

**REQUEST FOR APPLICATIONS - INDIVIDUALS – 30 DSDHH 95075-19
Sign Language Interpreting and Transliterators Services Vendor List (ISVL)**

| | | | |
|--------------------------------------|---|-------|--|
| RFA Posted | September 25, 2019 | | |
| Questions Due | Any time after posting date through end of contract | | |
| Applications Due | Open Enrollment of RFA throughout Contract Period | | |
| Anticipated Notice of Award | Continual Upon Review and Acceptance | | |
| Anticipated Performance Period | November 1, 2019 thru October 31, 2020, with options to renew for two (2) additional years in one (1) year increments | | |
| Service | Sign Language Interpreting and Transliterators Services Vendor List | | |
| Issuing Agency | Division of Services for the Deaf and the Hard of Hearing 820 S. Boylan Avenue, 2301 MSC, Raleigh, NC 27699-2301 | | |
| E-mail Applications and Questions to | Communication Access Manager | Email | DSDHH.ISVL@dhhs.nc.gov |

THIS REQUEST FOR APPLICATIONS (RFA) advertises the Division’s need for the services described herein and solicits applications offering to provide those services pursuant to the specifications, terms, and conditions specified herein. All applications received shall be treated as offers to contract. If the Division decides to accept an application, an authorized representative of the Department will sign in the space provided below. Acceptance shall create a contract that is effective as specified below.

THE UNDERSIGNED HEREBY SUBMITS THE FOLLOWING APPLICATION AND CERTIFIES THAT: (1) he or she is authorized to bind the named Contractor to the terms of this RFA and Application; (2) the Contractor hereby offers and agrees to provide services in the manner and at the costs described in this RFA and Application; (3) this Application shall be valid for 60 days after the end of the application period in which it is submitted.

To Be Completed by Contractor:

| | |
|-----------------------------------|-------------------------|
| Contractor Name (printed): | Social Security Number: |
| Contractor’s Street Address: | E-Mail Address: |
| City, State & Street Address Zip: | Telephone Number: |
| Signature of Contractor: | Date: |

Unsigned or Incomplete Applications Shall Be Returned Without Being Reviewed

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| <p>NOTICE OF AWARD/FOR NC DHHS USE ONLY: Application accepted and Contract 30-DSDHH 95075-19 awarded on _____. The Contract shall begin on _____ and shall terminate on October 30, 2020.</p> <p>By: _____ Signature of Authorized Representative Printed Name of Authorized Representative Title of Authorized Representative</p> |
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I. PURPOSE

The purpose of this Request for Applications (RFA) is to solicit applications from individual licensed sign language interpreters and/or transliterators (referred to hereinafter as “Vendor(s)”, “interpreters”, “applicants”, or “contractors”) depending upon the contexts that are interested in and qualified to provide the North Carolina Department of Health and Human Services (hereafter “Department” or “DHHS”) with sign language interpreting and transliterating services as needed by the Department, pursuant to and in accordance with the terms and conditions of this RFA, including all of its attachments.

Tendered applications will be evaluated, and those applications that present verified evidences that the applicant does meet the necessary requirements will be approved to be listed on an Interpreting Services Vendor List (ISVL). This RFA and resulting ISVL is developed and managed by the Division of Services for the Deaf and the Hard of Hearing (DSDHH); however, the listed Individual Vendors are available for hire to the entire DHHS in accordance with the terms and conditions as outlined in the RFA. For illustrative purposes of this contract, some of those locations are (this listing is representative of a broad summation of the locations within DHHS and does not represent or conclude that it lists every agency, office, or division within DHHS):

- a) **The Division of Vocational Rehabilitation Services** - Provides counseling, training, education, transportation, job placement, assistive technology, and other support services to citizens with disabilities: Has seventy-two (72) regional offices throughout the state.
- b) **The Division of Services for the Blind** - Assists individuals who are blind, deaf-blind, and visually impaired. Has seven (7) District Offices throughout the state.
- c) **The Division of Mental Health, Developmental Disabilities and Substance Abuse Services** - Provides quality support to achieve self-determination for individuals with intellectual and/or developmental disabilities and quality services to promote treatment and recovery of individuals with mental illness and substance abuse disorders.
- d) **The Division of Services for the Deaf and Hard of Hearing** – Works to ensure that all Deaf, Hard of Hearing, or Deaf-Blind North Carolinians are enabled to communicate their needs and to receive information easily and effectively in all aspects of their lives, especially their health and well-being. This Division has a central office location and seven (7) regional centers. The locations of these offices are:
 - 1) State Administrative Office - Raleigh, NC
 - 2) Asheville Regional Center – Asheville, NC
 - 3) Charlotte Regional Center – Charlotte, NC
 - 4) Greensboro Regional Center – Greensboro, NC
 - 5) Morganton Regional Center - Morganton, NC
 - 6) Raleigh Regional Center, Raleigh, NC
 - 7) Wilmington Regional Center, Wilmington, NC
 - 8) Wilson Regional Center, Wilson, NC
- e) **The Division of State Operated Healthcare Facilities (DSOHF)**, consisting of:
 - 1) Three Alcohol Drug Abuse Treatment Centers (ADATC), including:
 - i. Julian F. Keith Alcohol and Drug Abuse Treatment Center – Black Mountain, NC
 - ii. R. J. Blackley Alcohol and Drug Abuse Treatment Center – Butner, NC
 - iii. Walter B. Jones Alcohol and Drug Abuse Treatment Center – Greenville, NC

- 2) Three Psychiatric Hospitals, including:
 - i. Cherry Hospital – Goldsboro, NC
 - ii. Central Regional Hospital – Butner, NC
 - iii. Broughton Hospital – Morganton, NC

- 3) Three Development Centers, including:
 - i. Caswell Development Center – Kinston, NC
 - ii. J. Iverson Riddle Development Center – Morganton, NC
 - iii. Murdoch Development Center – Butner, NC

- 4) Three Neuro-Medical Treatment Centers, including:
 - i. O’Berry Neuro-Medical Treatment Center – Goldsboro, NC
 - ii. Longleaf Neuro-Medical Center, Wilson, NC
 - iii. Black Mountain Neuro-Medical Center, Black Mountain, NC

- 5) Two Residential Schools, including:
 - i. Whitaker Psychiatric Residential Treatment Center, Butner, NC
 - ii. Wright School – Durham, NC

During the application evaluation, an inquiry into the US Department of Health and Human Services, Office of the Inspector General’s (OIG) Exclusions Database, List of Excluded Individuals/Entities (LEIE), will be made to determine if the applying individual is excluded from working in a federal health care program. After an initial inquiry, DSDHH will thereafter regularly monitor the OIG Exclusion Database to ensure that a contracted individual does not become excluded from working in a federal health care program. If an applying individual is initially excluded, a contract will not be executed. If a contractor becomes excluded during the term of the contract, immediate actions will occur to cancel the contract.

An Individual Vendor will not be obligated to perform any services for the Department unless and until acceptance of a specified work order or request from the Department is received. Being listed on the ISVL does not guarantee an Individual Vendor that he or she will ever receive a specified work order or request. Any Division, Section, Branch, Unit, Office, Facility, or Institution of the Department may issue a specified work order or request to the Individual Vendor or Vendors of their choice. The work order or request may be issued by any written means. The entity issuing the work order or request shall be referred to hereinafter as the “Hiring Agency” or the “Requestor”. An Individual Vendor may decline to accept a work order or request if the vendor is not available at the time and place specified by the Hiring Agency or Requestor or if the vendor does not possess the knowledge and expertise required by the assignment.

The ISVL agreement is public information. What is not public is the identifying information such as social security numbers, driver’s license numbers, and date of birth. Individual Vendors may want to get a post office box number if they do not want their physical addresses published, however, earnings or salaries are public information.

II. BACKGROUND

The DHHS is the largest agency in North Carolina State government. It is divided into thirty (30) divisions and offices, oversees eighteen (18) facilities, has more than nineteen thousand (19,000) employees, and has an operating budget of \$14 billion. The Department is responsible for ensuring the health, safety, and well-being of

all North Carolinians; meeting the human service needs for fragile populations like the mentally ill, deaf, blind, and developmentally disabled; and, helping poor North Carolinians achieve economic independence.

