

Standard Contract & Engagement Forms Webinar

Overview

- Foundational Information
 - Terminology
 - Contract Types
 - Chapter 257
- Forms by contract type
 - Master Agreements
 - Cost Reimbursement
 - Negotiated Rate

Terminology

- **Contract:** Refers only to the Standard Contract Form and associated attachments. This is a formal legal document establishing contractual relationship between State and Provider.
- **Service Engagement:** Refers to the annual process of determining rates and allotting units. Documents are for planning purposes and do not represent binding contractual agreement.
- **Chapter 257:** Refers to Chapter 257 of the Acts of 2008 which requires the Executive Office of Health and Human Services to establish rates of payment for human service programs.

Form Types

Contract Documents

- Standard Contract Form
- Standard Contract Form Attachments
 - Attachment 1: Program Cover Page
 - Attachment 3: Fiscal Year Program Budget
 - Attachment 4: Rate Calculation Page
 - Attachment 6: Capital Budget

Service Engagement Documents

- Service Summary Form
- Statement of Work

Contract Types

There are only two primary types of contracts

- Rate Agreement
 - Contract is an agreement for provision of service and rates of payment
 - Encumbrance level may be modified without formal contract amendment
- Maximum Obligation
 - Contract is agreement to purchase specific amount of service
 - Must be accompanied by line item budget detailing reimbursable costs

Rate Agreement: Master Agreements

- Master Agreement contracts are issued when provider qualifies for an open enrollment procurement
- Multi-year rate agreements which remain in effect throughout the entire procurement lifetime
- Places provider on qualified list making them eligible for referrals from DDS Area Offices
- Specific rates and units managed through service engagement process

Master Agreements - Programs

The following service classes are managed through master agreement contracts:

- Adult Long Term Residential Services (ALTR-14)
- Shared Living / Placement Services (PS-15)
- Employment and Day Programs (EMP_Day_09)
- Family Support Services (SSQUAL-10)
- In Home Supports (IHS-16)

Once Master Agreement contract signed all activity will be managed through Service Engagement Document

Rates – Chapter 257

- All programs contracted under a Master Agreement will be reimbursed with rates established by EOHHS
- Rate Regulations may be found on EHS website:
 - <http://www.mass.gov/eohhs/gov/laws-regs/hhs/purchase-of-service-rates-for-social-services.html>
- DDS maintains chart of all Chapter 257 rates used by the Department which is available from Region and DDS website
 - <http://www.mass.gov/eohhs/consumer/disability-services/services-by-type/intellectual-disability/provider-support/pos-contracts/>
- Specific Rates to be used will be negotiated between Area/Region and Provider

Service Summary Form

- Service engagement document used for all non-blended rate agreements:
 - Employment and Day Programs
 - In Home Supports
 - Family Support Services
 - As Needed Support Services

Service Summary Form

20 character unique identifier. This ID will be used to search for contract in EIM. ID will be provided to you by Regional Contract Office

Must match Doc ID from Master Agreement Contract. If unknown check reference tab on SSF.

DEPARTMENT OF DEVELOPMENTAL SERVICES FY18 SERVICE SUMMARY FORM

Doc ID			Master Agreement:		
Activity Code:			Monthly Ready Pay Requested:		
Provider Information			Department Information		
Provider Name:			Region:		
Address:			Address:		
City, State, Zip:			City, State, Zip:		
Contact Person:			Contact Person:		
Telephone:			Telephone:		
Fax:			Fax:		
Email:			Email:		
Vendor Code:					

If unsure reference matrix.
Activity code is also listed in Doc ID (Last 4 numbers)

Ready Payment request may not exceed 80% of 1/24 of Estimated Expenditure Amount

Service Summary Form

- Sample Completed Header:

