

RESOLUTION NO. 2007 331

A RESOLUTION BY THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA, APPROVING THE TERMS, PROVISIONS, CONDITIONS, AND REQUIREMENTS OF AN AGREEMENT BETWEEN ST. JOHNS COUNTY, FLORIDA, AND PROJECT SPECIAL CARE, AND AUTHORIZING THE CHAIR OF THE BOARD OF COUNTY COMMISSIONERS TO EXECUTE THE AGREEMENT ON BEHALF OF THE COUNTY

WHEREAS, the St. Johns County Government is providing grant funds to Project Special Care which are to be disbursed by St. Johns County, Florida, in an amount not to exceed twenty-nine thousand seven hundred and seventy-nine dollars (\$29,779.00), for the purpose of providing the Adult Day Training Program up to the required match of thirteen thousand, one hundred twenty-four dollars (\$13,124.00); and, partial funding of Respite Care in the amount of sixteen thousand, six hundred forty-seven (\$16,647.00) and;

WHEREAS, the County has reviewed the terms, provisions, conditions, and requirements of the Agreement; and

WHEREAS, the County has determined that accepting the terms of the Agreement, and entering into said Agreement will serve the interests of the County.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA, AS FOLLOWS:

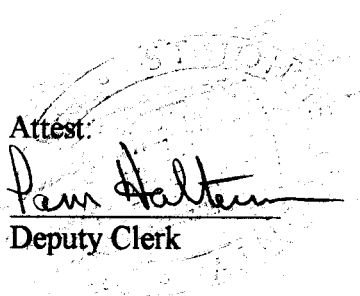
Section 1. The above Recitals are hereby incorporated into the body of this Resolution, and are adopted as Findings of Fact.

Section 2. The Board of County Commissioners hereby approves the terms, provisions, conditions, and requirements of the Agreement between the St. Johns County Government, Florida, and Project Special Care, and authorizes the Chair of the County Commissioners to execute the Agreement on behalf of the County.

PASSED AND ADOPTED by the Board of County Commissioners of St. Johns County, Florida, this 30<sup>th</sup> day of October, 2007.

BOARD OF COUNTY COMMISSIONERS OF  
ST. JOHNS COUNTY, FLORIDA

Attest:

  
Pam Halter  
Deputy Clerk

By:

Ben Rich  
Ben Rich, Chair

RENDITION DATE 11/2/07

CFSA # \_\_\_\_\_  
CFDA # \_\_\_\_\_  
Contract No. \_\_\_\_\_  
Funding Source: General Fund

**STANDARD NONPROFIT CONTRACT/Unit of Service**

**CONTRACT BETWEEN  
THE ST. JOHNS COUNTY BOARD OF COUNTY COMMISSIONERS  
And  
Project Special Care**

**THIS CONTRACT** is entered into and effective the 1<sup>st</sup> day of October, 2007, between St. Johns County, hereinafter referred to as "**COUNTY**" and Project Special Care a Nonprofit Corporation existing under the laws of the State of Florida and, hereinafter referred to as "**PROVIDER**".

**WHEREAS, COUNTY** believes it to be in the public interest to provide certain activities to the St. Johns County residents through the **PROVIDER** according to this Contract, the agency's intent as stated in the proposal and attachments and/or exhibits, and all other terms and conditions as specified.

**NOW THEREFORE**, in consideration of the mutual covenants, promises, and representations contained herein **COUNTY** and the **PROVIDER** agree as follows:

**ARTICLE I           SCOPE OF SERVICES**

- The **Respite Care program** reduces potential incidences of abuse and neglect of special needs children by providing parents a brief break in the continuing cycle of care that is demanded by special needs children.
- The **Adult Day Training Program** assists individuals with special needs who are experiencing the difficult transition from role of STUDENT to ADULT. Aging out of school, many young adults are without supports, interventions or meaningful daily routines. Confined to a wheel chair; unable to self feed; or perform personal hygiene, they are not welcomed into programs for higher functioning individuals.

Program(s) must be implemented to serve residents of St. Johns County in accordance with the approved proposal(s), exhibits/attachments.

