Delaware County Board of Developmental Disabilities Contract for Locally-funded Services Checklist for agency providers. Contract packets MUST include the following:

CONTRACT FORMS

- ☐ W9
- ☐ OPERS (Required for agencies with less than 5 employees. To be completed by agency CEO. This form MUST have an ORIGINAL signature. Please submit via US mail or and deliver.)
- ☐ HIPAA agreement
- ☐ Provider Verification form

COLLATERAL INFORMATION:

- ☐ Copy of CEO's driver's license, state id or other government issued id

MARKETING/ADVERTISING: As a DCBDD contracted provider, you have the opportunity to market yourself on the DCBDD website. There is no cost, this is a FREE opportunity. Please submit a copy of your most recent brochure or marketing information.

Registration Packets may be submitted to:
Delaware County Board of Developmental Disabilities
Attn: Cheryl Copley-Cimino, Provider Coordinator
7991 Columbus Pike
Lewis Center, OH 43035

Questions?
Cheryl Copley-Cimino, Provider Coordinator
Email: cheryl.copley@dcbdd.org
Phone/fax: 740-201-3605

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual /Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C= Corporation, P= Partnership) →
☐ Other (See instructions)

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, State, and ZIP code

List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (define below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here Signature of U.S. person → Date →

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report , for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition of abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7)

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

Vendor Phone # : **Fax:** **E-mail:**

Service Code (s): **DCBDD contact:** **Date:**

Please check all that apply:

☐ **Parent Reimbursement** ☐ **MC - Master Contract Client Services** ☐ **EM – Board Employee**

☐ **Family Secured** ☐ **CP - Community Providers** ☐ **TDD – Transition to Waiver**

☐ **BO - Board Operations** ☐ **DODD – DODD Waiver**

All payments to DCBDD vendors are listed in monthly board packets at www.dcbdd.org (vendors name and amount paid).

Are you retired from OPERS? ___Yes ___No If yes, please complete the attached OPERS form SR-6. If NO and you retire at anytime while you are providing a service to DCBDD you are required to complete the OPERS form SR-6 and return to DCBDD for processing.

INDEPENDENT CONTRACTOR
ACKNOWLEDGMENT

OPERS
Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
Employer Outreach: 1-888-400-0965
www.opers.org

This form is to be completed if you are an individual who begins providing personal services to a public employer on or after Jan. 7, 2013 but are not considered by the public employer to be a public employee and will not have contributions made to OPERS. This form must be completed not later than 30 days after you begin providing personal services to the public employer.

STEP 1: Personal Information

Social Security Number

First Name | MI | Last Name

STEP 2: Public Employment Information

Name of Public Employer

Delaware County

Employer Contact

First Name | MI | Last Name

Tina | | Archangel

Employer Code

206508

Employer Contact Phone Number

740 — 833 — 2920

Service Provided to Public Employer

Start Date of Service

Month Day Year

End Date of Service

Month Day Year

STEP 3: Acknowledgment

The public employer identified in Step 2 has identified you as an independent contractor or another classification other than a public employee. Ohio law requires that you acknowledge in writing that you have been informed that the public employer identified in Step 2 has classified you as an independent contractor or another classification other than a public employee for the services described in Step 2 and that you have been advised that contributions to OPERS will not be made on your behalf for these services.

If you disagree with the public employer's classification, you may contact OPERS to request a determination as to whether you are a public employee eligible for OPERS contributions for these services. Ohio law provides that a request for a determination must be made within five years after you begin providing personal services to the public employer, unless you are able to demonstrate through medical records to the Board's satisfaction that at the time the five-year period ended, you were physically or mentally incapacitated and unable to request a determination.

By signing this form, you are acknowledging that the public employer for whom you are providing personal services has informed you that you have been classified as an independent contractor or another classification other than a public employee and that no contributions will be remitted to OPERS for the personal services you provide to the public employer. This acknowledgment will remain valid as long as you continue to provide the same services to the same employer with no break in service regardless of whether the initial contract period is extended by any additional agreement of the parties. You also acknowledge that you understand you have the right to request a determination of your eligibility for OPERS membership if you disagree with the public employer's classification.

