State of North Carolina
Department of Health and Human Services
Division of Services for the Deaf and Hard of Hearing

ADDENDUM #3
NOTICE OF RENEWAL

Date: September 25, 2019
Contract Name: Request for Application – Agency Interpreter and Transliterator Contractor
Contract Number: 30-DSDHH-95058-17
Contract Description: Agency Sign Language Interpreting and Transliterator Services

TERM:
The Term of this Addendum will begin on November 1, 2019 (or any time after this date if you do not return this Addendum in time to be reviewed and approved before this date). The ending date for this Addendum will be October 31, 2020. These dates represent the second renewal year of the option to renew for two (2) additional years in one (1) year increments.

This Addendum #3 is subject to all terms and conditions of:

1) Request for Application (RFA) number 30-DSDHH-95058-17 posted on October 17, 2017;
2) Addendum #1 – Notice of Renewal dated September 27, 2018; and,
3) Addendum #2 – Changes to Contract dated April 18, 2019.

REVISIONS:
Section I. PURPOSE, addition of the following language:

During the application evaluation, an inquiry into the US Department of Health and Human Services, Office of the Inspector General’s (OIG) Exclusions Database, List of Excluded Individuals/Entities (LEIE), will be made to determine if the applying agency and listed individuals are excluded from working in a federal health care program. After an initial inquiry, DSDHH will thereafter regularly monitor the OIG Exclusion Database to ensure that a contracted agency and listed individuals does not become excluded from working in a federal health care program. If an applying agency is initially excluded, a contract will not be executed. If an applying agency listed individual is initially excluded, then DSDHH will request the application be resubmitted removing that individuals name. If a contractor becomes excluded during the term of the contract, immediate actions will occur to revise contractors list of interpreters under contract.

INSTRUCTIONS:
A complete application for renewal consists of the following:

a) The completed and signed addendum, Notice of Renewal;

b) Agreement to require a vendor’s interpreters assigned to a State Operated Healthcare Facilities (DSOHF) facility to be immunized and show proof of such before reporting to an assignment at
any one of the DSOHF locations (locations listed below). DSDHH realizes that a vendor may have interpreters that do not desire to work in a DSOHF facility.

i. If a vendor’s interpreter elects to work in a DSOHF location, the immunization records for the identified diseases (listed below) must be provided for the specific interpreter, including evidence of the influenza vaccine;

ii. If a vendor’s interpreter elects to NOT work in a DSOHF location, immunization records are not necessary for the specific interpreter.

iii. If a vendor’s interpreter elects to apply for an exemption due to a bona fide religious or medical reason, a Medical or Religious form must be completed and returned with this Amendment #3. These forms are attached for reference and marked Attachment C (Medical Exemption) and Attachment D (Religious Exemption).

c) A current copy of the letter of renewal/verification that the vendor’s interpreters possess a valid North Carolina Interpreter and Transliterator license issued pursuant to Chapter 90D of the North Carolina General Statutes;

d) A copy of all current interpreting or transliterating certifications held by the vendor’s interpreters; e.g. NIC, RID, NAD, NCICS, EIPA, etc.

State Operated Healthcare Facilities (DSOHF) and their locations

1. Alcohol and Drug Abuse Treatment Centers
   a. Julian F. Keith ADATC – Black Mountain, NC
   b. R. J. Blackley ADATC – Butner, NC
   c. Walter B. Jones ADATC – Greenville, NC

2. Development Centers
   a. Caswell Developmental Center – Kinston, NC
   b. J. Iverson Riddle Developmental Center – Morganton, NC
   c. Murdoch Developmental Center – Butner, NC

3. Neuro-Medical Treatment Centers
   a. Black Mountain Neuro-Medical Treatment Center – Black Mountain, NC
   b. O’Berry Neuro-Medical Treatment Center – Goldsboro, NC
   c. Longleaf Neuro-Medical Treatment Center – Wilson, NC

4. Psychiatric Hospitals
   a. Broughton Hospital – Morganton, NC
   b. Central Regional Hospital – Butner, NC
   c. Cherry Hospital – Goldsboro, NC

5. Residential Programs for Children
   a. Whitaker Psychiatric Residential Treatment Facility – Butner, NC
   b. Wright School – Durham, NC
Immunization Information

Per the Division of State Operated Healthcare Facilities (DSOHF) policy 182-AL, effective April 1, 2017, all DSOHF employees and others who work in DSOHF facilities must be immune (unless there is an approved religion or medical exemption based on a medical contra-indication, as described by the US Center for Disease Control, Advisory Committee on Immunization Practices [CDC/ACIP]) to the following:

1. Measles
2. Mumps
3. Rubella (German measles)
4. Varicella (Chickenpox)
5. Pertussis (Whooping cough)
6. An annual influenza vaccination will also continue to be required to work within a DSOHF facility. The influenza vaccine is due by 11/1 of each year and evidence to support having this vaccine must be dated prior to this date (Unless an individual is applying for a contract after 11/1. In that case, the evidence to support the influenza vaccine must have a recent date).

*If you choose to provide proof of immunizations and work in a DSOHF facility, you may be required to be tested for Tuberculosis (TB).