**ARTICLE II           TERM OF CONTRACT**

This Contract shall begin October 1, 2007 and end September 30, 2008 unless terminated as specified in Article VIII, Suspension/Termination.

**ARTICLE III      COMPENSATION AND REPORTS**

**A.      Contract Payment**

The **COUNTY** will make payments to the **PROVIDER** and the **PROVIDER** agrees to accept as full compensation the total amount not to exceed **\$29,779.00**. Payments will be authorized only for services provided during the term of the contract and prior to the payment request date. Payment is subject to the provisions of Article III B Deferred Payment/Return of Funds and Article VIII, Suspension/Termination. Funding is contingent upon the availability of funds.

The **COUNTY** has agreed to purchase the service(s) listed in Article I. This contract is for the payment of a fixed number of units of service at the fixed unit rate.

<b>Program</b>	<b>Unit Description</b>	<b>Units purchased by County</b>	<b>Unit rate reimbursed by County</b>	<b>Total</b>
Respite Care Program	Unit = 1 hour of care	1011.97 units	\$16.45	\$16,646.90
Adult Day Training Program	Unit = 1 day of program	197.50 Units	\$66.45	\$13,123.88

**B.      Deferred Payment/Return of Funds**

The **COUNTY** may defer payment to the **PROVIDER** for noncompliance with contract deliverables or program requirements.

If as a result of monitoring or audit, units of service provided are not documented a payment may be deferred. If units are found to be unallowable, no future payments will be made until the full amount of overpayment is remitted to St. Johns County or a repayment agreement is accepted by St. Johns County. If the monitoring or audit occurs after the term of this contract, the **PROVIDER** will be required to remit funds to the **COUNTY** in accordance with the repayment conditions below.

The **PROVIDER** agrees to return to the **COUNTY** any overpayments due to funds disallowed pursuant to the terms of this Contract. Such funds shall be considered **COUNTY** funds and must be refunded to the **COUNTY** within thirty (30) days of receiving notice from the **COUNTY** in writing regarding the overpayment. Should repayment not be made in a timely manner, the **COUNTY** will charge interest of one (1) percent per month compounded on the outstanding balance after forty (40) calendar days after the date of notification or discovery.

The **PROVIDER** will be required to reimburse the **COUNTY** for any acts of non-compliance resulting in disallowed costs or fines.

**C. Contract Deliverables**

**1. Required Reports (check if included in contract)**

- EXHIBIT 1- Payment Request for Unit rate contract- Due: Monthly by the 20<sup>th</sup> of the following month.** Must be based upon approved unit rates and actual uncompensated units provided during the reporting period. Payment will be made upon receipt and approval by the **COUNTY** of a completed Payment Request. Copies of supporting documentation for units provided during the reporting period must be attached to the Payment Request.
- EXHIBIT 2 – Program/Demographics – Due: April 30, 2008 and October 31, 2008.**
- EXHIBIT 3 – Performance Outcomes Report – Due: April 30, 2008 and October 31, 2008.**
- EXHIBIT 4 - Unit Rate Analysis Report – Due: 20 days following the end of each quarter.**
- EXHIBIT 5 - Certificate of Insurance - Insert in contract.**

**2. Required Documents**

- Audited Financial Statement and Management Letter for fiscal year(s) in which contract funds are expended – **Due: 180 days following the end of PROVIDER'S fiscal year(s).**
- Monitoring Reports – A copy of monitoring reports from other funding agencies to the **PROVIDER** will be due to the **COUNTY** no later than **30 days** after receipt by the **PROVIDER**. Copies of monitoring reports must include the **PROVIDER'S** response to the funding agency.

**D. Contract Closeout**

- √ Partnering for Results: Unit Rate Analysis Report - **Due: 30 days following end of contract.**
- √ Partnering for Results: Final Payment Request - **Due: 10 days following end of contract.**

**ARTICLE IV      AUDITS, MONITORING, AND RECORDS**

**A. Monitoring**

The **PROVIDER** agrees to permit persons duly authorized by the **COUNTY** and the Federal or State grantor agency (if applicable) or any representatives to inspect all records, papers, documents, facility's goods and services of the **PROVIDER** and/or interview any clients and employees of the **PROVIDER** to be assured of satisfactory performance of the terms and conditions of this contract to the extent permitted by the law after giving the **PROVIDER** reasonable notice. The monitoring is a limited scope review of the contract and agency management and does not relieve the **PROVIDER** of its obligation to manage the grant in accordance with applicable rules and sound management practices.

