INTERAGENCY AGREEMENT
TILLAMOOK COUNTY AND COMMUNITY ACTION TEAM, INC. HEAD START
HHS 22/23-004

This Agreement is made and entered into, in duplicate originals, by and between COMMUNITY ACTION TEAM, INC. HEAD START, hereafter "Agency" and Tillamook County, a political subdivision of the State of Oregon, hereafter "County", pursuant to ORS 203.010.

RECITALS

Whereas Agency desires to contract with County for the provision of providing to medical and dental access to children's health services and the completion of health statement for new employees; and

Whereas County is willing to provide said children access to medical and dental health services and the completion of health statement for new employees under the terms and conditions set forth herein.

WITNESSETH

NOW THEREFORE, it is hereby agreed by and between the parties as follows: the mutual promises of each party are given in exchange and as consideration for the promises of the other party.

SECTION 1.0 COUNTY'S RIGHTS, DUTIES AND AUTHORITIES

1.1 The County will provide access to medical and dental health services for Agency, as mutually agreed by and between the individual Agency and County in accordance with all applicable Community Action Team, Inc. Exhibits A through E.

1.2 The County shall provide all equipment, facilities and supplies reasonably necessary for performance of any services under this Agreement.

SECTION 2.0 AGENCY'S RIGHTS, DUTIES AND AUTHORITIES

2.1 The Agency shall make payment to County for services rendered in accordance with Exhibit A and will otherwise comply with the protocols set forth on Exhibits A through E.

2.2 The Agency shall provide any other information reasonable and necessary for County to perform the services associated with this Agreement.

SECTION 3.0 INSURANCE

3.1 Each party agrees to maintain insurance sufficient to meet sums specified by ORS 30.272 and 30.273. County coverage will be provided under provisions of Federal Tort Claim Act (FTCA).

SECTION 4.0 LIABILITY; INDEMNIFICATION

4.1 Each party shall indemnify and hold harmless the other party from all claims, costs, damages or expenses of any kind, including attorneys' fees and other costs and expenses of litigation, for personal or property damage arising out of that party's performance required by this Agreement. It is the intent of this section that each party assumes any and all liability for its respective torts, errors and omissions.

SECTION 5.0 EFFECTIVE DATE

5.1 This Agreement shall be effective on August 1, 2022.

SECTION 6.0 TERM

6.1 The term of this Agreement shall begin August 1, 2022 and continue in force and effect until July 31, 2023, or by termination pursuant to the provision of Section 7.0 of this Agreement.

SECTION 7.0 TERMINATION

7.1 Without Notice
- 7.1.1 The parties mutually consent to termination in writing.

7.2 With Notice
- 7.2.1 Any party breaches any duty, term or condition of this Agreement.
- 7.2.2 Either party commits a fraud or misrepresentation upon the other party.
- 7.2.3 Either party gives thirty (30) days written notice.

SECTION 8.0 GENERAL PROVISIONS

8.1 Waiver; Modification
Failure by County to enforce any provision of this Agreement does not constitute County's continuing waiver of that provision, any other provision or of the entire Agreement. The rights and duties under this Agreement shall not be modified, delegated, transferred or assigned, except upon the written, signed consent of both parties.

8.2 Attorney's Fees

Attorney fees, costs and disbursements necessary to enforce this Agreement through mediation, arbitration and/or litigation, including appeals, shall be awarded to the prevailing party, unless otherwise specified herein or agreed.

8.3 Legal Representation

In entering into this Agreement, each party has relied solely upon the advice of their own attorney. Each party has had the opportunity to consult with counsel or now waives that right. Each party represents and warrants to the other that they are fully satisfied with the representation received from their respective attorneys.

8.4 Notices

Any notice required or permitted under this Agreement shall be in writing and deemed given when:

8.4.1 Actually delivered, or

8.4.2 Three (3) days after deposit in the United States Post Office, certified mail, postage prepaid, addressed to the other party at their last known address.

8.5 Language

The headings of the Agreement paragraphs are intended for information only and shall not be used to interpret paragraph contents. All masculine, feminine and neuter genders are interchangeable. All singular and plural nouns are interchangeable unless the context requires otherwise.

