POLK COUNTY BOARD OF COMMISSIONERS

DATE: April 16, 2025
TIME: 9:00 a.m.
PLACE: Polk County Courthouse, Dallas, Oregon

THE LOCATION OF THIS MEETING IS ADA ACCESSIBLE. PLEASE ADVISE THE BOARD OF COMMISSIONERS AT (503-623-8173), AT LEAST 24 HOURS IN ADVANCE, OF ANY SPECIAL ACCOMMODATIONS NEEDED TO ATTEND OR TO PARTICIPATE IN THE MEETING VIRTUALLY.

PAGE: **AGENDA ITEMS**

1. **CALL TO ORDER AND NOTE OF ATTENDANCE**

2. **ANNOUNCEMENTS**

   (a) **Regular meetings of the Board of Commissioners are held on Tuesday and Wednesday each week. Each meeting is held in the Courthouse Conference Room, 850 Main Street, Dallas, Oregon. Each meeting begins at 9:00 a.m. and is conducted according to a prepared agenda that lists the principal subjects anticipated to be considered. Pursuant to ORS 192.640, the Board may consider and take action on subjects that are not listed on the agenda. The Board also holds a department staff meeting at 9:00am on every Monday in the Commissioners Conference Room at 850 Main Street, Dallas, Oregon.**

   (b) **A public meeting of the Budget Committee for Polk County will be held in the Main Conference Room, Polk County Courthouse, 9:00 a.m., on Tuesday, April 22, 2025. The purpose of the meeting is to discuss the budget for fiscal year July 1, 2025 to June 30, 2026 and to receive the budget message and document. The public meeting will continue on Wednesday, April 23, 2025. Additional time is reserved for public comment at 10:30 a.m. Wednesday, April 23, 2025. A copy of the budget document may be inspected or obtained on or after April 18, 2025 at the Board of Commissioners' Office, Polk County Courthouse, during regular business hours. This is a public meeting where deliberation of the Budget Committee will take place. Any person may appear at the meeting and discuss the proposed budget with the Budget Committee. Please advise the Board of Commissioners (503-623-9237) at least 24 hours in advance if you need special accommodations to attend or participate in the meeting virtually**

3. **COMMENTS (for items not on this agenda and limited to 3 minutes. We encourage all community members to engage with public comments to the Board of Commissioners. However, out of respect for our audience and a general sense of decorum please refrain from vulgar, threatening or inappropriate language.)**

4. **APPROVAL OF AGENDA**

5. **APPROVAL OF THE MINUTES FROM April 9, 2025**

6. **APPROVAL OF CONSENT CALENDAR**

7. **LIBERTY HOUSE UPDATE – Kameron Wolfer & Alison Kelley**

8. **REVISED TELE-WORKSITE/REMOTE WORK POLICY – Matt Hawkins**

CONSENT CALENDAR

a) **Polk County Contract No. 25-39 (Amendment 5 to 24-36), Oregon Health Authority (Rosana Warren, Behavioral Health)**

b) **Polk County Contract no. 25-44 (Amendment 2 to 15-169), Moda Health Plan, Inc**
c) **(Rosana Warren, Public Health)**

d) **Polk County Contract no. 25-45, Salem Health West Valley (Rosana Warren, Public Health)**

e) **Polk County Contract No. 25.42, Cigna Health & Life Insurance Company (Rosana Warren, Public Health)**

THE BOARD OF COMMISSIONERS WILL MEET IN EXECUTIVE SESSION PURSUANT TO ORS 192.660.

ADJOURNMENT

POLK COUNTY PUBLIC MEETINGS AND PUBLIC HEARINGS
GUIDELINE FOR CITIZENS

****

REGULAR MEETING AGENDA

Regular meetings of the Polk County Board of Commissioners convene at 9 a.m. each Wednesday morning. Any person wishing to bring a matter before the Board at one of these meetings may do so by mailing or delivering written notice, concisely describing the nature of the item, to the Board of Commissioners, Polk County Courthouse, Dallas, Oregon 97338, by noon on the preceding Thursday. Unless otherwise announced, meetings are held in the Main Conference Room of the Courthouse.

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APPEARANCE OF INTERESTED CITIZENS

The Board sets aside a time at each regular meeting for comment by the public on subjects not appearing on the Agenda. Individuals may come forward and make any statement they wish, but not to exceed three (3) minutes in length, except as is required to give concise answers to questions from Board members. If the subject will require a lengthier presentation, or merits inclusion as an item on the Agenda of a future meeting, the Board shall schedule it accordingly.

****

PUBLIC HEARING FORMAT
Land Use

1. Chairman opens hearing.
   a. Reading of hearing request or appeal statement.
   b. Call for abstentions (ex parte contact or conflict of interest).
2. County staff presents background, summary and its recommendation (20-minute limit).
3. Applicant (Appellant) presents his/her case (15-minute limit).
4. Public testimony. Note that all testimony and evidence must be directed toward the applicable factual and legal criteria as identified in the record and/or during this hearing. Do not repeat previous testimony. Simply note for the record that you are in agreement with that earlier testimony. Your time to present testimony is limited. FAILURE TO RAISE AN ISSUE IN THIS HEARING, IN PERSON OR BY LETTER, OR FAILURE TO PROVIDE ADEQUATE SPECIFICITY TO AFFORD THE BOARD AN OPPORTUNITY TO RESPOND TO THE ISSUE MAY PRECLUDE LATER APPEAL TO LUBA ON THAT ISSUE.
   a. Individuals in favor of the application or appeal.
   b. Individuals against the application or appeal. At the discretion of the Chairman, an attorney, consultant, or other designated representative of two or more individuals may be allowed the combined time for each represented individual who does not speak, not to exceed 20 minutes. The Chairman may require proof of designation.
5. Rebuttal by Applicant (Appellant) (10-minute limit).
6. Questions from Board (discussion limited to individuals questioned by the Board).
   a. Staff.
   b. Applicant (Appellant).
   c. Individuals testifying.
7. Chairman closes hearing and announces closing of Record.
8. Chairman announces date for deliberation and decision.
9. The Board's decision is deemed the final decision of Polk County. It may be appealed to LUBA within 21 days of its issuance in written form. The address and phone number of LUBA may be obtained from the Polk County Community Development Department and will also appear on the Notice of Decision which will be mailed to all persons who testify, submit comments, or print their name and address on the hearing attendance sheet at the back of the hearing room.

POLK COUNTY BOARD OF COMMISSIONERS
MINUTES April 9, 2025

1. CALL TO ORDER & ATTENDANCE

At 9:00 a.m., Commissioner Pope declared the meeting of the Polk County Board of Commissioners to be in session. Commissioner Gordon was present and Commissioner Mordhorst was absent.

Staff present: Greg Hansen, Administrative Officer
Morgan Smith, County Counsel
Matt Hawkins, Administrative Services Director

2. ANNOUNCEMENTS

Regular meetings of the Board of Commissioners are held on Tuesday and Wednesday each week. Each meeting is held in the Courthouse Conference Room, 850 Main Street, Dallas, Oregon. Each meeting begins at 9:00 a.m. and is conducted according to a prepared agenda that lists the principle subjects anticipated to be considered. Pursuant to ORS 192.640, The Board may consider and take action on subjects that are not listed on the agenda. The Board also holds a department staff meeting at 9:00 a.m. on every Monday in the Commissioners Conference Room at 850 Main Street, Dallas, Oregon.

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3. COMMENTS

None.

4. APPROVAL OF AGENDA

MOTION: COMMISSIONER GORDON MOVED, COMMISSIONER POPE SECONDED, TO APPROVE THE AGENDA.

BOTH VOTED YES.
MOTION PASSED BY VOTE OF THE QUORUM.

5. APPROVAL OF MINUTES OF April 2, 2025

MOTION: COMMISSIONER GORDON MOVED, COMMISSIONER POPE SECONDED, TO APPROVE THE MINUTES OF April 2, 2025.

BOTH VOTED YES.
MOTION PASSED BY VOTE OF THE QUORUM.

6. APPROVAL OF CONSENT CALENDAR

Commissioner Pope asked to remove item a) for discussion.

MOTION: COMMISSIONER GORDON MOVED THE CONSENT WITH THE REQUESTED CHANGES, COMMISSIONER POPE SECONDED, TO APPROVE THE CONSENT CALENDAR WITH THE REMOVAL OF ITEM A.

BOTH VOTED YES.
MOTION PASSED BY VOTE OF THE QUORUM.

Commissioner Pope wanted to talk about Polk County Contract No. 25-34, PacificSource Community Solutions and asked Greg Hansen, Administrative Officer, to provide background information and explain what this contract is for. Mr. Hansen explained what this contract is for, the dollar amount and what this is extending. Mr. Hansen stated that this is one of the main funding sources for Behavioral Health. Morgan Smith, County Counsel, stated that the original contract was signed by the Board back in January 2025, but was never signed by PacificSource due to some errors on their side and this is now the final, corrected version needed to be resigned. Commissioner Pope explained that CCO is a Coordinated Care Institution and explained what that meant for the record.

MOTION: COMMISSIONER GORDON MOVED, COMMISSIONER POPE SECONDED, TO APPROVE AND SIGN POLK COUNTY CONTRACT NO. 25-34.

BOTH VOTED YES.
MOTION PASSED BY VOTE OF THE QUORUM.

7. LENGTH OF SERVICE AWARDS – Matt Hawkins

The Polk County Board of Commissioners and staff recognized the following employees for their length of service:

- Todd Whitaker, 15 years of service
- Sidney Mulder, 10 years of service

8. PUBLIC HEARING – JURISDICTIONAL TRANSFER TO THE CITY OF INDEPENDENCE

At 9:09 a.m. Commissioner Pope stated that we were here to conduct a public hearing in regards to a Jurisdictional Transfer to the City of Independence and asked Darren Blackwell, Polk County Surveyor, to come and provide background information on this topic for them and for the record. Mr. Blackwell explained what this meant in regards to Polk County and how this could impact the public. Todd Whitaker, Public Works Director, provided some additional information with traffic impacts on Talmadge Road and is recommending that they hold off on making a final decision today. Morgan Smith stated that a final decision is not required today.

Commissioner Pope opened the public hearing to public comment at 9:11 a.m. and noted that no one was present to make comment nor was there anyone from the City of Independence.

Commissioner Pope opened the hearing to questions from the Board and he asked Mr. Whitaker and Mr. Blackwell to explain for the record what exactly this process is for to help the public better understand this process. Mr. Smith provided additional input on annexation and what that looks like for county roads to cities.

Commissioner Pope asked if they have any concerns on the Order or the verbiage. Mr. Hansen said that the Order should not be considered in the decision making and a modified one should be presented at a future date.

Commissioner Pope closed the public hearing at 9:29 a.m.

No decision was made today. Mr. Smith provided his recommended next steps for the Board and staff. Commissioner Pope recommended deferring the decision for three weeks from today.