DEPARTMENT OF DEVELOPMENTAL SERVICES FY18 SERVICE SUMMARY FORM				
Doc ID	17114015D036DDS3163H		Master Agreement:	DDSM01(A-G)(H-M)(N-Z)0000000000
Activity Code:	3163		Monthly Ready Pay Requested:	\$33,000
Provider Information			Department Information	
Provider Name:	Provider, Inc		Region:	Central West
Address:	123 Fake Street		Address:	140 High Street
City, State, Zip:	Springfield, MA 01020		City, State, Zip:	Springfield, MA 01105
Contact Person:	Mrs. Contract Manager		Contact Person:	Lisa Chevalier
Telephone:	413-555-0123		Telephone:	413-205-0800
Fax:	413-555-9876		Fax:	406-205-1604
Email:	contractmanager@provider.org		Email:	Lisa.Chevalier@state.ma.us
Vendor Code:	VC60001123456			

Service Summary Form

- The body of the Service Summary Form keeps a running tab of agreed upon units and rates
- Amendments to SSF should show the change value, not the new total
 - For downward changes, enter negative units

Enter Service Name

Start Date should be effective date of form (signature date)

Enter agreed upon rate

Enter agreed upon units

Frequency units will be billed in:
Month, Day, Hour,
Quarter Hour

Version #	Brief Description	Dates of Service	Number of Units	Unit Rate	Unit Type	Estimated Expenditure Amount
Initial		-				\$0.00
2		-				\$0.00
3		-				\$0.00

For each amendment enter changes on next available line. Do not delete or replace information from previous versions.

Service Summary Form

- Example of completed body with two amendments:

Version #	Brief Description	Dates of Service	Number of Units	Unit Rate	Unit Type	Estimated Expenditure Amount
Initial	Community Based Day Supports	7/1/17 - 6/30/18	290000	\$3.46	15 Min	\$1,003,400.00
2	Community Based Day Supports	1/1/18 - 6/30/18	-15000	\$3.46	15 Min	-\$51,900.00
3	Community Based Day Supports	4/15/18 - 6/30/18	5000	\$3.46	15 Min	\$17,300.00
Budget Total			280000			\$968,800.00

- Once completed, email signed copy to Regional Contract Staff

Statements of Work

- Service Engagement document used for all blended rate agreements
 - Adult Long Term Residential
 - Shared Living / Placement Services
 - Emergency Residential
- SOWs are filled out by the regional contract office and will be sent to you ready for signature
- SOWs come with attachments that detail how the blended rate is calculated
 - Providers should carefully review this documentation to ensure accuracy

ALTR SOW

This box is used for SOWs with one site

Lists total expected expenditure for year and the blended rate

Check and attach one of the following to this SOW:

☐ Attachment A: Estimated Expenditure Amount(s)

Expected Expenditure Amount for FY	\$	Rate: \$
Amount Pending Reserve Funding	\$	
Current Encumbrance Amount	\$	

☐ Attachment B: Blended rate worksheet if SOW covers more than one site

Expected Expenditure Amount for FY	\$	Rate: \$
Amount Pending Reserve Funding	\$	
Current Encumbrance Amount	\$	

Current Encumbrance Amounts have been calculated by reducing the Expected Expenditure Amount by 1.1%. The Department will automatically increase the encumbered amount to reflect the Expected Expenditure Amount when funding is received from the Chapter 257 Reserve. The blended rate will not change unless an updated SOW is executed.

This box is used for SOWs with multiple sites

Note: Some language in this example are specific to ALTR SOW only. SOWs for other services will vary slightly.

ALTR SOW Attachments

- The site detail report will show all the rate information for each site
- Be sure to check all of the highlighted information to make sure it matches what was negotiated with Area Director
 - Amendments will show both the previous units and the amount changing due to the amendment

Site Address Appears Here				Site ID:		[BSID:]	
Date Range	Model	Rate Value	SU Type	Previous Units	Units Changed	Total Units	Value
7/1/2016 to 6/30/2017	I4E	\$369.80	DAY	0	1,388	1,388	\$513,282.40
Site Model Totals:				0	1,388	1,388	\$513,282.40
add-on	MedClin: RN	\$45.48	Hour	0	208	208	\$9,459.84
add-on	MedClin: Clinician	\$52.72	Hour	0	221	221	\$11,651.12
Total Add-On Value:							\$21,110.96
Total Site Value:							\$534,393.36

