MATCH Requirements
D. Required Match Policy of the HSD
HSD seeks to maximize the dollars available for services to Clients and therefore requires a 10% unit of service match of contracted services, unless otherwise noticed in other sections of this Handbook or in the Agreement. The County reimburses for only 9 out of 10 units actually delivered, invoiced, and documented at the unit price specified in the Agreement.

Project match may be designated as either Units of Service and/or in-kind services that are dedicated to and utilized solely by the project outlined in the agreement as stipulated in the Match Certification Form submitted with the applicable procurement. Actual amounts of in-kind must be submitted to the County monthly with the Agency’s invoice and include supporting documentation that accurately reflects the monthly in-kind amount indicated to the County. County will apply the match requirement to agreements executed based on the appropriate procurement.
Match Documentation

- Match is not required for the advertised service category.
- Agency chooses to utilize the Unit of Service match option (if Match is required for the advertised service category).
- Agency chooses to use a combination of both Unit of Service match and in-kind services to meet the County's ten percent Match requirement (if Match is required for the advertised service category).
- Agency proposes to solely use in-kind services to meet the County's ten percent Match requirement (if Match is required for the advertised service category).

If proposing to either partially or fully use in-kind match, check the box below to confirm the Agency's understanding and acceptance of terms for using in-kind match.

- I verify the portion of in-kind match identified in the program budget submitted by (insert name of Applicant Agency here) is solely committed to the project proposed by said Agency. It is understood that should the Agency be recommended for funding renewal in any stated Agreement option period, the Agency agrees to abide by this commitment and understands that the use of in-kind funds will be monitored by County staff.

The use of in-kind services may be approved by the Contract Administrator following the Awarded Agency's submission of a written certification, which certifies that all in-kind services utilized to meet the required match requirements are limited to the performance obligations of the Agreement and satisfy the service requirements as specified in the Agreement. The Awarded Agency shall submit monthly, with its invoice, documentation that accurately details all of the in-kind services utilized to meet its match requirements for the previous month.

Executive Director/CEO signature ____________________________ Date ________________

STATE OF ____________
COUNTY OF ____________

PERSONALLY APPEARED BEFORE ME, the undersigned authority, __________________________ (Name of individual signing) who, after first being sworn by me, affixed his/her signature in the space provided above on the ___ day of ______________, 20__.

__________________________
NOTARY PUBLIC, State of Florida

My commission expires ____________________.
Match

- Match is 10% of Units delivered
- Match does not carryover month-to-month
- Cannot use In-kind match expenses for more than one funding source
<table>
<thead>
<tr>
<th>AGENCY</th>
<th>Service</th>
<th>Match not required</th>
<th>Unit of Service</th>
<th>Combination of Unit/in-kind</th>
<th>Solely use In-kind</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achievement and Rehabilitation Centers, Inc. (dba ARC Broward)</td>
<td>CSAS Special Needs, Behavior Modification</td>
<td></td>
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<tr>
<td>Children's Diagnostic &amp; Treatment Center, Inc. (CDTC)</td>
<td>CSAS Special Needs, Medical Home</td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>JAFCO Children's Ability Center</td>
<td>CSAS Special Needs, Respite (In-Home and/or Out-of-Home)</td>
<td></td>
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<td>X</td>
<td></td>
</tr>
<tr>
<td>JAFCO Children's Ability Center</td>
<td>CSAS Special Needs, Behavior Modification</td>
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<td>X</td>
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<tr>
<td>Legal Aid Service of Broward County, Inc.</td>
<td>HIP Homeless Supportive Services, Legal Assistance</td>
<td></td>
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<td>X</td>
</tr>
<tr>
<td>United Community Options of Broward, Palm Beach and Mid-Coast Counties</td>
<td>CSAS Special Needs, Respite (In-Home and/or Out-of-Home)</td>
<td></td>
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<td>X</td>
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<tr>
<td>Women in Distress of Broward County, Inc.</td>
<td>HCS Behavioral Health, Domestic Violence Counseling Services</td>
<td></td>
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<td>X</td>
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</tr>
</tbody>
</table>
In-Kind Match