9. RECLASSIFICATION OF AN EMPLOYEE

Matt Hawkins, Admin Services Director, is recommending the reclassification of a Road Maintenance Worker to a Heavy Equipment Operator. Should the reclassification be approved, it would be effective April 1, 2025 and would have a fiscal impact on the FY24-25 budget of approximately $3,200 including PERS contribution should it be for 12 months.

APPROVED BY CONSENSUS OF THE QUORUM.

The following items were approved by Motion under **5. APPROVAL OF CONSENT CALENDAR:**

a) Polk County Contract No. 25-34, PacificSource Community Solutions
(Rosana Warren, Health Services)

b) Polk County Resolution No. 25-07, In the matter of Community Dispute Resolution
(Greg Hansen, Administrative Officer)

There no need for an executive session and Commissioner Pope adjourned the meeting at 9:32 a.m.

POLK COUNTY BOARD OF COMMISSIONERS

Craig Pope, Chair

Jeremy Gordon, Commissioner

Lyle Mordhorst, Commissioner

Minutes: Nicole Pineda
Approved: April 16, 2025

Liberty House

Changing Hurt into Hope

Polk County Board of Commissioners

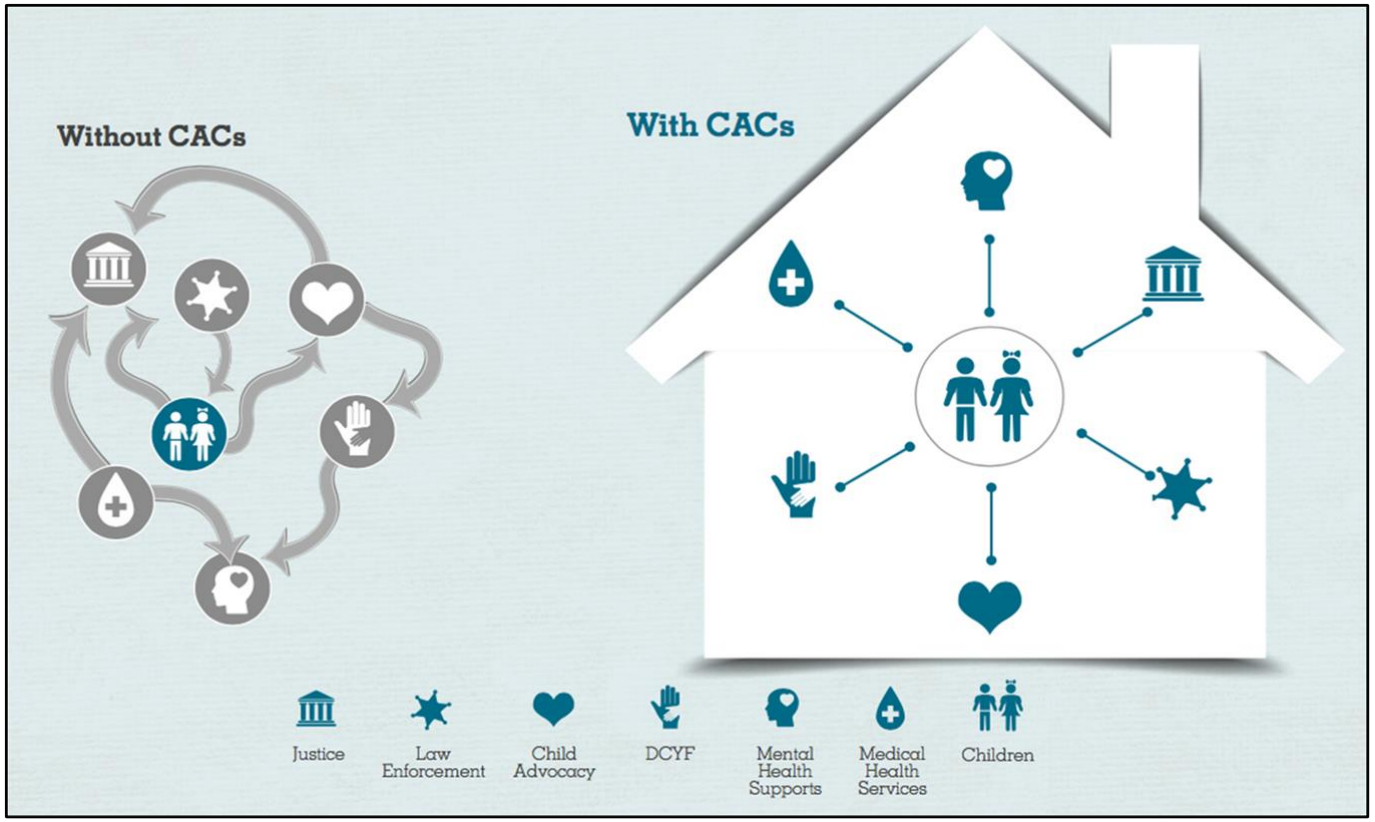
April 16, 2025

Liberty House

25 YEARS OF HEALING

The problem of child abuse

"Adverse childhood experiences are the single greatest unaddressed public health threat facing our nation today." – Dr. Robert Block, Former President of the American Academy of Pediatrics



- Lifelong physical and mental consequences if untreated
- Over 10,000 confirmed victims in Oregon annually
- Complex care requires many groups to respond

Responding to trauma from every angle

Excellence in the assessment, treatment, and prevention of child abuse, neglect, trauma, and grief in order to promote health and hope in children, youth, families and communities.

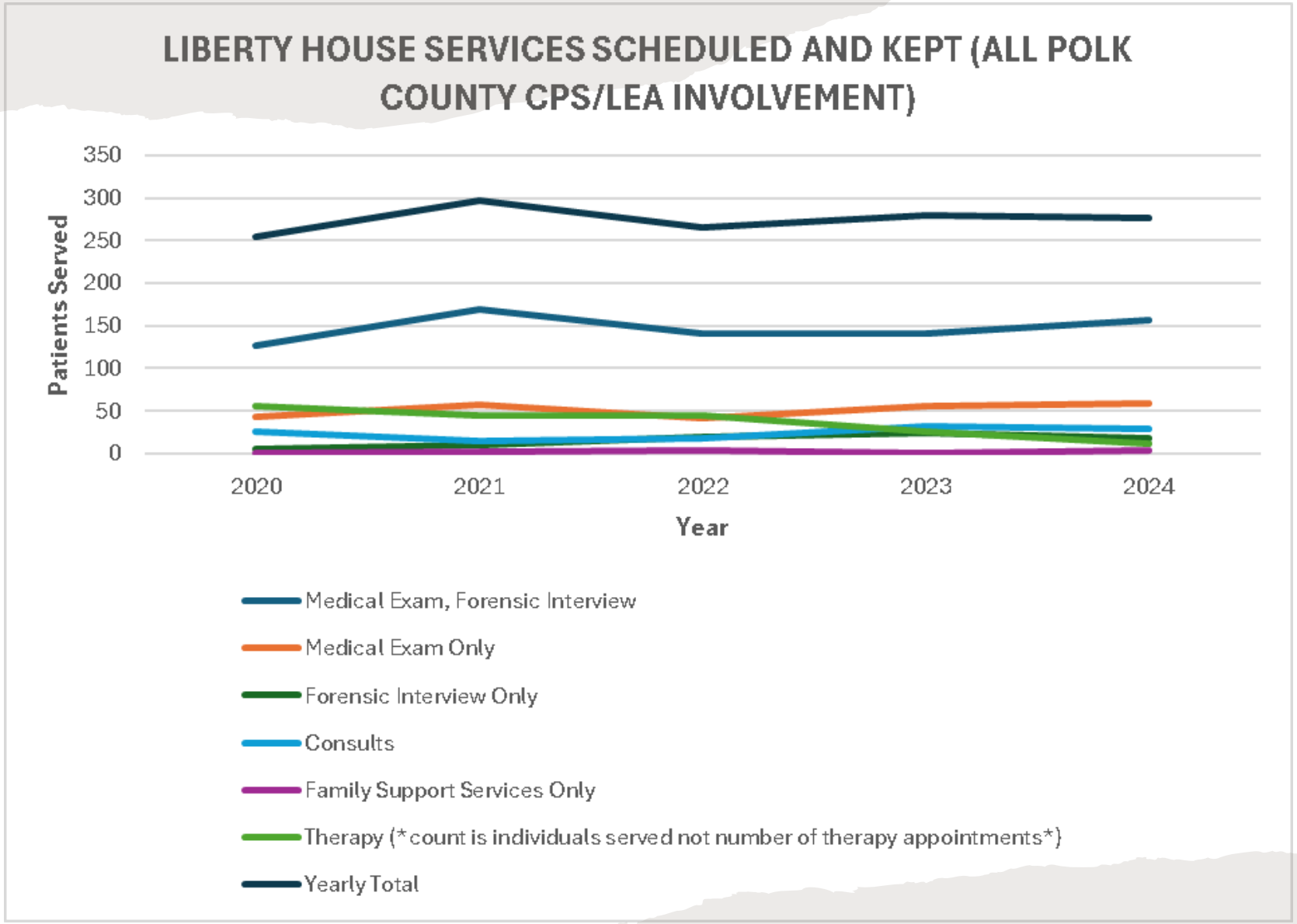
- **Child Abuse Assessment**
- **Mental Health Therapy**
- **Prevention Education**

