UNC HOSPITALS

CONTRACT TERM COVER SHEET

Note: It is the joint responsibility of both parties to provide information to complete the form. The party receiving and paying for the services is ultimately responsible for ensuring completion of the contract request, including properly submitting the request.

Submission Date 1/1/2022

Basic Information for Contract Request

Request Type ☑ New ☐ Amendment ☐ Renewal Revised Terms ☐ Renewal Same Terms ☐ Termination _____ (Complete Exh H) (Eff. date of Termination)

Contract # 100 **Effective Date** 7/1/2021 (Begin) 6/30/2022 (End) ☑ UNCH Receivable/University Payable ☐ UNCH Payable/University Receivable ☐ Both Receivable and Payable

Description of Contract This is an example. This contract is for nursing services at ABC Clinic

Note: Only complete the Exhibit associated with the contract type selected.

CONTRACT TYPE

- ☑ Physician or APP Clinical Services (complete Exhibit A)
- ☐ Admin Services Physicians (complete Exhibit B)
- ☐ Services by Staff – Non MD/App (complete Exhibit C)
- ☐ Program Support (complete Exhibit D)
- ☐ Medical Director/Service Lead/ACMO Physician Champion (complete Exhibit E)
- ☐ Pre-Transplant (complete Exhibit F)
- ☐ Other (complete Exhibit G)

Renewal Term: ☑ Written Renewal ☐ Will Not Renew ☐ Auto Renew (limited circumstances)

SCHOOL OF MEDICINE

(information to be provided by UNCFP/SOM)

Name of Person to Approve | Name of Person submitting the request for contract | E-mail contact of submitter of contract request | #provided by SOM

SOM Department and Division (if applicable) | **Submitted by** | **Submitter E-mail** | **RASR ID#**

OPSCA CRF Submitter Name: Name of Person submitting to OPSCA **OPSCA CRF Submitter E-mail** Contact e-mail for OPSCA Submitter

Chartfield	Invoice Contact Name	Invoice Contact E-mail
Contact E-mail of ACA Approver	Person in charge of SOM Invoice	Contact e-mail of SOM invoice person
		Contact E-mail

SOM Approvals

Legal to obtain electronic approval

SOM Division or Center (optional)
Name: Name of SOM Div Person to approve
E-mail: Contact E-mail of Approver

Legal to obtain electronic approval

SOM ACA/Designated OPSCA Approver
Name: Name of ACA or OPSCA Designee
E-mail: Contact E-mail of ACA Approver

Legal to obtain electronic approval

Additional Approver (optional)
Name: Name of Additional Approver
E-mail: Contact E-mail

FINANCIALS

(information to be completed by UNCFP/SOM or UNC Hospitals)

Reconciliation Schedule ☑ Quarterly ☐ Annual ☐ Semi-Annual ☐ N/A **SOM** Budgeted Yes ☑ No ☐

Invoice Schedule ☑ Quarterly ☐ Annual ☐ Semi-Annual ☐ Other **UNCH** Budgeted Yes ☑ No ☐

Amounts are Estimates ☐

Year	Annual Amount	Fixed/Variable	Mo. Accrual/12Mo
FY22	$50,000	Variable	$4,166.66

UNC HOSPITALS

(information to be completed by UNC Hospitals)

UNCH Department | UNCH Submitter Contact Name | UNCH Submitter Contact E-mail | Name and email of Business Analyst or Individual

UNC Hospitals/UNCHCS Department (if applicable) | **Submitted by** | **Submitter E-mail** | **Business Analyst/Individual to be copied on the route**

Company	Cost Center	Account	UNCH Invoice Approver Name	UNCH Invoice Approver E-mail
1000	123456	71999	The name of the person responsible for approving the invoice for U	Contact E-mail for UNCH Invoice Approver

Category: ISD to provide **(ISD Only)** Activity: ISD to provide **(ISD Only)** **Note**: Category and Activity only apply to ISD contracts

UNCH Approvals:

Legal to obtain electronic approval

UNCH Director or Additional Approver
Name: Name of UNCH Director
E-mail: Contact E-mail of Director

Legal to obtain electronic approval

UNCH Finance (Confirm Cost Center & Acknowledge)
Name: Name of UNCH Finance Rep
E-mail: Contact E-mail for Finance Rep

Legal to obtain electronic approval

UNCH VP
Name: Name of UNCH VP
E-mail: Contact E-mail for UNCH VP

The completed form must be submitted to the Lawtrac Portal - https://lawtrac.unch.unc.edu/UNCLegal/standardlogin.cfm

Note: In the event that information is missing from the CTC or required exhibit, the request will be rejected. It will then need to be completed and returned to the submitter. Contact legal for login credentials at unchcscontractlegal@unchealth.unc.edu. Email submissions will not be accepted.

Exhibit A

Agreement for Clinical Services that Generate Professional Receipts (MDs and/or APPs)

Please provide description of the services to be provided, including scope of services, extent of coverage, etc.

Provide nursing coverage to ABC Clinic at the Hillsborough Campus. Coverage will be M-F from 7am-7pm. (This is an Example not a real contract) Department to provide 2.0 FTE coverage. ADD ANY DETAILS re: Vacation or Holiday Coverage (this info will be included in the contract)

Identify all expenses to be included in the contract. Must include details including salary amounts, benefit amounts, and any overhead expenses. It is acceptable to include a chart or excel spreadsheet as an attachment.

	Amounts	Explanation-Additional Information
Salary	100,000	2 FTE $50K per FTE
Benefit	30,000	50/50 split between 2 FTE
Overhead Expenses		
Other Additional Expenses	3,000 LITF premium	50/50 split between 2 FTE

Provide estimate of professional receipts. Identify any fees that will be deducted from receipts. It is acceptable to include a chart or excel spreadsheet as an attachment.