8.6 Integration

This Agreement supersedes all prior oral or written agreements between Agency and County regarding this site. It represents the entire Agreement between the parties. Time is of the essence in all terms, provisions, covenants and conditions in this Agreement.

8.7 Savings

Should any clause or section of this Agreement be declared by a Court to be void or voidable, the remainder of this Agreement shall remain in full force and effect.

8.8 Jurisdiction; Law

This Agreement is executed in the State of Oregon and is subject to Tillamook County and Oregon law and jurisdiction. Venue shall be in Tillamook County, Oregon, unless otherwise agree by the parties.

IN WITNESS WHEREOF, County and the Agency have executed this Agreement on the days noted below.

DATED this 27 day of September 2022.

COMMUNITY ACTION TEAM, INC.

Joyce Ervin, Director
Child and Family Development Programs
PO Box 10
Rainier, OR 97048
jervin@nworheadstart.org

DATED this 27 day of Sept., 2022.

Daniel Brown, Executive Director
Community Action Team, Inc.
125 N 17th Street
St. Helens, OR 97051
dbrown@cat-team.org

INTERAGENCY AGREEMENT
TILLAMOOK COUNTY AND COMMUNITY ACTION TEAM, INC. HEAD START
HHS 22/23-004

DATED this 22nd day of February, 2023.

THE BOARD OF COMMISSIONERS
FOR TILLAMOOK COUNTY, OREGON

		Aye	Nay	Abstain/Absent
Erin D. Skaar, Chair	___	___	_____/_____	
Mary Faith Bell, Vice-Chair	___	___	_____/_____	
David Yamamoto, Commissioner	___	___	_____/_____	

ATTEST: Tassi O'Neil,
County Clerk

APPROVED AS TO FORM:

By: _____
Special Deputy

_____
William K. Sargent,
County Counsel

COMMUNITY ACTION TEAM, INC.- HEAD START

EXHIBIT A- SCOPE OF WORK

I. The County will provide well child exams for Head Start children to establish a medical home and dental exams for Head Start children to establish a dental home.

2. The County will bill any insurance company, the Oregon Health Plan and/or Head Start as applicable for services provided. Head Start funds are required to be the funding source of last resort.

3. Head Start shall pay County for:

Medical Services Provided/Cost:

a. Well Child Exam -One Hundred ($100) Dollars
b. Nutritional Assessment (114 hour)- Twenty-Seven- 50/00 ($27.50) Dollars (if available).

(If needed as indicated by the Medical Services provider, the following tests will be charged at these rates.)

c. TB Test- Thirty-Five ($35) Dollars
d. Urinalysis- Ten ($10) Dollars
e. Hemoglobin/Hematocrit-Twenty ($20) Dollars
f. Lead- Fifteen ($15) Dollars
g. Venipuncture- Twenty ($20) Dollars
h. Uninsured Head Start staff physical exam, TB Test and Statement of Heath Completion- One Hundred Thirty ($130) Dollars. *At the time of this contract, Head Start only pays $50 for item h. The Head Start staff member will be responsible for the difference.*

Dental Services Provided/Cost:

a. Oral Exam (one [1] per year) Eighty ($80) Dollars
b. Note: Head Start will pay for dental follow-up treatment identified during initial dental exam in accordance with our standard fee for the uninsured at Eighty ($80) Dollars per visit.
c. Dental No-Show charge- Twenty-Five ($25) Dollars

a. Note: Patient cannot schedule appointments until no-show charge has been paid unless Head Start assumes responsibility by written authorization. To avoid a no-show charge, notice of cancellation must be provided to the County at least twenty-four (24) hours in advance.

4. Head Start shall remain liable for the difference, if any, between any insurance or other payment other than Oregon Health Plan and the price of the service provided under this agreement.
5. Head Start shall provide any other information reasonable and necessary for County to perform the services associated with this Agreement.
6. Head Start will pay County for dental follow-up treatment identified during the initial dental exams to any non-insured family of child as specified in this Agreement.
7. Head Start will pay for services outlined by this Agreement provided the services are rendered before May 15th during the year the child is enrolled and provided Head Start has pre-authorized the services
8. The Head Start Center Manager must receive statement/billings from the Tillamook County Health Department by June 20th of the year the services were provided for children enrolled during that school year.
9. County shall have no duty to provide services under this Agreement to any family who does not sign (for any reason whatsoever) consent form releasing medical information from County to Head Start. County and Head Start shall exchange directory information only with a signed consent form. However, County may still provide the service.
10. County will provide patient medical information to Head Start upon receipt of a signed consent form releasing that information. The sites are as follows:

