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

ADDENDUM #1
NOTICE OF RENEWAL

Date: October 17, 2017
Contract Name: Request for Application – Individual Interpreter and Transliterator Contractor
Contract Number: 201702DSDHH-II
Contract Description: **Sign Language Interpreting and Transliterators Services Vendor List**

TERM:

The Term of this Addendum will **begin on November 1, 2017** (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, 2018.** These dates represent the first renewal year of the option to renew for two (2) additional years in one (1) year increments.

REVISIONS:

1. Revisions to the RFA posted March 15, 2017, are as follows:

   a. The address for the Division of Services for the Deaf and Hard of Hearing is changed –

      From: 1100 Navaho Dr., GL-3
      Raleigh, NC 27609

      To: 820 S. Boylan Avenue
      2301 MSC
      Raleigh, NC 27699-2301

   b. A revised Invoice (dated 9/19/17) is attached and marked “Attachment A”.

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 assigned to a DSOHF facility to be immunized and show proof of such before reporting to an assignment (Attachment B);
c) A current copy of the letter of renewal/verification that the applicant possesses 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 Applicant; e.g. NIC, RID, NAD, NCICS, EIPA, etc.;

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

NOTICE OF RENEWAL

1. To **RENEW** your contract, please provide the following information:

Your current telephone number	
Your current mailing address	
Your current email address	

Any **changes** in your credentialing since March, 2017? e.g. NIC, RID, NAD, NCICS, EIPA, etc.;
If yes, please list changes and include supporting documentation:

_____

_____

1. Return a signed copy of agreement to require a vendor assigned to a DSOHF facility to be immunized and show proof of such before reporting to an assignment (Attachment B);

2. Return a copy of the letter of renewal/verification that the applicant possesses 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:

Execute Addendum	
Contractor	
Authorized Signature	
Name Typed or Printed	
Date	

Addendum # 1 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 #1.

The contract shall begin on _____, and shall terminate on _____.

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

ATTACHMENT A

(An excel version of the invoice will be sent for vendor use upon approval of contract renewal)

DHHS ISVL Invoice for Individual Contractor

Interpreter Name		INVOICE #	
NC License #			
Address		DATE SUBMITTED:	September 19, 2017
City		First Submission	☐
State / Zip		Re-Submission	☐
		Past Due or Late	☐

BILL TO:		
DHHS Division or Office Name		*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*
Attention		
Address		*Questions regarding the invoice and/or the assignment should be referred to the requestor.*
City		
State / Zip		
Phone		
Email		

ASSIGNMENT INFORMATION				
Date of Assignment:		Requestor		
Consumer Name:				
Description of Assignment:				
Original Hours Scheduled:	Start Time:		End Time:	
Hours Billed	Start Time:		End Time:	

Services Provided

☐ Interpreting ☐ Mentoring ☐ Training ☐ NDBEDP ☐ Haptics ☐ Other (specify_____)

	Total Hours	Rate Per Hour	Services Total
Standard Rate:			$0.00
Enhanced Rate (Evenings, Weekends, Holidays):			$0.00
Flat Rate			$0.00
SERVICES TOTAL:			$0.00

Travel and Other Expenses	Number of Miles	Rate Per Mile	Mileage Total
☐ One Way ☐ Roundtrip From:_____ To:_____			$0.00

Additional Mileage Rates	Number of Hours	Rate Per Hour	Mileage Total
Additional Mileage Rates Add 1 hour (regular rate) for travel 75 miles or more each way Add 2 hours (regular rate) for travel 150 miles or more each way			$0.00
Other Expenses (Hotel, Meals, Parking (please attach receipt):			$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:		

Version Date 9/19/17

ATTACHMENT B

Agreement to have vendors being assigned to DSOHF facility being immunized

Applicants wishing to work in any of the Healthcare facilities requires an annual influenza vaccinations. Vendors who do not submit proof of immunization will not be able to work in any DSOHF Facility.

Per the Division of State Operated Healthcare Facilities (DSOHF) policy 148-AL (1), effective August 15, 2013, all DSOHF employees and others who work in DSOHF facilities are required to have an influenza vaccination in order to work for or within a DSOHF facility.

Facilities within the North Carolina Department of Health and Human Services

Alcohol and Drug Abuse Treatment Centers

- Julian F. Keith ADATC
- R.J. Blackley ADATC
- Walter B. Jones ADATC

Development Centers

- Caswell Developmental Center
- J. Iverson Riddle Development Center
- Murdoch Developmental Center

Neuro-Medical Treatment Centers

- Black Mountain Neuro-Medical Treatment Center
- O'Berry Neuro-Medical Treatment Center
- Longleaf Neuro-Medical Treatment Center

Psychiatric Hospitals

- Broughton Hospital
- Central Regional Hospital
- Cherry Hospital

Residential Programs for Children

- Whitaker Psychiatric Residential Treatment Facility
- Wright School

All other terms and conditions as set forth in the original document shall remain in effect for the duration of this agreement.

____ I **do wish** to provide proof of immunizations for those employees of the applicant assigned to a Healthcare facility. I understand doing so will result in being able to accept assignments in DHHS State Operated Health Care Facilities.

Please include proof of immunization with signed document.
If proof of immunization is provided, the date of vaccination must be the year that coincides with the date signed below.

Signature Title Date

____ I **do not wish** to provide proof of immunizations for those employees of the applicant. I understand doing so will result in my inability to accept assignments in DHHS State Operated Health Care Facilities.

Signature Title Date