This form must be retained by the public employer and a copy sent to OPERS. The public employer's failure to retain this acknowledgment may extend your right to request a determination beyond the five years referenced above.

Signature_____ Today's Date_____

Do not print or type name

AGENCY PROVIDER VERIFICATION FORM: As part of your contract with the Board, you are required to fill out the following and return it to DCBDD on an annual basis. This information will be used to identify your provider information, contacts and for Provider Book listings.

AGENCY INFORMATION:

Agency Name _____

Address _____

City _____ State _____ Zip _____

Website _____

AGENCY CONTACTS:

CEO/Agency Rep Name _____ Title _____

Email address _____ Telephone Number _____

Emergency/On-Call Rep Name _____ Title _____

Email address _____ Telephone Number _____

CONFLICT RESOLUTION:

	DCBDD - Adult	DCBDD - Transition	DCBDD – School Age	DCBDD – Early Intervention	Agency Provider
Level 1	Support Administrator	Support Administrator	Support Administrator	Developmental Specialist	
Level 2	Cheryl Smart, Director	Jennifer McCleese, Director	Kristy Schaber, Director	Peggy Kroon VanDiest, EI Coordinator	
Level 3	Kristine Hodge, Superintendent	Kristine Hodge, Superintendent	Kristine Hodge, Superintendent	Kristine Hodge, Superintendent	
Level 4	Board Chairperson	Board Chairperson	Board Chairperson	Board Chairperson	

PROVDER STATUS:

☐ Yes, I desire to be included in the provider book and receive email alerts for potential interviews. (open for new business)
☐ No, I do not desire to be included in the pool for interviews. (not open for new business at this time)

PROVIDER SERVICE INFORMATION AND PREFERENCES: this information will be used to populate provider book listing

Contact for new business: Name _____ Title _____

Phone _____ Email _____

Services Provided: (check all that apply) ☐ OT ☐ PT ☐ Speech ☐ Homemaker/Personal Care ☐ Transportation
☐ Vocational ☐ Day Hab ☐ Psychological/Counseling ☐ Respite ☐ Other: _____

Provider's Area of Specialty or Comments: _____

Services are offered in the following locations: (check all that apply)
☐ Client's Home ☐ Community ☐ Clinic: Clinic Location: _____

Services are available: (check all that apply)
☐ Monday – Friday ☐ Saturdays ☐ Sundays ☐ Daytime ☐ Evening

Age group(s) preferences: (check all that apply)
☐ EI (birth to 3 years) ☐ School Age (3 – 11 years) ☐ Transition (11 years – Graduation) ☐ Adults

In what areas of Delaware County will you provide service? (check all that apply)
☐ North ☐ North-East ☐ North-West ☐ Central ☐ South ☐ South-East
☐ South-West ☐ East ☐ West ☐ Open to All Delaware County

Signature of person completing this form: _____ Date: _____

DELAWARE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES
HIPAA PRIVACY POLICY
BUSINESS ASSOCIATE

Purpose

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted, in part to protect the privacy of individual healthcare information from unauthorized disclosures. As defined by HIPAA regulations, you are considered a Business Associate with regard to individual information in business transactions and, as such, are required by law to maintain the privacy of any individual healthcare information that you may be privy to.

Policy

In compliance with HIPAA requirements, The Delaware County Board of Developmental Disabilities (DCBDD) has enacted all reasonable measures to safeguard and protect the privacy of protected health information.