“Unfortunately, there is no national organization that maintains vaccination records. The records that exist are the ones you or your parents were given when the vaccines were administered and the ones in the medical record of the doctor or clinic where the vaccines were given. If you can’t find your personal records or records from the doctor, you may need to get some of the vaccines again. While this is not ideal, it is safe to repeat vaccines. The doctor can also sometimes do blood tests to see if you are immune to certain vaccine-preventable diseases.” (“Vaccine Information for Adults”, Center for Disease Control, 2016, www.cdc.gov/vaccines/adults/vaccination-records.html)

Mail one (1) copy of all documents to:

Email questions to:
DHHS.ISVL@dhhs.nc.gov

DHHS/DSDHH
Communication Access Manager
820 S. Boylan Avenue
2301 MSC
Raleigh, NC  27699-2301
DHHS ISVL Invoice for Agency Contractor

<table>
<thead>
<tr>
<th>Invoice #</th>
<th>Date Submitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First Submission</td>
</tr>
</tbody>
</table>

**BILL TO:**

- **Agency Name:**
- **Address 1:**
- **Address 2:**
- **City:**
- **State:**
- **Zip:**

- **Phone:**
- **Email:**

**Questions pertaining to the ISVL should be referred to the Communication Access Manager at the Division of Services for the Deaf and the Hard of Hearing at 919.527.6930 or dsdhh.isvl@dhhs.nc.gov**

**Questions regarding the invoice and/or the assignment should be referred to the requestor.**

**ASSIGNMENT INFORMATION**

<table>
<thead>
<tr>
<th>Date of Assignment:</th>
<th>Requestor</th>
</tr>
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<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

- **Interpreter Name:**
- **Consumer Name:**
- **Description of Assignment:**

<table>
<thead>
<tr>
<th>Original Hours Scheduled:</th>
<th>Start Time:</th>
<th>End Time:</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Hours Billed:</th>
<th>Start Time:</th>
<th>End Time:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Services Provided**

- **Interpreting**
- **Mentoring**
- **Training**
- **NDBEDP**
- **Haptics**
- **Other (specify _______________________________)**

<table>
<thead>
<tr>
<th>Total Hours</th>
<th>Rate Per Hour</th>
<th>Services Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

| Enhanced Rate (Evenings, Weekends, Holidays): | $0.00 |

<table>
<thead>
<tr>
<th>Flat Rate:</th>
<th>SERVICES TOTAL:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0.00</td>
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</table>

**Travel and Other Expenses**

<table>
<thead>
<tr>
<th>Number of Miles</th>
<th>Rate Per Mile</th>
<th>Mileage Total</th>
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<tbody>
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</tbody>
</table>

| One Way | Roundtrip | 0.580 | $0.00 |

**Additional Mileage Rates**

- Add 1.5 hours (regular rate) for travel 75 miles or more each way
- Add 2 hours (regular rate) for travel 125 miles or more each way

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<thead>
<tr>
<th>Number of Hours</th>
<th>Rate Per Hour</th>
<th>Mileage Total</th>
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<tr>
<td>0.00</td>
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</tbody>
</table>

**Other Expenses (Hotel, Meals, Parking):**

| Other Expenses | $0.00 |

**TRAVEL TOTAL:**

| $0.00 |

**GRAND TOTAL**

| Total Services Provided: | $0.00 |
| Total Mileage & Other Expenses: | $0.00 |
| TOTAL INVOICED: | $0.00 |

**For DHHS Agency Use Only**

- **Reviewed By:**
  - **Title:**
  - **Date:**

- **Approved By:**
  - **Title:**
  - **Date:**

| Budget Code: | 2601532199034141018422T |

Ver 10/1/19
## DHHS Interpreter Services
Application to be Used by Agency Vendor

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Agency Name</td>
<td></td>
</tr>
<tr>
<td>Federal Tax ID. No.</td>
<td></td>
</tr>
<tr>
<td>Primary Contact</td>
<td></td>
</tr>
<tr>
<td>Mailing Address</td>
<td>Street or PO Box</td>
</tr>
<tr>
<td></td>
<td>City, State, Zip</td>
</tr>
<tr>
<td>Billing Address</td>
<td>Street or PO Box</td>
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<td></td>
<td>City, State, Zip</td>
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<tr>
<td>Primary Phone No.</td>
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<td>Alternate Phone No.</td>
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<tr>
<td>Alternate Phone No.</td>
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<td>Fax Number</td>
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<td>Email Address</td>
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</table>

- [ ] Home Phone
- [ ] Office Phone
- [ ] Mobile Phone
## Interpreters Under Contract with Agency Applicant

<table>
<thead>
<tr>
<th>Interpreter's Name</th>
<th>NC Interpreter &amp; Transliterator License Number</th>
<th>Check Appropriate Box</th>
<th>DSOHF Locations – Please Check Appropriate Box</th>
</tr>
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<tbody>
<tr>
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[Attach as Many Additional Pages as Necessary to List All Interpreters Under Contract]
ATTACHMENT C

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING  
Vaccination Exemption Documentation Form  
For Religious Reasons

TO THE APPLICANT AND, if consulted, CLERGY:

The North Carolina Department of Health and Human Services (DHHS) has adopted a policy, “Required Vaccination for Employees and Others Who Work in a Division of State Operated Healthcare Facilities (DSOHF)”. The purpose of this policy is to protect DHHS patients, employees, and others who work in DSOHF facilities from vaccine preventable healthcare associated transmissible infections.

