GREATER COLUMBIA BEHAVIORAL HEALTH, LLC BH-ASO

101 N. Edison Street, Kennewick, WA 99336 - Phone: 509-737-2475 or 1-888-545-3022
Fax: 509-783-4165 or Secure Authorization Fax: 509-460-5238 - website: gcbhllc.org

SINGLE CASE AGREEMENT FOR BEHAVIORAL HEALTH SERVICES - IMPLEMENTATION FORMS

Single Case Agreements:

Single Case Agreements (SCA) with Greater Columbia Behavioral Health BH-ASO are for all Non-Medicaid Individuals who reside within the Greater Columbia Behavioral Health BH-ASO Regional Service Area (RSA) that are detained on an Involuntary Treatment Act (ITA).

1. **Complete Implementation Forms one time a year establishing the SCA.**
2. **Complete Form B - SCA for each Individual upon detainment to get ASO Authorization**

Reference Guides and/Protocols:

- ITAs – E&Ts, Inpatient, and Secure Detox Facilities
- Crisis Stabilization/Triage Facilities
- SUD – Withdrawal Management and Residential Facilities
- Financial – Billings/Payment

(Notifications can be made telephonically, however Clinical/ITA documentation is required as stated in each of the above guide/protocols)

If a Single Case Agreement is authorized, what are the terms and conditions of working with GCBH BH-ASO. Non-contracted facilities/professionals must agree to the following:

- Arrangement is for Implementation of a Single Case Agreement for only the individual for whom it was authorized and for only those services authorized, and there are no In-RSA providers whose qualifications or specialties match those required to adequately treat the individual.

- Financial Protocol: To accept current HCA State Rate for facility type, UB04 HealthClaim Form Completed In-Full. Submit completed UB04 to: karenr@gcbh.org and Jenniferd@gcbh.org Understand that the BH-ASO is considered payer of last resort, all other coverages have been billed and EOB is supplied with UBO4 Health Claim Form for BH-ASO authorized individual.

- All other terms and conditions within the fully implemented SCA, QSO/BAA and State and Federal laws.

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SINGLE CASE AGREEMENT IMPLEMENTATION

Section: 1

Provider - Facility Information:	
Provider Legal Name:	
DBA Name:	
Federal Tax ID:	**Agency NPI#:**
CEO/ Director Name:	
Mailing Address:	
City:	**State:**
Zip + 4:	**County:**
Telephone Number:	**Fax Number:**
Primary Contact Name:	
Mailing Address:	
City:	**State:**
Zip + 4:	**County:**
Telephone Number:	**Email:**
Primary Clinical Contact:	
Telephone Number:	**Email:**
Are you working with a Care Coordinator on this case? ☐ Yes ☐ No	**Coordinator's name:**

Section: 2

Provider Type:	
☐ **E&T Facility**	☐ **Inpatient Facility**
☐ **SUD Residential Facility**	☐ **Secure Detox Facility**
☐	☐

Section: 3

Organization Legal Entity Type: (W9 Attached)			
☐ C-Corp	☐ S-Corp	☐ Limited Liability	☐ Partnership (LLC)
☐ Sole Proprietorship	☐ Cooperative	☐ General Partnership	
☐ For Profit	☐ Not for profit	☐ Government	

Section: 4

Billing Information:			
Billing Contact:			
Billing Address:			
City:	State:	Zip:	County:
Phone Number:			
Fax Number:			
Email Contact:			

Section: 5

Service Location:			
Site Address:			
City:	State:	Zip + 4:	County:
NPI Number:		Taxonomy Number:	
List Service requested at this site for member (Include):			
Service Description:		Billing Code:	
Current License type (if applicable):			

Section: 6 – Please attached Accreditation Certificate

Accreditation Organization:	
Number of years Accredited:	Accreditation Expiration Date:
OR	
☐ We are not required to be Accredited for the services we provide.	
Do you currently have a Contract with another BH-ASO? ☐ Yes ☐ No	
☐ If yes, please list all BH-ASOs:	
Have you ever been sanctioned, placed on probation, and lost accreditation/certification?	

Section: 7

Note: For all LIPs whose NPI numbers you will be using please complete this section. Please use Attachment A for additional LIPs. – Copies of Licenses Required to be attached

Licensed Clinician Information:		
Legal Name:		
Address:		
City:	**State:**	**Zip + 4**
Date of Birth:	**Social Security No.:**	**Gender:**
Felony/Misdemeanor or Investigation: (If yes please explain) ☐Yes ☐ No		
Professional Schools attended:		**Graduation:**
License Type:		**License Number:**
Date Issued:		**Expiration Date:**
DEA Number: (if applicable)		**NPI number:**
Taxonomy Number:		
Do you currently have a Contract with another LME-ASO? ☐ Yes ☐ No		
☐ If yes, please list all LME-ASOs:		