- DCBDD requires that all Business Associates and Vendors sign a contract stipulating the need to protect individual healthcare information and to ensure that they have the necessary procedures in place to maintain the privacy of protected health care information.
- DCBDD has developed and implemented an employee training program to educate our staff on HIPAA requirements.
- All DCBDD employees are required to sign a confidentiality agreement stating that they will not divulge any individual information that they may have access to as part of their employment with DCBDD.
- In regard to web-based applications for associates, DCBDD maintains a high level of security to prevent unauthorized access to individual information. The information is encrypted over open networks and requires user and role based authentication to retrieve the data. User access is established at the request of the covered entity and can be terminated at any time.
- DCBDD audits its procedures to ensure compliance with the HIPAA requirement.
- DCBDD has documented and, where appropriate, altered its business processes to ensure individual privacy is maintained.

DCBDD reserves the right to change the terms of this privacy policy and to make the new policy provisions effective for all protected individual information that it maintains. Notice of any revisions will be distributed in writing. Full documentation of measures is available upon request.

Complaints

Unauthorized disclosures of individual information should be reported to Jennifer McCleese Privacy Officer, DCBDD 740/201-3600. Complaints may also be submitted directly to the U.S. Department of Health and Human Service. Any individual who submits a complaint will not be retaliated against in any way.

Effective Date

The effective date of this policy is April 14, 2003.

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("Agreement") is entered into as of this 1st day of July 2011, between PROVIDER and BOARD. This Agreement outlines how individual medical information may be used and disclosed and how individuals can get access to this information. Please review it carefully.

GENERAL RULE

An individual must be given adequate notice of the uses and disclosures of Protected Health Information that may be made by the Covered Entity and of the individual's rights, and the Covered Entity's duties, with respect to Protected Health Information. The exceptions to this rule are that an inmate has no right to such notice, and a correctional facility has no obligation to provide such a notice. Special rules and exceptions apply to group health plans.

RECITALS

WHEREAS, Business Associate provider support services ("services") to or on behalf of Covered Entity;

WHEREAS, in the course of contracted with the Covered Entity, the Business Associate will have access to Individually Identifiable Health Information, as hereinafter defined, maintained by Covered Entity that is protected as confidential under the Standards for privacy of Individually Identifiable Health Information made known in accordance with the Health Insurance Portability and Accountability Act of 1996 as set forth at 45 CFR Parts 160 and 164 (the "Privacy Standards"): and

WHEREAS, Covered Entity is required by the Privacy Standards to enter into this Agreement and keep this Agreement in full force and effect in order to disclose and/or grant access to Individually Identifiable Heath Information maintained by Covered Entity in connection with the performance of the Services; and

WHEREAS, this Agreement is intended to comply with the provisions of 45 CFR 164.504(e).

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained hereby acknowledged, the parties hereby agree as follows:

ARTICLE I.
DEFINITIONS

1.1 Individual. "Individual" means the person who is the subject of Protected Health Information, as defined herein, and shall include a person who qualifies as a personal representative pursuant to 45 CFR 164.02 (g)

1.2 Individually Identifiable Health Information. "Individually Identifiable Health Information" is information, including demographic information collected from an individual whether oral or recorded in any form or medium, that is:

- 1.2.1 Created or received by a health care provider, health plan, employer or health care clearinghouse; and
- 1.2.2 Relates to the past, present, or future health or condition, whether physical or mental, of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and
- 1.2.3 Identified the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

1.3 Protected Health Information. "Protected Health Information" is Individually Identifiable Health Information that is maintained or transmitted in any form or medium.

1.4 Secretary. "Secretary" mean the Secretary of the U.S. Department of Health and Human Services or his designee.

ARTICLE II.
OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

2.1 Limitation on Use. Business Associate shall not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as required by law or regulation. Any denial of an Amendment or Private Health Information shall be the responsibility of the Covered Entity, including, but not limited to, resolution and/or reporting of all appeals and/or complaints arising there from.

2.2 Appropriate Safeguards. Business Associate shall use all appropriate safeguards to prevent use or disclosure of Protected Health Information other than as provided for by this Agreement.

2.3 Minimum Necessary. Business Associate represents and warrants that if it uses or discloses Protected Health Information, it shall do so only in the minimum amount and to the minimum numbers of individuals necessary to perform its obligations to or on behalf or Covered Entity.