The Census Bureau and the National Center for Health Statistics estimate that approximately one million people in North Carolina have a hearing loss. Many of these individuals are customers, clients, and staff of DHHS. All Divisions, Sections, Branches, Units, Offices, Facilities, and Institutions are required to establish an accessibility plan to provide communication access for consumers, clients, or staff who may be deaf, hard of hearing, deaf-blind or blind. The plan must include procedures for the procurement of and payment for accessibility services. The ISVL is the principal tool used by DHHS Divisions, Sections, Branches, Units, Offices, Facilities, and Institutions to procure licensed sign language interpreters and transliterators.

III. DEFINITIONS

- a) **Business Hours:** Weekdays beginning at 8:00 am and ending at 5:00 pm, except for official state holidays as defined at: <http://www.osp.state.nc.us/holsched.htm>.
- b) **Consumer Report:** The Interpreting Services Consumer Report that is available for completion anytime during the term of the contract by the Hiring Agency and/or consumer and submitted to the Communication Access Manager. The Communication Access Manager uses the Consumer Report to monitor Vendor performance and resolve issues (Attachment C).
- c) **Contiguous Hours:** Connected throughout in an unbroken sequence.
- d) **DHHS and/or Department:** The North Carolina Department of Health and Human Services.
- e) **DI:** Deaf Interpreter: A Deaf person who performs the function of an interpreter.
- f) **DMH/DD/SAS:** The Division of Mental Health, Developmental Disabilities and Substance Abuse Services.
- g) **DSB:** The Division of Services for the Blind.
- h) **DSDHH:** The Division of Services for the Deaf and the Hard of Hearing.
- i) **DVRS:** The Division of Vocational Rehabilitation Services.
- j) **DSOHF:** The Division of State Operated Healthcare Facilities
- k) **Exclusions Database, LEIE:** List of Excluded Individuals/Entities currently excluded from participation in Medicare, Medicaid and all other Federal health care programs. Exclusions can be due to a variety of reasons, including a conviction for Medicare or Medicaid fraud.
- l) **Hiring Agency or Requestor:** The Division, Section, Branch, Unit, Office, Facility, or Institution, that issues a work order or request (by DHHS staff) to an Individual Vendor under this RFA.
- m) **Individual Vendor:** An individual (person) sign language interpreter or transliterator that is awarded an agreement to provide the services described in this RFA. Throughout this RFA, the Individual Vendor

may be referred to as “Applicant”, “Interpreter”, “Interpreter and/or Transliterater”, “Vendor”, or “Contractor”, depending upon the context.

- n) **Interpreter:** As defined in N.C. Gen. Stat. § 90D-3, a person who provides accessible communication, between and among persons who are deaf, hard-of-hearing, and those who are hearing. This process includes, but is not limited to, communication between American Sign Language and English. It may also involve various other modalities that involve visual, gestural, and tactile methods. Notwithstanding the foregoing definition, all further references in this RFA to “interpreters” shall be understood to constitute a joint reference to sign language interpreters and/or transliterators.
- o) **ISVL:** Interpreting Services Vendor List. The ISVL is a list of: All Individual Vendors (sign language interpreters and transliterators) who have an agreement directly with the Department to provide interpreting and transliterating services pursuant to the Department’s terms and conditions upon the receipt of a work order/request from a Hiring Agency/Requestor.
- p) **OIG:** Office of Inspector General, US Department of Health and Human Services
- q) **NAD/RID:** National Associate of the Deaf/Registry of Interpreters for the Deaf, Inc.
- r) **Point of Departure:** The location from which an interpreter or transliterator departs to go to a work assignment. The Point of Departure is typically the interpreter’s home or office, whichever is closer to the location of the work assignment. If the interpreter has two assignments with the same Hiring Agency or Requestor in the same day and the interpreter drives from the first assignment to the second without returning to his or her home or office, the location of the first assignment is the Point of Departure for the second assignment.
- s) **Transliterator:** As defined in N.C. Gen. Stat. § 90D-3, a person who provides accessible communication between one or more hearing persons and one or more deaf or hard-of-hearing persons using a form of manually coded English. Notwithstanding the foregoing definition, all further references in this RFA to “interpreters” shall be understood to constitute a joint reference to interpreters and/or transliterators.
- t) **Work Order or Request:** A Hiring Agency’s or a Requestor’s request that an Individual Vendor (s) provide the services described in this RFA. A work order or request may be issued by telephone, videophone, fax, mail, or email, provided that the telephone and videophone requests are followed-up with written confirmations.

IV. TERM

- A. **Term:** Contracts arising out of this RFA shall be effective on November 1, 2019 or upon the Department’s acceptance of the Contractor’s application, whichever occurs later, and shall terminate on October 30, 2020. The RFA and resulting contracts may be renewed for an additional two (2) years in one (1) year increments.
- B. **Renewal Options/Process:** The contract renewal(s), if exercised, will consist of the DSDHH sending each Contractor an opportunity to renew packet. This packet will be comprised of any changes to the current contract as established and requests for information/documentation from all individuals that desire to continue the contractual agreement. The Contractor, at a minimum, will be required to sign the

contract renewal form including listing a current address, telephone number, and email address, and returning the completed packet with a copy of the letter of renewal/verification that the applicant possesses a valid North Carolina Interpreter and Transliterators license issued pursuant to Chapter 90D of the North Carolina General Statutes.

Contractors that chose to agree to provide proof of being immunized for measles, mumps, rubella, varicella, pertussis, and an annual influenza vaccination to be approved to accept assignments in DHHS State Operated Health Care Facilities (Attachment F) must also return current annual proof of immunizations with the opportunity to renew form.

V. SCOPE OF SERVICES

A. **The Individual Vendor's Duties:** The Individual Vendor shall:

1. Possess a valid and current license granted by the NC Interpreter and Transliterators Licensing Board;
2. Possess the knowledge and expertise required by the engagement. If any special augmentation is needed to assist with facilitation of communication, the hiring agency will be responsible for informing the interpreter of the/those needs. The interpreter must determine at the time a work order is issued the specifics regarding the level of knowledge and expertise that will be required for the interpreter to meet the needs of the engagement. If the interpreter has any reason to believe that he/she does not possess the knowledge and expertise to complete the engagement adequately regarding all parties concerned, he/she must respectfully reject the proposed assignment.
3. Provide interpreter and/or transliterator services in the preferred mode of communication of the individual with a hearing loss. For purposes of this contract, the preferred mode of communication is construed to mean that the interpreter and/or transliterator will render the message faithfully by conveying the content and spirit of what is being communicated, using language most readily understood by the consumer, and correcting errors discreetly and expeditiously.
4. Adhere continually to NAD/RID Code of Professional Conduct, which requires that interpreters and transliterators:
 - a. Adhere to standards of confidential communication;
 - b. Possess the professional skills and knowledge required for the specific interpreting situation;
 - c. Conduct themselves in a manner appropriate to the specific interpreting situation;
 - d. Demonstrate respect for consumers;
 - e. Demonstrate respect for colleagues, interns, and students of the profession;
 - f. Maintain ethical business practices; and,
 - g. Engage in professional development.

The NAD/RID Code of Professional Conduct is continually available for review at: <http://www.rid.org/ethics/code-of-professional-conduct/>

5. When receiving a request for services (work order), the contractor must confirm that he/she is available, or when not available, respond with a rejection of assignment acceptance. The preferred method for acceptance or rejection is by written means.

6. There may be occasions when the Department will request interpreter(s) to mentor or lead skill development sessions for other interpreters, including ISVL interpreters and the Department's staff interpreters. When these occasions occur, the interpreter will invoice at rates established in **Section VII. Disbursement**, in accordance with his/her licensing credentials.

