ATTACHMENT A
SPECIAL APPROPRIATIONS AGREEMENT COVER
Public Entities

THIS AGREEMENT is hereby made between the State of North Carolina, Department of Health and Human Services, **Division of Mental Health, Developmental Disabilities and Substance Abuse Services** and **Guilford County** with an address at **301 West Market Street, Greensboro, NC 27402.**

This agreement consists of the following documents, which are incorporated herein by reference:

1. Attachment A - Special Appropriations Agreement Cover
2. Attachment B - General Terms and Conditions
3. Attachment C - Payment Request Form
4. Attachment D - Recipient Electronic Payment Form
5. Attachment E - W9 (Recipient to Attach)
6. Attachment F - Scope of Work
7. Attachment G - Reporting Requirements
8. Report 1 - Quarterly Status Report Template
9. Report 2 - State Grant Compliance Report Template
10. Report 3 - Schedule of Receipts and Expenditures Report Template
11. Report 4 - Program Activities and Accomplishment Report Template

Effective Date: **July 1, 2017**

Termination Date: **June 30, 2018**

State Financial Assistance Award Amount: **Two hundred fifty thousand dollars ($250,000)** State Appropriations

Scope of work: As provided in the Conference Committee Report for S.L. 2017-57, **Item #G-113, the recipient is provided funding for the development of a collaborative effort for rapid response teams to address opioid overdoses.**

Reporting Requirements: The Division has determined that this is a subaward for financial assistance. Financial Assistance Contracts are subject to the Uniform Administration of State Awards, Oversight and Reporting Requirements for recipient and subrecipients described in N.C. General Statue § 143C-6-23(d) and in 09 NCAC 03M.205.

(a) A non-governmental grantee who receives a combined $500,000 or more funds from all state agencies must continue to submit a single or program-specific audit prepared and completed in accordance with Generally Accepted Government Auditing Standards, also known as a Yellow Book audit, to Risk Mitigation and Audit Monitoring at NCGrantsReporting@dhhs.nc.gov **within 9 months** of the grantee's fiscal year end.

(b) DHHS encourages all of its non-governmental grantees that receive funds from other state agencies or DHHS divisions to contact their assigned contract monitor(s) to determine if year-end reports must be submitted for those particular grants/awards.

(c) North Carolina State agencies are exempt from the reporting requirements of this section. Local governments that have reporting requirements for the Local Government Commission are exempt. All others are not exempt and must adhere to the reporting requirements of this section.

1. Quarterly Reporting Requirements:
   Report 1 - Quarterly Status Report
2. End of Year Reporting (Final Quarterly Report) Requirements:
   Report 2 - State Grant Compliance Reporting

Report 3 - Schedule of Receipts and Expenditures
Report 4 - Program Activities and Accomplishment

3. Reporting Timeframes and Due Dates

Report Title	Reporting Period	Due Date
Quarterly Report 1	July 2017 - September 2017	November 13, 2017
Quarterly Report 2	October 2017 - December 2017	February 16, 2018
Quarterly Report 3	January 2018 - March 2018	May 18, 2018
Quarterly Report 4	April 2018 - June 2018	August 17, 2018
End of Year Report	July 2017 - June 2018	August 17, 2018

ATTACHMEMT B
GENERAL TERMS AND CONDITIONS

A. The failure of either party to insist in any one or more instances upon strict performance of any of the terms or provisions of this Agreement, or to exercise any option or election herein, shall not be construed as a waiver of such terms, provisions, option or election in the future. No waiver by any party of any one or more of its rights or remedies under this Agreement shall be deemed to be a waiver of any prior or subsequent rights or remedy hereunder or at law. All remedies afforded in this Agreement are cumulative and in addition to the various remedies available in law or in equity.

B. Choice of Law. The validity of this Agreement and any of its terms or provisions, as well as the rights and duties of the parties to this Agreement, are governed by the laws of North Carolina. The Recipient, by signing this Agreement, agrees and submits, solely for matters related to this Agreement, to the exclusive jurisdiction of the courts of North Carolina and agrees, solely for such purpose, that the exclusive venue for any legal proceedings shall be Wake County, North Carolina.

C. All notices permitted or required to be given by one Party to the other and all questions about the contract from one Party to the other shall be addressed and delivered to the other Party's Contract Administrator.