Prevention Education

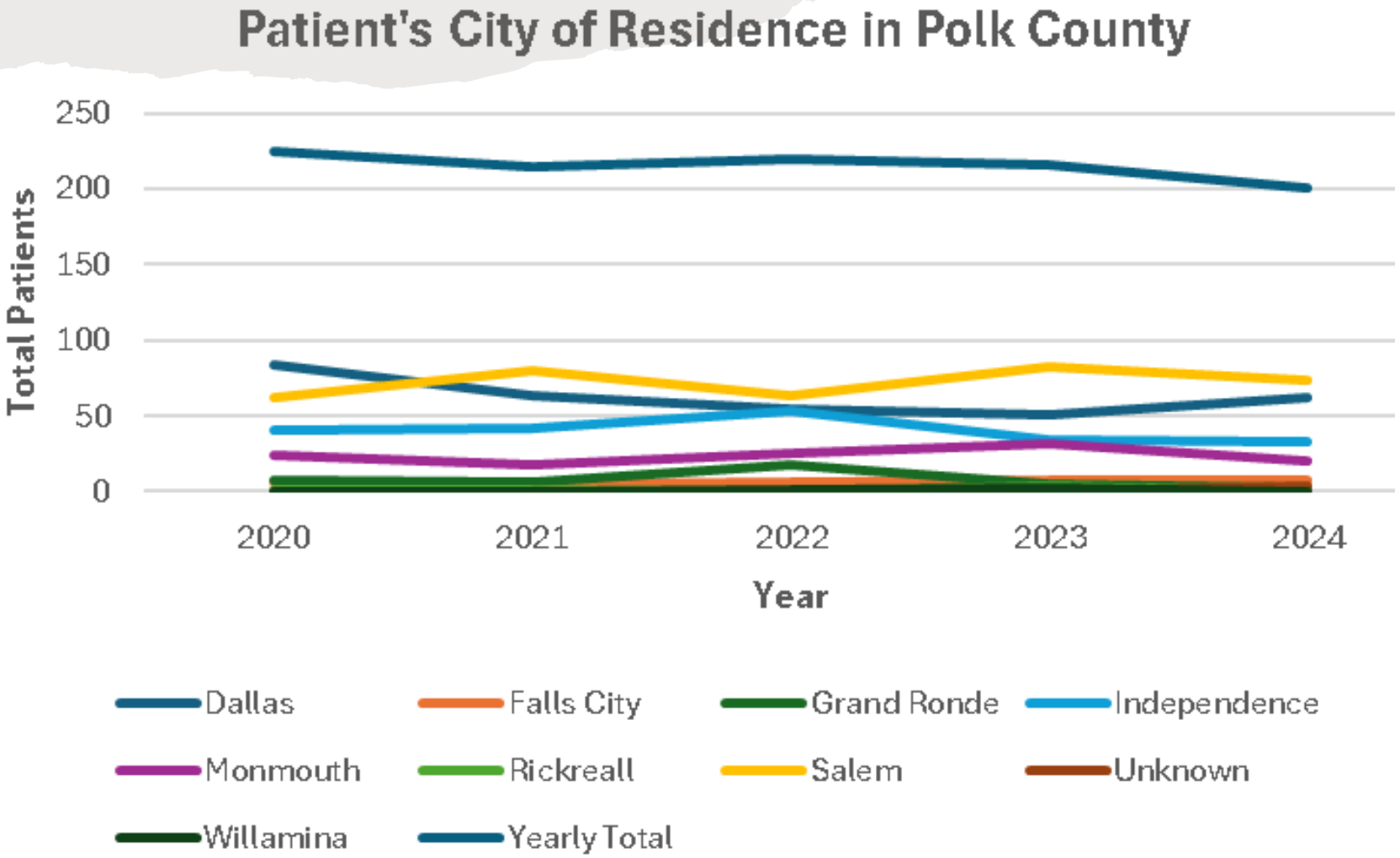
iRespect & Protect
Promoting You

iRespectAndProtect.com

Services for Polk County

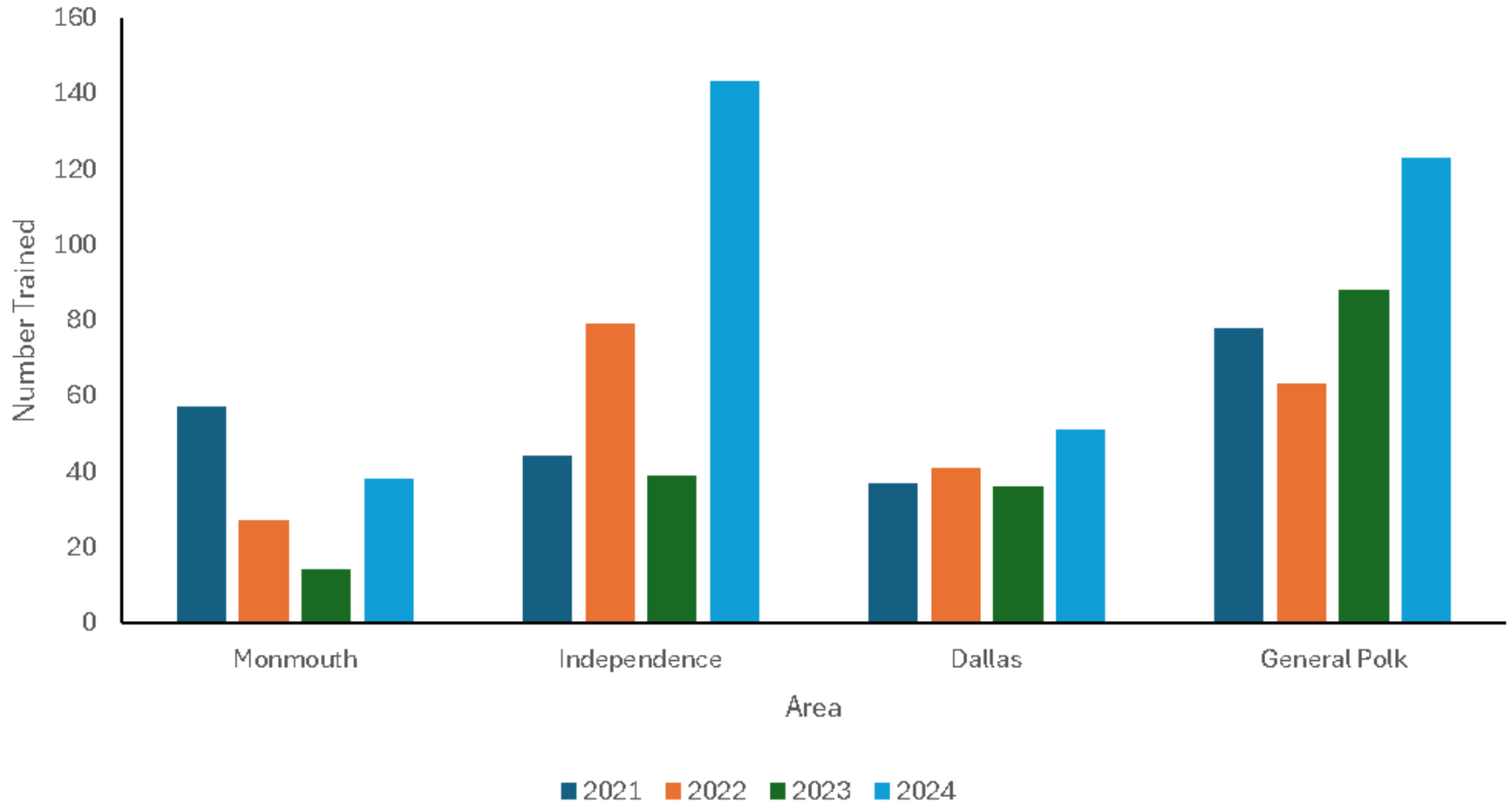


Services for Polk County



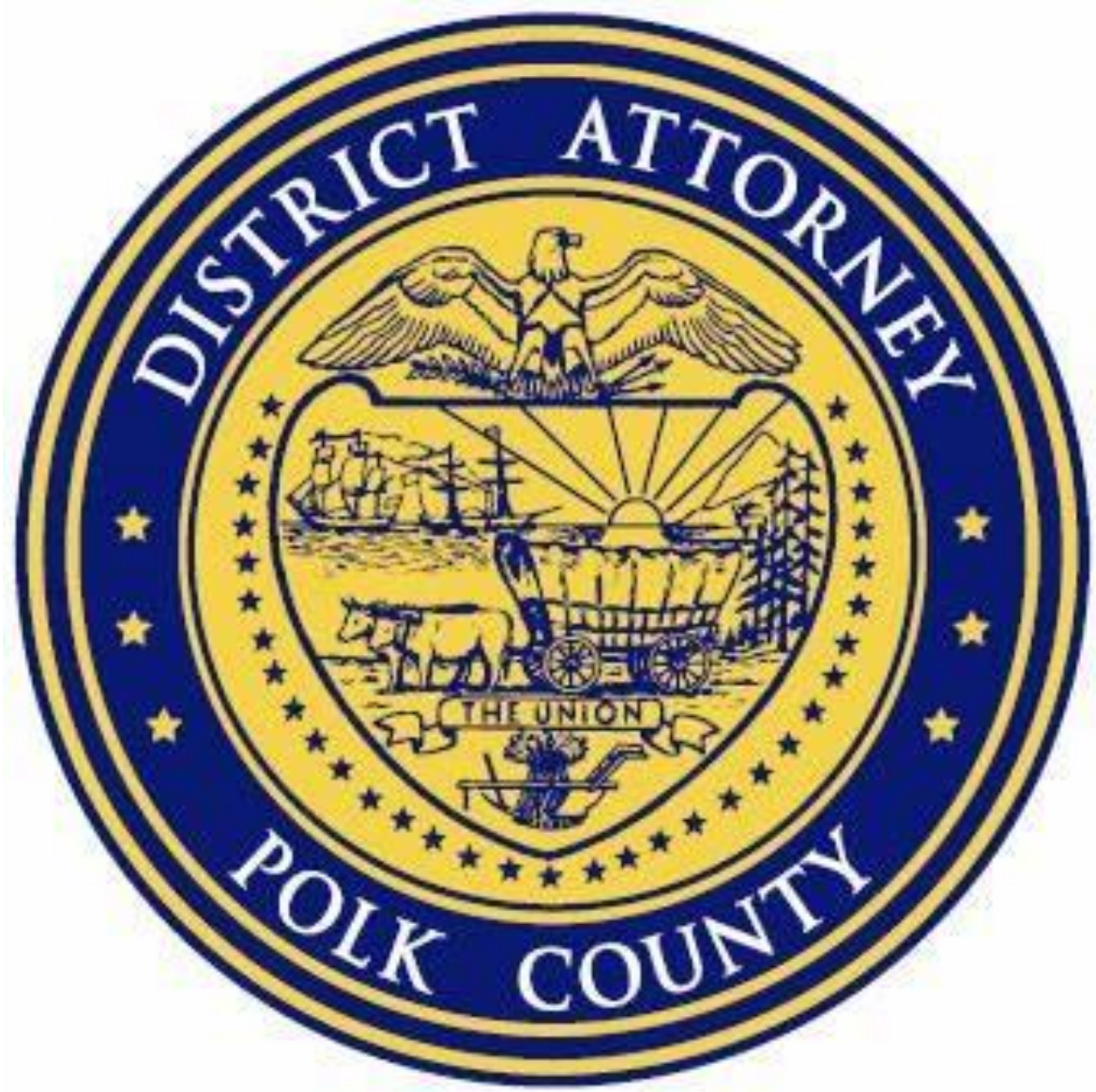
Liberty House Child Abuse Prevention

Community Education Numbers by Year



We are here to thank

For its leadership on the Polk County Child Abuse Multidisciplinary Team (MDT) and dedication in holding offenders accountable and keeping children in Polk County safe!



For the first time in 26 years……

Thank you for your investment!

Nearly **15,000** children, teens, and adults served since 1999!

Please reach out!

Liberty House
25 YEARS OF HEALING

Hope & Wellness SERVICES

iRespect & Protect

Backed by
National Children's Alliance®
Accredited Member

Alison Kelley
Chief Executive Officer
503-990-0915
akelley@libertyhousecenter.org

Kameron Wolfer
Assistant Deputy CEO
971-273-6666
kwolfer@libertyhousecenter.org

POLK COUNTY

HUMAN RESOURCES

POLK COUNTY COURTHOUSE ★ 850 MAIN STREET, DALLAS, OREGON 97338-3174
(503) 623-1888 ★FAX (503) 623-1889 EMAIL: HR@CO.POLK.OR.US

MEMORANDUM

TO: Board of Commissioners

FROM: Matt Hawkins, Administrative Services Director

DATE: April 11, 2025

SUBJECT: Revised Tele-Worksite/Remote Work Policy

Wednesday – April 16, 2025 (5 minutes)

RECOMMENDATION:

The Board approve the proposed recommendation for revisions to the tele-worksite/remote work policy.