Section: 8

Please identify your Insurance Carrier(s): (Attach Verification Certificate)	
Professional Liability: Name:	
Telephone No.:	**Policy #:**
Are there any claims? ☐Yes ☐ No	
Are there any current or unsettled claims? ☐Yes ☐ No	
Are there any circumstances that may result in a claim? ☐Yes ☐ No	
Are any of the polices cancelled? ☐ Yes ☐ No	
Commercial General Liability Insurance: Name:	
Telephone No.:	**Policy #:**
Workers' Compensation Insurance: Name:	
Telephone No.:	**Policy #:**

Section: 9

Required Attachments List: (Attachment B)
1. Electronic Funds Transfer (EFT) Agreement – (please complete and sign) – **Attachment E**
2. Copy of voided check or bank letter with account and routing number. (If signing up for EFT)
3. Qualified Service Organization/Business Associates Agreement (QSO/BAA)– Attachment D
4. Copies of Certificate(s) of Liability Insurance.
5. Copies of required current Licenses (Business and DOH).
6. Request for Taxpayer Identification Number (W-9)
7. Contractor Information & Disclosure of Ownership Form – Attachment C

Section: 10

Investigation and Sanction Attached Questions:
(1) Are there any actions or investigations against you/ any owner or QP in your organization, privileges, billing organizations or sanctions? ☐ **Yes** ☐ **No (if yes please describe)**
(2) Have any adverse actions been filed against you? This would include Medicaid, Medicare or other Insurances. ☐ **Yes** ☐ **No (if yes please describe)**
(3) Has anyone in your company who has an ownership, managerial, or clinical role, ever been sanctioned by any professional organization or government organization for violation of ethics, professional misconduct, unprofessional conduct, incompetence or negligence in any state or county? ☐ **Yes** ☐**No (if yes please describe)**
(4) Are you aware of any circumstances that may result in such action? ☐ **Yes** ☐ **No (if yes please describe)**
(5) Have you ever had a contract canceled by another BH-ASO, MCO, Area Authority, and County Program in Washington State or a similar entity in another state? ☐ **Yes** ☐ **No (if yes please describe)**
(6) Please Provide a listing of shareholders/partners with 5% or more ownership AND officers, directors, managers, EFT authorized individuals. **(Attachment C)**.

Upon full execution of this Application/Agreement, the parties agree as follows:

1. Provider shall submit Individual Single Case Agreement Form B for each individual detained within your facility as specified on the specific ASO Authorization guide/protocol.

2. Provider shall notify GCBH BH-ASO prior to the discharge of Individual and shall allow designated GCBH BH-ASO staff to attend any discharge or treatment meetings regarding the Individual served under this Agreement.

3. Provider warrants that it is in compliance with all applicable federal, state and local laws, rules and regulations, licensure and accreditation requirements governing the provision of services to Individual at all times relevant to this Agreement.

4. GCBH BH-ASO reserves the right to refer enrollees to other providers, and no referrals or authorizations are guaranteed to take place under this Agreement.

5. Provider shall be responsible for completion and retention of all necessary and customary documentation required for the services provided under this Agreement. Provider agrees and understands that GCBH BH-ASO may inspect records concerning claims paid on behalf of Individual, records of staff who delivered or supervised the delivery of paid services to Individual, Individual clinical records, and any other clinical or financial items related to the claims paid on behalf of Individual deemed necessary to assure compliance with

applicable state or federal laws, rules and regulations. Provider shall provide copies of records or other information within timeframes of written request from GCBH BH-ASO.

6. Provider warrants that it has and will continuously maintain insurance coverage with a carrier authorized to do business in Washington State, or maintain equivalent coverage under a self-insurance program that is actuarially sound, meeting the following coverage requirements:

    a. Professional Liability: Professional Liability Insurance shall protect the Provider and any employee performing work under this Agreement for an amount of not less than $1,000,000.00 per occurrence and proof of coverage at or exceeding $3,000,000.00 in the annual aggregate.

    b. Comprehensive General Liability: Bodily Injury and Property Damage Liability Insurance shall protect the Provider and any employee performing work under this Agreement from claims of Bodily Injury or Property Damage, which may arise from operations under the Contract. The amounts of such insurance shall not be less than $1,000,000.00 per Occurrence/$3,000,000.00 per Aggregate/ $1,000,000.00 Personal and Advertising Injury/$50,000.00 Fire Damage. The policy shall not include exclusion for contractual liability.

    c. Workers' Compensation and Occupational Disease Insurance: Provider shall maintain workers' compensation and occupational disease insurance as required by the statutory requirements of the State of Washington State.