The following individual, _______________________________________ (write name on line), has filed an “Application for Exemption to Vaccination” for religious reasons. To support that application, the individual must provide the following information:

A statement that the individual has a bona fide religious objection to the vaccination, that the vaccination conflicts with their religious beliefs, and the Statement must be signed by the Applicant.

This form may be signed below by a clergy member ordained by the authorities of the particular religious body, with a copy of supporting documentation attached to this Form.

I, __________________________________________ (printed name of applicant), have a bona fide religious objection to the following vaccination(s):

1. ___________________________________________
2. ___________________________________________
3. ___________________________________________
4. ___________________________________________
5. ___________________________________________

Requiring me to be vaccinated conflicts with my religious beliefs as follows:

______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________

(continue on additional pages if needed)

Signature of Applicant: (Required) _______________________________________________________
Date:  ______________________________

Signature and other information below may also be provided for religious exemption:

Signature of clergy member: ______________________________________________________________
Date:  ______________________________

Physical Address:  _________________________________________________________________________
________________________________________________________________________

Name of Denomination or Other Recognized Religious Body:  _____________________________________________

Note: May attach additional information.
TO THE HEALTH CARE PROVIDER:

The North Carolina Department of Health and Human Services (DHHS) has adopted a policy, “Required Vaccination for Employees and Others Who Work in Division of State Operated Healthcare Facilities (DSOHF)”. The purpose of this policy is to protect DHHS patients, employees, and others who work in DSOHF facilities from vaccine preventable healthcare associated transmissible infections. Employees working in DSOHF facilities must be immune to measles, mumps, rubella, pertussis, and varicella, unless a valid medical or religious exemption has been approved. NC DHHS follows the CDC and the ACIP recommendations for immunization practices.

The following individual, ______________________________________________, (write name on line), has filed an “Application for Exemption to Vaccination” for medical reasons for the following vaccination(s)

1. ______________________________________________
2. ______________________________________________
3. ______________________________________________
4. ______________________________________________
5. ______________________________________________

To support that application, the covered individual must request and submit the following documentation completed and signed by you, their Healthcare Provider:

1. When did you last examine the individual? ______________________________________________
2. Does this patient have a history of anaphylaxis or Neomycin?  ☐ Yes  ☐ No
3. Does this patient have a history of severe allergic reaction to any component of the vaccine or after a previous dose of the vaccine?  ☐ Yes  ☐ No  If yes, which vaccine(s)? ____________________________
   NOTE: “Severe allergic reaction” includes cardiovascular changes (e.g. hypotension), respiratory distress (e.g. wheezing), gastrointestinal changes (e.g. nausea/vomiting), that required treatment with epinephrine, or any other reaction that required emergency medical attention.
4. Does this individual have a known severe immunodeficiency?  ☐ Yes  ☐ No
5. Has the individual had a recent administration of blood products?  ☐ Yes  ☐ No
6. Is this individual pregnant?  ☐ Yes  ☐ No
7. Does this individual have a history of Guillain-Barre within 6 weeks or encephalopathy within 7 days of receipt of Tdap, Td, DTP, or DTaP vaccine?  ☐ Yes  ☐ No
8. Does this individual have a progressive neurologic disorder:  ☐ Yes  ☐ No  If yes, specify: ________________
9. Other vaccination contraindication or precaution: ____________________________________________
10. Is the condition temporary or permanent? (Circle applicable term).

Physician/PA/NP Printed Name: ___________________________________________________________
Physician/PA/NP Signature: ___________________________________________________________
License Number: ________________________________________________________________
Date Signed: __________________________ Telephone Number: __________________________
Address: __________________________________________________________________________

Note: May attach additional information.
NOTICE OF RENEWAL

1. Return Attachment B with your response. If any individual interpreter chooses to work in a DSOHF, immunization records must be returned also. If any individual interpreter chooses to request an exemption based on a religious or medical reason, return a completed Attachment C or Attachment D, whichever applicable.

2. Return a copy of the letter of renewal/verification that the vendor’s interpreters possess a valid North Carolina Interpreter and Transliterator license issued pursuant to Chapter 90D of the North Carolina General Statutes;

3. Return one properly executed copy of the addendum by completing the information below:

<table>
<thead>
<tr>
<th>Execute Addendum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contractor</td>
</tr>
<tr>
<td>Authorized Signature</td>
</tr>
<tr>
<td>Name Typed or Printed</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

Addendum # 3 Acceptance (For DHHS use only)

By my undersigned signature, as an authorized representative of the Division of Services for the Deaf and Hard of Hearing, I hereby accept this executed Addendum #3.

The contract shall begin on __________________ and shall terminate on ____________________ .

By: ____________________________________________
    Signature of Authorized Representative
    Printed Name of Authorized Representative
    Title of Authorized Representative