- Contribution from provider necessary to accomplish the contracted scope of work
- Provider must adequately document the contribution and provide supporting documentation with the monthly invoices.
- In-kind match contributions are subject to the same financial review procedures as the monthly invoices.
- Verifiable in Providers records

Circular A-110
Uniform Administrative Requirements for Grants and Agreements

Circular A-87
Cost Principles for State, Local and Indian Tribal Governments
Eligible In-Kind expenses

- Directly related to the operation of the program

- **Personnel expenses:**
  - Staff providing direct services
  - Direct supervision of direct service staff
  - Administrative support staff specifically assigned to the proposed program
  - Related fringe benefits, or volunteers
  - Personnel may only be used as match if the Applicant Agency has not requested reimbursement for personnel expenses in the proposed program budget.

- **Non-personnel expenses:**
  - Equipment: Office equipment, Furniture, Computers
  - Office space
  - Software
  - Training
  - Travel to deliver direct services
In-kind Match Supporting Documentation

Copies of:

- Paid Invoices
- Checks with the remittance summary
- Canceled Checks
- Time Sheets
- Receipts of purchase
- General Ledger
- Copies of pay stubs (with calculation of employees salary allocation)
- Copies of agreements with corresponding check copies
- Any additional documentation necessary to authenticate the in-kind match contribution

**Calculation allocation sheet if needed**
In-Kind Match Invoice Template
**Billing Period:** November 17

**Agency Name:**

**Contract #:**

**Program Name:**

**Program #:**

**Address 1:**

**Address 2:**

**City, St, Zip:**

**G. Approved Signator:**

**Date:**

**H. Approved Typed Name:**

**Title:**

---

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

**B1. Units of Service Match minus (-) In-Kind Match**

**B2. In-Kind Match**

**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 Center, Inc. hereby affirms and certifies that the services billed herewith have been delivered to clients on behalf of served have met the program eligibility requirements, and that sufficient written information is available to document services. Provider also represents to Broward County per agreement, that all clients County that no other reimbursement is used for invoiced services.

**G. Approved Signator:**

**Date:**

**H. Approved Typed Name:**

**Title:**

**THIS SECTION FOR COUNTY USE ONLY**

**Administrative Services Reviewer/Date:**

**Section Review/Approval:**

**Date:**

---

**CERTIFICATION OF PAYMENTS TO SUBCONTRACTORS AND SUPPLIERS**

- Yes, invoice not adjusted
- No, invoice adjusted

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

**Administrative Services Reviewer/Date:**

**Comments:**
## Contracted Services Invoice

**Billing Period:** November-17  
**Contract #:**  
**Program #:**  

**Agency Name:**  
**Program Name:**  

### A. Grand Total Units Billed (add additional sheets if more than 17 types of units)

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

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

**B1. Units of Service Match @10% of total submitted units.**

1. Total Units of Service Match This Month
   
2. Units of Service Match (used towards match)
   
3. Units of Service YTD (used towards match)
## Contracted Services Invoice

**Billing Period:** November-17  
**Contract #:**  
**Program #:**

### In-Kind Match

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Amount</th>
<th>Cumulative Year to Date Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Salary M. Smith - Behavioral Therapist (Monthly $2,600 x 35% = $182)</td>
<td>$182.00</td>
<td>$182.00</td>
</tr>
<tr>
<td>2</td>
<td>Office Space M. Smith Office space (300 sq ft = $140 per month x 35% = $49)</td>
<td>$49.00</td>
<td>$49.00</td>
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</tbody>
</table>

**TOTAL IN-KIND MATCH PROVIDED THIS MONTH**  
$231.00 $231.00

**Total In-Kind Match Required this month**  
$231.00

**In-Kind Match difference**  
$231.00

**Total In-Kind Match Year to Date**  
$231.00

**NOTE:** MATCH WILL NOT CARRY OVER EACH MONTH.

**Match Certification:**

I hereby affirm that the match described above adds to the organization's capacity to provide services in the above contract, and are not derived from any other Broward County grant or contract. Attached documentation supports the in-kind amount provided for this month.