ISSUE:

Shall the Board approve the above request for revisions to the tele-worksite/remote worksite plan for employees?

BACKGROUND:

In 2019 the County created a tele-worksite plan to put a policy into place to deal with employees that worked from home or away from the office on occasions. Over the years this policy was used to also address remote work for employees that were assigned to work from home on more than just an occasional basis. While we do not have many employees that utilize a mostly remote worksite, it is necessary for our policy to address these situations. The updates to this policy reflect that there is a difference between working a tele-worksite schedule and a remote worksite schedule.

We have also updated and created an application and agreement that all employees wishing to work at a tele-worksite or remote worksite will be required to fill out and go through an approval process with their department head and Human Resources.

OPTIONS:

1. Approve the new tele-worksite plan as currently written.
2. Approve the new tele-worksite/remote work policy with any recommended changes.
3. Deny approval of the recommended changes to the tele-worksite/remote work policy.

FISCAL IMPACT:

No Fiscal impact for FY 24-25.

Polk County
Tele-Worksite/Remote Work Plan

Purpose

Polk County recognizes that allowing employees to work at an alternate location can be a sound business practice which, when used appropriately, can reduce county operational costs, increase efficiency of work space, and improve employee efficiency, productivity and morale. This policy allows the County and employees flexibility in responding to employee and County business needs.

The County encourages the use of telework or remote work in situations where it will be to the mutual benefit of employees, the County and the County's stakeholders. Telework or remote work is not an employee benefit intended to be available to all county employees, rather, it is one work option used at the supervisor's and department head's discretion, such as flexible work schedules. The purpose of this policy is to define telework or remote work guidelines and procedures.

General Policy

An alternate worksite assignment is not a formal, universal employee benefit or a condition of employment, but rather an alternate method of meeting the needs of both the County and the employee. It is a voluntary arrangement and may be terminated by the employee or the County at any time. These agreements will be authorized by the Department Head with input from the ~~County Administrator and~~ Administrative Services Director based on the needs of the department and the costs and benefits to both the County, the employee involved, and the County's customers.

Commented [WH1]:

Definitions

Tele-worksite - a worksite that is at a location other than the central worksite, generally located in the employee's home, but upon mutual agreement may be at a location other than the employee's home.

Tele-worksite Agreement ("Agreement") - A mutually agreed upon work option between the County and the employee, where the employee performs work at a location other than the central worksite or regular office; from one to three days per week, with specified days and hours; and at the central worksite or regular office the remainder of the time, retaining flexibility as necessary to meet mutual needs and benefit of the work unit and its customers.

Central worksite or regular office - the traditional office or work place to which an employee is regularly assigned by the County.

Remote worksite – a worksite that is generally located in the employee's home, but upon mutual agreement may be at a location other than the employee's home.

Remote worksite Agreement ("Agreement") – A mutually agreed upon work option between the County and the employee, where the employee performs work at their home or a mutually agreed upon location; for the entirety of their work schedule, as long as it meets the mutual needs and benefit of the work unit and its customers.

Regular employee - a full or part-time (at least a .5 FTE) employee who has successfully completed his or her initial ~~probationary~~ trial service period(s).

Commented [WH2]:

Eligibility

A tele-worksite or remote work assignment may be considered:

1. Only when the principal duties of the employee may be performed at an alternative location.
2. When an employee is a regular employee with demonstrated successful work habits.
3. When a department may see a reduction to county costs and improve efficiency and productivity.
4. For temporary or modified jobs for injured or disabled workers.
5. For county employees during catastrophic events where the regular office is unavailable.
6. For other instances as approved by the Department Head with input from the ~~County Administrator and~~ Administrative Services Director.

Commented [WH3]:

Administration Procedures

1. Employee or supervisor expresses interest.
2. Department head and/or Human Resources reviews the job description to ensure that the duties may be performed at an alternative site.
3. Employee and supervisor complete "Tele-worksite/Remote Work Agreement" form.

4. Department head/elected official approve a tele-worksite or remote worksite after review and input from the ~~County Administrator and~~ Administrative Services Director.

Commented [WH4]:

5. Supervisor/employee implements Agreement. Additional equipment is purchased and installed.

6. Review of the Tele-worksite/Remote Work Agreement is completed as part of the employee's annual review for effectiveness of the agreement.

Duration, Work Hours, Accessibility

1. Work schedules including hours, overtime compensation, vacation, and sick time will be in compliance with standard county practice.

2. When working offsite, employees must maintain accessibility by the supervisor, co-workers, and customers. This may include specifying hours for phone accessibility in the Agreement.

3. Employees shall attend all job-related meetings, training sessions, and conferences as required.

4. Business visits, meetings with customers, or regularly scheduled meetings with co-workers shall NOT be held at the tele-worksite.

5. If an emergency closure of the regular office occurs, and work can be performed at the tele-worksite or remote worksite, employees are not excused from working. However, an employee may be excused or asked to return to the regular office if they experience tele-worksite or remote worksite ~~a~~ power outages or other similar work interruptions while at the tele-worksite or remote worksite. The supervisor must be notified of a power failure or other similar work interruption at the tele-worksite or remote worksite as soon as possible.

6. If an employee in a tele-worksite or remote worksite assignment completes all assigned work, the employee must notify ~~his/her~~ their supervisor. The supervisor may assign additional work to be completed at the tele-worksite or remote worksite or require the employee to return to the central worksite.

Equipment and Office Space

1. Furniture and equipment (other than ~~computer equipment used to connect to the County computer network~~ technology related hardware and software) for use in a tele-worksite or remote worksite assignment shall be provided by the employee, unless otherwise specified in the Agreement. The employee will be responsible for compliance with County standards.

2. The use of equipment, software, data, office supplies, and furniture when provided by the County for use at the tele-worksite or remote worksite is limited to authorized persons and for purposes related to County business. Personal use of such is prohibited and may result in termination of the Agreement and/or disciplinary action. The County will provide for repairs to County owned equipment and upgrades to County-owned software, except where concurrent use agreements prohibit the copying of software. ~~Departments must provide funding for tele- workspace hardware and software.~~

Commented [WH5]:

Commented [WH6]:

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3. Computers and equipment will be maintained by the County IT Department and County IT policies will apply to alternative work sites. Normal repair or maintenance work on computers will be performed at the County. Emergency repairs may be performed at the alternative work site as deemed appropriate by IT staff.

3.

4. To ensure hardware and software security, all software used in the tele-worksite assignment must be supplied and installed by the Information Technology department. Surge-protected power strips are required for County-owned computers and equipment. Other than a surge protector, all technology related hardware and software should be county issued. Any technical equipment for tele or remote work will be issued by the IT department with all costs approved and paid for by the requesting department. This includes desktops, laptops, monitors, mouse/keyboard, speakers, cameras, printers, hotspots and/or cell phones. No personal equipment may be connected to any County-issued equipment without specific approval from Polk County IS. The only exception this is a surge protector or battery backup, one of which is required.

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4. County Systems must only be connected to and accessed via county issued phones or hotspots. Use of any other wifi or internet connection is not permitted unless explicitly approved in advance by Polk County IS. Any changes to approved internet connections such as replacing a router must maintain or increase prior security levels.

5. Restricted access materials shall not be taken out of the office or accessed through the computer unless approved in advance by the supervisor. All work products, documents, or other records are the property of Polk County and are subject to department policies regarding confidentiality and authorized access.

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6. Should equipment become inoperable and repair or replacement of equipment is delayed or in any other circumstance under which it would be impossible for the employee to work at an tele-worksite or remote worksite, the employee may be assigned to do other work and/or required to return to the central worksite.

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7. The employee is responsible for any damage, loss, or theft of County property while it is in the care, custody and control of the employee, including damage from a power surge if no surge protector is used. The County is not responsible for damage, loss, or theft of any employee owned equipment.

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8. When the employee uses his or her own equipment, the employee is responsible for maintenance and repair of the equipment.

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Safety, Security, and Insurance

1. Employees who work at tele-worksite-s or remote worksites are responsible for maintaining proper health and safety standards in the tele-worksite or remote worksite as identified in the Health and Safety Standards Review form.

2. With a minimum of 24 hours notice, the County may conduct on-site visits to the employee's tele-worksite or remote worksite to ensure compliance with health and safety rules, and/or to conduct necessary maintenance, repair, or inspection of County equipment, and/or to retrieve County-owned property.

3. Employees working at tele-worksite-s or remote worksite are covered by workers compensation if the injury is found to arise out of and be within the scope of the Tele-worksite/Remote Work Agreement as well as the policies and collective bargaining agreements of Polk County. In the case of injury occurring during tele-worksite or remote worksite hours, the employee shall immediately report the injury to the supervisor and follow the Injured Worker Policy.

4. The employee remains liable for injuries to third persons and/or members of the employee's family on the employee's premises. Prior to beginning the tele-worksite or remote worksite assignment, the employee shall provide a copy of the declaration page for homeowners, renters, or other premise liability insurance policy covering the location to Risk Management. The employee is advised to contact his or her insurance agent for information regarding tele-worksite-s or remote worksite.

5. Individual tax implications related to tele-worksite-s or remote worksites shall be the responsibility of the employee. The employee is advised to contact a tax consultant for information regarding tele-worksite s.

Expenses

1. Travel between the tele-worksite and the regular office will not be reimbursed.
~~1.~~2. Travel between the remote worksite and the regular office will be reimbursed.

~~2.~~3. Equipment and supplies purchased for the tele-worksite or remote worksite will be reimbursed **only** if prior written approval is granted.

~~3.~~4. The cost of utilities at the tele-worksite or remote worksite will be paid by the employee. Work related telephone expenses may be reimbursed on a case by case basis. The employee must present an itemized telephone bill to his or her supervisor, along with an explanation justifying reimbursement.

Termination of the Tele-worksite/Remote Work **Agreement**

1. Tele-worksite and Remote Work assignments are voluntary; either the department or the employee may discontinue the arrangement at any time, usually providing at least two weeks notice.

2. Employees remain obligated to comply with all County rules, policies, contracts, practices, and instructions. Violation of such may result in termination of the tele-worksite Agreement and/or disciplinary action, up to and including termination of employment.

Adopted 1/19
Revised~~3~~4/25

Tele-Worksite/Remote Work Application and Agreement

Employee Information

Employee Name	
Position	
Supervisor's Name	
Department	
Work Phone	
Work Email	

Application for: Tele-Worksite Remote

Telework Location & Schedule

This Agreement will be effective: _____ to _____

My primary telework/remote location will be: _____

Address

_____

City, State, Zip Code

Schedule

Use the following chart to describe your anticipated work schedule:

Day	Work Hours	Lunch Time	Break Times	Total Hours Worked Per Day
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Tele-Worksite/Remote Work Application and Agreement

If the employee is required to come into the central worksite on a tele-worksite/remote work day, may another day be substituted?

