TOPICS TO BE COVERED

- AccessBROWARD
- New items
- FY18 Liability Requirements
- Invoicing
- Other Required Reports
- Questions
***To ensure future emails from AccessBROWARD are not treated as spam and you receive all email notifications, please add no-reply@broward.org to your email account contact list.***
You're almost finished. You have successfully created your account and an email was sent to email@address.org.

Please check your email and click on the link to confirm your AccessBROWARD account. You will be able to sign in after you confirm your new account.

Your AccessBROWARD account is now validated and ready for use. Simply sign in to continue.
Subscription saved = All notifications for the Community Partnerships Contracted Provider group will be sent to your email.

*Add no-reply@broward.org to your email account contact list to avoid going to spam.
PUBLICITY

- Promotion Materials (advertisements, press releases, or any other type of publicity):
  - "The services provided by Provider is a collaborative effort between Broward County and Provider with funding provided by the Board of County Commissioners of Broward County, Florida under an Agreement."
  - Use "Broward County" and the official Broward County logo in all Promotional Materials related to funded services.

- Official electronic Broward logo:
  - Broward County Public Communications Office
    115 S. Andrews Avenue
    Fort Lauderdale, FL 33301
    or publicinfo@broward.org
Minimum # Unduplicated Clients

- Demographic report tracks # of unduplicated clients
Rate Changes
For all contracts
Begin on October 1, 2017
Rate Changes

- Included in Provider Handbook
- Unit of service increased 2.5% - 5% depending on category
- Does not include training or consultants
NEW Liability Requirements

Per County Risk Management, the following is effective October 1, 2017

- **Workers Compensation Liability Insurance**
  - Minimum limits of one million dollars $1,000,000 each accident.

- **Commercial or General Liability insurance**
  - $1,000,000 per occurrence and $2,000,000 annual aggregate

- **Professional Liability insurance**
  - $1,000,000
Invoicing

- Monthly Invoice Submission
- Corrected Billing
Monthly Invoice Submission

- Due on or before the 15th day
- OR next business day if the 15th falls on a weekend or County holiday

All providers must submit an invoice monthly, including invoices with $0.
## FY 2018 - Exhibit E-1 (page 1 for Contracts with Match)

### Board of County Commissioners, Human Services Department

**Contracted Services Invoice**

**Billing Period:** October-17  
**Invoice #:** XXX-XXX-XXX-OCT17  
**Supplier ID #:** VC-000XXXXX  
**Address 1:** XXXXXXX  
**Address 2:** XXXXXXX  
**City, St, Zip:** XXXXX, FL 333XX  

**Program Name:** Special Needs: xxxxxxxxxx  
**Program #:** 1  

**Contract/Prog. Amount:** $xxxxxxx  

A. Grand Total $ For Units Delivered This Month (from page 2, "A")

B. Match this month

C. Net Amount Requested for Reimbursement/Month

D. Net Amount Requested Year-to-Date

E. Match Contribution YTD

F. CERTIFICATION: The undersigned, as an authorized signator for the contract between Broward County and Achievement & Rehabilitation Centers, Inc. hereby affirms and certifies that the services billed herewith have been delivered to clients on behalf of Broward County per agreement, that all clients served have met the program eligibility requirements, and that sufficient written information is available to document services. Provider also represents to County that no other reimbursement is used for invoiced services.

G. Approved Signator Name (typed):  

H. Authorized Signature:  

I. **On Time _____**

**DATE STAMP AREA**

**Not Required; subcontracting not authorized by COUNTY**

**Outcomes met for quarter?** Yes, invoice not adjusted □  

□ No, invoice adjusted

**Comments:**  

**Division Reviewer/Date:**  

**Certification of Payments to Subcontractors and Suppliers**

**FUND/DEPARTMENT/ACCOUNT/PROJECT:** 10010-40303020-580210-103691

I hereby certify that the backup documentation is complete, accurate, supports the payment and pricing requested and is on file in the Division.

**Administrative Services Reviewer/Date:**  

Outcomes met for quarter? Yes, invoice not adjusted □  

□ No, invoice adjusted

**Submission of previously unbilled units: Y or N.** If "Y", submit additional backup documentation to substantiate the unbilled units of service.