Cost Reimbursement Contract

- Contract that reimburses provider based on an accounting of actual costs incurred
- Contract is based on a line item budget that details program costs
- Contracts have a maximum obligation that cannot be exceeded without formal amendment
- Service Class Examples:
 - Financial Assistance / Stipends
 - Furnishings and Equipment
 - Agency with Choice
 - See Matrix for full list of activity codes

Cost Reimbursement Forms

Forms to Complete

- Standard Contract Form
- Attachment 1: Program Cover Page
- Attachment 3: Fiscal Year Program Budget
- Attachment 6: Capital Budget (if applicable)
 - For contracts that only purchase capital items, Attachment 3 is not needed

Standard Contract Form

- Default contract for all Commonwealth Departments
- Must be submitted for both new and amended contracts
- Requires original signature
- Includes:
 - Identifying contract information
 - Whether contract is new or amended
 - Terms and conditions
 - Compensation
 - Start date and end date
 - Certifications

Standard Contract Form: Header

Must match W9 on file with
Comptroller

<u>CONTRACTOR LEGAL NAME:</u> (and d/b/a):		<u>COMMONWEALTH DEPARTMENT NAME:</u> <u>MMARS Department Code:</u>	
<u>Legal Address:</u> (W-9, W-4, T&C):		<u>Business Mailing Address:</u>	
<u>Contract Manager:</u>		<u>Billing Address</u> (if different):	
<u>E-Mail:</u>		<u>Contract Manager:</u>	
<u>Phone:</u>	<u>Fax:</u>	<u>E-Mail:</u>	
<u>Contractor Vendor Code:</u>		<u>Phone:</u>	<u>Fax:</u>
<u>Vendor Code Address ID</u> (e.g. "AD001"): AD__ (Note: The Address ID must be set up for <u>EFT</u> payments.)		<u>MMARS Doc ID(s):</u>	
		<u>RFR/Procurement or Other ID Number:</u>	

List RFR ID number of procurement associated with contract. Obtain from region if unsure. Example: "ALTR-14"

Only list 20 digit ID. Obtain from regional contract office. ID stays the same over life of contract

Standard Contract Form: New/Amend

Fill out ONLY ONE section. For amendments, “New Contract” section must be blank

Always select Department Procurement unless specifically directed otherwise

Select Amendment to Scope or Budget unless directed otherwise

<u>NEW CONTRACT</u>	<u>CONTRACT AMENDMENT</u>
PROCUREMENT OR EXCEPTION TYPE: (Check one option only) <input type="checkbox"/> <u>Statewide Contract</u> (OSD or an OSD-designated Department) <input type="checkbox"/> <u>Collective Purchase</u> (Attach OSD approval, scope, budget) <input checked="" type="checkbox"/> <u>Department Procurement</u> (includes State or Federal grants <u>815 CMR 2.00</u>) (Attach RFR and Response or other procurement supporting documentation) <input type="checkbox"/> <u>Emergency Contract</u> (Attach justification for emergency, scope, budget) <input type="checkbox"/> <u>Contract Employee</u> (Attach <u>Employment Status Form</u> , scope, budget) <input type="checkbox"/> <u>Legislative/Legal or Other</u> : (Attach authorizing language/justification, scope and budget)	Enter Current Contract End Date <u>Prior</u> to Amendment: <u>20</u> ____ Enter Amendment Amount: \$ _____. (or “no change”) AMENDMENT TYPE: (Check one option only. Attach details of Amendment changes.) <input checked="" type="checkbox"/> <u>Amendment to Scope or Budget</u> (Attach updated scope and budget) <input type="checkbox"/> <u>Interim Contract</u> (Attach justification for Interim Contract and updated scope/budget) <input type="checkbox"/> <u>Contract Employee</u> (Attach any updates to scope or budget) <input type="checkbox"/> <u>Legislative/Legal or Other</u> : (Attach authorizing language/justification and updated scope and budget)
The following <u>COMMONWEALTH TERMS AND CONDITIONS</u> (T&C) has been executed, filed with CTR and is incorporated by reference into this Contract. <input type="checkbox"/> Commonwealth Terms and Conditions <input checked="" type="checkbox"/> Commonwealth Terms and Conditions For Human and Social Services	