Yes No

*Advance Supervisory Approval is Required to Vary Schedule

Equipment

Equipment *(List county-owned equipment only)*	**Identification Number**
Phone	
Laptop	
Printer	
Hotspot	
Other (*specify):*	
Other (*specify):*	
Other (*specify):*	

Tele-Worksite/Remote Work Tasks

Describe duties and expected results/performance measures.

Tele-Worksite/Remote Work Application and Agreement

Communication **(applies to Tele-Worksite applications only)**

Will call forwarding be utilized?

How will incoming calls to the central site by handled?

How many days will the employee call the central worksite to obtain messages?

Other Arrangements

List any additional conditions agreed upon by the Employee and Supervisor.

_____

_____

_____

We have read and understand both the Tele-Worksite/Remote Work policy and this Agreement. We agree to abide by and operate in accordance with the terms and conditions therein. We agree that the sole purpose of this agreement is to regulate work while at a tele-worksite/remote work and that it neither constitutes an employment contract nor an amendment to any existing contract. A tele-worksite/remote work assignment is not to be considered a benefit of employment. We understand and agree that this arrangement may be discontinued by either the Department or the employee at any time.

Signatures

Employee: _____ Date: _____

Supervisor: _____ Date: _____

Department Head: _____ Date: _____

IS Director: _____ Date: _____

Administrative Services Director: _____ Date: _____

Approved Denied

Adopted 1/19

Revised

CONTRACT REVIEW SHEET

Staff Contact: Rosana Warren | Phone Number (Ext): 2550

Department: Health Services: Behavioral Health | Consent Calendar Date: April 16, 2025

Contractor Name: Oregon Health Authority

Address: 635 Capitol St NE Suite 350

City, State, Zip: Salem, OR 97301

Effective Dates - From: January 01, 2025 | Through: June 30, 2025

Contract Amount: $24,306.98

Background:

Oregon Health Authority provides funds to finance Community Mental Health, Addiction Treatment, Recovery & Prevention and Problem Gambling services. This is the fifth amendment to the initial award from the state as IGA 026022. This award may be modified from time-to-time throughout the calendar year to reflect changes to funds and/or programs that are made a part of the grant.

Discussion:

This fifth amendment awards one time flex funding to Service Element 4 for Aid and Assist services specific to housing related needs, in an effort to address the barriers and shortages of available residential beds.

Fiscal Impact:

The total amount awarded for this amendment is $24,306.98 for FY25. Funds to be disbursed in equal installments for the remainder of FY25. These funds were not expected at the time of the budget process and will be used to offset current services.

Recommendation:

It is recommended that Polk County sign the fifth amendment to IGA 026022 with the Oregon Health Authority.

Copies of signed contract should be sent to the following:

Name: Rosana Warren | E-mail: hs.contracts@co.polk.or.us

Name: | E-mail:

In compliance with the Americans with Disabilities Act, this document is available in alternate formats such as Braille, large print, audio recordings, Web-based communications, and other electronic formats. To request an alternate format, please send an e-mail to dhs-oha.publicationrequest@odhsoha.oregon.gov or call 503-378-3486 (voice) or 503-378-3523 (TTY) to arrange for the alternative format.

AGREEMENT # PO-44300-00026022

FIFTH AMENDMENT TO OREGON HEALTH AUTHORITY 2024-2025 INTERGOVERNMENTAL AGREEMENT FOR THE FINANCING OF COMMUNITY MENTAL HEALTH, ADDICTION TREATMENT, RECOVERY, & PREVENTION, AND PROBLEM GAMBLING SERVICES

This **Fifth** Amendment to Oregon Health Authority 2024-2025 Intergovernmental Agreement for the Financing of Community Mental Health, Addiction Treatment, Recovery, & Prevention, and Problem Gambling Services effective as of January 1, 2024 (as amended, the "Agreement"), is entered into, as of the date of the last signature hereto, by and between the State of Oregon acting by and through its Oregon Health Authority ("OHA") and **Polk County** ("County").

RECITALS

WHEREAS, OHA and County wish to modify the Financial Assistance Award set forth in Exhibit C of the Agreement.

NOW, THEREFORE, in consideration of the premises, covenants and agreements contained herein and other good and valuable consideration the receipt and sufficiency of which is hereby acknowledged, the parties hereto agree as follows:

AGREEMENT

1. The financial and service information in the Financial Assistance Award is hereby amended as described in Attachment 1 attached hereto and incorporated herein by this reference. Attachment 1 must be read in conjunction with the portion of Exhibit C of the Agreement that describes the effect of an amendment of the financial and service information.

2. Capitalized words and phrases used but not defined herein shall have the meanings ascribed thereto in the Agreement.

3. County represents and warrants to OHA that the representations and warranties of County set forth in section 4 of Exhibit F of the Agreement are true and correct on the date hereof with the same effect as if made on the date hereof.

4. Except as amended hereby, all terms and conditions of the Agreement remain in full force and effect.

5. This Amendment may be executed in any number of counterparts, all of which when taken together shall constitute one agreement binding on all parties, notwithstanding that all parties are not signatories to the same counterpart. Each copy of this Amendment so executed shall constitute an original.

IN WITNESS WHEREOF, the parties hereto have executed this amendment as of the dates set forth below their respective signatures.

6. Signatures.

Polk County
By:

Authorized Signature	Printed Name	Title	Date

State of Oregon, acting by and through its Oregon Health Authority
By:

Authorized Signature	Printed Name	Title	Date

Approved by: Director, OHA Health Systems Division
By:

Authorized Signature	Printed Name	Title	Date

Approved for Legal Sufficiency:

Exempt per OAR 137-045-0050(2)

Oregon Department of Justice Date

ATTACHMENT 1

EXHIBIT C
Financial Pages

MODIFICATION INPUT REVIEW REPORT

MOD#: **M1069**
CONTRACT#: **026022** CONTRACTOR: POLK COUNTY
INPUT CHECKED BY: _____ DATE CHECKED: _____

SE#	FUND	PROJ CODE	CPMS PROVIDER	EFFECTIVE DATES	SLOT CHANGE/TYPE	RATE	OPERATING DOLLARS	STARTUP DOLLARS	PART ABC	PART IV	PAAF CD	BASE	CLIENT CODE	SP#
FISCAL YEAR: 2024-2025														
	BASE	AID & ASSIST PROJECT												
4	804	AAP		1/1/2025 - 6/30/2025	0 /NA	$0.00	$24,306.98	$0.00	A	1	N			
				TOTAL FOR SE# 4			$24,306.98	$0.00						
				TOTAL FOR 2024-2025			$24,306.98	$0.00						
				TOTAL FOR M1069 026022			**$24,306.98**	**$0.00**						

OREGON HEALTH AUTHORITY
Financial Assistance Award Amendment (FAAA)

CONTRACTOR: POLK COUNTY Contract#: 026022
DATE: 03/12/2025 REF#: 007

REASON FOR FAAA (for information only):

Aid and Assist Client Services (MHS 04) funds have been awarded to cover housing related needs beginning January 1, 2025. County must complete and submit a monthly Flex Funding CMHP Reporting Template that was provided to CMHPs by Behavioral Health program staff to HSD.Contracts@odhsoha.oregon.gov by the last day of the month following the reporting period. OHA will review this report to determine whether funds are spent in accordance with eligible expense listed on the reporting form such as rental assistance, eviction protection and utility assistance.

CONTRACT REVIEW SHEET

Staff Contact: Rosana Warren | Phone Number (Ext): 2550

Department: Health Services: Public Health | Consent Calendar Date: April 16, 2025

Contractor Name: Cigna Health and Life Insurance Company

Address: 920 5th Avenue, Suite 1350

City, State, Zip: Seattle, WA 98104

Effective Dates - From: April 01, 2025 | Through: EVERGREEN

Contract Amount: $ Varies

Background:

OHA has awarded funding through PE63 to Polk County Public Health to provide Family Connect services. The Family Connects program is available to all expectant mothers in Polk County regardless of their ability to pay. To ensure access, Polk County is seeking to establish service rate agreements with commercial insurance providers. One such provider is Cigna Health and Life Insurance Company.

Discussion:

This Agreement with Cigna Health and Life Insurance Company establishes an in-network service relationship for home visiting services provided through Polk County Public Health's Family Connects program to its members. Rates were negotiated by the Health Services Finance Officer and cover the costs of the service encounters.

Fiscal Impact:

The amount varies as it is dependent on the number of Cigna clients served. It is anticipated that there will be a positive impact as there is increased ability to seek revenue from this provider's members.

Recommendation:

It is recommended that Polk County sign this Agreement with Cigna Health and Life Insurance Company.

Copies of signed contract should be sent to the following:

Name: Rosana Warren | E-mail: hs.contracts@co.polk.or.us

Name: | E-mail:

Name: | E-mail:

Ancillary Services Agreement

This Ancillary Services Agreement ("Agreement") is between Cigna Health and Life Insurance Company ("Cigna") and Polk County ("Provider") and is effective upon Cigna's execution and implementation of the Agreement into its administrative systems. Provider will be notified of the Effective Date via Cigna's return of the signed contract to Provider, and will be indicated in the space below.

Effective Date: April 1, 2025

SECTION 1. DEFINITIONS

1.1 Administrative Guidelines
means the rules, policies and procedures adopted by Cigna or a Payor to be followed by Provider in providing services and doing business with Cigna and Payors under this Agreement.

1.2 Benefit Plan
means a certificate of coverage, summary plan description or other document or agreement which specifies the health care services to be provided or reimbursed for the benefit of a Participant.

1.3 Cigna Affiliate
means any subsidiary or affiliate of The Cigna Group.

1.4 Coinsurance
means a payment that is the financial responsibility of the Participant under a Benefit Plan for Covered Services that is calculated as a percentage of the contracted reimbursement rate for such services or, if reimbursement is on a basis other than a fee-for-service amount, as a percentage of a Cigna determined fee schedule or as a Cigna determined percentage of actual charges.

1.5 Copayment
means a payment that is the financial responsibility of the Participant under a Benefit Plan for Covered Services that is calculated as a fixed dollar amount.

1.6 Covered Services
means those health care services for which a Participant is entitled to receive coverage under the terms and conditions of the Participant's Benefit Plan.

1.7 Deductible
means a payment for Covered Services calculated as a fixed dollar amount that is the financial responsibility of the Participant under a Benefit Plan prior to qualifying for reimbursement for subsequent health care costs under the terms of a Benefit Plan.

1.8 Medically Necessary/Medical Necessity

means services and supplies that satisfy the Medical Necessity requirements under the applicable Benefit Plan. No service is a Covered Service unless it is Medically Necessary.

1.9 Participant
means any individual, or eligible dependent of such individual, whether referred to as "Insured", "Subscriber", "Member", "Participant", "Enrollee", "Dependent", or similar designation, who is eligible and enrolled to receive Covered Services, or who is a continuing care patient as defined by applicable federal law.

1.10 Participating Provider
means a hospital, physician or group of physicians, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide Covered Services with regard to the Benefit Plan covering the Participant.