Following such monitoring the **COUNTY** will deliver to the **PROVIDER** a written report regarding the manner in which services are being provided. The **PROVIDER** will rectify all noted deficiencies within the specified period of time indicated in the monitoring report or provide the **COUNTY** with a reasonable and acceptable justification for not correcting the noted shortcomings. The **PROVIDER'S** failure to correct or justify the deficiencies within the time specified by the **COUNTY** may result in the withholding of payments, being deemed in breach or default, or termination of this Contract.

**PROVIDER** must supply **COUNTY** with copies of all monitoring reports of programs that are funded by the **COUNTY** including agency response, within thirty (30) days of receipt.

**B. Audits and Inspections**

The **PROVIDER** will make all records referenced in Article IV. C., and all items included on financial statements available for audit or inspection purposes at any time during normal business hours and as often as **COUNTY** deems necessary.

The Clerk of Courts Internal Audit Division, the Federal or State grantor agency (if applicable), St. Johns County employees, or any of their duly authorized representatives have the right of timely and unrestricted access to any books, documents, papers, or other records of **PROVIDER** or Certified Public Accountant (CPA) that are pertinent to the contract, in order to make audits, examinations, excerpts, transcripts and copies of such documents. If contract non-compliance or material weaknesses in the organization are noted, the **COUNTY** or other authorized representatives have the right to unlimited access to records during an audit or inspection. This includes timely and reasonable access to a **PROVIDER'S** personnel for the

purpose of interview and discussion related to such documents.

**C. Records**

The **PROVIDER** shall retain all financial, client demographics, and programmatic records, supporting documentation, statistical records, and other records which are necessary to document service provision, expenditures, income and assets of the **PROVIDER** by funding source, program, and functional expenses category during the term of this contract and five (5) years from the date of contract expiration. If any litigation, claim, negotiation, audit, or other action involving the records has been initiated before the expiration of the 5-year period, the records shall be retained for one (1) year after the final resolution of the action and final resolution of all issues that arise from such action.

**C. Independent Audit**

For contracts where the total compensation, disbursement, grant, or reimbursable expense (or any combination thereof) exceeds three hundred thousand dollars (\$300,000.00), then an original, bound audit of the **PROVIDER'S** financial statements must be submitted to the **COUNTY**, in the form, format, and timeframe noted below, or elsewhere in this contract.

For contracts where the total compensation, disbursement, grant, or reimbursable expense (or any combination thereof) **does not exceed** three hundred thousand dollars (\$300,000.00), then an original, bound audit is not required, **unless the COUNTY** determines that an independent audit is warranted (base on among other things, the use of such funds), and provides the **PROVIDER** with a written explanation detailing the reason and/or rationale supporting the **COUNTY'S** determination that such an independent audit is warranted. Under those circumstances, the **COUNTY'S** written explanation will set forth the form, format, and timeframe for the independent audit.

An original, bound audit of the **PROVIDER'S** financial statements in accordance with Generally Accepted Accounting Principals (GAAP), and/or current Generally Accepted Government Auditing Standards (GAGAS) as applicable, including the auditor's opinion, requisite reports on internal control and compliance if required, management letter addressing internal controls, and management's response to such letter, must be submitted to the **COUNTY** no later than one hundred eighty (180) days following the end of **PROVIDER'S** fiscal year(s) along with any corrective action plan if applicable. Failure to submit the report within the required time frame will result in the withholding of payment requested, or termination of the contract by the **COUNTY**.

The audit must be conducted by an independent, licensed certified public accountant and must be in accordance with the General Accounting Office (GAO) Yellow Book, generally accepted Government Auditing Standards, OMB Circular A-133 "**Audits of States, Local Governments and Non-Profit Organizations**" if applicable, the Florida Single Audit Act (F.S. 215.97) if applicable, and the Auditor General Rule 10.550 (Government) or 10.650 (Not For Profit) as applicable. The audit must specifically identify the programs that are funded by this St. Johns County contract either in the statement of functional expenses, revenues and expenditures, footnotes, schedule of Federal awards and State financial assistance or as supplemental data in

the financial statements. The statement should be consistent with programs detailed in the corresponding proposal(s), exhibit(s), and attachment(s).