Check Commonwealth Terms and Conditions for Human and Social Services

Enter Contract End Date from most recent version of contract

Standard Contract Form: Compensation Type & Start Date

All Cost Reimbursement contracts are Maximum Obligation

Enter contract total. Must match multiyear total from Attachment 1

Check statutory/legal

Enter Brief Description

<p>COMPENSATION: (Check ONE option): The Department certifies that payments for authorized performance accepted in accordance with the terms of this Contract will be supported in the state accounting system by sufficient appropriations or other non-appropriated funds, subject to intercept for Commonwealth owed debts under 815 CMR 9.00.</p> <p><input type="checkbox"/> Rate Contract (No Maximum Obligation. Attach details of all rates, units, calculations, conditions or terms and any changes if rates or terms are being amended.)</p> <p><input checked="" type="checkbox"/> Maximum Obligation Contract Enter Total Maximum Obligation for total duration of this Contract (or new Total if Contract is being amended). \$ _____</p>
<p>PROMPT PAYMENT DISCOUNTS (PPD): Commonwealth payments are issued through EFT 45 days from invoice receipt. Contractors requesting accelerated payments must identify a PPD as follows: Payment issued within 10 days ___ % PPD; Payment issued within 15 days ___ % PPD; Payment issued within 20 days ___ % PPD; Payment issued within 30 days ___ % PPD. If PPD percentages are left blank, identify reason: ___ agree to standard 45 day cycle ___ statutory/legal or Ready Payments (G.L. c. 29, § 23A); ___ only initial payment (subsequent payments scheduled to support standard EFT 45 day payment cycle. See Prompt Pay Discounts Policy.)</p>
<p>BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT: (Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attach all supporting documentation and justifications.)</p>
<p>ANTICIPATED START DATE: (Complete ONE option only) The Department and Contractor certify for this Contract, or Contract Amendment, that Contract obligations:</p> <p>___ 1. <u>may</u> be incurred as of the Effective Date (latest signature date below) and no obligations have been incurred prior to the Effective Date.</p> <p>___ 2. <u>may</u> be incurred as of ____, 20__, a date LATER than the Effective Date below and no obligations have been incurred prior to the Effective Date.</p> <p>___ 3. were incurred as of ____, 20__, a date PRIOR to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.</p>

Start Dates – Situation for each option:

1. Amend to add money during the fiscal year.
2. Renew/extend contract to the next fiscal year. Check box and write start date (usually 7/1).
3. Special situations only—Region will direct you if this option is needed.

Make sure to change the check from 2 to 1 and remove start date the first time you amend the contract in the next year

Standard Contract Form: End Date & Signature

End date generally June 30 of current fiscal year. Multiyear contract will have end date in future year.

CONTRACT END DATE Contract performance shall terminate as of ____, 20__, with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS: Notwithstanding verbal or other representations by the parties, the "Effective Date" of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor makes all certifications required under the attached [Contractor Certifications](#) (incorporated by reference if not attached hereto) under the pains and penalties of perjury, agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, the applicable [Commonwealth Terms and Conditions](#), this Standard Contract Form including the [Instructions and Contractor Certifications](#), the Request for Response (RFR) or other solicitation, the Contractor's Response, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in [801 CMR 21.07](#), incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR:

X: _____ Date: _____
(Signature and Date Must Be Handwritten At Time of Signature)
Print Name: _____
Print Title: _____

AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:

X: _____ Date: _____
(Signature and Date Must Be Handwritten At Time of Signature)
Print Name: _____
Print Title: _____

Sign and Date in **BLUE INK**

Signature date must be prior to Effective Date if checked option 2 above




Attachment 1: Program Cover Page

- Provides general contractor and program information
- Creates historical starting point for all future amendments
- Includes:
 - Document ID #
 - UFR Program #
 - RFR Information
 - Anticipated contract duration
 - Fiscal terms
 - Pricing options
 - Current maximum obligation
 - Unit Rate
 - Billable Units
 - Funding