**Are any disallowed units from previous monitoring visits or Medicaid or Medicare payments included in this invoice?** (Y or N. If "Y" then see p.2 )

**Comments:**  

**No back dating**
**Contracted Services Invoice**

**Agency Name:** 

**Billing Period:** 

**Contract #:** 

**Program Name:** 

**Program #:** 

A. Grand Total Units Billed (add additional sheets if more than 10 types of units)

<table>
<thead>
<tr>
<th>Taxonomy</th>
<th>Unit/Service Type</th>
<th>(Unit Cost)</th>
<th>x</th>
<th>(# Units this month - # Disallowed Units)</th>
<th>=</th>
<th>Total $ Value</th>
<th>90% of Total $ Value of Units</th>
<th>Total Billable Value YTD</th>
<th>Annual Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Total Billable Value for This Month (to page 1, "A")

B. Match Contribution

1. Total Match This Month

2. Previous Month YTD

3. Required Contribution (10% of the amount billed year-to-date):
EXHIBIT B-1 – AUTHORIZED INVOICE SIGNATORS

Agreement #: 17-CP-CSA-8207-99

The following individuals are authorized to sign monthly invoices and certification statements on behalf of The School Board of Broward County, Florida, hereinafter known as “SBBC,” as required by this Agreement between County and SBBC:

______________________________________________________________ and

______________________________________________________________

(Name and Title Typewritten)

(Name and Title Typewritten)

This authorization is conferred upon the individuals listed above pursuant to ___________ (enter the authorizing body, legislation, regulation, code, or equivalent, including the date of such authorization, and attach a copy of supporting documentation, such as Board of Directors’ meeting minutes, the authorizing statute, etc.):

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Appearing below are samples of the authorized signatures.

<table>
<thead>
<tr>
<th>Authorized Signature</th>
<th>Date</th>
<th>Authorized Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____________________</td>
<td></td>
<td>_____________________</td>
<td></td>
</tr>
</tbody>
</table>

Witness Signature:

Signature _____________________

Name _________________________
(Print or Type)

Date _________________________
Monthly Invoice Submission

Packet 1
(submitted to Accounting Division monthly)

- **SIGNED Invoice** (not an electronic signature) (Exhibit E-1, pages 1-2)
- System **Summary** Report
- In-Kind Match Documentation (if required) (Exhibit E-1, page 3)

Invoices are Either e-mailed to AccountsPayable@broward.org or mailed to Broward County Commission P.O. Box 14740 Ft. Lauderdale, FL 33302-4740 Attn: Accounts Payable

Packet 2
(submitted to CPD monthly)

- **SIGNED Invoice** (wet signature) not an electronic signature) (Exhibit E-1, pages 1-2)
- In-Kind Match Doc. (if required) (Exhibit E-1, page 3)
- System **Summary**
- System **Detail** Report
- Other: Lease, check requests, cancelled checks, receipts, etc.

Delivered or mailed to:
Community Partnerships Division 115 S. Andrews Avenue, Room A-360 Ft. Lauderdale, FL 33301
Corrected Billing

1. When Provider needs to update a processed invoice (i.e. overbilling, back billing)

2. Submits corrected billing for processing
   - Schedule
   - Form
FY 2018 - Exhibit E-1 (page 1 for Contracts with Match)

Board of County Commissioners, Human Services Department

Contracted Services Invoice

Billing Period: October-17

Agency Name: XXXXX
Contract #: xx-CP-xxxx-xxxx-01

Program Name: Special Needs: xxxxxxxxxx
Program #: 1

Address 1 XXXXXX
Address 2
City, St, Zip XXXXX, FL 333XX

Contract/Prog. Amount: $xxxxxxxx

A. Grand Total $ For Units Delivered This Month (from page 2, "A")

B. Match this month

C. Net Amount Requested for Reimbursement/Month

D. Net Amount Requested Year-to-Date

E. Match Contribution YTD

F. CERTIFICATION: The undersigned, as an authorized signator for the contract between Broward County and Achievement & Rehabilitation Centers, Inc. hereby affirms and certifies that the services billed herewith have been delivered to clients on behalf of Broward County per agreement, that all clients served have met the program eligibility requirements, and that sufficient written information is available to document services. Provider also represents to County that no other reimbursement is used for invoiced services.