2.4 Mitigation of Harm. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

2.5 Report of Breach. Business Associate shall report to Covered Entity any use or disclosure of the Protected Health Information by Business Associate in violation of the requirements of this agreement.

2.6 Agents/Subcontractors. Business Associate shall require that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, agrees to essentially the same restrictions and conditions that apply through this Agreement to Business Associate with respect to Protected Health Information.

2.7 Access to Book and Records. Business Associate shall make internal practices, book, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created by Business Associate on behalf or, Covered Entity available to the Secretary in a timely manner for purposes of the Secretary determining Covered Entity's compliance with the Privacy Standards.

2.8 Documentation of Disclosures. Business Associate shall document disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of Protected Health Information to the extent required by 45 CFR 164.528.

2.9 Access to Information. Business Associate shall make Protected Health Information maintained in a Designated Record Set (as defined in the Privacy Standards) available to Covered Entity or, as directed by Covered Entity, to an Individual to enable Covered Entity to fulfill its obligations in accordance with 45 CFR 164.528.

2.10 Amendments. Business Associate shall incorporate any amendments to Protected Health Information maintained in Designated Record Set that Covered Entity directs or to which it agrees to enable Covered Entity to fulfill its obligations in accordance with 45 CFR 164.526.

2.11 Access to Protected Health Information. Business Associate agrees to make Protected Health Information available to an individual in accordance with 45 CFR 164.524.

ARTICLE III.
INDIVIDUAL'S RIGHTS

3.1 Restrictions. Each Individual who is the subject of Protected Health Information has the right to request restrictions on Covered Entity's uses or disclosures of Protected Health Information. Each Individual must also be given notice that the Covered Entity is not required to agree to the requested restriction(s).

3.2 Confidential Communications. Each Individual who is the subject of Protected Health Information has the right to request of providers, receipt of confidential communications by alternative means or at alternative locations, and to have the request reasonably accommodated. Each Individual also has the same right to request health plans, if the Individual clearly states that disclosure could endanger the Individual, and to have the request reasonably accommodated.

3.3 Inspection. Each Individual who is the subject of Protected Health Information has the right to inspect and copy Protected Health Information as permitted under the regulations.

3.4 Requesting. Each Individual who is the subject of Protected Health Information has the right to request amendment of Protected Health Information as permitted under the regulations.

3.5 Receive Accountings. Each Individual who is the subject of Protected Health Information has the right to receive an accounting of disclosures of Protected Health Information as permitted under the regulations.

3.6 Receive Paper Copy. Each Individual who is the subject of Protected Health Information has the right to receive paper copy of notice.

ARTICLE IV.
PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Performance of Services. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to perform the following functions, activities, or services for or on behalf of Covered Entity, provided that such use or disclosure would not violate the Privacy Standards if done by Covered Entity: Provision of Individual Support Services as authorized by DCBDD.

4.2 Management and Administration. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information in providing Services under this Agreement as necessary for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that such use or disclosure would not violate the privacy standards if done by Covered Entity.

4.3 Compliance with Laws. Except as otherwise limited in this Agreement, Business Associate may use or disclose Protected Health Information to report violations of law to appropriate Federal and State authorities or for any other purpose required by law, provided that such use or disclosure would not violate the Privacy Standards if done by Covered Entity.

ARTICLE V.
OBLIGATIONS OF COVERED ENTITY

5.1 Disclosure. Covered Entity shall disclose Protected Health Information upon Business Associate's request or upon the request of a third party if such disclosure is permissible by law, so that Business Associate may provide services to or on behalf of Covered Entity, unless Covered Entity otherwise objects to the disclosure, or Business Associate is no longer contracting with Covered Entity.