Receipts	Fees	Explanation-Additional Information
$100,000	$21,000	UNCFP Fees of 21% of receipts

Provide estimate of total subsidy/backstop. This should equal total expenses minus net receipts.

Is there a maximum amount for each fiscal year? ☐ Yes ☑ No

If yes, what is the maximum amount per year? _____

If yes, does the maximum amount increase over time? ☐ Yes ☐ No **If so, by how much?**_____

Identify method of payment—choose one of two options:

☑ **Option 1:** **UNCH pays estimated monthly subsidy. At end of fiscal year, parties reconcile to actuals.**

If this option is chosen, identify individuals who will be responsible for reconciling actuals.

If this option is chosen, provide monthly subsidy amount:_____

Name of SOM contact: Provide Name
E-Mail: Provide E-mail Contact
Name of UNCH contact: Provide Name
E-Mail: Provide E-mail Contact

☐ **Option 2:** **UNCH pays actual loss each month (monthly expenses- monthly receipts).**

Exhibit B

Administrative Services by Physicians (except medical director services)

Please provide description of the services to be provided, including estimated time/FTE commitment.

Dr. Jane Doe will provide administrative services to the hospital to plan and oversee the Hospital's Heart and Vascular program. Duties to include: Please provide a description of the program.
The hospital should have this information, and completing the CTC is a joint effort. Dr. Doe will spend 20% of her time on this program.

Identify all expenses to be included in the contract. Must include details including salary amounts, benefit amounts, and any overhead expenses. It is acceptable to include a chart or excel spreadsheet as an attachment.

Department will be reimbursed for 20% of Dr. Doe's salary and benefits. Her Salary is $150,000 with estimated $50,000 in benefits. An estimate of 20% is $40,000 per fiscal year

Expenses to be Covered in the Contract				
Employee Name	**Salary**	**Benefits**	**Other**	**%FTE for Reimbursement**
Jane Doe	$30,000	NA	N/A	20%

Exhibit C

Services by staff (non MDs/APPs)

Please provide description of the services to be provided, including estimated time/FTE commitment.

Hospital to reimburse SOM 50% of RN's salary for time that RN works in HBC. RN will provide the following duties to clinic:

RN to function as nurse in clinic (Describe Services)

Is this arrangement funded by a SOM grant? ☐ **Yes** ☑ **No**

If yes, identify grant:_____

If yes, identify where to send invoice:_____

Identify all expenses to be included in the contract. Must include details including salary amounts, benefit amounts, and any overhead expenses. It is acceptable to include a chart or excel spreadsheet as an attachment.

Hospital to reimburse SOM 50% of RN's Salary and benefits

Expenses to be Covered in the Contract				
Employee Name	**Salary**	**Benefits**	**Other**	**%FTE for Reimbursement**
Alexander Hamilton, RN	$40,000 (50% of $80,000	$12,000 (30% Estimate of $40,000	N/A	50%

Employee Name	Position Name	Job Code
Alexander Hamilton	Nurse	JC 12345

Exhibit D

Program Support

	Take Care of Our Own Program
Amount of Program Support:	$100,000

Reason for Program Support:

This is an example- this section should include goals/services of the program and why the hospital is providing support to the program

Provide any relevant details of how program support funding is used:

If there are hospital requirements as to how the funding is to be used, please provide that information here.

Exhibit E

Medical Director/Service Lead/ACMO/Physician Champion

Department: Surgery
Division: Plastic Surgery
Physician: Dr. Iam Beautiful

Role: **Medical Director - Inpatient**
Unit:

Role: **Service Leader**
Service: Plastic Surgery Service

Role: **Medical Director – Hospital Based Clinic**
Clinic:

Role: **ACMO**
Area of Responsibility

Role: **Physician Champion**
Area of Responsibility

Named MD	FTE Commitment	AAMC Specialty	AAMC Rank:	AAMC Salary
Iam Beautiful	10%	Plastic Surgery	Associate Professor	250,000 (not a real amount)

Payment Calculation:

250,000	X	.10	X	1.3	=	$ 32,500
AAMC Reference Salary		FTE Commitment		Benefits Adder		**Annual Amount of Contract***
	X		X	1.3	=	$
AAMC Reference Salary		FTE Commitment		Benefits Adder		**Annual Amount of Contract***
	X		X	1.3	=	$
AAMC Reference Salary		FTE Commitment		Benefits Adder		**Annual Amount of Contract***
	X		X	1.3	=	$
AAMC Reference Salary		FTE Commitment		Benefits Adder		**Annual Amount of Contract***

NOTE: Partial years should be prorated for the amount of months on the contract

***Amount to be included on the coversheet**.

Exhibit F

Pre Transplant

Department: Medicine
Division: Nephrology
Physician: Dr. New Nephrologist

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Physician:

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Exhibit G

Other

Explain contractual arrangement, including details of any funding.

If the contractual arrangement does not fit into any of the other categories, please complete the coversheet and put the details here.

Please reach out to the UNCHCS Legal Department if you would like assistance completing this exhibit.

Exhibit H

TERMINATION

Reason for Termination:

Hospital no longer wants to support this program. The Hospital should have already informed the SOM Department of termination. This is not necessary if a contract expires by its terms and is not going to be renewed. But if a contract is going to be terminated before it expires by its terms, this exhibit and the coversheet should be completed

Party Terminating* Hospital

Effective Date of Termination 1/1/2022

***Has the other parties been given notice of termination?** ☑ **Yes** ☐ **No**

If **Yes**, attach documentation. If **No**, this document will serve as notice of termination.