Tillamook Head Start
PO Box 713
Tillamook, OR 97141
(503) 842-5180
(503) 842-2580 (fax)

11. The Head Start timelines are noted below:
    a. Medical Home Documentation (ninety [90] calendar days from first day of service)
    b. Nutritional Assessment (ninety [90] calendar days from first day of service)
    c. Dental Home Documentation (ninety [90] calendar days from first day of service)
    d. Consulting nursing services will be provided at an hourly rate of Sixty ($60) Dollars per hour
    e. County staff (doctor, nutritionist, and consulting nurse) will agree to be members of the Head Start Health Services Advisory Committee and will meet with the Committee at its regular scheduled meetings at no charge.

EXHIBIT B
DATA MANAGEMENT

Definitions:

- **"Data Request Intervals"** means the frequency with which a data request may be made. Data may be requested up to four times a year.
- **"Data Request Delivery"** means the date on which the results of the data request will be sent to the requestor. Data will be delivered within 15 working days of the request submission.
- **"Secure Email"** is an e-mail that is altered (or "encrypted") so that it is unintelligible to unauthorized parties. Instead of receiving email directly to their inbox, recipients of a secure email will receive a notification message stating that a secure e-mail is waiting for them on a secure server. A web link in the notification will take them to the secure server where they can view the message and retrieve any attached data files.

Steps for Requesting WIC

- Collect the WIC ID#, DOB, and name for all participants you are requesting data.
- Enter the WIC ID#, DOB, and names into an Excel spreadsheet. Review the spreadsheet for accuracy of the WIC#s.
- Submit the Excel spreadsheet to the WIC representative via secure email.

Special Notes:

- Data requests must be compiled and submitted by a designated Head Start program representative and not individual Head Start sites.
- Submission of accurate and complete participant information is the responsibility of the Head Start representative. The WIC ID number must be accurate. The State WIC office will NOT process data for inaccurate WIC ID numbers. If the State WIC office receives a file containing missing or inaccurate WIC ID numbers, the State WIC office will notify the Head Start representative of the problem. Head Start representative then has two options:

Option 1) Submit a corrected data request. The corrected request will be processed within 15 working days of receipt.

Option 2) Ask the WIC representative to process the data request as is. The report will include only data for participants for whom complete and accurate WIC ID numbers were submitted.

- Data may be requested up to four times a year. A request for data for 10 participants and a request for data for 400 participants are each counted as one request towards the maximum number of requests allowed.

- The Head Start representative is responsible for the management of their user name and password for the secure email site.

CHILD & FAMILY DEVELOPMENT PROGRAMS

Child Nutrition Screening Survey

Child's Name: _____ **Age:** ____ **DOB:**_____

Head Start Center: _____ **Today's Date:**_____

Please circle YES or NO for each question as it applies to your child:

1. Does your child have a medical diagnosis of a food allergy?	**YES***	**NO**
2. Do you currently receive food stamps?	**YES**	**NO**
3. Does your child require a special food/diet or formula for medical reasons? Name of special food/diet or formula:	**YES***	**NO**
4. Is there any food your child should not eat for medical, religious or personal reasons? Please explain:	**YES**	**NO**
5. Has your child ever received services from WIC (Women, infant & Children)?	**YES**	**NO**
6. In the past 6 months have you been told by a health provider that your child has a low iron level and/or is anemic?	**YES***	**NO**
7. Were there any days last month when your family did not have enough food to eat or enough money to buy food?	**YES***	**NO**
8. Does your child have problems with: (mark all that apply) ( ) sucking ( ) swallowing ( ) chewing, ( ) gagging ( ) Dental issues	**YES***	**NO**
9. Does your child have ongoing chronic problems with: (mark all that apply) ( ) loose stools ( ) hard dry stools ( ) throwing up	**YES***	**NO**
10. Does your child eat clay, paint chips, dirt or any other things that are not food?	**YES***	**NO**
11. Does your child refuse to eat, throw food, or do other things that upset you at mealtime frequently enough to be a problem?	**YES***	**NO**

