The Arc of Florida

*Achieve with us.*

Dental Service Provider,

The Arc of Florida is currently recruiting Dental Service Providers and Dental Schools to its network to provide dental care to the individuals we serve. The Arc of Florida is a 501 (c)(3) Nonprofit Corporation that serves people with Intellectual and Developmental Disabilities throughout the State of Florida. Our population includes people with an Intellectual Disability (IQ below 70), Cerebral Palsy, Spina Bifida, severe forms of Autism, Prader-Willi Syndrome, Phelan McDermid Syndrome and Down Syndrome. Eligible individuals receive services from the Agency for Persons with Disabilities' (APO) iBudget Home and Community-Based Services Waiver, iBudget Waitlist or Consumer Directed Care Plus (CDC+).

In 2012, The Arc of Florida received a Special Legislative Appropriation to pay for dental services for our population, which is now recurring. With this funding, The Arc of Florida is able to pay for dental services at market rates (no Fee Schedule), render payments twice per week via United States Postal Service, and fund many dental procedures needed by our population that are not funded by Medicaid. A list of procedures (not all-inclusive) funded by our program can be found on our website at www.arcdental.org.

Our program has served thousands of individuals statewide and continues to grow each Fiscal Year. Thank you for your consideration and willingness to serve one of Florida's most underserved populations.

To become a part of our network, please complete and sign the attached packet (Enrollment Form, W-9 Form (for each location to be added to the network), Business Associate Agreement, a copy of the Liability Insurance Certificate). Then, return it to our office by email, dental@arcflorida.org, or fax (850-921-0418).

Sincerely,

Alan Abramowitz
Chief Executive Officer

The Arc of Florida

*Achieve with us.*

How the Dental Services Program Works: **PLEASE KEEP THIS PAGE FOR YOUR RECORDS**

- Providers who are willing to deliver services should complete, sign, and return the following documents: Dental Provider Enrollment Form, W-9 Form, Business Associate Agreement, and a copy of the Liability Insurance Certificate.
- Once enrolled, the Provider will be added to a Referral List from which clients or those acting on their behalf select a Dental Provider in or near their county of residence.
- Once a Client selects a Provider, the Client or someone acting on his/her behalf contacts the Provider's Office to request a Treatment Plan or New Patient Fee Estimate, if a current Treatment Plan was not submitted with the Client's Application. If approved for funding, a written Dental Treatment Plan Approval Form with an attached Treatment Plan for the client will be sent to the Provider. The Approval Form will show Amount of Funds, Expiration Date of Funds, and Services approved for funding. Services showing Strike-Throughs on the attached Treatment Plan/New Patient Estimate will not be funded by the program. A written Dental Treatment Plan Approval Form must be received by the Provider before an appointment for treatment is scheduled. Please visit our website, **www.arcflorida.org/dental-program-faq**, for more information regarding the services the program does and does not fund.
- Once services are performed, on or before the Expiration Date, the Provider should email, fax, or mail the Payment Invoice to our office at billing@arcflorida.org. If clients require more than one appointment for treatment, invoices should be sent after each appointment. Payment for approved services is rendered by Electronic Payment or Check sent via the United States Postal Service. Services provided without prior approval or performed after the Expiration Date as well as invoices sent after the end of the Fiscal Year will not be considered for payment. Checks that have not been cashed after the end of the Fiscal Year will be voided and funds will be donated to the Dental Program to serve clients.
- Treatment Plans are approved contingent upon available State Funding for the current Fiscal Year at the time of treatment. Dentists shall only be paid for one Treatment Plan per Client per Fiscal Year with no revisions, except in the case of emergencies as determined by The Arc of Florida. Funding is generally provided one time per Fiscal Year. All Treatment Plans are subject to review by the Dental Program's Consultation Dentists. Clients must reapply each Fiscal Year.

**METHODS OF CONTACT:**

Billing Email: billing@arcflorida.org
Correspondence Email: dental@arcflorida.org (Best Contact)
Telephone: 855.322.6735 Fax: 850.921.0418
Mail: The Arc of Florida, Attn: Dental Services Program, 2898 Mahan Drive, Suite 1, Tallahassee, FL 32308

The Arc of Florida

# DENTAL PROVIDER FORM

Location 1 Name of Practice: _____

Practicing Doctors: _____

License Number: _____ License Exp. Date: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Fax: _____

Primary Business Contact: _____

Primary Contact Email: _____

Business Website: _____

Multiple Locations: YES ☐ NO ☐ If YES, please complete Section B on page 2 of this Form.

