THIS CONTRACT, between {Enter Name}

(**First Party**)

{Enter Organization Address}

{Enter Organization City}, KY {Enter Organization Zip}

and {Enter Department Name}

Health Department

(**Health Department**)

{Enter Department Address}

{Enter Department City}, KY {Enter Department Zip}

is effective Start Date and ends No later than final day of FY.

**WITNESSETH THAT:**

WHEREAS, the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Department, in the exercise of its lawful duties has determined that individual Medical Nutrition Therapy (MNT) services and/or group MNT services are essential to the operation of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Department in fulfilling its legal responsibilities. The Dietitian may additionally provide basic nutrition, WIC certification, nutrition and breastfeeding services, and community nutrition, as appropriate.

WHEREAS, the \_\_\_\_\_\_\_\_\_\_\_\_ Health Department, is available, willing, and qualified to perform these services.

NOW, THEREFORE, the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Department agrees to perform the following described services, which are

Hereinafter described in detail as follows:

PROVIDER CREDENTIALS: The Registered Dietitian (RD)/Registered Dietitian Nutritionist (RDN) will have the following credentials:

Be licensed as a Licensed Dietitian (LD) by the Kentucky State Board of Licensure and Certification

as provided in KRS 310.021.

**Scope of Work:**

The RD/RDN will:

1. Assess basic nutrition status of individual using medical history, anthropometric, biochemical, clinical, dietary, cultural, ethnic and socioeconomic data in compliance with the WIC and Nutrition Manual and the Academy of Nutrition and Dietetics practice guidelines.

2. Develop a nutrition care plan appropriate for each client or client group according to Academy of Nutrition and Dietetics Nutrition Care Manual and the WIC and Nutrition Manual.

3. Document services in the medical record according to guidelines in the Administrative Reference and the WIC and Nutrition Manual.

4. Write reports to document and communicate program activities, as appropriate.

5. Code clinical or community services on the appropriate reporting or billing form in order to receive reimbursement for services.

6. Adhere to Local Health Department policies in regard to confidentiality.

7. Follow Local Health Department policies in regards to human resource procedures (e.g., dress codes, etc.).

8. Maintain credentials as outlined by the Kentucky State Board of Licensure and Certification, as provided in KRS 310.021.

The RD/RDN will receive training that will include at a minimum:

1. Provision of basic nutrition services guidelines, MNT guidelines, documentation and coding information.

2. Special formula training for the WIC Program, as needed.

3. Appropriate referral guidelines for local area services and within the Administrative Reference and the WIC and Nutrition Manual.

The RD/RDN will not bill or charge clients for her services separately from Local Health Department billing procedures. *Procedures and supply items that are incidental and integral to procedures are be provided by the first party and shall not be billed separately.*

{COMPENSATION/PAYMENT: Describe compensation in terms of hourly rate, number of hours per task, unit pieces, cost per task, cost per deliverable, etc.}

{COMPENSATION/PAYMENT: The contractor will be paid at $\_\_\_\_\_\_ per hour.

Attach Medicaid Statement of Authorization (CH-55) for each medical provider under a contract that is billable to Medicaid.

The First Party agrees to abide by the rules and regulations regarding the confidentiality of personal medical records as mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164.

The First Party agrees to comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) and all implementing regulations and executive orders. No person shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination in relation to activities carried out under this contract on the basis of race, color, age, religion, sex, disability or national origin. This includes the provision of language assistance services to individuals of limited English proficiency seeking and/or eligible for services under this contract.

**Section 601 of Title VI of the Civil Rights Act of 1964, (42 U.S.C. 2000d)**, provides that no person shall "on the ground of race, color or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."

In 1974 the Supreme Court (Lau v. Nichols, 414 U.S. 563) interpreted regulations promulgated by the former Department of Health, Education and Welfare (HHH's predecessor), 45 CFR 80.3 (b) (2), to hold that Title VI prohibits conduct that has a disproportionate effect on **Limited English Proficient (LEP) persons** because such conduct constitutes national-origin discrimination. On August 11, 2000, **Executive Order 13166** was issued, "Improving Access to Services for Persons with Limited English Proficiency (LEP)."

1. For the services described in this contract, the First Party agrees to pay the Health Department in the following manner, {Enter payment time period.} payable upon receipt of appropriate billing.
2. The total payments made under the terms of this contract shall not exceed ${Enter Contract Value}.
3. The Parties to this contract agree to comply with Section 504 of the Rehabilitation Act of 1973, (P.L. 93-112) and the Kentucky Equal Employment Act of 1978 (H.B. 683) KRS 45.550 to 45.640, and Americans with Disabilities Act, (ADA), (P.L. 101-336).
4. The Health Department certifies that no constitutional, statutory, common law, or regulation adopted by the Cabinet for Health and Family Services pertaining to conflict of interest will be violated by this contract.
5. Either Party shall have the right to terminate this contract at any time upon 30 days written notice to the other Party.

**FIRST PARTY:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ {Enter Date Signed}

(SIGNATURE OF AUTHORIZED AGENT)

{Enter First Party Name}

**HEALTH DEPARTMENT:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ {Enter Date Signed}

(SIGNATURE OF AUTHORIZED AGENT)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(PRINT OR TYPE NAME OF AUTHORIZED AGENT)

{Enter Health Department Name}