B. The Department's Duties: The Hiring Agency or Requestor shall:

1. Contact the Individual Vendor to request services at least one week before the date of the assignment, whenever possible.
2. Determine how many interpreters will be needed for each assignment. Considerations such as length of assignment, size of audience, and dynamics of the setting and language needs are often factors influencing the decisions regarding quantity of interpreters assigned.
3. Provide essential information regarding the engagement, including the expected duration of the engagement (in increments of 15 minutes), the names of the parties involved, contact person, the date and time of the engagement, driving directions, building name, room number, parking information, etc.
4. Complete the DHHS Interpreting Services Consumer Report ("Consumer Report"), which is attached hereto as Attachment C, and submit it to the Communication Access Manager if there is a concern, issue, or a compliment the Hiring Agency and/or consumer wishes to report.
5. Pay for the Individual Vendor's services, as described in RFA Section VII upon receipt of a correct invoice and upon availability of funds.

VI. PERFORMANCE EVALUATIONS

1. The Communication Access Manager in the Division of Services for the Deaf and the Hard of Hearing ("DSDHH") will use feedback from consumers, staff, and others to monitor the Individual Vendor's performance. Feedback comes through the DHHS Interpreting Services Consumer Report (Attachment C). The Consumer Report is available for completion anytime during the term of the contract by the Hiring Agency and/or consumer and submitted to the Communication Access Manager.
2. If a Consumer Report raises a concern(s), the Communication Access Manager may tender written documentation to the Vendor apprising him/her of the concern, including recommendation(s) for correcting the situation(s) that caused the concern(s). Thereafter, the Vendor will be given ten (10) business days to respond to the notification with comments regarding how he/she will make corrections that will result in the events or actions that caused the concern(s) to cease. The Communication Access Manager will also share with the Vendor any positive comments made by consumers.
3. The Communication Access Manager, or his/her designee, may periodically visibly observe an interpreter's performance. This visible observance will only be performed when written approval is granted by the consumer involved/included in an interpreter assignment session.
4. If a Vendor is not in compliance with the NAD/RID Code of Professional Conduct, the Hiring Agency, Requestor or Consumers may do any of the following:

- Compile an ISVL Consumer Report;
- Report to the NC Interpreter and Transliterator Licensure Board;
- Report to RID’s Ethical Practices System.

5. The NAD/RID Code of Professional Conduct upholds high standards of professionalism and ethical conduct for interpreters. Embodied in this Code of Professional Conduct are seven tenets setting fourth guiding principles, including illustrative behaviors. The illustrative behaviors are not exhaustive but are indicative of the conduct that may either conform to or violate a specific tenet or the code entirely. Reports of any violations of any tenet by a Vendor will result in a complete analysis of the violation and may result in immediate cancellation of the Vendor’s contract for interpreter/tranliterator services.

The NAD/RID Code of Professional Conduct may be viewed at:
http://wasli.org/wp-content/uploads/2013/10/78_rid-code-of-ethics.pdf

VII. DISBURSEMENT

A. Payment for Services

The Individual Vendor shall be paid as detailed on the schedule below:

| NC Interpreter License | Credentials | | Standard Rate | Enhanced Rate |
|------------------------|---|----------------------|---------------|---------------|
| | Interpreting | Transliterating | | |
| Full | RID, NAD 5, NAD 4, NCICS A, NCICS B | CLTSLA | \$40.00 | \$60.00 |
| Full or Provisional | NAD 3, NAD 2, NCICS C, EIPA III or higher, DI | CLTSLA IV, CLTSLAIII | \$30.00 | \$45.00 |
| Full or Provisional | EIPA II, EIPA I or no additional credentials | CLTSLA II, CLTSLA I | \$25.00 | \$37.50 |

This disbursement chart is applicable when the Vendor has been engaged to interpret for a deaf or hard of hearing person, to mentor other interpreters, or to lead interpreter skill development sessions.

1. The **standard** rate shall be paid for services rendered Monday through Friday between the hours of 7:00 AM and 5:00 PM.
2. The **enhanced** rate shall be paid for services rendered Monday through Friday between the hours of 5:00 PM and 7:00 AM; any time on weekends; and any time on State holidays. A list of State holidays can be found online at: <http://www.osp.state.nc.us/holsched.htm>.
3. The standard and enhanced rates are applicable, regardless of advanced notice of need for services.
4. The Individual Vendor shall bill in quarter-hour increments and may bill for a quarter-hour increment if the interpreter works for any portion of that quarter-hour.

Example: If an Individual Vendor is confirmed to interpret for three (3) hours and interprets for three hours and five minutes, the Vendor may bill for three hours and fifteen minutes (3.25).

Example: If an Individual Vendor is confirmed to interpret for three (3) hours and interprets for three hours and thirty-five minutes, the Vendor may bill for three hours and forty-five minutes (3.75).

5. The Individual Vendor may bill the State for a full two (2) hours for any assignment that lasts less than two (2) hours, except as provided in Section C, below.
6. The Individual Vendor may not bill the State for arriving ten (10) to fifteen (15) minutes early to an assignment for preparation time, even when specifically requested to do so by the Requestor. Arriving ten (10) to fifteen (15) minutes early is a professional courtesy and an industry standard.
7. When providing interpreting and/or transliterating services for more than one (1) day at national, regional, or statewide meetings or conferences held in the State of North Carolina, the hiring agency may negotiate with the Vendor an all-inclusive flat fee for the meeting or conference in lieu of paying the Vendor the standard and enhanced hourly rates specified in RFA Section VII. A. Payment for Services and the Travel Expenses specified in RFA Section VII. B. The all-inclusive flat fee must be agreed upon in advance and must have a detailed breakout, justifying any excess subsistence above state rates as in RFA Section VII. B.

B. Travel Expenses

1. The only travel expense approved for an Individual Vendor is mileage charges, UNLESS and EXCEPT when a Vendor is requested to accept an assignment that will require an overnight stay. When an overnight stay is included in an assignment, the Vendor may bill the Hiring Agency or Requestor his or her travel expenses pursuant to the terms of the Travel Policies for State Employees. Those policies are set out in Section 5.1 of the State Budget Manual, which can be found online at: <https://www.osbm.nc.gov/budman5-travel-policies>

Note: For mileage charges, follow the Office of State Budget and Management (OSBM) mileage rate which may be modified from time to time by the State Budget Director. Notice of such modifications may be found online at: <https://www.osbm.nc.gov/budman5-travel-policies> (Click on “Budget Publications Memorandums” and then type in “Mileage Rate” in the search field. Follow the most recent mileage memo.)

The Travel Policies for State Employees in Section 5.1 of the State Budget Manual, and all future amendments thereto, are adopted and incorporated herein by reference.

NOTE: Section 2. and 3. below include opportunities for contractors to add hours of service to their invoices for miles driven when they exceed seventy-five (75) miles for number 2., and, one-hundred fifty (150) miles for number 3. All contractors should be aware that the DHHS makes every effort within its scheduling scheme to schedule interpreters/transliterators to every assignment that are less than seventy-five miles from the actual work assignment location. Approximately ninety (90) percent of assignments are within the seventy-five (75) mile radius.

2. If the Individual Vendor travels seventy-five (75) miles or more from the point of departure to the location of an engagement and then seventy-five (75) miles or more from the location of the engagement

back to the point of departure, the Vendor may bill the Hiring Agency an additional **1.5 hours** for each leg of the trip, provided the Vendor obtains the Hiring Agency's prior written approval to do so. If the Vendor does not return to the point of departure immediately following the engagement because of intervening business or personal reasons, the Vendor may not bill the Hiring Agency for the return trip. The additional time will be reimbursed at the standard rate, regardless of the day or time of the travel.

3. If the Individual Vendor travels one-hundred twenty five (125) miles or more from the point of departure to the location of an engagement and then one-hundred twenty five (125) miles or more from the location of the engagement back to the point of departure, the Vendor may bill the Hiring Agency for **2 hours** for each leg of the trip, provided the Vendor obtains the Hiring Agency's prior written approval to do so. If the Vendor does not return to the point of departure immediately following the engagement because of intervening business or personal reasons, the Vendor may not bill the Hiring Agency for the return trip. The additional time will be reimbursed at the standard rate, regardless of the day or time of the travel. If an overnight stay is required pertaining to the assignment, Individual Vendor will be reimbursed for the hotel and meals.