DEPARTMENT	RECIPIENT
Marjorie Donaldson Department of Health and Human Services (DHHS), Division of Budget & Analysis 2001 Mail Service Center Raleigh, N.C. 27699-2001 Telephone: 919 855-4860 Email: marjorie.donaldson@dhhs.nc.gov	Marty Lawing, County Manager 301 West Market Street, Greensboro, NC 27402 **Phone Number:** (336) 641-3383 **Mailing Address:** PO Box 3427, Greensboro NC 27402 Email:mlawing@myguilford.com

D. Availability of Funds. The parties to this contract agree and understand that the payment of the sums specified in this contract is contingent upon and subject to the availability of funds for this purpose.

E. Payment Provisions. Upon execution of this contract, the Recipient may request and, upon approval by the Agency, receive a single payment for amounts up to one hundred thousand dollars ($100,000). For grants-in-aid of more than one hundred thousand dollars ($100,000) payments will be paid in quarterly installments, consistent with G. S. 143C-6-21.

F. Effective Period: This contract shall be effective on **July 1, 2017** and shall terminate on **June 30, 2018.**

G. The Recipient shall comply with all laws, ordinances, codes, rules, regulations, and licensing requirements that are applicable to the conduct of its business, including those of federal, state, and local agencies having jurisdiction and/or authority.

H. The Recipient shall maintain its accounting records relating to the performance of the Services and this Agreement in accordance with generally accepted accounting procedures. Upon reasonable prior notice to Recipient, the Office of State Budget and Management may, during the term of this Agreement and for a period of up to six years following the expiration or termination for any reason of this Agreement, audit and copy such records.

I. Antitrust Laws. This Agreement is entered into in compliance with all State and Federal Antitrust laws.

J. Record Retention. The Recipient shall maintain all pertinent records for a period of five years or until all audit exceptions have been resolved, whichever is longer.

K. The State Auditor and Office of State Budget and Management shall have access to persons and records as a result of all contracts or State financial assistance entered into by State agencies or political subdivisions in accordance with General Statute 147-64.7. Additionally, as the State funding authority, the Department of Health and Human Services shall have access to persons and records as a result of all contracts or State financial assistance entered into by State agencies or political subdivisions.

L. Assignment. This Agreement or any interest therein shall not be assigned or transferred by the Contractor.

M. The term of this Agreement shall begin on the effective date described in Article I and shall terminate upon the earlier of (1) completion of all required services, or (2) an earlier termination as provided for in paragraph B below.

N. Either Party may, upon sixty (60) days prior written notice to the other party, terminate all or any portion of this Agreement or the services required to be performed herein without cause.

O. The Department of Health and Human Services may, by written notice, immediately terminate all or any portion of this Agreement or the Services for cause in any of the following circumstances:

(1) Recipient breaches any obligation hereunder, or fails to make progress sufficient to assure performance of this Agreement or any of the Services;

(2) Recipient is adjudged insolvent or bankrupt; Contractor makes an assignment for the benefit of creditors; or the appointment of a receiver, liquidator or trustee of any of Contractor's property or assets.

P. Neither party shall be liable, or deemed to be in default, for any delay, interruption or failure in performance under this Agreement resulting directly or indirectly from acts of God, acts of civil or military authority; fires, floods; accidents, explosions, earthquakes, strikes or labor disputes, loss or interruption of electrical power or other public utility, or delays in transportation or any cause beyond its reasonable control.

Q. Signature Warranty: The undersigned represent and warrant that they are authorized to bind their principals to the terms of this agreement.

Signatures follow on the next page

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed.

Department of Health and Human Services: By: _____

_____ _____

(Date) Signature Authority Name/Title

Guilford County By:_____

_____ _____

(Date) Signature Authority Name/Title

ATTACHMENT C

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
SPECIAL APPROPRIATION (SA)
Payment Request Form

I. **Recipient Information** *(Make sure information is complete & accurate)*

A. Recipient: **Guilford County**

B. Address: *(Complete Mailing, including suite if applicable)*

_____

C. City_____State_____Zip_____

D. Contact's Name: **Marty Lawing**
Position in Organization: _____

E. Phone No: (_ _ _) _ _ _ - _ _ _ _

II. **Payment Allocation**

A. SFY **2018** Amount: $_____

B. Amount Request this Payment: $_____

C. Funds Requested to Date: $_____

D. SA Balance (if applicable): $_____

F. Kind of Organization:

Corporation	☐	Trust	☐
Government	☐	Unincorporated Association	☐
Partnership	☐	Other	☐