Are you specialized? Check all that apply: General ☐ Pediatric ☐ Oral/Maxillofacial Surgeon ☐

Orthodontics ☐ Endodontics ☐ Periodontics ☐ Dental School ☐ Dental Public Health Clinic ☐

Does your office offer Sedation? YES ☐ NO ☐

Have you worked with Individuals with Intellectual and/or Developmental Disabilities: YES ☐ NO ☐

Are you a Medicaid Managed Care Provider? YES ☐ NO ☐

If YES, please check Plan(s) accepted: MCNA ☐ Liberty ☐ DentaQuest ☐

If your office is Handicap Accessible and a Reduced Stimuli Environment, please check the Accessibility/Sensory Calming Features of the building:

Handicap Ramp ☐ Low Threshold Entrance (facilitates use of Walkers and other Mobility Devices) ☐

Hoyer Lift ☐ Hand Railing/Grab Bar ☐ Electronic Door Opener(s) ☐ Signs in Braille Format ☐

Low Lighting ☐ Low Noise ☐ Individual Exam Rooms ☐ Wheelchair Accessible Exam Rooms ☐

Wheelchair Accessible Restroom ☐ Handicap Parking Space(s) ☐

**PLEASE SUBMIT COMPLETED PACKET TO:**

Fax: 850.921.0418
Email: dental@arcflorida.org
Mail: The Arc of Florida
Attn: Dental Services Program
2898 Mahan Drive, Suite 1
Tallahassee, FL 32308

The Arc of Florida

# DENTAL PROVIDER FORM - MULTIPLE LOCATIONS

Location 2 Name of Practice: _____

Practicing Doctors (if different): _____

License Number (if different): _____ License Exp. Date: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Fax: _____

Primary Business Contact: _____

Primary Contact Email: _____

Business Website: _____

Multiple Locations: YES ☐ NO ☐ If YES, please complete Section B on page 2 of this Form.

Are you specialized? Check all that apply: General ☐ Pediatric ☐ Oral/Maxillofacial Surgeon ☐

Orthodontics ☐ Endodontics ☐ Periodontics ☐ Dental School ☐ Dental Public Health Clinic ☐

Does your office offer Sedation? YES ☐ NO ☐

Have you worked with Individuals with Intellectual and/or Developmental Disabilities: YES ☐ NO ☐

Are you a Medicaid Managed Care Provider? YES ☐ NO ☐

If YES, please check Plan(s) accepted: MCNA ☐ Liberty ☐ DentaQuest ☐

If your office is Handicap Accessible and a Reduced Stimuli Environment, please check the Accessibility/Sensory Calming Features of the building:

Handicap Ramp ☐ Low Threshold Entrance (facilitates use of Walkers and other Mobility Devices) ☐

Hoyer Lift ☐ Hand Railing/Grab Bar ☐ Electronic Door Opener(s) ☐ Signs in Braille Format ☐

Low Lighting ☐ Low Noise ☐ Individual Exam Rooms ☐ Wheelchair Accessible Exam Rooms ☐

Wheelchair Accessible Restroom ☐ Handicap Parking Space(s) ☐

**PLEASE SUBMIT COMPLETED PACKET TO:**

Fax: 850.921.0418
Email: dental@arcflorida.org
Mail: The Arc of Florida
Attn: Dental Services Program
2898 Mahan Drive, Suite 1
Tallahassee, FL 32308

The Arc of Florida

# DENTAL PROVIDER FORM - MULTIPLE LOCATIONS

Location 3 Name of Practice: _____

Practicing Doctors (if different): _____

License Number (if different): _____ License Exp. Date: _____

Address: _____

City: _____ State: _____ Zip: _____

County: _____ Phone: _____ Fax: _____

Primary Business Contact: _____

Primary Contact Email: _____

Business Website: _____

Multiple Locations: YES ☐ NO ☐ If YES, please complete Section B on page 2 of this Form.