C. Cancellations, Late Arrivals, and Other Circumstances

1. If an interpreting assignment is cancelled and the Individual Vendor receives notice of the cancellation twenty-four (24) or fewer business hours before the assignment was scheduled to begin, the Hiring Agency or Requestor will pay the Vendor a fee equal to the total number of hours approved for the assignment times the applicable hourly rate. However, the Vendor shall not be reimbursed for any travel expenses.
2. If an interpreting assignment is cancelled, through no fault of the Vendor, after the Vendor arrives at or is in route to the site of the engagement, the Hiring Agency or Requestor will pay the Vendor a fee equal to the total number of hours approved for the engagement times the applicable hourly rate and will also reimburse the Vendor for his or her travel expenses.
3. Cancellations may occur due to severe meteorological weather conditions. Payment for services may be authorized when it is necessary for a contractor to cancel because of severe meteorological weather conditions. These conditions must be in process or forecast by a local or national weather forecasting service in a current or imminent timeframe. In addition, the severe meteorological weather conditions must be occurring or in the imminent future in the route that encompasses traveling to the consumer's location from the Vendor's duty station or home, whichever applicable. The Vendor **MUST** contact the Hiring Agency Office to explain the weather-related circumstances, and the Hiring Agency must send a written document/email message to the Contractor that approves the submittal of an invoice.

If approval to submit an invoice is granted, the Hiring Agency will only pay the Vendor a fee up to one-half the number of hours scheduled for the assignment multiplied by the applicable hourly rate, and the Vendor shall not be compensated for travel expenses.

The Hiring Agency reserves the right to reject the Vendor's claim and deny submittal of an invoice.

4. If an interpreting assignment is cancelled because of events beyond DHHS's control, such as necessary roadway detours an interpreter may encounter, or obstructions in roadways that result in traffic

stoppages (i.e. vehicle accidents), the Vendor shall not be compensated for the lost time or travel expenses.

5. If the Vendor finds that he or she will be late for an assignment, the Vendor shall immediately notify the Hiring Agency or Requestor of that fact. If the Vendor arrives late for an assignment, they may only bill from the time of their arrival until the original confirmed end time; the two (2) hour minimum will not apply.

Example: The confirmed assignment time is 9 am to 11 am. The Vendor arrives at 9:30 am. The submitted invoice must reflect 9:30 am to 11 am.

6. If the Vendor must leave the assignment early for their own reason(s), they must seek approval from the Hiring Agency or Requestor and may not bill for the time after they leave. The two (2) hour minimum will not apply.

Example: The confirmed assignment time is 9 am to 11 am. The Vendor must leave at 10:30 am due to illness. The submitted invoice must reflect from 9 am to 10:30 am

7. If the Vendor does not respond to a Work Order or Request at least forty-eight (48) contiguous hours before the assignment is scheduled to begin, the Hiring Agency or Requestor may cancel that Work Order or Request and make a request to another Vendor.

D. Invoicing

The Individual Vendor must submit invoices to the Hiring Agency or Requestor within thirty (30) contiguous days after services are provided, using the form that is attached hereto as Attachment B.

Note: The invoicing processes may be handled differently from one division to another. An Individual Vendor needs to be aware of the following variations regarding invoicing procedures:

- a. **Division of Vocational Rehabilitation Service (DVRS)** - Invoices from Individual Vendors for services provided to DVRS clients are processed as follows:

- (1) The Individual Vendor will provide the service they were contracted to provide.
- (2) After the interpreting services' have been provided, the Individual Vendor shall complete and return an ISVL interpreting invoice to the counselor that requested the service.
- (3) The counselor shall review the invoice and the counselor shall sign the interpreter invoice indicating agreement.
- (4) The interpreter invoice will be sent to the controller's office by the VR counselor for processing.
- (5) If all the information is correct, the controller's office will process the invoice and issue a check.
- (6) If there is an error, the controller's office will return the papers to the DVRS Fiscal Services Section for further review and corrective action.

- b. **Division of Services for the Blind (DSB)** - Processing ISVL invoices for services authorized by DSB VR Counselors using case service funds.

- (1) The DSB counselor coordinates and authorizes for interpreting services through an Individual Vendor for the hours requested.
- (2) The Vendor prepares an original signed ISVL invoice.

- (3) The Vendor submits the signed ISVL invoice back to the person who authorized for the service.
- (4) The counselor reviews the invoice and if correct, signs and submits the invoice and the authorization to the controller's office for payment.
- (5) The controller reviews the signed invoice and if correct, processes the invoice for payment.
- (6) If an error is found, the controller will return the invoice to the rehabilitation counselor and the counselor will request a corrected invoice and the corrected invoice is processed and paid.

c. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Division of State Operated Health Facilities (DSOHF):

- (1) Interpreting or transliterating services may be requested from the ISVL Vendors for a) state employees, or b) patients receiving inpatient or residential services from Psychiatric Hospitals, Alcohol and Drug Treatment Centers, Neuro-Medical Treatment Centers, Developmental Centers, and Residential Programs for Children.
- (2) The Vendor prepares an original ISVL invoice. The signed invoice is sent via US MAIL to the person who requested the service. Invoices containing health information such as a patient name or record number shall be placed in a sealed envelope and marked "CONFIDENTIAL", with the name of the Vendor and a return address clearly marked on the envelope.
- (3) Submitted invoices are reviewed for accuracy and coding, and then forwarded to the Controller's Office for payment.

VIII. INSTRUCTIONS TO APPLICANTS

1. **Award or Rejection:** All complete applications will be evaluated against the requirements of the RFA. The Department reserves the unqualified right to reject any or all offers if rejection serves the best interests of the State. Applicants will be notified of application status via letter upon completion of application review.
2. **Cost of Application Preparation:** The Department will not reimburse any Applicant for any Application costs.
3. **Elaborate Applications:** Elaborate applications in the form of brochures or other presentations beyond that necessary to present a complete and effective application are not desired.
4. **Oral Explanations:** The Department will not be bound by oral explanations or instructions given at any time during the RFA process or afterward.
5. **Reference to Other Data:** Only information that is received in response to this RFA will be evaluated; references to information previously submitted in other applications or proposals will not be considered.
6. **Titles:** Titles and headings in this RFA are for convenience only and shall have no binding force or effect.
7. **Form of Application:** Applications must be submitted in the form and format specified by this RFA and must provide the information specified in this RFA.
8. **Acceptance of RFA Terms & Conditions:** All Applications are subject to the terms and conditions outlined herein. All Applications shall be controlled by such terms and conditions and the submission of other terms and conditions, price lists, catalogs, or other documents as part of an Application shall be waived and have no effect either on this Request for Applications or on any contract that may be awarded through this solicitation. By submitting an executed Application, the Applicant specifically agrees to the conditions set forth in this paragraph.

9. **Right to Submitted Material:** All responses, inquiries, or correspondence relating to or regarding this RFA, and all other reports, charts, displays, schedules, exhibits, and other documentation submitted by an Applicant shall become the property of DHHS when received.
10. **Competitive Offer:** Pursuant to the provision of G.S. 143-54, and under penalty of perjury, the signer of any application submitted in response to this RFA thereby certifies that this application has not been arrived at collusively or otherwise in violation of either Federal or North Carolina antitrust laws.
11. **Trade Secrets:** Trade secrets will be kept confidential to the extent permitted by G.S. 132-1.2 and 01 NCAC 5B .1501, provided each page that contains a trade secret is marked “CONFIDENTIAL” before it is submitted to the Department.
12. **Questions:** Questions about the RFA specifications may be submitted to the Department via email, telephone, or written correspondence. Please use the email address, telephone number, or mailing address listed on first page of this RFA when submitting such questions. Responses will be made promptly by the Communication Access Manager at DSDHH.
13. **Submission of Application:** Applicants may contact the nearest Regional Center or the State Administrative Office of the Division of Services for the Deaf and the Hard of Hearing for an application packet. See cover page for State Administrative Office information or go to <http://www.ncdhhs.gov/dsdhh/where.htm> to find the Regional Center that serves your location. Mail **one signed original** of your application to the Mail Service Center address on the cover page of the RFA. A “signed original” is a document that bears hand-written signatures rather than photocopies of hand-written signatures. Faxed applications will not be reviewed.
14. **Incomplete Applications:** Incomplete applications will be returned to the Applicant with a checklist that identifies information that was not submitted. The applicant may choose to resubmit an application, but the applicant should ensure that all information identified by the checklist is provided.
15. **Deadline for Submission of Application:** Applications may be received from the date the RFA is posted until three (3) months prior to the RFA’s ending date.