1.11 Payor
means the person or entity obligated to a Participant to provide reimbursement for Covered Services under the Participant's Benefit Plan and which Cigna has agreed may access services under this Agreement. Cigna is the Payor only for Covered Services under an insurance policy or HMO contract issued by a Cigna company.

1.12 Quality Management
means the program described in the Administrative Guidelines relating to the quality of Covered Services provided to Participants.

1.13 Utilization Management
means a process to review and determine whether certain health care services provided or to be provided are Medically Necessary and in accordance with the Administrative Guidelines.

SECTION 2. DUTIES OF PROVIDER

2.1 Provider Services
Provider shall provide Covered Services to Participants upon the terms and conditions set forth in this Agreement and the Administrative Guidelines. All services provided by Provider within the scope of Provider's practice or license must be provided on a participating basis. Regardless of Provider's physical location, all aspects of Provider's practice are participating under the terms of this Agreement unless Covered Services are provided under the terms of another applicable Cigna participation agreement.

2.2 Standards
Provider shall provide Covered Services with the same standard of care, skill and diligence customarily used by similar providers in the community, the requirements of applicable law, and the standards of applicable accreditation organizations. Provider shall provide Covered Services to all Participants in the same manner, under the same standards, and with the same time availability as offered to other patients. Provider shall not differentiate or discriminate in the treatment of any Participant because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age,

health status, veteran's status, handicap or source of payment. Provider shall assure that all health care providers who perform any of the services for which Provider is responsible under this Agreement maintain all necessary licenses or certifications required by state and federal law. Provider shall immediately restrict, suspend, or terminate any such health care provider from providing services to Participants under this Agreement if such provider ceases to meet the licensing/certification requirements or other professional standards described in this Agreement.

2.3 Insurance/Application for Participation Information

Provider shall maintain general and professional liability coverage in a form and amount acceptable to Cigna, give Cigna evidence of such coverage upon request and provide Cigna with immediate written notice of a material modification or termination of such insurance. Provider shall also notify Cigna in writing within 30 days of any material change in the information contained in Provider's application for participation with Cigna.

2.4 Administrative Guidelines

Provider shall comply with the Administrative Guidelines. Some or all Administrative Guidelines may be communicated in the form of a provider reference manual, in other written materials distributed by Cigna to Provider and/or at a website identified by Cigna. Administrative Guidelines may change from time to time. Cigna will give Provider advance notice of material changes to Administrative Guidelines.

2.5 Quality Management

Provider shall comply with the requirements of and participate in Quality Management as specified in the Administrative Guidelines.

2.6 Utilization Management

Provider shall comply with the requirements of and participate in Utilization Management as specified in this Agreement and the Administrative Guidelines. Payment may be denied for failure to comply with such Utilization Management requirements, and Provider shall not bill the Participant for any such denied payment. Cigna's Utilization Management requirements include, but are not limited to, the following: a) precertification must be secured from Cigna or its designee for those services and procedures for which it is required as specified in the Administrative Guidelines; b) Provider must provide Cigna or Cigna's designee with all of the information requested by Cigna or its designee to make its Utilization Management determinations within the timelines specified by Cigna or its designee in such request; and c) Provider will refer Participants to and/or use Participating Providers for the provision of Covered Services except in the case of an emergency or as otherwise required by law. If Provider inappropriately refers a Participant to a non-Participating Provider in a non-emergency situation without the Participant's express written consent, and thereby cause the Participant to become responsible, for the charges of the non-Participating Provider, or to incur more charges than if such care had been received from a Participating Provider, Cigna or a Cigna Affiliate may, in its sole discretion, satisfy the obligation to the non-Participating Provider for such services. If this occurs,

Cigna or a Cigna Affiliate may offset the amount paid to such non-Participating Provider for such services against future compensation payable to Provider.

2.7 Records

Provider shall maintain medical records and documents relating to Participants as may be required by applicable law and for the period of time required by law. Medical records of Participants and any other records containing individually identifiable information relating to Participants will be regarded as confidential, and Provider and Cigna shall comply with applicable federal and state law regarding such records. Provider will obtain Participants' consent to or authorization for the disclosure of private and medical record information for any disclosures required under this Agreement if required by law. Upon request, Provider will provide Cigna with a copy of Participants' medical records and other records maintained by Provider relating to Participants. These records shall be provided to Cigna at no charge and within the timeframes requested by Cigna and will also be made available during normal business hours for inspection by Cigna, Cigna's designee, accreditation organizations, or to any governmental agency that requires access to these records. This provision survives the termination of this Agreement.

2.8 Cooperation with Cigna and Cigna Affiliates

Provider shall cooperate with Cigna in the implementation of Cigna's Participant appeal procedure. Provider shall also cooperate with Cigna and Cigna Affiliates in implementing those policies and programs as may be reasonably requested by Cigna or a Cigna Affiliate for purposes of Cigna's or the Cigna Affiliate's business operations or required by Cigna or a Cigna Affiliate to comply with applicable law or accreditation requirements.

SECTION 3. DUTIES OF CIGNA

3.1 Payors, Benefit Plan Types, Notice of Changes to Benefit Plan Types

Cigna may allow Payors to access Provider's services under this Agreement for the following Benefit Plan types: a) Benefit Plans where Participants are offered a network of Participating Providers and are required or given the option to select a Primary Care Physician; b) Benefit Plans where Participants are offered a network of Participating Providers and are not required or given the option to select a Primary Care Physician; and c) Benefit Plans where Participants are not offered a network of Participating Providers from which they may receive Covered Services. Benefit Plans may include workers' compensation plans. Cigna will give Provider advance notice if Cigna changes this list of Benefit Plan types for which Payors may access Provider's services under this Agreement.

3.2 Benefit Information

Cigna will give Provider access to benefit information concerning the type, scope and duration of benefits to which a Participant is entitled as specified in the Administrative Guidelines.

3.3 Participant and Participating Provider Identification

Cigna will establish a system of Participant identification and will identify Participating Providers to those Payors and Participants who are offered a network of Participating Providers. However, Cigna makes no representations or guarantees concerning the number of Participants that will be referred to Provider as a result of this Agreement and reserves the right to direct Participants to selected Participating Providers and/or influence a Participant's choice of Participating Provider.

SECTION 4. COMPENSATION

4.1 Payments

Payments for Covered Services will be the lesser of the billed charge or the applicable fee under Exhibit A, subject to the Administrative Guidelines and minus any applicable Copayments, Coinsurance and Deductibles. The rates in this Agreement will be payment in full for all services furnished to Participants under this Agreement. Provider shall look solely to Payor for payment for Covered Services except for Copayments, Coinsurance and Deductibles. Provider shall submit claims for Covered Services at the location identified by Cigna and in the manner and format specified in this Agreement and the Administrative Guidelines. Claims for Covered Services must be submitted within 90 days of the date of service or, if Payor is the secondary payor, within 90 days of the date of the explanation of payment from the primary payor. Claims received after this 90 day period may be denied except as provided in the Administrative Guidelines, and Provider shall not bill Cigna, the Payor or the Participant for those denied services. Amounts due and owing under this Agreement with respect to complete claims for Covered Services will be payable within the timeframes required by applicable law.

4.2 Underpayments

If Provider believes a Covered Service has been underpaid, Provider must submit a written request for an appeal or adjustment with Cigna or its designee within 180 days from the date of Payor's payment or explanation of payment. The request must be submitted in accordance with the dispute resolution process set out in the Administrative Guidelines. Requests for appeals or adjustments submitted after this date may be denied for payment, and Provider will not be permitted to bill Cigna, the Payor or the Participant for those services.

4.3 Copayments, Coinsurance and Deductibles

Provider may charge Participants applicable Copayments, Coinsurance and Deductibles in accordance with the process set out in the Administrative Guidelines.

4.4 Limitations on Billing Participants

Provider agrees that in no event, including but not limited to nonpayment by Payor, Payor's insolvency or breach of this Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons other than the applicable Payor for Covered Services or for any amounts denied or not paid under this Agreement due to Provider's failure to comply with the requirements of Cigna's or its designee's Utilization Management Program or other Administrative Guidelines, or failure to file a timely claim or appeal. This provision does not prohibit collection of any applicable

Copayments, Coinsurance and Deductibles. This provision survives termination of this Agreement, is intended to be for the benefit of Participants, and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Participant or persons acting on the Participant's behalf. Modifications to this section will become effective no earlier than the date permitted by applicable law.

4.5 Billing Patients Who Cease to Be Participants

Provider may bill a patient directly for any services provided following the date that patient ceases to be a Participant, and Payor has no obligation to pay for services for such patients.

4.6 Participant Incentives Prohibited

Provider shall not directly or indirectly establish, arrange, encourage, participate in or offer any Participant incentive.

(A) Participant Incentive means any arrangement by Provider:

(1) to reduce or satisfy a Participant's cost-sharing obligations (including, but not limited to Copayments, Deductible and/or Coinsurance);

(2) to pay on behalf of or reimburse a Participant for any portion of the Participant's costs for coverage under a policy or plan insured or administered by Cigna or a Cigna Affiliate;

(3) that provides a Participant with any form of material, financial incentive (other than the reimbursement terms under this Agreement), to receive Covered Services from Provider or its affiliates.

(B) In the event of non-compliance with this provision:

(1) Cigna may terminate this Agreement, such non-compliance being a "material breach" of this Agreement;

(2) Provider shall not be entitled to reimbursement under this Agreement with respect to Covered Services provided to a Participant in connection with a Participant Incentive, and;

(3) Cigna may take such other action appropriate to enforce this provision.

4.7 Non-Medically Necessary Services

Provider shall not charge a Participant for a service that is not Medically Necessary unless, in advance of providing the service, Provider has notified the Participant that the particular service will not be covered and the Participant acknowledges in writing that he or she will be responsible for payment for such service.

4.8 Reimbursement of Amounts Collected In Error

If Provider collects payment from a Participant when not permitted to collect under either this Agreement or the Administrative Guidelines, Provider must repay the amount within 2 weeks of a request from Cigna or the Participant or of the date Provider has knowledge of the error. If Provider fails to make the repayments, then Cigna may (but is not obligated to) reimburse the Participant the amount inappropriately paid and then withhold this amount from future payments.

4.9 Overpayments

Provider shall refund to Cigna any excess payment made by a Payor to Provider if Provider is for any reason overpaid for health care services or supplies. Cigna may, at its option, deduct the excess payment from other amounts payable, and Provider will be notified of any such deduction as specified in the Administrative Guidelines.

4.10 Audits

Upon reasonable notice and during regular business hours, Cigna or its designee will have the right to review and make copies of all records maintained by Provider with respect to all payments received by Provider from all sources for Covered Services provided to Participants. Cigna or its designee will have the right to conduct audits of such records and may audit its own records to determine if amounts have been properly paid under this Agreement. Any amounts determined to be due and owing as a result of such audits must be promptly paid or, at the option of the party to whom such amounts are owed, offset against amounts due and owing by such party hereunder. This provision survives the termination of this Agreement.

4.11 Coordination of Benefits

Certain claims for Covered Services are claims for which another payor may be primarily responsible under Coordination of Benefit (COB) rules. Provider may pursue those claims in accordance with the process set out in the Administrative Guidelines.