5.2 Notice of Privacy Practices. Covered Entity shall notify Business Associate of any limitations in its notice of Privacy Practices of Covered Entity in accordance with 45 CFR 164.520, to the extent that such changes may affect Business Associate's use or disclosures of Protected Health Information

5.3 Notice of Individual Revocations. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

5.4 Notice of Restrictions to Use. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

5.5 No Impermissible Use. Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Standards if done by Covered Entity.

5.6 Appointment Reminders. Covered Entity may contact the individual for appointment reminders or with information about treatment alternatives or other health related benefits or services.

ARTICLE VI.
TERM AND TERMINATION

6.1. Term. This Agreement shall commence as of the date first above mentioned.

6.2. Termination. This Agreement shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity. If it is infeasible to return or destroy Protected Health Information, Business Associate shall continue to extend the protections of this agreement to such information, in accordance with the termination provisions in Section 7.2.

6.3. Termination for Cause. Upon Covered Entity's knowledge of material breach by Business Associate of this Agreement, Covered Entity shall either:

6.3.1. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement;

6.3.2. Immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and cure is not possible; or

6.3.3. If neither termination not cure are feasible, Covered Entity shall report the violations to the Secretary.

ARTICLE VII.
EFFECT OF TERMINATION

7.1. Return/Destruction of Information. Except as provided in Section 7.2 of this Agreement, and by regulations put into effect by the Food and Drug Administration, upon termination of this Agreement, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. The provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

7.2. Returned/Destruction Infeasible. In the event that Business Associate determinates that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, Business Associate shall extend the protections of this Agreement to such Protected Health Information and limited further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such Protected Health Information.

7.3. Survival. The respective rights and obligations of Business Associate under Section 7.1 and 7.2 of this Agreement will survive termination of this Agreement.

ARTICLE VIII.
MISCELLANEOUS

8.1. Regulatory references. A reference in this Agreement to a section of the Privacy Standards means the section as in effect or as amended.

8.2. Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as necessary for Covered Entity to comply with the requirements of the Privacy Standards.

8.3. Interpretations. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Standards.

8.4. Entire Agreement. This Agreement, as amended from time to time pursuant to Paragraph 8.2, constitutes the entire agreement and understanding between the parties with respect to the Services specified and agreed upon in the Agreement and supersedes all prior oral or written agreements and understanding between them in respect to such services.

8.5. Severability. The invalidity of any portion of this document shall not invalidate the remainder, and the remainder shall continue in full force and effect.

8.6. Indemnification. Each party shall indemnify, hold harmless and defend the other party to this Agreement from and against all claims, losses, liabilities, costs, and other misrepresentation, breach of warranty or non-fulfillment of any undertaking outlined in this agreement; and (b) any claims, demands, awards, judgments, actions and proceedings made by any person or organization, arising out of or in any way connected with the party's performance under this Agreement.

8.7. Assignment. No party may assign or transfer any or all of its rights or obligations under this Agreement or any part of it, nor any benefit or interest in or under it, to any third party without the prior written consent of the other party which shall not be unreasonably withheld.

8.8. Notices. Any notice which maybe or is required to be given under this Agreement shall be written and shall be sent by first class mail, fax, courier or as an electronic record attached to an email. All notices shall be effective upon receipt at the addresses stated below which may be changed from time to time upon thirty (30) days notice.

8.9. Headings. Headings are for convenience only and form no part of this Agreement and shall not affect its interpretation.

8.10. Governing Law. This Agreement shall be governed in accordance with the terms of any underlying agreement made between the parties wherein choice of law has already been negotiated and to which this Business Associates Agreement pertains, or if no previous choice of law provision exists, then in accordance with the sustainable laws of the State of Incorporation of the Business Associate without regard to the conflict of law principles.

IN WITNESS THEREOF, the undersigned have executed the Agreement as of the day and year first written above.

DELAWARE COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Kristine Hodge

Superintendent

7991 Columbus Pike
Lewis Center, OH 43035

Date

Name of Business Associate: (agency name or "Independent Provider")

Representative's Name: (agency representative or Independent Provider)

Signature of Representative or Independent Provider

Title: (agency representative or "Independent Provider"

Address of Business Associate: (agency address or Independents Provider's address)

Date