G. Purpose: **As provided in the Conference Committee Report for S.L. 2017-57, Item #G-113, the recipient is provided funding for the development of a collaborative effort for rapid response teams to address opioid overdoses.**

III. Period Ending: (check one)

One-time payment	☐	(Jul-Sept)	☐
Semi-annual (Jan-Jun)	☐	(Oct-Dec)	☐
Semi-annual (Jul-Dec)	☐	(Jan-Mar)	☐
		(Apr-Jun)	☐

IV. Match Required (check one): Yes ☐ No ☐ On a _____ to _____basis.

If matching required, is cash match in hand? Yes ☐ No ☒

If match not on hand, by what date and from what source does the recipient expect to have the cash match?

_____

_____

V. ***Certification: Under penalty of law, I hereby certify to the best of my knowledge and belief, the above information is correct; expenditures will be properly documented, and will be valid expenditures of actual receipts; and that the financial assistance will be in full compliance with G.S. 143C-6-21 through G.S. 143C-5-23.*** **FORM MUST BE NOTARIZED**

_____	_____
Recipient Fiscal Officer or Other Official	Notary Public (Official Seal)
_____	_____
Printed Name	Printed Name
_____	_____
Date	Date

****

For DHHS Use Only

Recipient/Tax ID #: _____ Center: _____ Fiscal Year: _____

_____	_____
Department or Division Budget Officer Date	Department Official/Manager Date

RECIPIENT ELECTRONIC PAYMENT FORM - ATTACHMENT D

Office of the State Controller

Return to: OSC Support Services Center

Address: 1410 Mail Service Center
Raleigh, NC 27699-1410

Recipient Electronic Payment Form

Email: osc.support.services@osc.nc.gov
Telephone: 919-707-0795
Fax: 919-981-5561

☐ New Add Request

☐ Change Existing ePay Account

For your convenience and benefit, the State of North Carolina offers payees the opportunity to receive future payments electronically, rather than by check. Your payments will be deposited into the checking or savings account of your choice. In addition to having the money deposited electronically, you also will be notified of the deposit either by fax or by e-mail. The fax or e-mail will provide you with all the information that would normally be on your check stub. To receive payments electronically, you must complete this form, attach a voided check, and return via mail, e-mail, or fax to the information listed above.

PRINT the following information.		**FAX or E-MAIL ADDRESS for payment notification.** (Place a check mark in front of the method that you prefer.)	
Payee Name:		Required E-mail Address:	
Federal ID #/SSN #:		If you would like to receive remittances via fax, please check the box below. Otherwise remittances will be sent via E-mail.	
Payee Address for Applicable Accounts:		☐ FAX Number:	
Bank Name:		Print Name and Title:	
Bank Routing Number:		Contact Phone Number:	
☐ Checking Acct #:		☐ Savings Acct #:	

ATTACH VOIDED CHECK OR PROVIDE A BANK LETTER WITH ACH ROUTING/ACCOUNT INFO

I acknowledge that electronic payments to the designated account must comply with the provisions of U.S. law, as well as the requirements of the Office of Foreign Assets Control (OFAC). Check one of the following:

☐ I affirm that, regarding electronic payments the State of North Carolina may remit to the financial institution for credit to the account that I have designated, the entire payment amount is not subject to being transferred to a foreign bank account.

☐ I affirm that, regarding electronic payments the State of North Carolina may remit to the financial institution for credit to the account that I have designated, the entire payment amount is subject to being transferred to a foreign bank account. I understand that any electronic payments that may be remitted to me may be labeled with "IAT" as the standard entry class. I acknowledge that availability of funds credited to the account will be subject to my receiving financial institution's policies and procedures. I also understand that the remitting agency may elect to remit future payments to me via paper check instead of electronically.

I authorize the Office of the State Controller to initiate direct deposit entries each pay period, and if necessary, adjustments for any direct deposit entries in error, to the financial institution and account identified on the attached certification document. I understand and accept the conditions of participation in the direct deposit program. This authority will remain in effect until I cancel it in writing.