Cigna's Payment as Secondary Payor (Non-Medicare)

Cigna's payment when added to the amount payable from other sources under the applicable COB rules, will be no greater than the payment for Covered Services under the Cigna provider agreement, and is subject to the terms and conditions of the Participant's health benefit plan and applicable state and federal law. Use of applicable COB provisions may result in a payment from Cigna that, when added to the amount payable from other sources, is less than 100 percent of the payment for Covered Services under the Cigna provider agreement. Payment may, however, be in a lesser amount as determined by the terms of the participant's benefit plan.

Medicare is the Primary Payor

When the Cigna plan is the secondary payor to Medicare, Provider and Cigna are required to follow Medicare billing rules. Payment will be made in accordance with all applicable Medicare requirements, including but not limited to Medicare COB rules. The Medicare COB rules require Cigna's financial responsibility as the secondary payor to be limited to the Participant's financial liability (i.e., the applicable Medicare copayment, coinsurance, and/or deductible) after application of the Medicare-approved amount. The Medicare payment plus the Participant liability (applicable Medicare copayment, coinsurance, and/or deductible) amounts constitute payment in full, and Provider is prohibited from collecting any monies in excess of this amount.

4.12 Applicability of the Rates

The rates in this Agreement apply to all services provided to Participants in the Benefit Plan types covered by this Agreement, including services covered under a Participant's in or out-of-network benefits, and whether the Payor or Participant is financially responsible for payment.

4.13 Excluded Services

This Agreement excludes services that Cigna has elected to obtain under an arrangement between Cigna or a Cigna Affiliate and a national or regional vendor or provider or a capitated provider, except as otherwise agreed by Cigna. Provider will not be reimbursed and will not bill Participants for any such excluded services. If Cigna notifies Provider that it no longer chooses to exclude a particular service from this Agreement, that service will no longer be excluded and those services will be reimbursed as specified in Exhibit A.

4.14 Provider Facilities

This Agreement shall specifically exclude those services rendered at Provider facilities other than those facilities agreed upon and utilized as of the Effective Date unless otherwise agreed in writing by Cigna.

SECTION 5. TERM AND TERMINATION

5.1 Term of This Agreement

This Agreement begins on the Effective Date and continues from year to year unless terminated as set forth below.

5.2 How This Agreement Can Be Terminated

Either Provider or Cigna can terminate this Agreement at any time by providing at least 90 days advance written notice. Either Provider or Cigna can terminate this Agreement immediately if the other becomes insolvent. Cigna can terminate this Agreement immediately (or upon such longer notice required by applicable law, if any) if Provider no longer maintains the licenses required to perform its duties under this Agreement, Provider is disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over Provider, or if Provider no longer satisfies Cigna's credentialing requirements. Upon termination of this Agreement for any reason, the rights of each party terminate, except as provided in this Agreement. Termination will not release Provider or Cigna from obligations under this Agreement prior to the effective date of termination.

5.3 Services upon Termination

Upon termination of this Agreement, Provider shall continue to provide Covered Services for specific conditions for which a Participant was under Provider's care at the time of such termination so long as the Participant retains eligibility under a Benefit Plan until the later of the completion of such services or the date required by applicable law. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the terms of the applicable Benefit Plan and applicable law. Provider has no obligation under this Agreement to provide services to individuals who cease to be Participants.

SECTION 6. GENERAL PROVISIONS

6.1 Confidentiality

As a result of this Agreement, Provider may have access to certain of Cigna's confidential and proprietary information. Provider shall hold such information, including the terms of this Agreement, in confidence and will not use or disclose such information to any person without the prior written consent of Cigna except as may be required by law. This provision shall not be construed to prohibit Cigna from disclosing information to Cigna Affiliates or the agents or subcontractors of Cigna or Cigna Affiliates or from disclosing the terms and conditions of this Agreement, including reimbursement rates, to existing or potential Payors, Participants or other customers of Cigna or Cigna Affiliates or their representatives. This provision does not prohibit communications necessary or appropriate for the delivery of health care services, communications about coverage and coverage appeal rights or any other communications specifically protected under applicable law. This provision survives the termination of this Agreement.

6.2 Independent Parties

Provider is an independent contractor. Cigna and Provider do not have an employer-employee, principal-agent, partnership, or similar relationship. Nothing in this Agreement, including Provider's participation in care collaboration, population management, pay for performance, Quality Management, Utilization Management, and other similar programs, nor any coverage determination made by Cigna or a Payor, is intended to interfere with or affect Provider's independent judgment in providing health care services to its patients. Nothing in the Agreement is intended to create any right for Cigna or any other party to intervene in or influence your medical decision-making regarding any Participant.

6.3 Indemnification

Each party agrees to indemnify, defend and hold harmless the other, its agents and employees from and against any and all liability or expense, including defense costs and legal fees, incurred in connection with third party claims for damages of any nature, including but not limited to bodily injury, death, personal injury, property damage, or other damages arising from the performance of or failure to perform, its obligations under this Agreement, unless it is determined that the liability was the direct consequence of negligence or willful misconduct on the part of the other party, its agents or employees. This provision shall survive the termination of this Agreement.

6.4 Internal Dispute Resolution

Disputes that might arise between the parties regarding the performance or interpretation of the Agreement must first be resolved through the applicable internal dispute resolution process outlined in the Administrative Guidelines. In the event the dispute is not resolved through that process, either party can request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter is not resolved within 60 days of such a request, either party may initiate arbitration by providing written notice to the other. With respect to a payment or termination dispute (excluding termination with notice), Provider must submit a request for arbitration within 12 months of the date of the letter communicating the final decision under Cigna's internal dispute resolution process unless applicable law

specifically requires a longer time period to request arbitration. If arbitration is not requested within that 12 month period, Cigna's final decision under its internal dispute resolution process will be binding on Provider, and Provider shall not bill Cigna, Payor or the Participant for any payment denied because of the failure to timely submit a request for arbitration.

6.5 Arbitration

If the dispute is not resolved through Cigna's internal dispute resolution process, the controversy shall be resolved through binding arbitration. The arbitration shall be conducted in accordance with the Rules of the American Arbitration Association then in effect, and which to the extent of the subject matter of the arbitration, shall be binding not only on all parties to the agreement, but on any other entity controlled by, in control of or under common control with the party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each party shall assume its own costs, but the compensation and expenses of the arbitrator and any administrative fees or costs shall be borne equally by the parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis.

6.6 Material Adverse Change Amendments

For amendments that are a material adverse change in the terms of this Agreement, Cigna can amend this Agreement by providing 90 days advance written notice except if a shorter notice period is required to comply with changes in applicable law. The change will become effective at the end of the 90 day notice period or, if applicable, the shorter notice period required to comply with changes in applicable law. If Provider objects to the material adverse change and notifies Cigna of its intent to terminate within 30 days of the date of the notice of amendment, the termination will be effective at the end of the 90 day notice of the material adverse change or, if applicable, at the end of the shorter notice period required to comply with changes in applicable law, unless Cigna agrees to retract the amendment, in which case the Agreement will remain in force without the proposed amendment.

6.7 All Other Amendments

For amendments that are not material adverse changes in the terms of this Agreement, Cigna can amend this Agreement by providing 30 days advance written notice to Provider. Alternatively, both parties can agree in writing to amend this Agreement.

6.8 Assignment and Delegation

Neither Cigna nor Provider may assign any rights or delegate any obligations under this Agreement without the written consent of the other party; provided, however, that any reference to Cigna includes any successor in interest and Cigna may assign its duties,

rights and interests under this Agreement in whole or in part to a Cigna Affiliate or may delegate any and all of its duties to a third party in the ordinary course of business.

6.9 Sale of Business/Change in Management

If, during the term of this Agreement, Provider desires (i) to sell, transfer or convey its business or any substantial portion of its business assets to another entity, or Provider is the subject of a sale, transfer or conveyance of its business by another entity, or (ii) Provider enters into a management contract with another entity, Provider shall so advise Cigna in writing at least 120 days prior to the transaction effective date in order to obtain Cigna's written consent as to which Cigna participating provider agreement applies, if any, to services rendered by you or the surviving entity, on a post-transaction basis. Failure to provide advance notification and obtain Cigna's written consent will result in Cigna determining which, if any, Cigna participating provider agreement applies to services rendered on a post-transaction basis. Dependent upon when Cigna learns of the transaction, this may result in a retroactive adjustment to reimbursement and an overpayment recovery process. Provider warrants and covenants that this Agreement will be part of the transfer, and will be assumed by the new entity and that the new entity will honor and be fully bound by the terms and conditions of this Agreement unless the new entity already has an agreement with Cigna or a Cigna Affiliate, in which case Cigna, in its sole discretion, will determine which Agreement will prevail. Notwithstanding the above, if Cigna, in its sole discretion, is of the opinion that the Agreement cannot be satisfactorily performed by the assuming entity or does not want to do business with that entity for whatever reason, Cigna may terminate this Agreement by giving Provider 60 days written notice, notwithstanding any other provision in the Agreement.

6.10 Acquisitions and Other Arrangements

This Agreement shall not, without Cigna's written consent, be applicable to any hospital, physician or physician group or ancillary provider that is acquired (directly or indirectly) by or enters into a management, co-management, professional services, leasing, joint venture or similar agreement or arrangement with Provider or a Provider affiliate. Provider shall notify Cigna 120 days in advance of any such acquisition or arrangement.

6.11 Use of Name

Provider agrees that Cigna may include descriptive information about Provider in literature distributed to existing or potential Participants, Participating Providers and Payors. That information will include, but not be limited to, Provider's name, telephone number, address, and specialties. Provider may identify itself as a Participating Provider with respect to those Benefit Plan types in which Provider participates with Cigna. Provider's use of Cigna's name or a Cigna Affiliate's name, or any other use of Provider's name by Cigna will be upon prior written approval or as the parties may agree.

6.12 Notices

Notices required under this Agreement shall be in writing and shall be deemed to have been duly given (i) on the third day after deposit in the United States mail, postage

prepaid, and properly addressed as specified below; or, (ii) on the date of delivery if sent via overnight delivery to the party to whom notice is to be given and properly addressed as specified below; or (iii) on the date of service if served personally on the party to whom notice is to be given. Cigna may also notify Provider by sending an electronic notice with automatic receipt verification to Provider's e-mail address if listed below. Either party can change the address for notices by giving written notice of the change to the other party in the manner just described.

The proper address for notices under this Agreement is as follows:

If to Cigna:
920 5th Ave, Ste 1350
Seattle, WA 98104
Attention: VP of Provider Contracting

If to Provider:
Polk County
182 SW Academy St Suite 302
Dallas, OR 97338

Attention: Administrator/CEO

Email address: moran.stacey@co.polk.or.us

6.13 Governing Law/Regulatory Addenda

Applicable federal law and the law of the jurisdiction where Provider is domiciled governs this Agreement. One or more regulatory addenda may be attached to the Agreement setting out provisions that are required by law with respect to Covered Services rendered to certain Participants (i.e. Participants under an insured plan). These provisions are incorporated into this Agreement to the extent required by law and as specified in such Addenda.

