# STATE OF CONNECTICUT

*DEPARTMENT OF SOCIAL SERVICES*

55 FARMINGTON AVENUE – HARTFORD, CONNECTICUT 06105-5033

June 20, 2016

Ms. Molly R Gavin
President
Connecticut Community Care, Inc.
43 Enterprise Drive
Bristol, CT 06010-7472

Contract Number: 017CCC-CHC-04/13DSS6501FO Amendment: **A5**
Term as Amended: **07/01/13 -06/30/16** Amount as Amended: **$45,687,535.00**

Dear Ms. Gavin:

I have attached documents to amend the contract referenced above. Please review all documents carefully, sign IN BLUE INK where indicated, and return all documents requiring signature to me via PDF no later than **May 10, 2016**. Please use blue ink for signatures. The following documents are included:

- **Amendment**
- **Budget**
- **Signature & Approvals** – Please sign and date, preferably in blue ink. The date must be on or after the applicable Board meeting, and on or before the date of the Secretary of the Corporation's signature on the bottom of the Authorization of Signature (Certified Resolution) form.
- **PLEASE NOTE THAT THE STATE OF CONNECTICUT DOES NOT REQUIRE THE SUBMISSION OF THE CORPORATE RESOLUTION.**
- **Request for Payment (W-1270)** for the extension of the Pilot Project– This form must be signed, dated, and submitted to your Program Representative, **Kathy Bruni at (860) 424-5177.** Please discard any earlier versions.

**As of July 1, 2012, a PDF of the following forms must be uploaded onto the Department of Administrative Services' BizNet contracting portal** https://www.biznet.ct.gov/Company/CompanyInfo.aspx . The forms which apply to this contract are attached for your convenience, as you have uploaded to BizNet.

- **Nondiscrimination Certification (revised July 2009)**
- **OPM Ethics Form 1 - Gift and Campaign Contribution Certification**
- **OPM Ethics Form 5 - Consulting Agreement Affidavit**
- **OPM Ethics Form 6 – Affirmation of Receipt of State Ethics Laws Summary**
- **CHRO Form**
- **Iran Certification Form 7**

If you have any questions regarding this process please contact me at (860) 424-5214 or through e-mail at *marcia.mcdonough@ct.gov*. For questions regarding the program, please contact Kathy Bruni at (860) 424-5177or through e-mail at *Kathy.a.Bruni@ct.gov*.

Sincerely,

*Marcia McDonough*

Contract Administration and Procurement

Cc: Kathy Bruni, Manager, Director, HCBS Unit

OAG Template 18
04/09

**STATE OF CONNECTICUT**
**DEPARTMENT OF SOCIAL SERVICES**

# CONTRACT AMENDMENT

| | |
|---|---|
| **Contractor:** | CONNECTICUT COMMUNITY CARE, INC. |
| **Contractor Address**: | 43 ENTERPRISE DRIVE, BRISTOL, CT 06010-7472 |
| **Contract Number:** | 017CC-CHC-04/13DSS6501FO |
| **Amendment Number:** | A5 |
| **Amount as Amended:** | **$45,687,535.00** |
| **Contract Term as Amended:** | 07/01/13 - 06/30/16 |

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The contract between **Connecticut Community Care, Inc.** (the Contractor and/or CCCI) and the Department of Social Services (the Department), which was last executed by the parties and approved by the Office of the Attorney General on 1/5/16 , is hereby further amended as follows:

1. The total maximum amount payable under this contract is increased by **$10,892.00** from **$45,676,643.00 to $45,687,535.00**. This increase is due to the one (1) month extension of the ABI Waiver I Pilot Program (AWPP) found in Amendment 1 (A1) of the Original Contract and further amended in Amendment 4, (A4) of the Original Contract.

2. Part I, SECTION FOUR, labeled THE ABI WAIVER I PILOT PROGRAM SUMMARY OF SERVICES, subsection A. labeled TERM of A4 shall be amended, extending the term of ABI Waiver I Pilot Program for one (1) month, from April 30, 2016 to May 31, 2016.

3. Part I, SECTION E. labeled BUDGET AND PAYMENT of A4 of the Original Contract shall be supplemented with the following:

    a. The budget for the services related to the ABI Waiver I Pilot Program is supplement to include the period between April 30, 2016 to May 31, 2016, shown on page 2 of this agreement.

**PART I** **FINANCIAL SUMMARY**

| | |
|---|---|
| **PROGRAM NAME:** | **Pilot Program for ABI Waiver I** |
| **PROGRAM NUMBER:** | **017CCC-CHC-04/13DSS6501FO** |

| | Requested | Adjustments | Approved |
|---|---|---|---|
| **Contract Amount** | | | **$ 45,687,535.00.** |
| *For Amendments Only* | | | |
| **Previously Approved Contract Amount** | | | **$45,676,643.00** |
| **Amount of Amendment 4** | **$ 10,892.00** | | **$ 10,892.00** |