7. For some purposes of the Agreement (other than treatment purposes) the PROVIDER may be considered a "Business Associate" of the BH-ASO as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and as such will comply with all applicable HIPAA regulations for Business Associates as further expanded by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), which was adopted as part of the American Recovery and Reinvestment Act of 2009, commonly known as "ARRA" (Public Law 111-5). Pursuant to Controlling Authority, specifically 45 C.F.R. § 164.506, PROVIDER and BH-ASO may share an Enrollee's protected health information ("PHI") for the purposes of treatment, payment, or health care operations without the Enrollee's consent.

8. Provider understands and agrees that claims for services must be submitted within thirty (30) days of the date of service or discharge (whichever is later), except where the Individual has primary insurance which has not yet paid or denied its claim. In such instances, Provider may bill GCBH BH-ASO within thirty (30) days of receipt of notice by the Provider of the Individual's final action (including payment or denial) by the primary insurance or Medicare (whichever is later).

Signatures:

By signing below, Provider certifies that all of the information and attachments provided herein are true and accurate to the best of their knowledge. Provider further understands that any false or misleading information may be cause for denial or termination of any and all agreements or contracts with GCBH BH-ASO. Provider understands submission of the application does not guarantee the issuance of an agreement. Provider signifies their willingness for GCBH BH-ASO to verify all information presented in this application and to provide additional information to GCBH BH-ASO, if needed, to verify the accuracy of the information contained herein. Provider agrees to provide any additional information at request of GCBH BH-ASO to verify information and address issues of concern prior to the approval of the application.

IN WITNESS WHEREOF, each party has caused this agreement to be executed in multiple copies, each of which shall be deemed an original, as the act of said party. Each individual signing below certifies that he or she has been granted the authority to bind Provider to the terms of this Agreement and any Addendums or Attachments thereto.

Enter Provider Name: _____

Sign: _____ Date: _____

Print Name: _____

Title: _____

GCBH BH-ASO

Address: 101 N Edison Street
Kennewick, WA 99336
(509) 737-2457

_____ _____
Karen Richardson Date
Co-Director/Finance Director

ASO Approved Begin Date: _____ ASO Approved End Date: _____

The request was processed on timeframe to match the service authorization request and was processed as:

ASO use only:
☐ **Involuntary - ITA**
☐ **Voluntary**

Attachment A

Licensed Clinician Information:		
Legal Name:		
Address:		
City:	**State:**	**Zip + 4**
Date of Birth:	**Social Security No.:**	**Gender:**
Felony/Misdemeanor or Investigation: (If yes please explain) ☐Yes ☐ No		
Professional Schools attended:	**Graduation:**	
License Type:	**License Number:**	
Date Issued:	**Expiration Date:**	
DEA Number: (if applicable)	**NPI number:**	
Taxonomy Number:		
Do you currently have a Contract with another BH-ASO? ☐ Yes ☐ No		
If yes, please list BH-ASO(s):		

Licensed Clinician Information:		
Legal Name:		
Address:		
City:	**State:**	**Zip + 4**
Date of Birth:	**Social Security No.:**	**Gender:**
Felony/Misdemeanor or Investigation: (If yes please explain) ☐Yes ☐ No		
Professional Schools attended:	**Graduation:**	
License Type:	**License Number:**	
Date Issued:	**Expiration Date:**	
DEA Number: (if applicable)	**NPI number:**	
Taxonomy Number:		
Do you currently have a Contract with another BH-ASO? ☐ Yes ☐ No		
If yes, please list BH-ASO(s):		

Note: you may add additional pages as necessary for additional clinicians.

Attachment B

Required Attachments List:

1. Electronic Funds Transfer (EFT) Agreement – (please complete and sign) – Attachment E

2. Copy of voided check or bank letter with account and routing number.(if submitting EFT Request)

3. Qualified Service Organization/Business Associate Agreement (QSO/BAA) – Attachment D

4. Copies of Certificate(s) of Liability Insurance.

5. Copies of required current Licenses, (Business and DOH).

6. Request for Taxpayer Identification Number (W-9)

7. Contractor Information & Disclosure of Ownership Form – Attachment C

Attachment C
Contractor Information &
Disclosure of Ownership Form

Section 1: Information Authorization		
Date:	Agency/Organization Name:	
Legal Entity Name (as registered with the IRS):		
Name of Person Completing Form:	Title:	
Section 2: Address Information		
Physical Address:	Mailing Address:	
City State Zip Code	City State Zip Code	
Phone Number:	Fax Number:	
Section 3: Ownership Information		
TIN/EIN:	UBI No.:	
DUNS No.:	NPI No.:	
Ownership Type: Select Type	Ownership Structure: Select Structure Type	
Has there been a past bankruptcy or do you anticipate filing for bankruptcy within the next year? Select If yes, please give dates:		
Section 4: Director/CEO		
Is this individual authorized to sign contracts? Select	Is this the individual who reviews contracts for your agency? Select	
Name: Title:	E-mail Address:	
Address:	City State Zip Code	
Phone Number:	Fax:	Cell Phone:
Section 5: Authorized Signatory (If you have additional authorized signatories, please attach a separate page).		
Is this individual authorized to sign contracts? Select	Is this the individual who reviews contracts for your agency? Select	
Name: Title:	E-mail Address:	
Address:	City State Zip Code	
Phone Number:	Fax:	Cell Phone:
Section 6: Primary Clinical Contact (For additional clinical contact persons, please attach a separate page).		
Is this individual authorized to sign contracts? Select	Is this the individual who reviews contracts for your agency? Select	
Name: Title:	E-mail Address:	
Address:	City State Zip Code	
Phone Number:	Fax:	Cell Phone:
Section 7: Primary Fiscal Contact Person(s) (For additional fiscal contact persons, please attach a separate page).		
Is this individual authorized to sign contracts? Select	Is this the individual who reviews contracts for your agency? Select	
Name: Title:	E-mail Address:	
Address:	City State Zip Code	
Phone Number:	Fax:	Cell Phone:
Section 8: Information Systems Contact (For additional IS contacts, please attach a list).		
Is this individual authorized to sign contracts? Select	Is this the individual who reviews contracts for your agency? Select	
Name: Title:	E-mail Address:	
Address:	City State Zip Code	
Phone Number:	Fax:	Cell Phone:

Section 9: Governing Board or Body/Board of Directors (attach a separate list for more individuals)		
Name: Title:		E-mail Address:
Address:		City State Zip Code
Name: Title:		E-mail Address:
Address:		City State Zip Code
Name: Title:		E-mail Address:
Address:		City State Zip Code
Name: Title:		E-mail Address:
Address:		City State Zip Code
Name: Title:		E-mail Address:
Address:		City State Zip Code
Name: Title:		E-mail Address:
Address:		City State Zip Code
Section 10: Debarment Information Contact (attach a separate list for more individuals)		
Name: Title:		E-mail Address:
Address:		City State Zip Code
Phone Number:	Fax:	Cell Phone:
Section 11: Chief Executive Officer		
Name: Title:		E-mail Address:
Address:		City State Zip Code
Phone Number:	Fax:	Cell Phone:
Section 12: Chief Financial Officer		
Name: Title:		E-mail Address:
Address:		City State Zip Code
Phone Number:	Fax:	Cell Phone:
Section 13: Chief Operating Officer		
Name: Title:		E-mail Address:
Address:		City State Zip Code
Phone Number:	Fax:	Cell Phone:
Section 14: Owners – Any individual or entity with direct or indirect ownership that is 5% or more (attach a separate list for more individuals)		
Have any the Owners listed in this section been convicted of a criminal offense related to that individual's involvement in any program under Medicaid, Medicare, or the Title XX services program (since the inception of those programs)? Select		
Has there been a change in ownership or control interest within the last 12 months? Select Explain:		
Do you anticipate any change in ownership or control interest within the next 12 months? Select Explain:		
Name: Percentage of Ownership:		E-mail Address:
Address:		City State Zip Code
Phone Number:	Fax:	Cell Phone:
Relationship to other Owners: Select Relationship	New Owner (within the last 12 months)? Select	
Name: Percentage of Ownership:		E-mail Address:

Address:			City State Zip Code	
Fax:	Fax:		Cell Phone:	
Relationship to other Owners: Select Relationship		New Owner (within the last 12 months)? Select		
Section 15: Managing Employees of the Contractor (attach a separate list for more individuals)				
Has there been a change in Director, Administrator, or other Managing Employee within the last 12 months? Select Explain:				
Do you anticipate any change in Director, Administrator, or other Managing Employee within the next 12 months? Select Explain:				
Name: Title:			E-mail Address:	
Address:			City State Zip Code	
Date of Birth:	Relationship to Owners: Select Relationship		New Manager (within the last 12 months)? Select	
Name: Title:			E-mail Address:	
Address:			City State Zip Code	
Date of Birth:	Relationship to Owners: Select Relationship		New Manager (within the last 12 months)? Select	
Name: Title:			E-mail Address:	
Address:			City State Zip Code	
Date of Birth:	Relationship to Owners: Select Relationship		New Manager (within the last 12 months)? Select	
Name: Title:			E-mail Address:	
Address:			City State Zip Code	
Date of Birth:	Relationship to Owners: Select Relationship		New Manager (within the last 12 months)? Select	
Name: Title:			E-mail Address:	
Address:			City State Zip Code	
Date of Birth:	Relationship to Owners: Select Relationship		New Manager (within the last 12 months)? Select	
Name: Title:			E-mail Address:	
Address:			City State Zip Code	
Date of Birth:	Relationship to Owners: Select Relationship		New Manager (within the last 12 months)? Select	
Name: Title:			E-mail Address:	
Address:			City State Zip Code	
Date of Birth:	Relationship to Owners: Select Relationship		New Manager (within the last 12 months)? Select	
Name: Title:			E-mail Address:	
Address:			City State Zip Code	
Date of Birth:	Relationship to Owners: Select Relationship		New Manager (within the last 12 months)? Select	

Printed Name   Title

Signature   Date

Any changes to this information must be reported to GCBH BH-ASO within ten (10) business days at the address below.