**Signature:**  
**Date:**
QUESTIONS???
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.***
AccessBROWARD Registration Cont.

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.
Broward County Welcomes US Conference on Aids September 15-18th
New Landlord Recruitment Initiative Underway
Connect with the Nancy J. Cotterman Center (NJCC) on Facebook
Homeless Helpline 954-563-4357
**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](mailto: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

Agency Name: XXXXX

Contract #: xx-CP-xxxx-xxxx-01

Program Name: Special Needs: xxxxxxxxx

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:

DATE STAMP AREA

On Time _____ Late _____

THIS SECTION FOR COUNTY USE ONLY

Division Reviewer/Date:__________________________________________

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
### 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># Units this month</th>
<th># Disallowed Units</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>
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</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-8207-69

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>(Authorized Signature)</td>
<td>(Date)</td>
<td>(Authorized Signature)</td>
<td>(Date)</td>
</tr>
<tr>
<td>(Authorized Signature)</td>
<td>(Date)</td>
<td>(Authorized Signature)</td>
<td>(Date)</td>
</tr>
</tbody>
</table>

Witness Signature:

Signature __________________________

Name __________________________
(Print or Type) __________________________
Date __________________________

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** (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
Board of County Commissioners, Human Services Department

Contracted Services Invoice

Billing Period: October-17

Agency Name: XXXXX

Contract #: xx-CP-xxxx-01

Program Name: Special Needs: xxxxxxxxx

Program #: 1

Contract/Prog. Amount: $xxxxxx

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>
| 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:

THIS SECTION FOR COUNTY USE ONLY

Division Reviewer/Date: _____________________________

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 and disallowable billing units

*Delivered/mailed to Community Partnerships Division
SERVICE ACTIVITY REPORT

<table>
<thead>
<tr>
<th>Service</th>
<th>Unit</th>
<th>WrapHour(s)</th>
<th>Wraparound Facilitation</th>
<th>Wraparound/Youth &amp; Family</th>
<th>SubTotal</th>
<th>Total</th>
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<tbody>
<tr>
<td>Wraparound Facilitation</td>
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<td>SubTotal: 299.25</td>
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<td>Wraparound/Youth &amp; Family</td>
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<td></td>
<td></td>
<td>SubTotal: 25.00</td>
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From: 11/01/2016 To: 11/30/2016
Agency: 
Location: 
Program: 
Service: All Services
Case Manager: All Case Managers
Fund Allocation: All Fund Allocation
Fund Source: All Fund Source

Pre

Post
## Corrected Billing Detail Form

**REQUIRED SERVICES DOCUMENTATION**

<table>
<thead>
<tr>
<th>Agency Name:</th>
<th>Billing Period:</th>
<th>Contract #:</th>
<th>Taxonomy/Unit:</th>
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<tbody>
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<table>
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<th>Program Name:</th>
<th>Program #:</th>
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<table>
<thead>
<tr>
<th>Client ID:</th>
<th>date of entry:</th>
<th>date of exit:</th>
<th>Total units:</th>
<th>3rd Party Payments</th>
<th>Type:</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Total # units this page:</th>
<th>Total 3rd party $$ this page:</th>
<th>Verified by:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FIRST PAGE ONLY:**

Grand total # units:  
Grand total 3rd party $$:
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>Invoice and supporting documentation</td>
<td>15th day of each month (if needed, final reconciled invoice due annually on October 15th)</td>
<td>Original plus 1 copy</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>Invoice sent to Accounts Payable and 1 copy of the invoice and supporting documentation sent to CGA</td>
</tr>
<tr>
<td>Outcomes Report</td>
<td></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 Report</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>
</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

Laptop as you exit
www.surveymonkey.com/r/PT1018
QUESTIONS???
www.surveymonkey.com/r/PT1017