Attachment 1: Program Cover Page

Use the anticipated UFR code

Use activity code

Contractor Name:	Department Name:
Program Type:	Document ID #:
Program Name:	UFR Program #:
Program Address:	MMARS Program Code:
City/State/Zip:	Other Reference Information (Information Purposes Only):
Contact Person:	Contact Person:
Telephone:	Telephone:
RFR INFORMATION: Attached  RFR Reference # _____ legislative exemption emergency collective purchase interim  amendment	
SCOPE OF SERVICES: Bidders Response Attached  Description of Services Attached	
TOTAL ANTICIPATED CONTRACT DURATION: _____ to _____	
INITIAL DURATION: _____ to _____	
OPTIONS TO RENEW: _____ options to renew for _____ years each option	

Leave blank

Use the original date
range

Use original start date to
current end date

Must match RFR ID
from SCF

Attachment 1: Program Cover Page

Fiscal Terms

Include one row with contract total for each previous year

One row for each version during year

Include future years if extending to next fiscal year

	FUNDING SUMMARY					
	Prior Years		Current Year		Future Years	
	FY	Amount	FY	Amount	FY	Amount
PRICE IS ESTABLISHED THROUGH: (CHECK 1,2, OR 3)						
OPTION 1: PRICE AGREEMENT (list price) \$ _____ rate regulation (if any) _____						
OPTION 2: SUMMARY BUDGET (T lines only) unit rate _____ cost reimbursement _____ other _____						
OPTION 3: COMPLETE BUDGET cost reimbursement _____ unit rate _____ other _____						
	Total: \$		Total: \$		Total: \$	
	Multi-Year Total:					\$
CURRENT MAX OBLIGATION						
\$ _____	UNIT RATE: \$	_____	per	_____	# BILLABLE UNITS: _____	
\$ _____	UNIT RATE: \$	_____	per	_____	# BILLABLE UNITS: _____	
\$ _____	UNIT RATE: \$	_____	per	_____	# BILLABLE UNITS: _____	

Check Cost reimbursement under option 3

Leave blank

Multi-year total must match maximum obligation on SCF

Attachment 1: Program Cover Page

Sample completed Fiscal Terms:

Contract active since FY14. There were 4 versions during FY17. Contract is being extended into FY18

FISCAL TERMS

				FUNDING SUMMARY					
				Prior Years		Current Year		Future Years	
				FY	Amount	FY	Amount	FY	Amount
PRICE ESTABLISHED THROUGH: (CHECK 1, 2, OR 3) <input type="checkbox"/> OPTION 1: PRICE AGREEMENT (list price) \$ _____ rate regulation (if any) _____ <input type="checkbox"/> OPTION 2: SUMMARY BUDGET (* lines only) <input type="checkbox"/> unit rate <input type="checkbox"/> cost reimbursement <input type="checkbox"/> other _____ <input checked="" type="checkbox"/> OPTION 3: COMPLETE BUDGET <input checked="" type="checkbox"/> cost reimbursement <input type="checkbox"/> unit rate <input type="checkbox"/> other _____				14	265,000.00	17	285,000.00	18	310,000.00
				15	275,000.00	17	(25,000)		-
				16	285,000.00	17	(25,000)		-
					-	17	75,000		-
					-		-		-
					-		-		-
					-		-		-
					-		-		-
					-		-		-
					-		-		-
					-		-		-
					-		-		-
					-		-		-
					-		-		-
				Total		825,000.00	Total	310,000.00	Total
Multi - Year Total: \$						1,445,000.00			
CURRENT MAX OBLIGATION:	\$		\$	per	#N/A	# BILLABLE UNITS:			
\$	-	Unit Rate	\$	-	per	# Billable Units:			
\$	-	Unit Rate	\$	-	per	# Billable Units:			
\$	-	Unit Rate	\$	-	per	# Billable Units:			