Updated: 04/06

12. Do you have concerns about your child's appetite? If yes, describe:	YES*	NO
13. Do you have concerns about your child's energy level? If yes, please describe:	YES*	NO
14. Does you child seem tired or pale?	YES*	NO
15. Is your child drinking liquids from a bottle?	YES	NO
16. Do you sit down and eat meals with your child?	YES	NO
17. How does your child look to you? (mark all that apply) ( ) just right ( ) too heavy ( ) underweight ( ) short	YES*	NO
18. Are you and /or your doctor concerned about your child's growth?	YES*	NO
19. Does your child watch TV and/or play on the computer more than 2 hours per day?	YES	NO
20. Does your child drink more than 8 ounces per day of sugared drinks (Kool-Aid, soda pop, etc)?	YES	NO
21. Is there a family history (parents/grandparents) of: (mark all that apply) ( )Heart disease ( )Diabetes ( ) Cancer ( ) High blood pressure ( ) Other (please describe):	YES	NO
22. Is your child taking a multivitamin or herbal supplement? If yes, what kind?	YES	NO

This form and the child's growth chart will be sent to a nutrition consultant for review. Starred (*) answers may require follow-up.

( ) **I do give** permission for the nutrition consultant to contact me by phone.

Phone: _____ The best time to reach me is: _____

( ) **I do not give** permission for the nutrition consultant to contact me by phone.

Signature: _____ DATE: _____

Updated: 04/06

Exhibit D - Form 3-34

CHILD AND FAMILY DEVELOPMENT PROGRAMS

Your Child's Food Record

Your child's name:_____ Date:_____

Tell us everything your child ate or drank in the last 24 hours.

1. Write down the time of each meal or snack.
2. Write down foods you offered your child.
3. Write the amount your child ate (cups, spoons, ounces).

Time	Foods you offered your child	Amounts child ate (cups, spoonfuls, ounces)
Example: 9:00am	Example: Whole milk Green beans	Example: 2 ounces None
Total Servings Eaten:		

Office Use Only					
Fats/Sauces	Milk Products	Vegetables	Protein Foods	Fruits	Grains
4	3	2	2	6	

Updated: 07/08

CHILD & FAMILY DEVELOPMENTAL PROGRAMS
Statement of Health

Federal & State Performance Standards Part 1304.52 (j &l)

(j) Staff and Volunteer Health

(l) Grantee and delegate agencies must assure that each staff member has an initial health examination (that includes screening for tuberculosis) and a periodic re-examination (as recommended by their health care provider or as mandated by State, Tribal, or local laws) so as to assure that they do not, because of communicable diseases, pose a significant risk to the health or safety of others in the Early Head Start or Head Start program that cannot be eliminated or reduced by reasonable accommodation. This requirement must be implemented consistent with the requirements of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

THIS SECTION TO BE COMPLETED BY THE EMPLOYEE

Name of Individual Examined: _____

EMPLOYER: Child & Family Development Programs

PURPOSE OF EXAMINATION: Initial employment exam, which includes a tuberculosis screen

THE MAJOR JOB RESPONSIBILITIES OF MY JOB DUTIES INCLUDE: (check all applicable)

__Food Preparation __Driver of Vehicle __Teaching Children __Desk Work
__Facility Maintenance

THIS SECTION TO BE COMPLETED BY A HEALTH PROFESSIONAL

		YES	NO
1.	Is there a special medical problem or chronic disease which requires restriction of activity or medication that might effect his/her work role? If yes, explain on back of this form.	____	____
2.	Does this individual have any special medical problems or communicable diseases which might pose a significant risk to the health or safety of others in the program that cannot be eliminated or reduced by reasonable accommodations which might prohibit the individual from providing adequate care for the children? If yes, explain on back of this form.	____	____

3. Tuberculosis screening: Date: _____ Results: _____

SIGNATURE OF PHYSICIAN _____ Today's Date _____

Name of Physician _____ Telephone _____

Address of Physician _____ Date of Exam: _____

Please mail or fax this completed form to: Child & Family Development Programs
PO Box 10
Rainier, OR 97048
FAX: (503) 556-0705

Updated: 09/11