6.14 Force Majeure

In the event that performance by either Cigna or Provider of any covenant, duty or obligation imposed under this Agreement becomes impossible or impracticable because of the occurrence of an event of force majeure, including, without limitation, acts of war, insurrection, civil strife and commotion, labor unrest, sentinel event, or acts of God, then performance of such covenant, duty or obligation by such party shall be excused during the continuance of such event of force majeure; provided, however, that such performance by such party shall be accomplished as soon as reasonably practicable after such event of force majeure has ceased.

6.15 Waiver of Breach/Severability/Entire Agreement/Copy of Original Agreement

If any party waives a breach of any provision of this Agreement, it will not operate as a waiver of any subsequent breach. If any portion of this Agreement is unenforceable for any reason, it will not affect the enforceability of any remaining portions. This

Agreement, including any exhibits to this Agreement, contains all of the terms and conditions agreed upon and supersedes all other agreements between the parties, either oral or in writing, regarding the subject matter. A copy of this fully executed Agreement is an acceptable substitute for the original fully executed Agreement.

IN WITNESS WHEREOF the parties have caused this Agreement to be executed by their duly authorized representatives below.

AGREED AND ACCEPTED BY:

Provider	**Cigna**
Polk County	Cigna Health and Life Insurance Company
Signature	Signature
Printed Name	Printed Name
Title	Title
Date Signed	Date Signed
93-6002310 Federal Tax ID	
1710910781, 1881401735 National Provider Identifier	

ADDENDUM TO PROVIDER AGREEMENT
FOR THE STATE OF OREGON

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as "Provider") to comply with legislative and regulatory requirements of the State of Oregon regarding provider contracts with providers rendering health care services in the State of Oregon. To the extent that such Oregon laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

I

1. Provider shall mean "Provider," "Hospital," or "Group and/or Represented Provider," as named in the Agreement, or as otherwise set forth in the Agreement.

II

(1) Cigna, upon request by Provider, shall give Provider an annual accounting accurately summarizing the financial transactions between the parties for that year.

(2) Provider may withdraw from the care of a Participant when, in the professional judgment of Provider, it is in the best interest of the Participant to do so.

(3) Upon request by Provider, the criteria used in the Utilization Management review process and the method of development of the criteria shall be made available for review.

(4) Cigna shall employ or retain a physician licensed under ORS 677.100 to 677.228 who shall be responsible for all final medical and mental health decisions relating to coverage or payment made pursuant to the Agreement.

(5) Provider will be paid for Covered Services rendered to Participants in accordance with ORS Sec. 743B.450 and ORS Sec. 743B.452.

(6) In the event Cigna fails to pay for health care services covered by the Benefit Plan, Provider shall not bill or otherwise attempt to collect from Participants amounts owed by Cigna, and Participants shall not be liable to Provider for any sums owed by Cigna.

(7) Cigna may not terminate or otherwise financially penalize Provider for:

(1) Providing information to or communicating with a Participant in a manner that is not slanderous, defamatory or intentionally inaccurate concerning:

(a.) Any aspect of the Participant's medical condition;

(b.) Any proposed treatment or treatment alternatives, whether covered by the Participant's Benefit Plan or not; or

(c.) Provider's general financial arrangement with Cigna.

(2) (a.) Referring a Participant to another provider, whether or not that provider is under contract with Cigna. If Provider refers Participant to another provider, Provider shall:

(i) Comply with Cigna's written policies and procedures with respect to any such referrals; and

(ii) Inform the Participant that the referral services may not be covered by Cigna.

(b.) Allocation of costs for referral services shall be a matter of contract between Provider and Cigna. Allocation of costs to Provider by contract shall not be considered a penalty under this section.

(8) Cigna and Provider shall provide continuity of care to Participants as provided in ORS Sec. 743B.225.

(9) Except in cases of fraud or abuse of billing, Payor may not request a refund from Provider of a payment previously made to satisfy a claim unless Payor does so in writing, specifying the reasons for the request, within 18 months after the date the payment was made. If Payor requests a refund for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim, the request for refund must be made in writing, specifying the reasons for the request, within 30 months after the date the payment was made. If Provider fails to contest the request for a refund in writing to Cigna or Payor within thirty (30) days of receipt, the request for refund shall be deemed accepted and the refund must be paid.

(10) Except in cases of fraud, Provider may not request additional payment from Payor to satisfy a claim unless Provider does so in writing, specifying the reasons for the request, within 18 months after the date the claim was denied or the payment intended to satisfy the claim was made. If Provider requests additional payment from Payor to satisfy a claim for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim, the request for additional payment must be made in writing, specifying the reasons for the request, within 30 months after the date the claim was denied or payment intended to satisfy the claim was made.

(11) The Agreement may permit network arrangements which grant access to Cigna's rights as a contracting entity, as defined in applicable state laws and regulations, to Provider's health care services and discounted rates to a third party, as defined in applicable state laws and regulations, provided that the third party accessing Provider's health care

services and discounted rates is contractually obligated to comply with all applicable terms, limitations and conditions of the Agreement.

(12) Notwithstanding any provision to the contrary set forth in the Compensation section of the Agreement, or any similar provision in the Agreement, or a rate exhibit, the rates in the Agreement will be payment in full for all Covered Services furnished to Participants under the Agreement by a Provider who is a vision care provider as defined by applicable state laws and regulations.

Cigna

EXHIBIT A1

Fee Schedule and Reimbursement Terms

This is an Exhibit to an Agreement between:
Provider: Polk County
Cigna Party: Cigna Health and Life Insurance Company
Effective Date of Base Agreement: April 1, 2025

This Rate Exhibit:
Applies to: Polk County
Federal Tax ID: 93-6002310
National Provider Identifier: 1710910781
Effective Date: April 1, 2025

I. DEFINITIONS

Cigna Resource Based Relative Value Scale or Cigna RBRVS means the methodology designated by Cigna to produce the allowable fee for certain Covered Services rendered to Participants that uses the components of Relative Value Units (RVU's), geographic practice cost indices (GPCI's), conversion factor and base relativity factors, as defined by Cigna.

Cigna Standard Fee Schedule means the standard Cigna fee schedule applicable to the provider types (e.g. MD, DO, NP, PA etc.) as designated by Cigna in effect at the time of service and applicable to this Agreement for certain Covered Services provided to Participants. The Cigna Standard Fee Schedule is subject to change.

II. FEE FOR SERVICE REIMBURSEMENT

A. Except as otherwise provided below, Covered Services will be reimbursed at the lesser of 100% of billed charges or the Cigna RBRVS allowable fee, less applicable Copayments, Deductibles and Coinsurance. The Cigna RBRVS allowable fees are updated periodically by Cigna to reflect new information regarding RVU's, GPCI's, conversion factor, and the addition of new codes and services. The GPCI locality used for this Agreement is Portland, OR.

B. Cigna will apply the following base relativity factors in its Cigna RBRVS calculation to the services specified below. Provider agrees to identify the actual rendering provider's name that provided services to Participant on the claim submission to Cigna:

CPT Procedure Code Group	Base Relativity Factor
Surgery Codes	100.40%
Evaluation & Management Codes	100.40%

CPT Procedure Code Group	Base Relativity Factor
Medicine Codes	100.40%
Physical Therapy Codes	100.40%
Radiology Codes	100.40%

C. The following services, as defined within the Current Procedural Terminology (CPT) coding system published by the American Medical Association and the Healthcare Common Procedure Coding System (HCPCS) published by the Centers for Medicare & Medicaid Services, are excluded from the reimbursement methodology described above, and such Covered Services, if not specified above, will be reimbursed at the lesser of 100% of billed charges or the applicable fee under the Cigna Standard Fee Schedule, less applicable Copayments, Deductibles and Coinsurance.

   Injectable Drugs, Immunizations, Vaccines, Toxoids

   American Society of Anesthesiologists (ASA) Procedure Codes

   Immunization Administration

   Pathology and Laboratory Services

   Routine Venipuncture

   All Services (excluding injectable medications) defined within the Healthcare Common Procedure Coding System (HCPCS) Schedule.

D. All procedure codes for Covered Services for which reimbursement has not been established above, including but not limited to those for unlisted procedures as well as new Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and/or American Society of Anesthesiologists (ASA) procedure codes, will be paid at a 50% reduction from billed charges, less applicable Copayments, Deductibles and Coinsurance until such time as the applicable RVU's have been loaded into the appropriate claims systems.

E. Notwithstanding anything to the contrary set forth above, those services that are excluded from this Agreement under the Excluded Services section of the Agreement shall not be reimbursed and Participants shall not be billed for such services.

F. Notwithstanding the above, Cigna will apply site of service claim adjudication and the applicable reimbursement for place of service billed.

G. For workers' compensation Benefit Plans, the Cigna Standard Fee Schedule shall not exceed the state fee schedule.

H. The reimbursement terms set forth in this Exhibit are applicable to all services rendered as part of your practice or scope of license. Any services provided by an out of network provider or vendor as part of your practice or scope of license are not separately reimbursable.

Cigna

Oregon Newborn Nurse Home Visit Program

Exhibit A2

Fee Schedule and Reimbursement Terms

This is an Exhibit to an Agreement between:
Provider: Polk County
Cigna Party: Cigna Health and Life Insurance Company
Effective Date of Base Agreement: April 1, 2025

This Rate Exhibit:
Applies to: Polk County
Federal Tax ID(s): 93-6002310
National Provider Identifier(s): 1881401735
Effective Date: April 1, 2025

I. Reimbursement Terms

1. All-Inclusive Rates. Reimbursement rates include all supplies and services necessary for newborn home visits.

2. Full and Final Payment. Provider shall accept as full and final payment for Covered Services provided to Participants the lesser of billed charges or the reimbursement specified in this Exhibit. Payor shall deduct any Copayments, Deductibles, or Coinsurance required by the Participant's Benefit Plan.

3. Coding Updates. Cigna may adjust coding in its systems to remain consistent with the parties' intent to reimburse for the services listed in this Exhibit.

4. Additional Services. For services not included on the rate table below, no reimbursement will be made. Participants may not be billed for such services.

5. The reimbursement terms set forth in this Exhibit are applicable to all services rendered as part of your practice or scope of license. Any services provided by an out of network provider or vendor as part of your practice or scope of license are not separately reimbursable.

II. Reimbursement Rates

1. CPT Code and Modifiers must be included in all billing for all services as per CMS 1500 guidelines.

2. Modifier 95 must be included when billing for virtual services as per CMS 1500 guidelines.

Description	Coding	Reimbursement
Home visit for newborn care and assessment	CPT Code: 99502 32	Reimbursement rates will adhere to the State of Oregon requirements in force on the date of service.
Home visit for newborn care and assessment	CPT Code: 99502 32 TT	Reimbursement rates will adhere to the State of Oregon requirements in force on the date of service
Home visit for newborn care and assessment	CPT Code: 99502 32 TD	Reimbursement rates will adhere to the State of Oregon requirements in force on the date of service