Attachment 3: Fiscal Year Program Budget

- Reflects total annual program costs associated with the fiscal year operation of the program
- Required where payment is based on submission of program budget
- Includes:
 - Line item detail of all program costs
 - Current, Amended, and New Subtotals
 - Budget Total

Attachment 3: Fiscal Year Program Budget

B. PURCHASE OF SERVICE - ATTACHMENT 3: FISCAL YEAR PROGRAM BUDGET

FY _____ Contractor Name: _____ If Federal Funds, CFDA #: _____ (12/19/2003)

Program Name:	Document ID#:	MMARS Code:	Program Type	UFR Prog. #
---------------	---------------	-------------	--------------	-------------

		Current		Amend. Change		New		COST REIMBURSEMENT ONLY		
		FTE	Amount	FTE	Amount	FTE	Amount	**Offset	Source	Reimbursable Cost
	Program Component									
UFR Title #	Direct Care/Program Support Staff/Overtime/Shift Differential & Relief(Titles 101-141)									

Fill in UFR Title # and UFR Position Title. Only use titles defined in UFR Preparation Manual

New FY Contracts:
Fill in initial FTE and Amount

Amendments: Enter Total FTE and Amount from previous version

For Amendments Only: Enter change value of amendment (not new total)

Enter sum of Current and Amend. Change columns

Enter offsets as negatives. Subtract Offsets from Total to establish Reimbursable Cost

Attachment 3: Fiscal Year Program Budget

Continue to fill in lines as shown on previous slide

410 & 390	Other Direct Administrative Expenses						
T	Total Direct Administrative Exp.						
T	SUBTOTAL PROGRAM COSTS						
410 T	Agency Admin. Support Allocation	%	\$				
T	PROGRAM TOTAL						

COMMERCIAL FEE, if applicable (FYI; not to be included in the price paid by the Commonwealth) N/A for Cost Reimbursement | % | \$

** A.S. Subtotal of offsets which are for non-reimbursable costs.

Program total must match FY total from Attachment 1 Funding Summary

Attachment 3: Fiscal Year Program Budget

- Example: Part 1 (Staff Expenses)

UFR Title #	Program Component Direct Care / Program Support Staff Overtime/Shift Differential & Relief f	Current		Amended / Change		New		COST REIMBURSEMENT ONLY		
		FTE	Amount	FTE	Amount	FTE	Amount	** Offset	Source	Reimbursable Cost
102	Program Director	0.250	20,000.00	0.063	5,000.00	0.313	25,000.00	-		25,000.00
135	D. C./ Prog. Staff II	5.000	150,000.00	1.000	30,000.00	6.000	180,000.00	(15,000.00)	3rd Party Pay	165,000.00
-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
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-	-	-	-	-	-	-	-	-		-
-	-	-	-	-	-	-	-	-		-
	SUBTOTAL STAFF	5.250	170,000.00	1.063	35,000.00	6.313	205,000.00	(15,000.00)		190,000.00
150	Payroll Taxes		17,000.00		-		17,000.00	-		17,000.00
151	Fringe Benefits		25,000.00		-		25,000.00	-		25,000.00
T	Total Direct Care / Program Staff	5.250	212,000.00	1.06	35,000.00	6.313	247,000.00	(15,000.00)		232,000.00

Attachment 3: Fiscal Year Program Budget

- Example: Part 2 (Below the Line Expenses and Total)

Title	OCCUPANCY									
301	Program Facilities		8,000.00		-		8,000.00	-		8,000.00
***390	Fac. Oper/Main/Furn		3,500.00		-		3,500.00	-		3,500.00
T	Total Occupancy		11,500.00		-		11,500.00	-		11,500.00
UFR TITL E #	Other Direct Care / Program Support		Amount		Amount		Amount	Offset	Source	Reimbursable Cost
212	Prov. Of Material Good				40,000.00		40,000.00	-		40,000.00
	-				-		-	-		-
	-				-		-	-		-
	-		-		-		-	-		-
-	-				-		-	-		-
-	-				-		-	-		-
-	-				-		-	-		-
-	-		-		-		-	-		-
-	-				-		-	-		-
-	-				-		-	-		-
-	-				-		-	-		-
-	-		-		-		-	-		-
T	Care / Program Support	5.25	-	1.06	40,000.00	6.31	40,000.00	-		40,000.00
Title	Direct Admin Expense									
216	Program Support				-		-	-		-
***410 & 390	Other Direct Administrative		-		-		-	-		-
T	Total Direct Admin Expenses		-		-		-	-		-
T	Subtotal Program Costs		223,500.00		75,000.00		298,500.00	(15,000.00)		283,500.00
T	Agency Admin. Support Allocation	10.60%	26,500.00		-	8.15%	26,500.00	-		26,500.00
T	PROGRAM TOTAL#	5.25	250,000.00	1.06	75,000.00	6.31	325,000.00	(15,000.00)		310,000.00