Please return this form to: Greater Columbia Behavioral Services, LLC BH-ASO
101 N Edison Street, Kennewick, WA 99336
Phone (509) 737-2475 Fax (509) 783-4165
jenniferd@gcbh.org or karenr@gcbh.org

ATTACHMENT - D

SINGLE CASE AGREEMENT - BEHAVIORAL HEALTH SERVICES

QUALIFIED SERVICE ORGANIZATION/BUSINESS ASSOCIATE AGREEMENT

This Qualified Service Organization/Business Associate Agreement (QSO/BAA) is entered into by and between Greater Columbia Behavioral Health (GCBH) (Covered Entity or Business Associate) and the Contractor (Covered Entity or Business Associate), each a Party to the Agreement whereby GCBH agrees to provide Contractor access to the GCBH Provider Portal, CIS system, Raintree system, and authorization system and Contractor agrees to provide necessary data for the purposes of training and/or testing in preparation for the integration of behavioral health services as well as any information needed for the provision and/or payment of behavioral health services under this Agreement.

WHEREAS, the Parties have engaged or intend to engage in one or more Agreements which may require the Use of discloser of PHI in performance of services described in such Agreement(s) on behalf of the Covered Entity;

WHEREAS, each Party shall serve the role of Covered Entity when disclosing protected health information and the role of Business Associate when receiving protected health information;

WHEREAS, the Parties are committed to complying with 42 FCR Part 2, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) and any regulations promulgated thereunder; and

WHEREAS, this QSO/BAA, in conjunction with 42 CFR Part 2 and HIPAA Rules, sets forth the terms and conditions pursuant to which protected health information (in any format) that is created, received, maintained or transmitted by, the Business Associate from or on behalf of the Covered Entity, will be handled between the Business Associate and the Covered Entity and with third parties during the term of the Agreement(s) and after it termination.

NOW THEREFORE, the Parties agree as follows:

1. **Definitions.** Unless otherwise provided for in the QSO/BAA, terms used in this WSOS/BAA shall have the same meanings as set forth in 42 CFR Part 2 and HIPAA Rules including, but not limited to the following: “Availability”, “Confidentiality”, “Data Aggregation”, “Designated Record Set”, “Health Care Operations”, “Integrity”, “Minimum Necessary”, “Notice of Privacy Practices”, “Required by Law”, “Secretary”, and “Subcontract”.
   Specific definitions are as follows:

   1.1 **Business Associate,** as used in this Agreement, means the “Contractor” and generally has the same meaning as the term “business associate” in 45 CFR 160.103. Any reference to Business Associate in this Agreement includes the Business Associate’s employees, agents, officers, Subcontractors, third party contractors, volunteers, or directors.

   1.2 **Business Associate Agreement** means this Agreement and includes the Business Associate provisions required by the U.S. department of Health and Human Services, Office for Civil Rights.

1.3 **Breach** means the acquisition, access, use or disclosure of Protected Health Information in a manner not permitted under the HIPAA Privacy Rule which compromises the security or privacy of the Protected Health Information, with the exclusions and exceptions listed in 45 CFR 164.402.

1.4 **Covered Entity** means GCBH, a Covered Entity as defined at 45 CFR 160.103, in its conduct of covered functions by its health care components.

1.5 **Designated Record Set** means a group of records maintained by or for a Covered Entity, that is: the medical and billing records about Individuals maintained by or for a covered health care provider; the enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or Used in whole or part by or for the Covered Entity to make decisions about Individuals.

1.6 **Electronic Protected Health Information (EPHI)** means Protect Health Information that is transmitted by electronic media or maintained in any medium described in the definition of electronic media at 45 CFR 160.103.

1.7 **HIPAA** means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, as modified by the American Recovery and Reinvestment Act of 2009 ("ARRA"), Sec. 13400 – 13424, H.R. 1 (2009) (HITECH Act).

1.8 **HIPAA Rules** means the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Parts 160 and Part 164.

1.9 **Individual(s)** means the person(s) who is the subject of PHI and includes a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

1.10 **Minimum Necessary** means the least amount of PHI necessary to accomplish the purpose for which the PHI is needed.