IX. THE APPLICATION

A complete application consists of the following documents, **mail one signed original:**

- a. Vendor Information (Attachment D);
- b. Agreement to require a vendor assigned to a DSOHF facility to be immunized and show proof of such before reporting to an assignment (Attachment E); and, if applicable, Vaccination Exemption Documentation Medical (Attachment I) or Religious (Attachment J);
- c. A copy of the letter of renewal/verification that the applicant possesses a valid North Carolina Interpreter and Transliterater license issued pursuant to Chapter 90D of the North Carolina General Statutes;
- d. A copy of all current interpreting or transliterating certifications held by the Applicant; e.g. NIC, RID, NAD, NCICS, EIPA, etc.;
- e. Documentation of any interpreting degrees held by the Applicant; and,
- f. A completed copy of the State of North Carolina’s SUBSTITUTE W-9 FORM. This document is attached for reference and marked Attachment H.

ATTACHMENT A

GENERAL TERMS AND CONDITIONS

- 1) **Contract Documents:** The Contracts that are awarded pursuant to and in accordance with this RFA shall consist of the following documents:

- (a) This RFA; and
- (b) The Vendor's Application.

In the event of a conflict between or among the terms of the Contract Documents, the terms in the RFA shall control. These documents constitute the entire agreement between the parties and supersede all other prior oral or written statements or agreements.

- 2) **Relationships of the Parties**

A. Independent Contractor: The Contractor is and shall be deemed to be an independent contractor in the performance of this contract and as such shall be wholly responsible for the work to be performed.

B. Assignment: No assignment of the Contractor's obligations or the Contractor's right to receive payment hereunder shall be permitted. However, upon written request approved by the issuing purchasing authority, the State may:

- (a) Forward the Contractor's payment check(s) directly to any person or entity designated by the Contractor, or
- (b) Include any person or entity designated by Contractor as a joint payee on the Contractor's payment check(s).

In no event shall such approval and action obligate the State to anyone other than the Contractor and the Contractor shall remain responsible for fulfillment of all contract obligations.

- 3) **Beneficiaries:** Except as herein specifically provided otherwise, this contract shall inure to the benefit of and be binding upon the parties hereto and their respective successors. It is expressly understood and agreed that the enforcement of the terms and conditions of this contract, and all rights of action relating to such enforcement, shall be strictly reserved to the Department and the named Contractor. Nothing contained in this document shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of the Department and Contractor that any such person or entity, other than the Department or the Contractor, receiving services or benefits under this contract shall be deemed an incidental beneficiary only.

- 4) **Indemnity**

A. Indemnification: The Contractor agrees to indemnify and hold harmless the Department, the State of North Carolina, and any of their officers, agents and employees, from any claims of third parties arising out of any act or omission of the Contractor commensurate with the performance of this contract.

- 5) **Termination**

A: Termination without Cause: The Department may terminate this contract without cause by giving **30 day's written notice** to the Contractor.

B: Termination for Cause: If, through any cause, the Contractor shall fail to fulfill its obligations under this contract in a timely and proper manner, the Department shall have the right to terminate this contract by giving written notice to the Contractor and specifying the effective date thereof. Notwithstanding the foregoing provision, the Contractor shall not be relieved of liability to the Department for damages sustained by the Department resulting from the Contractor's breach of this agreement, and the Department may withhold any payment due the Contractor for the purpose of setoff until such time as the exact amount of damages due the Department from such breach can be determined. In case of default by the Contractor without limiting any other remedies for breach available to it, the Department may procure the contract services from other sources and hold the Contractor responsible for any excess cost occasioned thereby. The filing of a petition for bankruptcy by the Contractor shall be an act of default under this contract. The Contractor's failure to maintain a valid North Carolina Interpreter and Transliterator License issued pursuant to Chapter 90D of the North Carolina General Statutes shall also be an act of default under this contract. **The Department may terminate this contract immediately for just cause if the Department determines that the Contractor has violated the RID Code of Professional Conduct.**

- 6) **Waiver of Default:** Waiver by the Department of any default or breach in compliance with the terms of this contract by the Contractor shall not be deemed a waiver of any subsequent default or breach and shall not be construed to be modification of the terms of this contract unless stated to be such in writing, signed by an authorized representative of the Department and the Contractor and attached to the contract.
- 7) **Availability of Funds:** The parties to this contract agree and understand that the payment of the sums specified in this contract is dependent and contingent upon and subject to the appropriation, allocation, and availability of funds for this purpose to the Department.
- 8) **Force Majeure:** Neither party shall be deemed to be in default of its obligations hereunder if and so long as it is prevented from performing such obligations by any act of war, hostile foreign action, nuclear explosion, riot, strikes, civil insurrection, earthquake, hurricane, tornado, or another catastrophic natural event or act of God.
- 9) **Survival of Promises:** All promises, requirements, terms, conditions, provisions, representations, guarantees, and warranties contained herein shall survive the contract expiration or termination date unless specifically provided otherwise herein, or unless superseded by applicable Federal or State statutes of limitation.
- 10) **Compliance with Applicable Laws**
 - A. **Compliance with Laws:** The Contractor shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and/or authority.
 - B. **Equal Employment Opportunity:** The Contractor shall comply with all federal and State laws relating to equal employment opportunity.

C. Health Insurance Portability and Accountability Act (HIPAA): The Contractor agrees that, if the Department determines that some or the entirety of the activities within the scope of this contract are subject to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-91, as amended (“HIPAA”), or its implementing regulations, it will comply with the HIPAA requirements and will execute such agreements and practices as the Department may require to ensure compliance.

11) **Confidentiality:** Any information, data, instruments, documents, studies or reports acquired by the Contractor under this agreement shall be kept confidential and not divulged or made available to any individual or organization without the prior written approval of the Department. The Contractor acknowledges that in receiving, storing, processing or otherwise dealing with any confidential information it will safeguard and not further disclose the information except as otherwise provided in this contract.

12) Oversight

A. Access to Persons and Records: The State Auditor shall have access to persons and records of all contracts or grants executed by State agencies or political subdivisions in accordance with General Statute 147-64.7. Additionally, as the State funding authority, the Department of Health and Human Services shall have access to persons and records of all contracts or grants executed by State agencies or political subdivisions.

B. Record Retention: Records shall not be destroyed, purged or disposed of without the express written consent of the Department. The Department of Health and Human Services' basic records retention policy requires all records to be retained for a minimum of three years following completion or termination of the contract. If the contract is subject to Federal policy and regulations, record retention will normally be longer than one year since records must be retained for a period of one year following submission of the final Federal Financial Status Report, if applicable, or one year following the submission of a revised final Federal Financial Status Report. Also, if any litigation, claim, negotiation, audit, disallowance action, or other action involving this contract has been started before expiration of the one-year retention period described above, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular one year period described above, whichever is later.

13) Miscellaneous

A. Contract Administrators: All questions relating to the administration or interpretation of this contract should be addressed to:

Division of Services for the Deaf and the Hard of Hearing
Attn: Communication Access Manager
2301 Mail Service Center
Raleigh, NC 27699-2301
Phone: (919) 527-6930
Email: DSDHH.ISVL@dhhs.nc.gov

All questions relating to the administration or interpretation of a Work Order issued under this contract should be addressed to the person who issued the Work Order.