Are you specialized? Check all that apply: General ☐ Pediatric ☐ Oral/Maxillofacial Surgeon ☐

Orthodontics ☐ Endodontics ☐ Periodontics ☐ Dental School ☐ Dental Public Health Clinic ☐

Does your office offer Sedation? YES ☐ NO ☐

Have you worked with Individuals with Intellectual and/or Developmental Disabilities: YES ☐ NO ☐

Are you a Medicaid Managed Care Provider? YES ☐ NO ☐

If YES, please check Plan(s) accepted: MCNA ☐ Liberty ☐ DentaQuest ☐

If your office is Handicap Accessible and a Reduced Stimuli Environment, please check the Accessibility/Sensory Calming Features of the building:

Handicap Ramp ☐ Low Threshold Entrance (facilitates use of Walkers and other Mobility Devices) ☐

Hoyer Lift ☐ Hand Railing/Grab Bar ☐ Electronic Door Opener(s) ☐ Signs in Braille Format ☐

Low Lighting ☐ Low Noise ☐ Individual Exam Rooms ☐ Wheelchair Accessible Exam Rooms ☐

Wheelchair Accessible Restroom ☐ Handicap Parking Space(s) ☐

**PLEASE SUBMIT COMPLETED PACKET TO:**

Fax: 850.921.0418
Email: dental@arcflorida.org
Mail: The Arc of Florida
Attn: Dental Services Program
2898 Mahan Drive, Suite 1
Tallahassee, FL 32308

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

# Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

**Give Form to the requester. Do not send to the IRS.**

**Print or type.** See **Specific Instructions** on page 3.

**1** Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

**2** Business name/disregarded entity name, if different from above

**3** Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

**Note:** Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

**4** Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

*(Applies to accounts maintained outside the U.S.)*

**5** Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

**6** City, state, and ZIP code

**7** List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

**Social security number**

| | | | – | | | – | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

**or**

**Employer identification number**

| | | – | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

**Sign Here** **Signature of U.S. person** ► **Date** ►

# General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments**. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

## Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See* What is backup withholding, *later.*

**The Arc of Florida, Inc.**
**BUSINESS ASSOCIATE AGREEMENT**
**Revised as of July 1, 2021**

THIS BUSINESS ASSOCIATE AGREEMENT (this "Agreement") is entered into as of the _____day of _____, 20___ (the "Effective Date") by and between The Arc of Florida, Inc, ("Covered Entity") and _____ ("Business Associate"), each individually a "Party" and collectively the "Parties."

The purpose of this Agreement is to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, Title XIII of the American Recovery and Reinvestment Act of 2009 (the "HITHCH Act") and associated regulations, as may be amended (collectively referred to as "HIPAA"), unless otherwise defined in this Agreement, capitalized terms have the meanings given in HIPAA. The Parties agree to comply with the requirements of HIPAA as follows.

I. Services. Covered Entity and Business Associate may have entered into an agreement (the "Services Agreement") under which Business Associate may create, receive, use, maintain or transmit Protected Health Information ("PHI") from or on behalf of Covered Entity in the course of providing certain services (the "Services") for Covered Entity. In the event of a conflict between the terms of the Services Agreement and this Agreement, this Agreement shall control. If there is no Services Agreement between the Parties, the Services shall include the following:

2. Relationship of the Parties. None of the provisions of this Agreement create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting this Agreement and any other agreements between the Parties evidencing their business relationship. Business Associate is an independent contractor, and not an agent of Covered Entity.

3. Permitted Uses and Disclosures. Business Associate may use and/or disclose PHI only as permitted or required by this Agreement, or as otherwise permitted by law. Business Associate may disclose PHI to, and permit the use of PHI by, its employees, contractors, agents, or other representatives only to the extent directly related to and necessary for the performance of the Services. Business Associate shall make uses and disclosures, and requests for all from Covered Entity, consistent with the minimum necessary to perform the Services, Business Associate shall not use or disclose PHI in a manner (i) inconsistent with Covered Entity's obligations under HIPAA, or (ii) that would violate HIPPA if disclosed or used in such a manner by Covered Entity. Business Associate may use PHI for the proper management and administration of Business Associate's business and to carry out its legal responsibilities in accordance with HIPPA.