1.11 **Protected Health Information (PHI)** means Individually identifiable health information created, received, maintained or transmitted by Business Associate on behalf of a health care component of the Covered Entity that relates to the provision of health care to an Individual; the past, present, or future physical or mental health or condition of an Individual (45 CFR 160.103). PHI includes demographic information that identifies the Individual or about which there is reasonable basis to believe can be used to identify the Individual (45 CFR 160.103). PHI is information transmitted or held in any form or medium and includes EPHI (45 CFR 160.103). PHI does not include education records covered by the Family Educational Rights and Privacy Act, as amended, 20 USCA 1232g(a)(4)(B)(iv) or employment records held by a Covered Entity in its role as employer.

1.12 **Security Incident** means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system.

1.13 **Subcontractor** means a Business Associate that creates, received, maintains, or transmits Protect Health Information on behalf of another Business Associate. Use includes the sharing, employment, application, utilization, examination, or analysis, or PHI within an entity that maintains such information.

1.14 **Term.** The term of this QSO/BAA shall coincide with the term of this Program Agreement it is attached to, or on the date either Party terminates for cause as defined below.

1.15 **Effect**. This QSO/BAA supersedes any prior QSO/BAA between the Parties and those portions of any Agreement between the Parties that involve the discloser of PHI by the Covered Entity to the Business Associate. To the extent any conflict or inconsistency between this QSO/BAA and the terms and conditions of any Agreements exists, the terms of this QSO/BAA shall prevail.

1.16 **Compliance**. Business Associate shall perform all Agreement duties, activities and tasks in compliance with 423 CFR Part 2, HIPAA, the HIPAA Rules, and all attendant regulations as promulgated by the U.S. Department of Health and Human Services, Office of Civil Rights.

1.17 **Use and Disclosure of PHI**. Business Associate is limited to the following permitted and required uses or disclosures of PHI:

1.17.1 Duty to Protect PHI. Business Associate shall protect PHI from, and shall use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 (Security Standards for the Protection of Electronic Protected Health Information) with respect to EPHI, to prevent the unauthorized Use of disclosure of PHI other than as provided for in this Agreement or as required by law, for as long as the PHI is within its possession and control, even after the termination or expiration of this Agreement.

1.17.2 The Parties acknowledge that in receiving transmitting, transporting, storing, processing or otherwise dealing with any information received from the other Party identifying or otherwise relating to the patients of the Contractor, it is fully bound by the provisions of the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and HIPAA 45 CFR Parts 142, 160, 162 and 164.

1.17.3 Minimum Necessary Standard. Business Associate shall apply the HIPAA Minimum Necessary Standard to any Use or disclosure of PHI necessary to achieve the purposes of this Agreement. See 45 CFR 164.514 (d)(2) through (d)(5).

1.17.4 Disclosure as Part of the Provision of Services. Business Associate shall only use or disclose PHI as necessary to perform the services specified in this Agreement or as required by law, and shall not Use or disclose such PHI in any manner that would violate Subpart E of 45 CFR Part 164 (Privacy of Individually identifiable

health Information) if done by Covered Entity, except for the specific uses and disclosures set forth below.

1.17.5 Use for Proper Management and Administration. 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.

1.17.6 Discloser for Proper Management and Administration. Business Associate may disclose PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes 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.

1.17.7 Impermissible Use or Disclosure of PHI. Business Associate shall report to GCBH in writing all Uses or disclosures of PHI not provided for by this Agreement within five (5) business days of becoming aware of the unauthorized Use or disclosure of PHI, including Breaches of unsecured PHI as required by 45 CFR 164.410 (Notification by a Business Associate), as well as any Security Incident of which it becomes aware. Upon request by GCBH, Business Associate shall mitigate, to the extent practicable, any harmful effect resulting from the impermissible Use or disclosure.

1.17.8 Failure to Cure. If either party leans of a pattern or practice of the other Party that constitutes a violation of the Business Associate's obligations under the terms of this Agreement and reasonable steps by the Party do not end the violation either Party may terminate this Agreement, if feasible. In addition, if Business Associate learns of a pattern or practice of its Subcontractors that constitutes a violation of the Business Associate's obligations under the terms of their Agreement and reasonable steps by the Business Associate do not end the violation, Business Associate shall terminate the Subcontract, if feasible.

1.17.9 Termination for Cause. Either Party may authorize immediate termination of this Agreement if either Party determines that the other Party has violated a material term of this QSO/BAA. Either Party may, at its sole discretion, offer the other Party an opportunity to cure a violation of this QSO/BAA before exercising a termination for cause.

1.17.10 Consent to Audit. Business Associate shall give reasonable access to PHI, its internal practices, record, books, documents, electronic data and/or all other business information received from, or created or received by Business Associate on behalf of GCBH, DSHS, to the Secretary of DHHS, to DSHS and HCA for use in determining compliance with HIPAA privacy requirements.