## **ARTICLE V            AMENDMENTS**

**PROVIDER** must request a contract amendment in writing detailing the nature of and justification for the requested amendment. The **COUNTY** reserves the right to approve or deny all contract amendments. An approved amendment shall be documented on the contract amendment form and signed by both parties. **See Attachment I.**

## **ARTICLE VI            CONTRACTOR STATUS**

### **Independent Contractor**

It is the Parties' intention that the **PROVIDER** will be an independent contractor and not the County's employee for all purposes, including, but not limited to, the application of the Fair Labor Standards Act minimum wage and overtime payments, Federal Insurance Contribution Act, the Social Security Act, the Federal Unemployment Tax Act, the provisions of the Internal Revenue Code, Florida revenue and taxation law, Florida Worker's Compensation law and Florida Unemployment Insurance Law. The **PROVIDER** will retain sole and absolute discretion in the judgment of the manner and means of carrying out the **PROVIDER'S** activities and responsibilities hereunder. The **PROVIDER** agrees that it is a separate and independent enterprise from the public employer, that it has made its own investment in its business, and that it will utilize a high level of skill necessary to perform the work. This agreement shall not be construed as creating any joint employment relationship between the **PROVIDER** and **COUNTY**, and **COUNTY** will not be liable for any obligation incurred by the **PROVIDER**, including, but not limited to, unpaid minimum wages and/or overtime premiums.

### **Subcontracts**

Primary roles and responsibilities of **PROVIDER** cannot be subcontracted. It is mutually agreed that any County-funded program component that is subcontracted by **PROVIDER** must have a written contract upon execution of this contract. The **PROVIDER** must ensure each subcontractor conforms to the terms and conditions of this contract and must be subject to indemnification as stated in Article VII.

## **ARTICLE VII            RISK MANAGEMENT**

### **Indemnification**

The **PROVIDER** will defend, hold harmless, and indemnify the **COUNTY** from and against any and all liability, loss, claims, damages, wages or overtime compensation due its employees, costs, attorneys' fees, and expenses of whatever kind or nature which the **COUNTY** may sustain, incur, or be required to pay either by reason of the loss or improper use of any monies disbursed or to be disbursed hereunder including but not limited to fraud, embezzlement, or dishonesty on the part of any person represented or employed by the **PROVIDER**, or by

reason of the intentional or negligent act of the **PROVIDER** or its agents, representatives and/or employees.

The **PROVIDER** further agrees that it will, at its own expense, defend any and all claims, actions, suits, or proceedings that may be brought against the **COUNTY** in connection with the above and satisfy, pay, and discharge any and all judgments or other resolution of claims that may be entered against the **COUNTY** in any such action or proceedings.

The **PROVIDER** further agrees that it is responsible for any and all claims arising from the hiring of individuals relating to activities provided under the Contract. All individuals hired are employees of the **PROVIDER** and not of the **COUNTY**.

• **Insurance**

The **PROVIDER** agrees to secure and maintain the insurance coverage outlined below during the term of this Contract. All insurance policies shall be issued by companies authorized to do business under the laws of the State of Florida. The **PROVIDER** shall furnish Certificates of Insurance to the **COUNTY** prior to the commencement of operations. The **PROVIDER** agrees that this insurance requirement shall not relieve or limit **PROVIDER'S** liability and that the **COUNTY** does not in any way represent that the insurance required is sufficient or adequate to protect the **PROVIDER'S** interests or liabilities, but are merely minimums. It is the responsibility of the **PROVIDER** to insure that all subcontractors comply with the insurance requirements.