4. Safeguards for the Protection of PHI. Business Associate warrants that Business Associate has implemented and will maintain appropriate safeguards to ensure that PHI obtained by or on behalf of Covered Entity is not used or disclosed by Business Associate in violation of this Agreement. Such safeguards shall be designed to protect the confidentiality and integrity of such shall be created, received, used, maintained or transmitted from or on behalf of Covered Entity. Security measures maintained by Business Associate to protect Electronic PHI shall include administrative safeguards, physical safeguards, and technical safeguards as necessary to protect such PHI as required by HIPAA. Upon request by Covered Entity, Business Associate shall provide a written description of such safeguards. Business Associate shall comply with HIPAA to the extent Business Associate is to carry out any of Covered Entity's obligations under HIPAA.

5. Reporting and Mitigating the Effect of Unauthorized Uses and Disclosures. If Business Associate has knowledge of any use or disclosure of PHI not provided for by this Agreement, then Business Associate shall promptly notify Covered Entity in accordance with Section 13. Business Associate shall establish and implement procedures and other reasonable efforts for mitigating, to the extent possible, any harmful effects arising from any improper use and/or disclosure of PHI of which it becomes aware, in the event Business Associate becomes unware of a Security Incident involving PHI ("Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in an information system), by itself or any of its agents or subcontractors, Business Associate shall notify Covered Entity in writing within three (3) calendar days, of such Security Incident. Business Associate shall identity the: (i) date of the Security Incident; (ii) scope of the Security Incident; (iii) Business Associate's response to the Security Incident; and (iv) identification of the party responsible for the Security Incident, if known. Covered Entity and Business Associate agree to act together in good faith to take reasonable steps to investigate and mitigate any harm caused by the Security Incident.

6. Data Breach Notification and Mitigation. Business Associate agrees to promptly notify Covered Entity of any "breach" of "unsecured PHI" as those terms are defined by HIPAA (hereinafter a "Data Breach"). Business Associate shall, following the discovery of a Data Breach, promptly notify Covered Entity and in no event later than three (3) calendar days after Business Associate discovers such Data Breach, unless Business Associate is prevented from doing so by HIPAA concerning law enforcement investigations. Such information shall include a brief description of the circumstances of the Data Breach, including the date of the Data Breach, date of discovery, and estimated number of individuals affected by the Data Breach. For purposes of reporting a Data Breach to Covered Entity, the discovery of a Data Breach shall occur as of the first day of which such Data Breach is known to Business Associate or, by exercising reasonable diligence, would have been known to Business Associate. Business Associate shall be considered to have had knowledge of a Data Breach if the Data Breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the Data Breach) who is an employee, officer or other agent of Business Associate. No later than seven (7) calendar days following the Data Breach, Business Associate shall provide Covered Entity with sufficient information to permit Covered Entity to comply with the Data Breach notification requirements set forth in HIPAA. Specifically, such information shall include but not be limited to Business Associate's risk assessment which conforms to the requirements of HIPAA, and shall include: (i) the nature and extent of the PHI involved (e.g., names, social security number, date of birth, address(es), account numbers of any type, disability codes, diagnosis

and/or billing codes and similar information), and the likelihood of re-identification; (ii) contact information for all individuals who were or who may have been impacted by the Data Breach (e.g., first and last name, mailing address, street address, phone number, email address); (iii) a detailed description of the circumstances of the Data Breach, and number of individuals affected by the Data Breach; (iv) the identity of the unauthorized person who used the PHI or to whom the disclosure was made; (v) whether the PHI was actually acquired or viewed by the unauthorized person; (vi) the probability that the impermissible use or disclosure did or did not compromise PHI; (vii) what Business Associate has done to mitigate harm to the individuals impacted by the Data Breach; (viii) a brief description of what Business Associate has done or is doing to protect against future Data Breaches; and (ix) contact information for a liaison appointed by Business Associate so that Covered Entity may ask questions and/or learn additional information concerning the Data Breach. Covered Entity shall be responsible for any required notification to the affected individuals within the time frames required by HIPAA. Any and all costs incurred by Covered Entity, including but not limited to any investigation and notification, shall be the sole responsibility of Business Associate. Business Associate accepts direct liability and any potential resulting penalties or any Data Breach, as detailed in HIPAA, as well as contractual liability as detailed in Section 12.2, of this Agreement. Following a Data Breach, Business Associate shall have a continuing duly to inform Covered Entity of new information learned by Business Associate regarding the Data Breach, including but not limited to the information described Above.