G. Approved Signator Name (typed): 

H. Authorized Signature: 

DATE STAMP AREA

THIS SECTION FOR COUNTY USE ONLY

Division Reviewer/Date:__________________________

CERTIFICATION OF PAYMENTS TO SUBCONTRACTORS AND SUPPLIERS

FUND/DEPARTMENT/ACCOUNT/PROJECT: 10010-40303020-580210-103691

I hereby certify that the backup documentation is complete, accurate, supports the payment and pricing requested and is on file in the Division.

Administrative Services Reviewer/Date:__________________________

Outcomes met for quarter? Yes, invoice not adjusted □ No, invoice adjusted □

Submission of previously unbilled units: Y or N. If "Y", submit additional backup documentation to substantiate the unbilled units of service.

Are any disallowed units from previous monitoring visits or Medicaid or Medicare payments included in this invoice? (Y or N. If "Y" then see p.2 )

Comments: ____________________________
Invoicing & Corrected Billing Schedule

<table>
<thead>
<tr>
<th>Month of Service</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
</tr>
</thead>
</table>

***IMPORTANT***

Providers are only allowed to submit corrected billing **once** for any given month. Additional changes are at the discretion of the CGA.

*If due date falls on a weekend or a County observed holiday, invoices/correction packets are due the next business day.*
Invoices Containing Corrected Billing Information Allowable or Disallowable

Packet 1
(submitted to Accounting monthly)

- Current month’s invoice
- System Summary Report for current month
- Copy of System Summary Report for corrected billing month labeled “BEFORE”
- Updated System Summary report for corrected billing month labeled “AFTER”
- Completed Corrected Billing Detail form for allowable and disallowable billing units

*Emailed or mailed to Accounting

Packet 2
(submitted to CPD monthly)

- Current month’s invoice
- System Summary report for current invoice
- System detail activity report for current invoice
- Copy of System Summary Report for corrected billing month labeled “BEFORE”
- Updated System Summary report for corrected billing month labeled “AFTER”
- Completed Corrected Billing Detail form for allowable Corrected Billing Detail form for allowable and disallowable billing units

*Delivered/mailed to Community Partnerships Division
## SERVICE ACTIVITY REPORT

<table>
<thead>
<tr>
<th>Location:</th>
<th>Program:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Service:
- All Services
- All Case Managers
- All Fund Allocation
- All Fund Source

### Fund Source:
- All Fund Source

### Wraparound Facilitation
- WrapHour(s): SubTotal: 299.25 Total: 299.25
- Wraparound Facilitation
- Service: Wraparound/Youth & Family
- Unit: WrapHour(s): SubTotal: 25.00 Total: 25
- Wraparound Case Management Program
- Total: 327.75

### Post Wraparound Facilitation
- Service: Wraparound/Youth & Family
- Unit: WrapHour(s): SubTotal: 302.75 Total: 302.75
- Wraparound Case Management Program
- Total: 327.75

---

**Pre:**

- Service: All Services
- Case Manager:
- Fund Allocation: All Fund Allocation
- Fund Source: All Fund Source

**Post:**

- Service: All Services
- Case Manager:
- Fund Allocation: All Fund Allocation
- Fund Source: All Fund Source

---

From: 11/01/2016 To: 11/30/2016
# Corrected Billing Detail Form

## REQUIRED SERVICES DOCUMENTATION

| Client ID: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|-----------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| date of entry: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| date of exit: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total units: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3rd Party Payments | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| Client ID: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|-----------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| date of entry: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| date of exit: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total units: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3rd Party Payments | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| Client ID: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|-----------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| date of entry: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| date of exit: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total units: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3rd Party Payments | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| Client ID: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|-----------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| date of entry: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| date of exit: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total units: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3rd Party Payments | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

| Client ID: | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 |
|-----------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| date of entry: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| date of exit: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total units: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3rd Party Payments | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Type: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**FIRST PAGE ONLY:**

| Total # units this page: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total 3rd party $$ this page: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Grand total # units: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Grand total 3rd party $$: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Verified by: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