1.2 Obligations of Business Associate Upon Expiration or Termination. Upon expiration or termination of this Agreement for any reason, with respect to PHI received from GCBH, or created, maintained, or received by Business Associate, or any Subcontractors, on behalf of GCBH, Business Associate shall:

1.2.1 Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

1.2.2 Return to GCBH or destroy the remaining PHI that the Business Associate or any Subcontractors sill maintain in any form;

1.2.3 Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 (Security Standards for the Protection of Electronic Protected Health Information) with respect to Electronic Protected Health Information to prevent Use or disclosure of the PHI, other than a provided for in this Agreement, for as long as Business Associate or any Subcontractors retain the PHI;

1.2.4 Not Use or disclose the PHI retained by Business Associate or any Subcontractors other than the purposes for which such PHI was retained and subject to the same conditions set out in the "Use and Disclosure of PHI" section of this Agreement which applied prior to termination; and

1.2.5 Return to GCBH or destroy the PHI retained by Business Associate, or any Subcontractors, when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

1.3 **Survival.** The obligations of the Business Associate under section 5.10 shall survive the termination or expiration of this Agreement and shall remain in force as long as the Business Associate stores or maintains PHI in any form or format (including archival data). Termination of the QSO/BAA shall not affect any of the provision of this QSO/BAA, by working or nature, are intended to remain effective and to continue in operation.

2. Individual Rights

2.1 Accounting of Disclosures.

2.1.1 Business Associate shall document all disclosures, except those disclosures that are exempt under 45 CFR 164.528, of PHI and information related to such disclosures.

2.1.2 Within ten (10) business days of a request from GCBH, Business Associate shall make available to GCBH the information in Business Associate's possession that is necessary for GCBH to respond in a timely manner to a request for an accounting of disclosures of PHI by the Business Associate. See 45 CFR 164.504(2)(ii)(G) and 164.528(b)(1).

2.1.3 At the request of GCBH or in response to a request made directly to the Business Associate by an Individual, Business Associate shall respond, in a timely manner and in accordance with HIPAA and the HIPAA Rules, to requests by Individuals for an accounting of disclosures of PHI.

2.1.4 Business Associate record keeping procedures shall be sufficient to respond to a request for an accounting under this section for the ten (10) years prior to the date on which the accounting was requested.

2.2 Access.

2.2.1 Business Associate shall make available PHI that it holds that is part of a Designated Record Set when requested by GCBH or the Individual as necessary to satisfy GCBH's obligations under 45 CFR 164.524 (Access of Individuals to Protected Health Information).

2.2.2 When the request is made by the Individual to the Business Associate or if GCBH asks the Business Associate to respond to the request, the Business Associate shall comply with requirements in 45 CFR 164.524 (Access of Individuals to Protected Health Information) on form, time and manner of access. When the request is made by GCBH, the Business Associate shall provide the records to GCBH with ten (10) business days.

2.3 Amendment. Either Party may amend this QSO/BAA to maintain consistency and/or compliance with any State or Federal law, policy, directive, regulation or government sponsored program requirement, upon forty-five (45) business days notice to the other Party unless a shorter timeframe is necessary for compliance. Either Party my otherwise materially amend this QSO/BAA only after forty-five (45) business days prior written notice to the other Party and only if mutually agreed to by the parties as evidenced by the amendment being executed by each party hereto. If the Parties fail to execute a mutually agreeable amendment within forty-five (45) days of the notice, either Party shall have the right to immediately terminate this QSO/BAA and any Agreement(s) between the Parties which may require the Business Associate's use or disclosure of PHI in performance of services described in such Agreement(s) on behalf of the Covered Entity.

3. Subcontracts and other Third Party Agreements:

3.1 In accordance with 42 CFR Part 2 and 45 CFR 164.502(e)(1)(ii), 164.504(e)(1)(i), and 164.308(b)(2), Business Associate shall ensure that any agents, Subcontractors, independent contractors or other third parties that create, receive, maintain, or transmit PHI on Business Associate's behalf, enter into a written Agreement that contains the same terms, restrictions, requirements, and conditions as the HIPAA compliance provisions in this Agreement with respect to such PHI. The same provisions must also be included in any Agreement(s) by a Business Associate's Subcontractor with its own business associates as required by 42 CFR Part 2 and 45 CFR 164.314(a)(2)(b) and 164.504(e)(5).

4. Obligations:

4.1 To the extent the Business Associate is to carry out one or more of GCBH's obligation(s) under Subpart E of 45 CFR Part 164 (Privacy of Individually Identifiable Health Information), Business Associate shall comply with all requirements that would apply to GCBH in the performance of such obligation(s).

5. Liability:

5.1 Within ten (10) business days, Business Associate must notify GCBH of any complaint, enforcement or compliance action initiated by the Office for Civil Rights based on an allegation of violation of the HIPAA Rules and must inform GCBH of the outcome of that action. Business Associate bears all responsibility for any penalties, fines or sanctions imposed against the Business Associate for violations of 45 CFR Part 2 and/or the HIPAA Rules and for any imposed against its Subcontractors or agents for which it is found liable.