7. Use and Disclosure, of PHI by Subcontractors, Agents, and Representatives. Business Associate shall require any subcontractor, agent, or other representative that is authorized to create, receive, maintain, or transmit PHI on behalf of Business Associate to execute a business associate agreement to agree in writing to the same terms set forth herein. Business Associate shall terminate its business associate agreement with any subcontractor, agent or other representative if such subcontractor, agent or representative foils to abide by any material term of such agreement. Such Business Associate Agreement shall identify Covered Entity as a third-party beneficiary with rights of contractual enforcement in the event of any HIPAA violations. Business Associate warrants that neither it nor its owners, directors, officers, agents, employees or subcontractors have been excluded from participating in Medicare, Medicaid or any other federal health care plan.

8. Individual Rights. Business Associate shall comply with the following individual rights requirements as applicable to PHI used or maintained by Business Associate:

8.1 Right of Access. Business Associate agrees to provide access to PHI maintained by Business Associate in a Designated Record Set, at the request of Covered Entity to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under HIPAA. Such access shall be provided by Business Associate in the time and manner designated by Covered Entity, including, where applicable, access by electronic means pursuant to HIPAA.

8.2 Right of Amendment. Business Associate agrees to make any amendment(s) to PHI maintained by Business Associate that Covered Entity directs or agrees to pursuant to HIPAA at the request of Covered Entity or an individual, and in the time and manner designated by Covered Entity.

8.3 Right to Accounting of Disclosures. Business Associate agrees to document such disclosures of PHI as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with HIPAA. Business Associate agrees to provide to Covered Entity or an individual, in the time and manner designated by Covered Entity, such information collected in order to permit Covered Entity to respond to a request by an individual for an accounting of disclosure of PHI in accordance with HIPAA.

9. Ownership of PHI. Covered Entity holds all right, title and interest in and to any and all PHI received by Business Associate from, or created or received by Business Associate on behalf of Covered Entity, and Business Associate does not hold, and will not acquire by virtue of this Agreement or by virtue of providing any services or goods to Covered Entity in the course of fulfilling its obligations pursuant to this Agreement, any right, title or interest in or to such PHI. Except as specified In this Agreement, Business Associate shall have no right to compile or distribute any statistical analysis or report utilizing such PHI derived from such PHI, any aggregate information derived from such PHI, or any other health and medical information obtained from Covered Entity.

10. Prohibition on Sale of PHI. Business Associate shall not sell PHI or receive any remuneration, direct or indirect, in exchange for PHI, except as expressly permitted by the Covered Entity.

11. Inspection of Books and Records. Business Associate shall make its internal practices, books, records, and policies and procedures relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of Covered Entity, available to the Federal Department of Health and Human Services ("HHS"), the Office of Civil Rights ("OCR"), or their agents or to Covered Entity for purposes of monitoring compliance with HIPAA. Such information shall be made available in a time and manner designated by Covered Entity, HHS or OCR. With reasonable notice, Covered Entity may audit Business Associate to monitor compliance with this Agreement. Business Associate shall cooperate with any monitoring of compliance detailed herein, will promptly correct any violation of this Agreement found by Covered Entity, HHS or OCR, and will certify in writing to the Covered Entity that the correction has been made. Covered Entity's failure to detect any unsatisfactory practice does not constitute acceptance of the practice or a wavier of Covered Entity's enforcement rights under this Agreement.

12. Term and Termination.

12.1 Term. Unless otherwise terminated pursuant to Section 12, the term of this Agreement shall be from the Effective Date through the date that all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

12.2 Termination for Breach by Either Party. If either Party determines that the other Party (the "Breaching Party") has breached a material term of this Agreement, the Reporting Party (the "Reporting Party") shall provide the Breaching Party with written notice, compliant with Section 13 of this Agreement, of the existence of the breach and shall provide the Breaching Party within fifteen (15) calendar days to cure breach to the responsible satisfaction of Reporting Party. Failure by the Breaching Party to cure the breach within the 15-day cure period shall be grounds for immediate termination of this Agreement and the Services Agreement.

