CSA PROVIDER AGREEMENT (SHORT FORM)

This Comprehensive Services Act (CSA) Provider Agreement (Agreement) is made and entered into this ____ day of ____________, 20__, by and between the Albemarle County Community Policy and Management Team ("CPMT") and the __________________________ ("Provider"), which is located at __________________________.

The Provider agrees to provide the Services as described in Schedule A of this Agreement. In return, CPMT agrees to pay the Provider, upon successful completion of the Services, or as agreed to otherwise, the amount stated in this Agreement.

1. **Agreement Documents.** The body of this document and the attached Schedule A are the sole and entire documents constituting this Agreement. In the event of any conflict between the body of this document and Schedule A, the terms in the body of this document shall take precedence over any Schedule A and/or any other Schedules or attachments.

2. **Term of Agreement: Termination.** This Agreement shall take effect starting on the date by which both parties have signed this Agreement and shall automatically terminate once all services specifically described on Schedule A have been provided, except for the confidentiality provisions of Section 9. CPMT may terminate the Agreement by providing written notice to Provider, effective immediately, should the safety or welfare of the staff, child and/or family, or others require it. Otherwise, CPMT may terminate this Agreement for any breach of this Agreement upon providing thirty (30) days’ written notice to the Provider. Provider may terminate this Agreement for CPMT’s failure to pay, upon providing thirty (30) days’ written notice, provided that Provider has complied with all other terms of this Agreement.

3. **Independent Contractor.** CPMT and Provider agree that the Provider is an independent contractor, not an employee of Albemarle County, or CPMT, and that CPMT shall not provide the Provider any insurance coverage or benefits of any kind. Payment will be made to the Provider without withholdings or deductions of any kind and the Provider will be responsible for paying all taxes and other deductions as required by law.

4. **Direct Contact with Children.** Provider agrees that all of its employees and staff, including any volunteers or students working under Provider’s supervision, providing any services to an identified child and/or family designated by CPMT, that requires direct contact with children ("Direct Contact Providers") shall have successfully completed a Virginia State Police criminal background record check and a check through the Virginia Child Protective Service Registry, or the State in which such services are being rendered, prior to providing any services for CPMT. If it is known that an employee, staff and/or any volunteer, has moved from another state and has worked with children within one year of his or her employment, a criminal background check and child protective service registry check from the previous State must be performed. If the Provider is notified that any of its employees, staff and/or volunteers are named in a child protective service registry, then the Provider shall immediately notify CPMT and remove the employee, staff and/or volunteer from working with any CPMT client. In addition, Contractor agrees to certify, and prior to the provision of any services to any CPMT client, that no Direct Contact Provider has been: (a) convicted of a felony or any offense involving the sexual molestation or physical or sexual abuse or rape of a child; or (b) convicted of a sexually violent offense as defined in Virginia Code §9.1-902.

5. **Insurance.** Provider shall: (a) during the performance of this Agreement, keep in force an insurance policy for general liability in the amount of at least one million dollars ($1,000,000) per occurrence/$2,000,000 general aggregate, that covers personal injury and death, bodily injury, professional malpractice (if professional services are being provided), and property damage; and (b) upon request, furnish a certificate of insurance or other valid documentation showing the Albemarle County CPMT as an additional insured on this policy, unless checked off otherwise below.

☐ Additional insured requirement not applicable because Provider is a governmental entity.

6. **Limitation of Liability.** THE PARTIES AGREE THAT IN NO EVENT SHALL EITHER PARTY BE LIABLE TO THE OTHER FOR ANY SPECIAL DAMAGES ARISING FROM THE PERFORMANCE OF THIS AGREEMENT, INCLUDING BUT NOT LIMITED TO, INCIDENTAL DAMAGES, OR LOST PROFIT, EVEN IF SUCH SPECIAL DAMAGES ARE REASONABLY FORESEEABLE.
7. **Indemnification and Hold Harmless.** Unless checked off below, Provider agrees to indemnify and hold harmless CPMT, the County of Albemarle, and their respective boards, employees and agents, from any and all claims for bodily injury, and personal injury and/or property damage, including cost of investigation, all expenses of litigation, including reasonable attorneys’ fees, and the cost of appeals arising out of any claims or suits which result from errors, omissions, or negligent acts of the Contractor or its employees and agents.

☐ Indemnification not required because the Contractor is a governmental entity.

8. **Nonappropriation.** All payment under this Agreement is subject to adequate appropriation by the Albemarle County Board of Supervisors. In the event that the Albemarle County Board of Supervisors fails to appropriate adequate funds for this Agreement, this Agreement shall immediately and automatically terminate, and CPMT will be obliged to pay Provider for all services performed prior to termination but shall have no obligation for any unperformed services.

