure Business Associate and its employees, agents, representatives or subcontractors against any and all claims or claims for damages arising under this Business Associate Agreement and such insurance coverage shall apply to all services provided by Business Associate or its agents or subcontractors pursuant to this Business Associate Agreement. Business Associate shall indemnify, hold harmless and defend Covered Entity from and against any and all claims, losses, liabilities, costs and other expenses (including but not limited to, reasonable attorneys' fees and costs, administrative penalties and fines, costs expended to notify individuals and/or to prevent or remedy possible identity theft, financial harm, reputational harm, or any other claims of harm related to a breach) incurred as a result of, or arising directly or indirectly out of or in connection with any acts or omissions of Business Associate, its employees, agents, representatives or subcontractors, under this Business Associate Agreement, including, but not limited to, negligent or intentional acts or omissions. This provision shall survive termination of this Agreement.

**8. Acknowledgment.**

The undersigned affirms that he/she is a duly authorized representative of the Business Associate for which he/she is signing and has the authority to execute this Addendum on behalf of the Business Associate.

Acknowledged and agreed to by:

**STATE OF RHODE ISLAND:**

**INSERT AGENCY NAME:**

\_\_\_\_\_  
JOSEPH MURPHY, ASSOCIATE DIRECTOR  
DEPARTMENT OF HUMAN SERVICES  
OFFICE OF REHABILITATION SVCS.

\_\_\_\_\_  
AUTHORIZED AGENT/  
SIGNATURE

TITLE: \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date