- B. Choice of Law:** The validity of this contract and any of its terms or provisions, as well as the rights and duties of the parties to this contract, are governed by the laws of North Carolina. The Contractor, by signing this contract, agrees and submits, solely for matters concerning this Contract, to the exclusive jurisdiction of the courts of North Carolina and agrees, solely for such purpose, that the exclusive venue for any legal proceedings shall be Wake County, North Carolina. The place of this contract and all transactions and agreements relating to it, and their situs and forum, shall be Wake County, North Carolina, where all matters, whether sounding in contract or tort, relating to the validity, construction, interpretation, and enforcement shall be determined.
- C. Amendment:** This contract may not be amended orally or by performance. Any amendment must be made in written form and executed by duly authorized representatives of the Department and the Contractor.
- D. Severability:** If a court of competent jurisdiction holds that a provision or requirement of this contract violates any applicable law, each such provision or requirement shall continue to be enforced to the extent it is not in violation of law or is not otherwise unenforceable and all other provisions and requirements of this contract shall remain in full force and effect.
- E. Headings:** The Section and Paragraph headings in these General Terms and Conditions are not material parts of the agreement and should not be used to construe the meaning thereof.
- F. Time of the Essence:** Time is of the essence in the performance of this contract.
- G. Advertising:** The Contractor shall not use the award of this contract as a part of any news release or commercial advertising.

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| DHHS ISVL Invoice for Individual Contractor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---------------|----------------|---|---|--|--|--|---------|--|--|--|------|--|--|--|-------|--|-----|--|---|--|--|-----------|--|--|--|---|--|--|--|------------------|--------------------------|--|--|---------------|--------------------------|--|--|------------------|--------------------------|--|--|
| <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width: 50%;">Interpreter Name</td><td colspan="3"></td></tr> <tr><td>NC License #</td><td colspan="3"></td></tr> <tr><td>Address</td><td colspan="3"></td></tr> <tr><td>City</td><td colspan="3"></td></tr> <tr><td>State</td><td style="width: 15%;"></td><td style="width: 15%;">Zip</td><td style="width: 15%;"></td></tr> </table> | Interpreter Name | | | | NC License # | | | | Address | | | | City | | | | State | | Zip | | <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="text-align: right;">INVOICE #</td><td colspan="3"></td></tr> <tr><td colspan="4" style="text-align: right;">DATE SUBMITTED: September 19, 2017</td></tr> <tr><td style="text-align: right;">First Submission</td><td colspan="3"><input type="checkbox"/></td></tr> <tr><td style="text-align: right;">Re-Submission</td><td colspan="3"><input type="checkbox"/></td></tr> <tr><td style="text-align: right;">Past Due or Late</td><td colspan="3"><input type="checkbox"/></td></tr> </table> | | | INVOICE # | | | | DATE SUBMITTED: September 19, 2017 | | | | First Submission | <input type="checkbox"/> | | | Re-Submission | <input type="checkbox"/> | | | Past Due or Late | <input type="checkbox"/> | | |
| Interpreter Name | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NC License # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| INVOICE # | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DATE SUBMITTED: September 19, 2017 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Submission | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Re-Submission | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Past Due or Late | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> BILL TO: DHHS Division or Office Name Attention Address City State Zip Phone Email </td> <td style="width: 50%; vertical-align: top;"> <p style="text-align: center;"><i>Questions pertaining to the ISVL should be referred to the Communication Access Manager at the Division of Services for the Deaf and the Hard of Hearing at 919.527.6930 or dsdhh.isvl@dhhs.nc.gov</i></p> <p style="text-align: center;"><i>Questions regarding the invoice and/or the assignment should be referred to the requestor.</i></p> </td> </tr> </table> | | | | BILL TO: DHHS Division or Office Name Attention Address City State Zip Phone Email | <p style="text-align: center;"><i>Questions pertaining to the ISVL should be referred to the Communication Access Manager at the Division of Services for the Deaf and the Hard of Hearing at 919.527.6930 or dsdhh.isvl@dhhs.nc.gov</i></p> <p style="text-align: center;"><i>Questions regarding the invoice and/or the assignment should be referred to the requestor.</i></p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ASSIGNMENT INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Assignment: | | Requestor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consumer Name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Description of Assignment: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Original Hours Scheduled: | Start Time: | End Time: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hours Billed | Start Time: | End Time: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Services Provided | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> Interpreting <input type="checkbox"/> Mentoring <input type="checkbox"/> Training <input type="checkbox"/> NDBEDP <input type="checkbox"/> Haptics <input type="checkbox"/> Other (specify _____) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Total Hours | Rate Per Hour | Services Total | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Standard Rate: | | | \$0.00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Enhanced Rate (Evenings, Weekends, Holidays): | | | \$0.00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Flat Rate | | | \$0.00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SERVICES TOTAL: | | | \$0.00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Travel and Other Expenses | Number of Miles | Rate Per Mile | Mileage Total | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> One Way <input type="checkbox"/> Roundtrip From: _____ To: _____ | | | \$0.00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Additional Mileage Rates | Number of Hours | Rate Per Hour | Mileage Total | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Additional Mileage Rates Add 1 hour (regular rate) for travel 75 miles or more each way Add 2 hours (regular rate) for travel 150 miles or more each way | | | \$0.00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other Expenses (Hotel, Meals, Parking (please attach receipt): | | | \$0.00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TRAVEL TOTAL: | | | \$0.00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| GRAND TOTAL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total Services Provided: | | | \$0.00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total Mileage & Other Expenses: | | | \$0.00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TOTAL INVOICED: | | | \$0.00 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| For DHHS Agency Use Only | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Reviewed By: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Title: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Approved By: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Title: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Budget Code: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

ATTACHMENT C

INTERPRETING SERVICES CONSUMER REPORT

| DHHS Information | | |
|---|---|---|
| Your Name: | Your Division/Office: | |
| Today's Date: | Contact Information: | |
| Contractor Information | | |
| This report is for: | Individual Contractor <input type="checkbox"/> | Agency Contractor <input type="checkbox"/> |
| | Interpreter's name: | Agency Name: |
| If this report is for a Business Contractor, please indicate the individual who you are reporting and their position (i.e. interpreter, receptionist, scheduler, etc.): | | |
| Please list any additional names pertinent to this report: | | |
| Briefly explain the reason for this report: | | |
| Performance Evaluation | | |
| Please check the following boxes to indicate areas related to the report. If applicable, please provide a brief description or example. | | |
| Personal and Professional Conduct: | If applicable, please explain: | |
| <input type="checkbox"/> Possess or provides interpreters who possess valid NC Interpreter/Transliterator License | | |
| <input type="checkbox"/> Provides interpreting services in preferred mode of communication to the individuals(s) with hearing loss. | | |
| <input type="checkbox"/> Provides adequate notice for cancellations. | | |
| <input type="checkbox"/> Other: | | |
| Adheres to the NAD/RID "Code of Professional Conduct" (see below 1 – 6): | | If applicable, please explain: |
| <input type="checkbox"/> 1. Adheres to standards of confidential communication. | | |
| <input type="checkbox"/> 2. Possess professional skills and knowledge require for the specific interpreting situation. | | |
| <input type="checkbox"/> 3. Conduct themselves in a manner appropriate to the specific interpreting situation. | | |
| <input type="checkbox"/> 4. Demonstrate respect for consumers. | | |
| <input type="checkbox"/> 5. Demonstrate respect for colleagues, interns and students of the profession. | | |
| <input type="checkbox"/> 6. Maintains ethical business practices. | | |
| Invoicing: | | If applicable, please explain: |
| <input type="checkbox"/> Submits invoices within thirty days | | |
| <input type="checkbox"/> Invoices in accordance with agreed upon rates of service and additional expenses. | | |
| Additional Comments | | |
| Please feel free to express any additional comments: | | |
| Signature: | | Date: |
| Please submit this report and any supporting documents to the Communication Access Manager from the Division of Services for the Deaf and the Hard of Hearing: DSDHH 2301 Mail Services Center Raleigh, NC 27699-2301 If you have any questions, please feel free to call or email at 919.874.2212 and dsdhh.isvl@dhhs.nc.gov | | |
| For ISVL Administrator Only | | |
| Received on: | Review Date: | Reviewed by: |
| Notes: | | |
| Signature: | | Date: |