9. **Confidentiality.** Any information obtained by the Provider pursuant to this Agreement shall be treated as confidential. Use and/or disclosure of such information by the Provider shall be limited to the purposes directly connected with the Provider’s responsibility for services under this Agreement. Both parties further agree that this information shall be safeguarded in accordance with the provisions of the Code of Virginia, as amended, and any other relevant provisions of state and federal laws.

10. **Notice.** Any notice, request, invoice or other communication to either party by the other concerning the terms and conditions of this Contract, shall be in writing and shall be deemed given only when (1) actually received by the addressee; (2) sent by electronic mail to the recipient’s correct electronic mail address, with confirmation of receipt; or (3) sent postage prepaid, by certified or registered United States mail, return receipt requested, addressed to the persons as listed below:

**CPMT:**
Attn: Fiscal Agent
Kevin Wasilewski
PO Box 297
1600 5th Street, Suite A
Charlottesville, VA 22902

**Provider:**
Name:
Attn:
Address:

11. **Applicable Law.** This Agreement shall be governed by and construed in accordance with the laws of the Commonwealth of Virginia. The parties agree that proper venue, in the event of litigation concerning this matter, shall be in the Circuit Court of Albemarle County, Virginia.

**PROVIDER SIGNATURE SECTION**

NAME AND TITLE OF AUTHORIZED OFFICER OF PROVIDER

SIGNATURE OF AUTHORIZED OFFICER OF PROVIDER

DATE

**CPMT SIGNATURE SECTION:**

SIGNATURE OF AUTHORIZED CPMT CHAIR

SIGNATURE OF AUTHORIZED CPMT FISCAL AGENT

DATE
I. DELIVERABLES AND PAYMENT TABLE
Provider shall provide all labor, equipment, and materials to provide the services (hereinafter "Services") described below on the dates or estimated dates set forth in the Deliverables & Payment Table below. In the alternative, an attached proposal containing all of the information required by this table may be attached to this Schedule A.

<table>
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<th>Service/Deliverable Description</th>
<th>Date(s) to be Delivered</th>
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II. PAYMENT PROCEDURE
Unless otherwise specified above in express terms, CPMT shall not be responsible for the payment of any travel, accommodation, or other kind of out-of-pocket or incidental costs incurred by the Provider to perform the Services. Invoices for completed Services shall be submitted by the Provider to CPMT with sufficient information about the Services performed to permit payment by CPMT. Payment shall be provided net forty five (45) days of receiving complete invoices.
REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION
(Substitute Form W-9)

Under the Federal Income Tax Law, we are required to file Form 1099 with the IRS to report certain payments made to you. You are required to furnish us with your correct Taxpayer Identification Number (TIN) regardless of whether payments made to you are reportable. We are requesting the information below regarding your account with us, to comply with the law. If you are an individual or sole proprietor, you should supply your Social Security Number (SS #) as your TIN. If you are operating as a partnership, corporation, or other entity, please supply us with your Federal Employer Identification Number (EIN). To assist us in determining your status, please fill out as much of this form as you can. This information is for Albemarle DSS only and will not be shared with any other entity.

Name as registered with the Internal Revenue Service (your name if an individual or sole proprietor):

__________________________________________

Doing Business As: (if applicable) _______________________________________________________

Address: ____________________________________________

Mailing address: _______________________________________

Contact Person ___________________________ Phone _______________________

Email Address: _______________________________________

SS #: ____________ OR EIN #: ____________

Business designation (You may select more than one)

____ Individual or Sole proprietor

____ Corporation

____ LLC

____ Medical

____ Government entity

____ Partnership

____ Non-Profit organization

____ Other (Explain) ________________________________

Principal service or product you provide to our department: ____________________________

Check Here if Receiving Rental Payments ______ Check Here if a Foster Parent ______

Certification:

Under penalties of perjury, I declare TIN provided above is correct (or I am waiting for one to be issued to me), the organization entity and all other information provided is accurate, and I am not subject to backup withholding as a result of failure to report all interest and dividends, or the Internal Revenue Service has notified me that I am no longer subject to backup withholding.

Name and title (print or type) _______________________________________________________

Signature __________________________________________ Date _______________________

Please return to the Albemarle County Department of Social Services
Attn: Kevin Wasilewski, P.O. Box 297, Charlottesville, VA 22902 OR fax to 434-244-4923

at your earliest convenience. We must have this information within 30 days of the date
at the top this form in order to keep your status active. If this information is not
on file at this time, we may be required to withhold 28% of your payment as required by
the IRS. If you have any questions, please contact us at 434-972-4010.

Thank you for your prompt attention to this request.

Office Use Only:

Requested by: _______ Date: _______

Input by: _______________ Date: ______