6. Breach Notification:

6.1 In the event of a Breach of unsecured PHI or disclosure that compromises the privacy or security of PHI obtained from GCBH or involving GCBH Individuals, Business Associate will take all measures required by state or federal law.

6.2 Business Associate will notify the GCBH HIPPA Office within five (5) business days by email or by telephone, of any acquisition, access, Use or disclosure of PHI not allowed by the provisions of this Agreement or not authorized by HIPAA Rules or required by law of which it becomes aware which potentially compromises the security or privacy of the Protected Health information a defined in 45 CFR 164.402 (Definitions).

6.3 Business Associate will notify the GCBH HIPAA Office with five (5) business days by email or by telephone, of any potential Breach of security or privacy of PHI by the Business Associate or tis Subcontractors or agents. Business Associate will follow telephone or e-mail notification with a faced or other written explanation of the Breach, to include the following: date and time of the Breach, date Breach was discovered, location and nature of the PHI, type of Breach, origination and destination of PHI, Business Associate unit and personnel associated with the Breach, detailed description of the Breach, anticipated mitigation steps, and the name, address, telephone number, fax number, and e-mail of the Individual who is responsible as the primary point of contact. Business Associate will address communications to the GCBH HIPAA Office. Business Associate will coordinate and cooperate with GCBH to provide a copy of its investigation and other information requested by GCBH, including advance copies of any notifications required for GCBH review before dissemination and verification of the dates notifications were sent.

6.4 If either Party determines that Business Associate or its Subcontractor(s) or agent(s) is responsible for a Breach of unsecured PHI received from GCBH or involving GCBH Individuals, the following must occur:

6.4.1 Requiring notification of Individuals under 45 CFR 164.404 (Notification to Individuals), Business Associate bears the responsibility and costs for notifying the affected Individuals and receiving and responding to those Individuals' questions or request for additional information;

6.4.2 Requiring notification of the media under 45 CFR 164.406 (Notification to the media), Business Associate bears the responsibility and cost for notifying the media and receiving and responding to media questions or request for additional information;

6.4.3 requiring notification of the U.S. Department of Health and Human Services Secretary under 45 CFR 164.408 (notification to the Secretary), Business Associate bears the responsibility and cost for notifying the Secretary and receiving and responding to media questions or request for additional information; and

6.4.4 Either Party will take appropriate remedial measures up to termination of this Agreement.

7. Miscellaneous Provisions.

7.1 Regulatory References. A reference in this Agreement to a section in the HIPAA Rules means the section as in effect or amended.

7.2 Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with 42 CFR Part 2 and the HIPAA Rules.

7.3 Indemnification. In addition to any indemnities set forth in this Agreement, each Party will indemnify and defend the other party from and against any and all claims, losses, damages, expensed or other liabilities, including reasonable attorney fees, incurred as a result of any breach by such Party of any representation, warranty, covenant, Agreement or other obligation expressly contained herein by such Party, its employees, agents, Subcontractors or other representatives.

7.4 No third Party Beneficiaries. Nothing express or implied in this QSO/BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations or liabilities whatsoever.

7.5 Governing Law and Venue. This QSO/BAA shall be governed by Washington law notwithstanding any conflicts of law provisions to the contrary. Any action at law, suit in equity, or judicial proceeding for the enforcement of the Agreement or any provisions thereof shall be instituted and maintained only in any of the courts of competent jurisdiction in Benton County, Washington.

8. TERMS AND CONDITIONS

8.1 All additional terms and conditions as outlined in the Agreement are incorporated as though fully set forth herein.

ATTACHMENT - E

GREATER COLUMBIA BEHAVIORAL HEALTH, LLC BH-ASO

101 N. Edison Street, Kennewick, WA 99336 - Phone: 509-737-2475 or 1-888-545-3022
Fax: 509-783-4165 or Secure Authorization Fax: 509-460-5238 - website: gcbhllc.org

EFT/ACH - PROFILE FORM

1099 Business Name:
Business Name, if different from above:
Physical Address:
Remittance Address:
Federal Tax ID: **Duns Number:**
Primary Account Contact Name:
Phone Number: **Fax Number:**
Email:
W9 Attached - Required

BANK INFORMATION

Bank Account Owner:
E-Mail(*Required for ACH Delivery Notification):
Bank Name:
Account Type ☐ ***Checking*** ☐ ***Savings***
Account Number:
Routing Number (must be 9 digits):

By submission of this form to Greater Columbia Behavioral Health, LLC BH-ASO, I authorize payment of invoice(s) via ACH to the business account provided.

Name: **Title:**

Signature: **Date:**