ATTACHMENT D

**DHHS Interpreter Services RFA #30 DSDHH 95075-19
Vendor Information**

| | | | |
|---|--|---|--|
| Name | | SSN/Tax ID # | |
| Mailing Address | Street or PO Box | | |
| | City, State, Zip | | |
| Billing Address <input type="checkbox"/> Same as Above | Street or PO Box | | |
| | City, State, Zip | | |
| Primary Phone No. | | <input type="checkbox"/> Home Phone <input type="checkbox"/> Office Phone <input type="checkbox"/> Mobile Phone Text Messages – <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Alternate Phone No. | | <input type="checkbox"/> Home Phone <input type="checkbox"/> Office Phone <input type="checkbox"/> Mobile Phone Text Messages – <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Fax Number | | Email Address | |
| License Number | | <input type="checkbox"/> Full <input type="checkbox"/> Provisional <input type="checkbox"/> Grandfathered | |
| Current certifications | | | |
| Interpreting Degrees Received: | | | |
| Specialized Skill Set | <input type="checkbox"/> Tactile <input type="checkbox"/> Close Vision <input type="checkbox"/> Tracking <input type="checkbox"/> Voicing <input type="checkbox"/> Platform <input type="checkbox"/> Legal | | |

[Remainder of Page Intentionally Left Blank]

ATTACHMENT E

Agreement to have vendors being assigned to DSOHF facility being immunized

Per the Division of State Operated Healthcare Facilities (DSOHF) policy 182-AL, effective April 1, 2017, all DSOHF employees and others who work in DSOHF facilities must be immune (unless there is an approved religion or medical exemption based on a medical contra-indication, as described by the US Center for Disease Control, Advisory Committee on Immunization Practices [CDC/ACIP]) to the following:

1. Measles
2. Mumps
3. Rubella (German measles)
4. Varicella (Chickenpox)
5. Pertussis (Whooping cough)
6. **An annual influenza vaccination will also continue to be required to work within a DSOHF facility. The influenza vaccine is due by 11/1 of each year and evidence to support having this vaccine must be dated prior to this date** (Unless an individual is applying for a contract after 11/1. In that case, the evidence to support the influenza vaccine must have a recent date).

*If you choose to provide proof of immunization and work in a DSOHF facility, you may be required to be tested for Tuberculosis (TB).

Unfortunately, there is no national organization that maintains vaccination records. The records that exist are the ones you or your parents were given when the vaccines were administered and the ones in the medical record of the doctor or clinic where the vaccines were given. If you can't find your personal records or records from the doctor, you may need to get some of the vaccines again. While this is not ideal, it is safe to repeat vaccines. The doctor can also sometimes do blood tests to see if you are immune to certain vaccine-preventable diseases." ("Vaccine Information for Adults", Center for Disease Control, 2016, www.cdc.gov/vaccines/adults/vaccination-records.html)

Please Check One and Sign the one you check

I DO WISH to provide proof of immunizations as required by DSOHF that will authorize me to work in the identified facilities.

Signature Date

I DO NOT WISH to provide proof of immunizations as required by the DSOHF, understanding that doing so will result in me not being authorized to work in the identified facilities.

Signature Date

I WISH TO APPLY FOR AN EXEMPTION to provide proof of immunizations due to a bona fide religious or medical reason. [If this line is checked, Attachment I (Medical) or Attachment J (Religious) must be completed and returned with application package].

Signature Date

ATTACHMENT F

DSOHF Locations

State Operated Healthcare Facilities (DSOHF) and their locations

1. Alcohol and Drug Abuse Treatment Centers
 - a. Julian F. Keith ADATC – Black Mountain, NC
 - b. R. J. Blackley ADATC – Butner, NC
 - c. Walter B. Jones ADATC – Greenville, NC
2. Development Centers
 - a. Caswell Developmental Center – Kinston, NC
 - b. J. Iverson Riddle Developmental Center – Morganton, NC
 - c. Murdoch Developmental Center – Butner, NC
3. Neuro-Medical Treatment Centers
 - a. Black Mountain Neuro-Medical Treatment Center – Black Mountain, NC
 - b. O’Berry Neuro-Medical Treatment Center – Goldsboro, NC
 - c. Longleaf Neuro-Medical Treatment Center – Wilson, NC
4. Psychiatric Hospitals
 - a. Broughton Hospital – Morganton, NC
 - b. Central Regional Hospital – Butner, NC
 - c. Cherry Hospital – Goldsboro, NC
5. Residential Programs for Children
 - a. Whitaker Psychiatric Residential Treatment Facility – Butner, NC
 - b. Wright School – Durham, NC

[Remainder of Page Intentionally Left Blank]

**STATE OF NORTH CAROLINA
SUBSTITUTE W-9 FORM
Request for Taxpayer Identification Number**



NC Office of the State Controller
(IRS Form W-9 will not be accepted in lieu of this form)
***Denotes a Required Field**

| | | | | | | |
|---|---|---|---|---|---------------------|-----------------------------|
| Section 1 – Taxpayer Identification | <p>*1. Social Security Number (SSN), OR Employer Identification Number (EIN), OR Individual Taxpayer Identification Number (ITIN)</p> <p>*2.</p> | | <p>Please select the appropriate Taxpayer Identification Number (EIN, SSN, or ITIN) type and enter your 9-digit ID number. The U.S. Taxpayer Identification Number is being requested per U.S. Tax Law. Failure to provide this information in a timely manner could prevent or delay payment to you or require The State of NC to withhold 28% for backup withholding tax.</p> | | | |
| | <p>*4. Legal Name (as shown on your income tax return):</p> | | <p>3. Dunn & Bradstreet Universal Numbering System (DUNS) (see instructions)</p> | | | |
| | <p>5. Business Name/DBA/Disregarded Entity Name, if different from Legal Name:</p> | | | | | |
| | Contact Information | | | | | |
| | <p>*6. Legal Address</p> | | <p>7. Remittance Address (Location specifically used for payment that is different from Legal Address, if applicable)</p> | | | |
| | <p>*Address Line 1:</p> | | <p>Address Line 1:</p> | | | |
| | <p>Address Line 2:</p> | | <p>Address Line 2:</p> | | | |
| | <p>*City</p> | <p>*State</p> | <p>*Zip (9 digit)</p> | <p>City</p> | <p>State</p> | <p>Zip (9 digit)</p> |
| | <p>*County</p> | | <p>County</p> | | | |
| | <p>*8. Contact Name:</p> | | | | | |
| | <p>*9. Phone Number:</p> | | | | | |
| <p>10. Fax Number:</p> | | | | | | |
| <p>11. Email Address:</p> | | | | | | |
| <p>*12. Entity Type</p> | | <p>*13. Entity Classification</p> | | <p>14. Exemptions (see instructions)</p> | | |
| <p>Individual/Sole Proprietor/Single-member LLC C-Corporation S-Corporation</p> <p>Partnership Trust/Estate Other _____</p> <p>Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) _____</p> | | <p>Medical Services</p> <p>Legal/Attorney Services</p> <p>NC Local Govt</p> <p>Federal Govt</p> <p>NC State Agency</p> <p>Other Govt</p> <p>Other (specify)</p> | | <p>Exempt payee code (if any):</p> <hr/> <p>Exemption from FATCA reporting code (if any):</p> | | |
| <p>Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.</p> | | | | | | |
| Section 2 – Certification | <p>Under penalties of perjury, I certify that:</p> <ol style="list-style-type: none"> 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 I am not subject to backup withholding because: (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 because 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, and I am a U.S. citizen or other U.S. person (defined later in general instructions), and The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct. | | | | | |
| | <p>Certification instructions: Please refer to the IRS Form W-9 located on the IRS Website (https://www.irs.gov/):</p> | | | | | |
| | <p>*Printed Name:</p> | | <p>*Printed Title:</p> | | | |
| | <p>*Authorized U.S. Signature:</p> | | | <p>* Date:</p> | | |

Please complete the "Modification to Existing Vendor Records" section below if there have been any changes to the following: Tax Identification Number (TIN), Legal Name, Business Name, Remittance Address

Return to the NC State Agency from which you are requesting payment.