12.3 Effect of Termination. Upon termination of this Agreement, Business Associate shall recover any PHI relating to this Agreement in possession or Business Associate and its subcontractors, agents, or representatives. Business Associate shall return to Covered Entity or destroy all such PHI plus all other PHI relating to this Agreement in its possession, and shall retain no copies. Business Associate agrees that all paper, film, or other hard copy media shall be shredded or destroyed such that it may not be reconstructed, and Electronic PHI shall be purged or destroyed. If Business Associate believes that it is not feasible to return or destroy the PHI as described above, Business Associate shall notify Covered Entity in writing. The notification shall include: (i) a written statement that Business Associate has determined that it is infeasible to return or destroy the PHI in its possession, and (ii) the specific reasons for such determination. If the Parties agree that Business Associate cannot feasibly return or destroy the PHI, Business Associate shall ensure that any and all protections, requirements and restrictions contained in this Agreement will be extended to any PHI retained after the termination or this Agreement, and that any further uses and/or disclosures will be limited to the purposes that make the return or destruction of the PHI infeasible. Business Associate agrees to comply with applicable Florida or federal law, which may require a specific period of retention, redaction, or other treatment of such PHI.

13. Notices. All notices and other communications required or permitted under this Agreement shall be sent by registered mail, return receipt requested, addressed to the signatories of this Agreement for each Party.

14. Indemnification. Business Associate shall indemnify, defend and hold harmless Covered Entity and its respective shareholders, directors, officers, members, managers, employees, and agents from and against all claims, actions, damages, judgments, losses, liabilities, fines, penalties, costs, or expenses (including without limitation reasonable attorney's fees, expert witness fees, consultant fees and costs of investigation, litigation or dispute resolution), resulting from or related to the acts or omissions of Business Associate or its employees, directors, officers, subcontractors, or agents in connection with the breach of any representations, duties and obligations of Business Associate under this Agreement. This indemnification obligation of Business Associate shall survive termination of this Agreement.

15. Injunctive Relief. Business Associate expressly acknowledges and agrees that the breach, or threatened breach, by it of any provision of this Agreement may cause Covered Entity to be irreparably harmed and that Covered Entity may not have an adequate remedy at law. Therefore, Business Associate agrees that upon such breach, or threatened breach, Covered Entity shall be entitled to seek injunctive relief to prevent Business Associate from commencing or continuing any action constituting such breach without having to post a bond or other security and without having to prove the inadequacy of any other available remedies. Nothing in this Section shall be deemed to limit or abridge any other remedy available to Covered Entity at law or in equity.

16. Miscellaneous. If any section of this Agreement is declared invalid, the remainder of the Agreement shall remain in force. The respective rights and obligations of the Parties under Sections 11, 12.3 and 15 shall survive termination of this Agreement indefinitely, and those other provisions of this Agreement that apply to rights or obligations of a Party, which continue or arise upon or after the termination of this Agreement shall survive the termination this Agreement. Any ambiguity in this Agreement shall be interpreted to permit compliance with HIPAA. In addition to HIPAA, the Parties shall comply with Florida law. This Agreement may be amended or modified only in a writing signed by both Parties. The Parties agree that they will negotiate amendments to this Agreement to conform to any changes in HIPAA as are necessary for the Parties to comply with the current requirements of HIPAA. In addition, if either Party believes in good faith that any provision of this Agreement fails to comply with the then current requirements of HIPAA or any other applicable legislation, such Party shall notify the other Party of its belief in writing. For a period of up to thirty (30) days, the Parties shall address in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Agreement fails to comply with HIPPA or any other applicable legislation, then either Party has the right to terminate this Agreement and the Services Agreement upon written notice to the other Party. This Agreement, and any claims arising from it shall be governed by and construed in all respects by the laws of the State of Florida. Venue for any notion commenced under this Agreement shall be Hillsborough County, Florida. In the event of any dispute over the terms of this Agreement, or their enforcement, the prevailing Party shall have its attorneys fees and costs (whether before trial, during trial, on appeal, or otherwise) paid by the other Party. Except as provided in Section 7, nothing express or implied in this Agreement is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors and permitted assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement as of the.Effective Date.

| | |
|---|---|
| The Arc of Florida, Inc. | [BUSINESS ASSOCIATE] |
| By:  | By: _____ |
| Alan Abramowitz | |
| Its: Chief Executive Officer | Its: |