DATE

Re: RETAINWOR*KS* Return to Work Program Letter Agreement

Dear Dr. \_\_\_\_\_\_\_\_\_\_\_:

Thank you for your continued support of the RETAINWOR*KS* Return to Work Program (the “RETAINWOR*KS* Program” or “Program”) conducted under the Retain Grant Subaward Agreement (the “RETAINWOR*KS* Grant” or “Grant”), between Medical Provider and the Kansas Department of Commerce, executed DATE The purposes of the Program include assisting and supporting Program participants as they transition from medical care back to employment. Among other things, PROVIDER provides both administrative and clinical navigators to assist Program participants in making this transition back to work.

In support of the RETAINWOR*KS* Program, you agree to be available to perform the following services from time-to-time:

* Attend a minimum of four hours of RETAINWOR*KS* Program training.
* Refer qualifying patients for participation in the Program by completing and submitting to Medical Provider a patient referral form. A patient is eligible for the Program if he/she lives or works in Kansas and has a work disability either occurred on or off the job. Work disability as an injury, illness, or medical condition that has the potential to inhibit or prevent continued employment or labor force participation. (See Exhibit A)
* Complete an activity prescription for each patient admitted to the Program.
* Perform a 30-day assessment of each of your patients admitted to the Program.
* Prepare a return-to-work plan for each of your patients admitted to the Program.
* Communicate with Program navigators via telephone, email, and in-person meetings.

To the extent the foregoing services require the completion of any forms or records, you agree to complete such forms or records in the form and format required by Provider and to deliver such information to Provider upon request.

As consideration for the foregoing services, MEDICAL PROVIDER will pay you the following fees:

* $1,600.00 for eight (8) hours of Program training you complete during the second phase of the Grant (if applicable); plus
* $100 for each qualifying patient you refer to the Program; plus
* $100 for each 30-day assessment you complete for your patients admitted to the Program; plus
* $50 for each activity prescription you complete for your patients admitted to the Program; plus
* $100 for each return-to-work plan you complete for your patients admitted to the Program; plus
* $25 for each substantive communication with a Program navigator you complete with respect to your patients admitted to the Program (not to exceed $100 per month).

As a condition to earning the fees payable under this Agreement, you agree to be reasonably available to respond to inquiries from Program navigators via telephone and email. Medical Provider will pay you the fees for qualifying referrals within thirty days after the end of each calendar quarter. Because you are providing these services as an independent contractor, MEDICAL PROVIDER will not withhold any amounts for tax purposes, and you are solely responsible for filing and paying all required taxes and withholdings. Moreover, you are not eligible to participate in any MEDICAL PROVIDER employment benefit programs.

Nothing in this Agreement may be construed as requiring you to admit or refer patients to MEDICAL PROVIDER (or its affiliates) for inpatient, outpatient, or other healthcare items or services, or to otherwise generate business for MEDICAL PROVIDER (or its affiliates), and nothing in this Agreement may be considered fees or payments in consideration for any such admissions or referrals. You agree to comply with all applicable law in connection with this Agreement.

The term of this Agreement commences \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_, 2021, and continues for a period of one year thereafter, unless earlier terminated as set forth in this Agreement. After the initial one-year term, this Agreement will automatically renew for successive one-year terms until terminated by either party as provided herein. Notwithstanding the foregoing, this Agreement automatically terminates upon termination or expiration of the RETAINWOR*KS* Grant, and either party may terminate this Agreement at any time upon written notice to the other party.

This Agreement will be listed in MEDICAL PROVIDER centrally maintained master list of contracts available for review by the Secretary of Health and Human Services, upon request. To the extent you have any contracts with MEDICAL PROVIDER for personal services, they are amended to include this provision.

This Agreement sets forth our entire understanding regarding this relationship and replaces all prior agreements and understandings with respect to the subject matter of this Agreement. Any changes must be in writing signed by both of us.

If you agree to the foregoing, please sign this Agreement below.

Sincerely,

Medical Provider

\_\_\_\_\_

NAME~~,~~ COO and Hospital President

**ACCEPTED AND AGREED**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, M.D.