General Instructions

For General Instructions, please refer to the IRS Form W-9 located on the IRS Website (<https://www.irs.gov/>).

Specific Instructions

Section 1 -Taxpayer Identification

1. **Taxpayer Identification Type.** Check the type of identification number provided in box 2.
2. **Taxpayer Identification Number (TIN).** Enter taxpayer's nine-digit Employer Identification Number (EIN), Social Security Number (SSN), or Individual Taxpayer Identification Number (ITIN) without dashes.

Note: If an LLC has one owner, the LLC's default tax status is "disregarded entity". If an LLC has two owners, the LLC's default tax status is "partnership". If an LLC has elected to be taxed as a corporation, it must file IRS Form 2553 (S Corporation) or IRS Form 8832 (C Corporation).

3. **Dunn and Bradstreet Universal Numbering System (DUNS).** Vendors are requested to enter their DUNS number, if applicable.
4. **Legal Name.** Enter the legal name as registered with the IRS or Social Security Administration. In general, enter the name shown on your income tax return. Do not enter a Disregarded Entity Name on this line.
5. **Business Name.** Business, Disregarded Entity, trade, or DBA ("doing business as") name.

Contact Information

6. Enter your **Legal Address**.
7. Enter your **Remittance Address, if applicable.** A **Remittance Address** is the location in which you or your entity receives business payments.
8. Enter the **Contact Name**.
9. Enter your **Business Phone Number**.
10. Enter your **Fax Number**, if applicable.
11. Enter your **Email Address**, if applicable.

For clarification on IRS Guidelines, see www.irs.gov.

12. **Entity Type.** Select the appropriate entity type.
13. **Entity Classification.** Select the appropriate classification type.

Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the Exemptions box, any code(s) that may apply to you. See Exempt payee code and Exemption from FATCA reporting code below.

14. **Exempt payee code.** Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends. Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following codes identify payees that are exempt from backup withholding:

- 1 - An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)
- 2 - The United States or any of its agencies or instrumentalities
- 3 - A state, the District of Columbia, a possession of the United States, or any of their political subdivisions, or instrumentalities
- 4 - A foreign government or any of its political subdivisions, agencies, or instrumentalities
- 5 - A corporation
- 6 - A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States
- 7 - A futures commission merchant registered with the Commodity Futures Trading Commission
- 8 - A real estate investment trust
- 9 - An entity registered at all times during the tax year under the Investment Company Act of 1940
- 10- A common trust fund operated by a bank under section 584(a)
- 11 - A financial institution
- 12 - A middleman known in the investment community as a nominee or custodian
- 13 - A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

| If the payment is for... | THEN the payment is exempt for... |
|--|---|
| Interest and dividend payments | All exempt payees except for 7 |
| Broker transactions | Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012. |
| Barter exchange transactions and patronage dividends | Exempt payees 1 through 4 |
| Payments over \$600 required to be reported and direct sales over \$5,000 ¹ | Generally, exempt payees 1 through 5 ² |
| Payments made in settlement of payment card or third party network transactions | Exempt payees 1 through 4 |

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements.

- A - An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)
- B - The United States or any of its agencies or instrumentalities
- C - A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities
- D - A corporation the stock of which is regularly traded on one or more established securities markets, as described in Reg. section 1.1472-1(c)(1)(i)
- E - A corporation that is a member of the same expanded affiliated group as a corporation described in Reg. section 1.1472-1(c)(1)(i)
- F - A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state
- G - A real estate investment trust
- H - A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940
- I - A common trust fund as defined in section 584(a)
- J - A bank as defined in section 581
- K - A broker
- L - A trust exempt from tax under section 664 or described in section 4947(a)(1)
- M - A tax exempt trust under a section 403(b) plan or section 457(g) plan

Section 2 - Certification

To establish to the paying agency that your TIN is correct, you are not subject to backup withholding, or you are a U.S. person, or resident alien, sign the certification on NC Substitute Form W-9. You are being requested to sign by the State of North Carolina.

For additional information please refer to the IRS Form W-9 located on the IRS Website (<https://www.irs.gov/>).

ATTACHMENT H

**NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING
Vaccination Exemption Documentation Form Medical
From the Health Care Provider**

TO THE HEALTH CARE PROVIDER:

The North Carolina Department of Health and Human Services (DHHS) has adopted a policy, "Required Vaccination for Employees and Others Who Work in Division of State Operated Healthcare Facilities (DSOHF)". The purpose of this policy is to protect DHHS patients, employees, and others who work in DSOHF facilities from vaccine preventable healthcare associated transmissible infections. Employees working in DSOHF facilities must be immune to measles, mumps, rubella, pertussis, and varicella, unless a valid medical or religious exemption has been approved. NC DHHS follows the CDC and the ACIP recommendations for immunization practices.

The following individual, _____, (write name on line), has filed an "Application for Exemption to Vaccination" for medical reasons for the following vaccination(s)

1. _____
2. _____
3. _____
4. _____
5. _____

To support that application, the covered individual must request and submit the following documentation completed and signed by you, their Healthcare Provider:

1. When did you last examine the individual? _____
2. Does this patient have a history of anaphylaxis or Neomycin? Yes No
3. Does this patient have a history of **severe allergic reaction** to any component of the vaccine or after a previous dose of the vaccine? Yes No If yes, which vaccine(s)? _____
NOTE: "Severe allergic reaction" includes cardiovascular changes (e.g. hypotension), respiratory distress (e.g. wheezing), gastrointestinal changes (e.g. nausea/vomiting), that required treatment with epinephrine, or any other reaction that required emergency medical attention.
4. Does this individual have a known severe immunodeficiency? Yes No
5. Has the individual had a recent administration of blood products? Yes No
6. Is this individual pregnant? Yes No
7. Does this individual have a history of Guillain-Barre within 6 weeks or encephalopathy within 7 days of receipt of Tdap, Td, DTP, or DTaP vaccine? Yes No
8. Does this individual have a progressive neurologic disorder: Yes No If yes, specify: _____
9. Other vaccination contraindication or precaution: _____
10. Is the condition temporary or permanent? (Circle applicable term).

Physician/PA/NP Printed Name: _____

Physician/PA/NP Signature: _____

License Number: _____

Date Signed: _____ Telephone Number: _____

Address: _____

Note: May attach additional information.

ATTACHMENT I

**NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING
Vaccination Exemption Documentation Form
For Religious Reasons**

TO THE APPLICANT AND, if consulted, CLERGY:

The North Carolina Department of Health and Human Services (DHHS) has adopted a policy, "Required Vaccination for Employees and Others Who Work in a Division of State Operated Healthcare Facilities (DSOHF)". The purpose of this policy is to protect DHHS patients, employees, and others who work in DSOHF facilities from vaccine preventable healthcare associated transmissible infections.

The following individual, _____ (write name on line), has filed an "Application for Exemption to Vaccination" for religious reasons. To support that application, the individual **must** provide the following information:

A statement that the individual has a bona fide religious objection to the vaccination, that the vaccination conflicts with their religious beliefs, and the Statement must be signed by the Applicant.

This form may be signed below by a clergy member ordained by the authorities of the particular religious body, with a copy of supporting documentation attached to this Form.

I, _____ (printed name of applicant), have a bona fide religious objection to the following vaccination(s):

1. _____
2. _____
3. _____
4. _____
5. _____

Requiring me to be vaccinated conflicts with my religious beliefs as follows:

(continue on additional pages if needed)

Signature of Applicant: (Required) _____

Date: _____

Signature and other information below may also be provided for religious exemption:

Signature of clergy member: _____

Date: _____

Physical Address: _____

Name of Denomination or Other Recognized Religious Body: _____

Note: May attach additional information.