---

**Agency Name:**

**Billing Period:**

**Contract #:**

**Program #:**

**Taxonomy/Unit:**

---

**Total # units this page:**

**Total 3rd party $$ this page:**

---

**Grand total # units:**

**Grand total 3rd party $$:**

---

**Verified by:**
4.5.4.2 Corrected Invoices:
A. In the event that Provider determines that it has previously incorrectly billed and been reimbursed for a period within the current contract term, Provider shall include the corrections on the next regular monthly invoice. Unless the Contract Administrator has authorized or required additional corrections, corrected billing is limited to one time for any month in which services were rendered and must be received by County no later than ninety (90) days following the date the invoice being corrected was originally due to County, or forty-five (45) days after the end of the Agreement term, whichever is earlier. Provider must resubmit the original supporting documentation and submit the revised supporting documentation, along with a completed "Required Services Documentation" form as provided in the Provider Handbook, for each month in the period of previous incorrect billing, unless the Contract Administrator has, in writing, provided alternate documentation requirements. The invoice, which includes the corrections, must be accompanied by a cover letter signed by Provider’s authorized signator summarizing the corrections, explaining the reason for the error, and detailing the actions Provider is taking to prevent recurrence of the error(s).
Other Required Reports

The following reports must be submitted to Contract Grants Administrator within 30 calendar days of receipt by Provider:

- Monitoring reports issued by agencies or funding source for similar services.
- Accreditation reports
- Single audit reports
<table>
<thead>
<tr>
<th>Report</th>
<th>Due Date/Frequency</th>
<th># Copies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal Employment Opportunity Policy</td>
<td></td>
<td>1 copy</td>
</tr>
<tr>
<td>Americans with Disabilities Act Policy</td>
<td></td>
<td>1 copy</td>
</tr>
<tr>
<td>Nondiscrimination Policy, if applicable</td>
<td></td>
<td>1 copy</td>
</tr>
<tr>
<td>CBE Policy</td>
<td></td>
<td>1 copy</td>
</tr>
<tr>
<td>Blank Client Satisfaction Survey</td>
<td></td>
<td>1 copy</td>
</tr>
<tr>
<td>Certificate of Insurance/Certification of Coverage</td>
<td>Due prior to execution and upon revision by Provider</td>
<td>1 copy</td>
</tr>
<tr>
<td></td>
<td>15th day of each month (if needed, final reconciled invoice due annually on October 15th)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Invoices are Either e-mailed to <a href="mailto:AccountsPayable@broward.org">AccountsPayable@broward.org</a> or mailed to Broward County Commission P.O. Box 14740 Ft. Lauderdale, FL 33302-4740 Attn: Accounts Payable</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Original plus 1 copy (Invoice sent to Accounts Payable and 1 copy of the invoice and supporting documentation sent to CGA)</td>
</tr>
<tr>
<td>Invoice and supporting documentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outcomes Report</td>
<td>Semi-Annually (April 15th &amp; October 15th)</td>
<td>Original plus 1 copy</td>
</tr>
<tr>
<td>Client Demographic Report</td>
<td>Semi-Annually (April 15th &amp; October 15th)</td>
<td>Original plus 1 copy</td>
</tr>
<tr>
<td>Certification of Coverage</td>
<td>Due at time of this Agreement’s term extension or renewal via Option Period; submit to Repository</td>
<td>1 copy</td>
</tr>
<tr>
<td>Audited Financial Statement</td>
<td>Due within 120 days after the close of Providers fiscal year end; submit to Repository</td>
<td>1 copy</td>
</tr>
<tr>
<td>State Financial Assistance Reporting Package (if applicable)</td>
<td></td>
<td>1 copy</td>
</tr>
<tr>
<td>Compiled Client Satisfaction Survey</td>
<td>July 15th of each year</td>
<td>1 copy</td>
</tr>
<tr>
<td>Monitoring and/or Accreditation Reports from other agencies or funding sources</td>
<td>Due within 30 days of receipt</td>
<td>1 copy</td>
</tr>
<tr>
<td>Incident Reports</td>
<td>Due within 24 hours</td>
<td>1 copy</td>
</tr>
<tr>
<td>Organizational Profile</td>
<td>Due upon request – Send directly to First Call for Help on behalf of The Coordinating Council of Broward</td>
<td>1 copy</td>
</tr>
</tbody>
</table>

Note: Failure to submit the foregoing reports on or before the due date shall result in the suspension of any payments due by County to Provider.
Incident Report

Due within 24 hours
4 Question Quiz

Good luck!
Customer Service Survey

SurveyMonkey sent out

One representative per agency