Budget Total

Attachment 6: Capital Budget

- Documents capital expenditures required to support the delivery of contracted human and social services
- Items may only be included after approval from Regional Contract office
- Includes:
 - List of capital items
 - Need for item
 - Quantity
 - Estimated Costs

Attachment 6: Capital Budget

PURCHASE OF SERVICE - ATTACHMENT 6: CAPITAL BUDGET

For Purchase of Capital Assets with Commonwealth Funds

Program Name:		Document ID#:	MMARS Activity Code:	Program Type:	UFR Prog. #:
Item to Be Purchased	Need For Item	Quantity	Estimated Unit Cost	Estimated Total Cost	

DEPARTMENT USE ONLY: Check the appropriate box:

Capital items purchased by the contractor: ☒

Capital items purchased by the Commonwealth (object code M11): ☐

Total Cost: \$ _____

List each capital purchase in it's own row

Select Items purchased by contractor

Negotiated Rate Agreements

- Used for programs that are paid on a rate basis but are not priced under Chapter 257
- Rate is developed based on program budget and anticipated units of service
- Service Classes:
 - Unblended Transportation
 - As Needed Support Services (LUSA)
 - Only for non-Chapter 257 service

Negotiated Rate Agreement Forms

Forms to Complete

- Service Summary Form
- Attachment 3
- Attachment 4

Attachment 4: Rate Calculation

Program Costs

UNIT RATE CALCULATION

1. Program Total Costs

	Source section 8	Previous	Amended	New
2a.(1) Program Offsets				\$ -
Applied to occupancy and meals	Food stamps			\$ -
	SSI			\$ -
2a.(2) Program Offsets				\$ -
Applied to non-occupancy and meals				\$ -
2a.(3) Other Offsets		\$ -		\$ -
2b. Offsets for Non-Reimbursable Costs:				

NOTE: Total reimbursable costs listed in line 2b must be detailed on ATTACHMENT 5.

2. SUBTOTAL OFFSETS (Line 2A + Line 2B)

(\$ -)

3. Net Adjusted Program Costs (LINE 1 minus LINE 2)

\$ -

Enter Program Total from Attachment 3

Enter Program Offsets (no offsets should be entered on Attachment 3).
Enter all offsets on line 2a.(2)

Net of Program Costs and Offsets

Attachment 4: Rate Calculation

Billing Reconciliation

Section only used for amendments during fiscal year. If calculating initial rate for FY skip this section.

3a.	Amounts previously billed:	Units:	_____	Rate	_____	Enter Dollars billed at each previous rate	\$	_____	-
	3a1. Date of Service		_____	lo	_____		\$	_____	-
3a.	Amounts previously billed:	Units:	_____	Rate	_____	Enter units billed at each previous rate during the FY	\$	_____	-
	3a1. Date of Service		_____	To	_____		\$	_____	-
	3a2. Lump Sum Adjustment: Reimbursement		_____			Enter amount remaining to billed	\$	_____	-
3b.	Remaining Maximum Obligation						\$	_____	-