SIGNATURE:	DATE:

ATTACHMENT E
W9 (RECIPIENT TO ATTACH)

ATTACHMENT F
SCOPE OF WORK

Services, Objectives and Expected Results

Grantee Name:		***Guilford County***
Project/Activity Title:		***Opioid Overdose Rapid Response Team***
Period Covered:		**July 1 2017 through June 30, 2018**

Grant Award ($). These funds are to be utilized for (cite purpose as stated in Appropriation Bill or Conference Committee Report). In compliance with the requirements of G.S. 143C-6-23, The following is a description of activities and accomplishments to be undertaken by our organization using the provided state funding:

Grantee is to complete the following section:

As provided in the Conference Committee Report for S.L. 2017-57, Item #G-113, the recipient is provided funding for the development of a collaborative effort for rapid response teams to address opioid overdoses.

Grantee is to provide a general description of planned expenditures to serve as a guide for preparing an annual budget related to this award (add or delete categories if needed).

Expenditure Category	**Amount of Expenditure**
Employee Expenses (e.g. program related staffing):	**$**
Services/Contract Expenses (e.g. utilities, telephone, lease related expenses:	**$**
Goods Expenses (e.g. supplies and equipment):	**$**
Administrative Expenses (e.g. overhead and project management):	**$**
Other Expenses (Specify):	**$**
Total Expenses:	**$**

ATTACHMENT G
REPORTING REQUIREMENTS

Reporting Requirements: The Division has determined that this is a subaward for financial assistance. Financial Assistance Contracts are subject to the Uniform Administration of State Awards, Oversight and Reporting Requirements for recipient and subrecipients described in N.C. General Statue § 143C-6-23(d) and in 09 NCAC 03M.205.

(a) A non-governmental grantee who receives a combined $500,000 or more funds from all state agencies must continue to submit a single or program-specific audit prepared and completed in accordance with Generally Accepted Government Auditing Standards, also known as a Yellow Book audit, to Risk Mitigation and Audit Monitoring at NCGrantsReporting@dhhs.nc.gov **within 9 months** of the grantee's fiscal year end.

(b) DHHS encourages all of its non-governmental grantees that receive funds from other state agencies or DHHS divisions to contact their assigned contract monitor(s) to determine if year-end reports must be submitted for those particular grants/awards.

(c) North Carolina State agencies are exempt from the reporting requirements of this section. Local governments that have reporting requirements for the Local Government Commission are exempt. All others are not exempt and must adhere to the reporting requirements of this section.

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Quarterly Report 4	April 2018 - June 2018	August 17, 2018
End of Year Report	July 2017 - June 2018	August 17, 2018

QUARTERLY STATUS REPORT
REPORT 1: Please use this reporting template for each of the quarterly reports

Recipient Name:	
Recipient Tax ID #	
Project/Activity Title:	
Reporting Period (Quarter):	
Recipient's Fiscal Year End:	
Date of This Report:	
Preparer of This Report:	

1. Provide a brief description of the entity's mission, purpose, and governance structure.

2. Provide a brief description of the types of programs, services, and activities supported by State Fiscal Year 2017/2018 Special Appropriations.

3. Provide a summary of expenditures during the reporting period (quarter).

Expenditure Category	Amount of Expenditure
Employee Expenses (e.g. program related staffing):	**$**
Services/Contract Expenses (e.g. utilities, phone, lease):	**$**
Goods Expenses (e.g. supplies and equipment):	**$**
Administrative Expenses (e.g. overhead and project management):	**$**
Other Expenses (Specify):	**$**
Total Expenses:	**$**

4. **Provide the number of persons served by the programs, services, and activities supported by these funds, including the counties in which services are provided.**
5. Provide a summary of deliverables, outputs, and outcomes that demonstrate the impact and effectiveness of the programs, services, and activities supported by these funds.
6. Have there been any significant changes to the intended goals or Scope of Work during this reporting period (quarter)? If so, please provide an explanation here.

If there are any questions, please contact the state agency that provided your grant.