| *Line #* | *Item* | Subcategory (a) | Line Item Total (b) | Adjustments (c) | Revised Total (d) |
|---|---|---|---|---|---|
| 1 | **UNIT RATE** | | | | |
| | **TOTAL UNIT RATE** | | | | |
| 2 | **CONTRACTUAL SERVICES** | | | | |
| | **TOTAL CONTRACTUAL SERVICES** | | | | |
| 3 | **ADMINISTRATION** | | | | |
| | 3a. Admin. Salaries | | | | |
| | 3b. Admin. Fringe Benefits | | | | |
| | 3c. Admin. Overhead | 1,483 | | | |
| | **TOTAL ADMINISTRATION** | **1,483** | | | |
| 4 | **DIRECT PROGRAM STAFF** | | | | |
| | 4a. Program Salaries | 5,923 | | | |
| | 4b. Program Fringe Benefits | 2,923 | | | |
| | **TOTAL DIRECT PROGRAM** | **8,846** | | | |
| 5 | **OTHER COSTS** | | | | |
| | 5a. Program Rent | | | | |
| | 5b. Consumable Supplies | | | | |
| | 5c. Travel & Transportation | 65 | | | |
| | 5d. Utilities | | | | |
| | 5e. Repairs & Maintenance | | | | |
| | 5f. Insurance | | | | |
| | 5g. Food & Related Costs | | | | |
| | 5h. Other Project Expenses | 498 | | | |
| | **TOTAL OTHER COSTS** | **563** | | | |
| 6 | **EQUIPMENT** | | | | |
| 7 | **PROGRAM INCOME** | | | | |
| | 7a. Fees | **10,892** | | | |
| | 7b. Other Income | | | | |
| | **TOTAL PROGRAM INCOME** | | | | |
| 8 | **TOTAL NET PROGRAM COST** | **0** | | | |



**This document constitutes an amendment to the above numbered contract. All provisions of that contract, except those explicitly amended herein, shall remain in full force and effect.**

## SIGNATURES AND APPROVALS

### 017CCC-CHC-04/13DSS6501FO A5

The Contractor IS NOT a Business Associate under the Health Insurance Portability and Accountability Act of 1996 as amended.

Documentation necessary to demonstrate the authorization to sign must be attached.

**CONTRACTOR - CONNECTICUT COMMUNITY CARE, INC.**

_____ _____

Molly Rees Gavin, *President* Date

**DEPARTMENT OF SOCIAL SERVICES**

_____ _____

Roderick L. Bremby, *Commissioner* Date

**OFFICE OF THE ATTORNEY GENERAL**

_____ _____

**ASST. / ASSOC. ATTORNEY GENERAL** *(Approved as to form)* **Date**

W-1270
(Rev. 9/10)

**STATE OF CONNECTICUT - DEPARTMENT OF SOCIAL SERVICES**

**REQUEST FOR PAYMENT**

**DSS ACCOUNTS PAYABLE**

Voucher #: VR Processed by: VR Date: Voucher Approved by:

Date:

## PAYEE INFORMATION

Vendor Invoice #: _____

Vendor/Contractor Name: **Connecticut Community Care, Inc.**

Business Address:

**43 Enterprise Drive, Bristol, CT 06010-7472**

Remittance Address: (where the check is to be mailed – YOU MUST FILL THIS IN)

**43 Enterprise Drive, Bristol, CT 06010-7472**

Purchase/Contract Type: Check One: ☐ PO ☒ POS ☐ PSA ☐ MOA/TI ☐ BOND

Check One: ☐ Competitive ☐ Non-Competitive

Spending Plan Code: **CHC**

CORE-CT Contract #: **13DSS6501FO A5**

DSS Contract #: **017CCC-CHC-04 A5**

PO #: _____ Receipt # _____

FEIN #: **061024632** Vendor # **0000013795**

Contract Period: From: **07/01/13** To: **06/30/16**

Payment Period: From: _____ To: _____

Total Contract: **$45,687,535.00**

Previous Payments: $ _____

This Payment:

Program is operating in compliance with Contract and expenditures have been incurred accordingly.

Authorization: _____ _____

Contractor Name (print) Contractor Signature Date

**DON'T FILL IN BELOW – THIS IS FOR DSS USE ONLY: DSS PROGRAM VERIFICATION – If multi funding source, provide all appropriate accounts.**

| $ | Budget Reference | Fund | Department | Program | SID | Account | Project/Grant | Chartfield 1 | Chartfield 2 |
|---|---|---|---|---|---|---|---|---|---|
| $ | 20 | | DSS | | | | | 168 | |
| $ | 20 | | DSS | | | | | 168 | |
| $ | 20 | | DSS | | | | | 168 | |
| $ | 20 | | DSS | | | | | 168 | |

I do certify that this program is operating in compliance with Contract and expenditures are authorized and properly chargeable as indicated.

Authorization: _____ _____ **(860) 424-5177**

Date Phone #

DSS PROGRAM

STAFF REP Signature -**KATHY BRUNI**

_____

Co-sign (if required) Signature Phone #

_____

DSS FISCAL STAFF APPROVAL - Name (sign & date)

*Financial Report Required ☐ Yes ☐ No

*Financial Report within last 3 mos. ☐ Yes ☐ No

*Attach Explanation If Report Is More Than 3 Months Old