Attachment 4: Rate Calculation

Unit Rate Calculation

<div>Leave Blank</div>		<div>Enter TOTAL units for FY</div>	<div>Enter Unit Type (Month, Day, Hour, Quarter Hour)</div>
4 . Total Program Capacity	<input type="text"/>	(# of Units <input type="text" value="#N/A"/> (Type of Unit)	
5 . Share of Total Capacity Being Purchased by Contract	<input type="text" value="-"/>	(# of units ; <input type="text" value="100.00%"/> (% of line 4)	
6 . Negotiated Utilization Factor, if any	<input type="text" value="100.00%"/>		
7 . Adjusted Capacity Used To Establish Price (LINE 4 x LINE 6) (# of Units)		<input type="text" value="-"/>	
7a. Units Previously Billed		<input type="text" value="-"/>	
7b. Remaining Units:		<input type="text" value="-"/>	
8 . Unit Rate (LINE 3 / LINE 7)			\$ <input type="text" value="-"/>
For amendment only: 3b divided by 7b			
Effective Dates of Rate: _____ to _____			
9 . Maximum # of Billable Units (LINE 5 x LINE 6)		<input type="text" value="-"/>	

Utilization Factor is 100% unless directed by Region

Enter units previously billed (from section 3a)

Enter net of total units and previously billed

Divide remaining dollars by remaining units to arrive at unit rate

Attachment 4: Rate Calculation Sample

1.	Program Total Costs				\$ 310,000.00
		<u>Source</u>	<u>Previous</u>	<u>Amended</u>	<u>New</u>
2a.(1)	Program Offsets	section 8			\$ -
	Applied to occupancy and meals	Food stamps			\$ -
		SSI			\$ -
2a.(2)	Program Offsets		\$ 20,000.00	\$ 5,000.00	\$ 25,000.00
	Applied to non-occupancy and meals				\$ -
2a.(3)	Other Offsets		\$ -		\$ -
2b.	Offsets for Non-Reimbursable Costs:				
NOTE: Total reimbursable costs listed in line 2b must be detailed on ATTACHMENT 5.					
2.	SUBTOTAL OFFSETS (Line 2A + Line 2B)				(\$ 25,000.00)
3.	Net Adjusted Program Costs (LINE 1 minus LINE 2)				\$ 285,000.00
3a.	Amounts previously billed:	Units:	200	Rate \$ 290.00	\$ 58,000.00
	3a1. Date of Service		7/1/2016	To 10/31/2016	
3a.	Amounts previously billed:	Units:	150	Rate \$ 200.00	\$ 30,000.00
	3a1. Date of Service		11/1/2016	To 12/31/2016	
	3a2. Lump Sum Adjustment: Reimbursement				\$ -
3b.	Remaining Maximum Obligation				\$ 197,000.00
4.	Total Program Capacity		1500	(# of Units)	#N/A (Type of Unit)
5.	Share of Total Capacity Being Purchased by Contract		1,500.00	(# of units)	100.00% (% of line 4)
6.	Negotiated Utilization Factor, if any		100.00%		
7.	Adjusted Capacity Used To Establish Price (LINE 4 x LINE 6) (# of Units)				1,500.00
	7a. Units Previously Billed		350.00		
	7b. Remaining Units:		1,150.00		
8.	Unit Rate (LINE 3 / LINE 7)				\$ 171.30
	For amendment only: 3b divided by 7b				
	Effective Dates of Rate: _____ to _____				
9.	Maximum # of Billable Units (LINE 5 x LINE 6)				1,500.00

Service Summary Form

Negotiated Rate

- Update Service Summary Form with new unit rate and remaining units
- Service Summary Form functions exactly the same as with Chapter 257 rate
- Sign and return SSF to Region along with Attachment 3 and 4

Additional Resources

- DDS POS Website
 - <http://www.mass.gov/eohhs/consumer/disability-services/services-by-type/intellectual-disability/provider-support/pos-contracts/>
- Activity Code Matrix
 - Lists all DDS service codes and which forms are required for each
- DDS Purchase of Service Manual
 - DDS Contracting Policies
 - Bidding and Procurement Processes
 - Service Code Definitions
- UFR Preparation Manual
 - <http://www.mass.gov/anf/budget-taxes-and-procurement/procurement-info-and-res/conduct-a-procurement/human-soc-serv-policies/ufrlearnmore.html>