STATE GRANT COMPLIANCE REPORTING
REPORT 2: Please use this reporting template for the end of year report

1. Organization:	
Organization Name:	
Organization Tax ID #:	
Project/Activity Title:	
Reporting Period:	July 1, 2017 to June 30, 2018
Organization Fiscal Year End:	
Mailing Address (street, city, state, zip code):	
Phone Number (area code + number):	
Fax Number (area code + number):	
Contact Person:	
Contact Person Title:	
E-Mail Address:	

2. Preparer: [PLEASE INDICATE WHO PREPARED THIS INFORMATION BY CHECKING]		Employee		CPA/Accountant
Name of Preparer:				
Phone Number:				

3. Please provide a list of the Organization's Board Members. [ADD ADDITIONAL PAGES, IF NEEDED]	
Name of Board Member	**Board Member Title**

4. What restrictions are placed upon the grant by the grant award document? If the grant award document does not identify specific restrictions, please identify the intended use of the grant funds as included in the award document.

Restrictions:

5. Does the organization have a Conflict of Interest policy?		yes		no
6. Is the organization a for profit entity?		yes		no

7. Did the organization subgrant or pass down any funds to another organization?		yes		no
If yes, answer the following:				

a. Name of Subgrantee	b. Program Name	c. Amount Subgranted

8. Program Activities and Accomplishments:
Recipient must complete and submit a separate Program Activities and Accomplishments Report, detailing the program name, the original goals of each program, and a brief narrative of program accomplishments for each funded program. This information is required of all recipients of state funding in an amount greater than or equal to $25,000.

SCHEDULE OF RECIPTS AND EXPENDITURES

REPORT 3: Please use this reporting template for the end of year report

9. Organization:	
Organization Name:	
Organization Tax ID#:	
Organization Fiscal Year End:	
Mailing Address (street, city, state, zip code):	
Phone Number (area code + number):	
Fax Number (area code + number):	
Contact Person:	
Contact Person Title:	
E-Mail Address:	

a. Receipts		
Funding State Agency	**Grant Title**	**Total Receipts**

b. Expenditures	
Category	**Dollar Amount**
Personnel	
Contracted Services	
(a)Total Personnel/Contracted Srvcs Costs:	
Office Supplies & Materials	
Service Related Supplies	
(b)Total Supplies & Material Costs:	
Travel	
Communications & Postage	
Utilities	
Printing & Binding	
Repair & Maintenance	
Meeting/Conference Expense	
Employee Training (no travel)	
Classified Advertising	
In-State Board Meeting Expenses	
(c)Total Non-Fixed Operating Expense:	
Office Rent (Land, Buildings, etc.)	
Furniture Rental	
Equipment Rental (Phones, Computers, etc.)	
Vehicle Rental	
Dues & Subscriptions	
Insurance & Bonding	
Books/Library Reference Materials	
Mortgage Principal, Interest and Bank Fees	
(d)Total Fixed Charges & Other Expenses:	
Buildings & Improvements	
Leasehold Improvements	
Furniture/Non-Computer Equip., $500+ per item	
Computer Equipment/Printers, $500+ per item	
Furniture/Equip., under $500 per item	
(e)Total Property & Equipment Outlay:	
Purchase of Services	
Contracts with Service Providers	
Stipends/Scholarships/Bonuses/Grants	

(f)Total Services/Contracts:	
Food	
Other (provide description here): _____	
Other (provide description here): _____	
Other (provide description here): _____	
Other (provide description here): _____	
(g)Total Other Expenses:	
Total Expenditures (sum a through g)	

Unexpended cash balance (do <u>NOT</u> use with reimbursement grants)

Beginning of the year cash balance	
End of the year cash balance	

NOTE: If total receipts, expenditures, beginning or ending unexpended grant balance available for expenditures is $500,000 or more, an audit is required *by G.S. 143C-6-23.*

PROGRAM ACTIVITIES AND ACCOMPLISHMENTS REPORT
REPORT 4: Please use this reporting template for the end of year report

Recipient Name:	
Recipient Tax ID #	
Project/Activity Title:	
Recipient's Fiscal Year End:	
Date of This Report:	
Preparer of This Report:	

1. What were the original goals and expectations for the activity supported by this grant?

2. If applicable, how have those goals and expectations been revised or refined during the course of the project?

3. What has the activity accomplished with these grant funds? Please include specific information including facts and statistics to support conclusions and judgments about the activity's impact.

4. If the activity is a continuing one, briefly summarize future plans and funding prospects.

If there are any questions, please contact the state agency that provided your grant.