Certificate(s) of Insurance *namimg St. Johns County Board of County Commissioners as Certificate Holder* will be attached to this contract as an exhibit. Certificate(s) must be provided for the following:

1. **Workers' Compensation**– The **PROVIDER** shall maintain during the life of this Contract, adequate Workman's Compensation Insurance and Employer's Liability Insurance in at least such amounts as are required by the law for all of its employees (if four or more) per Florida Statute 440.02.
1. **Professional Liability** – The **PROVIDER** shall maintain during the term of this Contract, standard Professional Liability Insurance in the amount of \$1,000,000 per occurrence
1. **Comprehensive General Liability** - The **PROVIDER** shall maintain during the life of this Contract, Comprehensive General Liability Insurance in the amount of \$1,000,000 per occurrence to protect the PROVIDER from claims for damages for bodily injury, including wrongful death, as well as from claims or property damages which may rise from any operations under this Contract whether such operations be by the PROVIDER or by anyone directly employed by or contracting with the **PROVIDER**.

The General Liability Policy Certificate shall name "St. Johns County, a political subdivision of the State of Florida, its agents, employees, and public officials" as "Additional Insured". The **PROVIDER** agrees that the coverage granted to the Additional Insured applies on a primary basis, with the Additional Insured's coverage being excess.



1. **Business Auto Liability** – The following Automobile Liability will be required and coverage shall apply to all owned, hired, and non-owned vehicles used with minimum limits of:
  - \$100,000 bodily injury per person (BI)
  - \$300,000 bodily injury per occurrence (BI)
  - \$100,000 property damage (PD) or
  - \$300,000 combined single limit (CSL) of BI and PD
1. **Directors & Officers Liability** – Entity coverage to cover claims against the organization directly for wrongful acts with limits not less than \$100,000.
1. **Fidelity Bonding** – Covering all employees who handle the agency’s funds. The bond amount must be equivalent to the highest daily cash balance or a minimum amount of \$50,000.

**C. Notice of cancellation or modification**

St. Johns County will be given thirty (30) days notice prior to cancellation or modification of any stipulated insurance. Such notification will be in writing by registered mail, return receipt requested and addressed to the **St. Johns County** Risk Manager, P. O. Box 349, St. Augustine, FL 32085-0349.

**ARTICLE VIII      SUSPENSION/TERMINATION**

**A. Suspension**

The **COUNTY** reserves the right to suspend funding for failure to comply with the requirements of this contract.

In the event **PROVIDER** ceases operation for any reason or files for protection from creditors under bankruptcy law, any remaining unpaid portion of this Contract, less funds for expenditures already incurred, shall be retained by the **COUNTY** and the **COUNTY** shall have no further funding obligation to the **PROVIDER** with regard to those unpaid funds.

**B. Termination by COUNTY**

The **COUNTY** may at any time and for any reason cancel this Contract by giving twenty-four (24) hours written notice to the **PROVIDER** by Certified Mail following a determination by the Board of County Commissioners, at its sole discretion, that such cancellation is in the best interest of the people of the county. From the date of cancellation, neither party shall have any further obligation unless specified in the termination notice.

**C. Termination by PROVIDER**

The **PROVIDER** may at any time and for any reason cancel this Contract by giving seventy-two (72) hours prior written notice to the **COUNTY** by Certified Mail of such and specifying the effective date.

**COUNTY'S** obligation to make any payments under any provision of this Contract shall cease on the effective date of termination.

## **ARTICLE IX      ASSURANCE, CERTIFICATIONS, AND COMPLIANCE**

The **PROVIDER** agrees that compliance with these assurances and certifications constitutes a condition of continued receipt of or benefit from funds provided through this Contract, and that it is binding upon the **PROVIDER**, its successors, transferees, and assignees for the period during which services are provided.

The **PROVIDER** further assures that all contractors, subcontractors, or others with whom it arranges to provide services or benefits to participants or employees in connection with any of its programs and activities are not discriminating against those participants or employees in violation of statutes, regulations, guidelines and standards. By acceptance of this funding, the **PROVIDER** assures and certifies the following:

- A. That they will comply with all applicable laws, ordinances, and regulations of the United States, the State of Florida, the **COUNTY**, and the municipalities as said laws, ordinances, and regulations exist and are amended from time to time. In entering into this contract, the **COUNTY** does not waive the requirements of any **COUNTY** or local ordinance or the requirements of obtaining any permits or licenses that are normally required to conduct business or activity contemplated by the **PROVIDER**.
- B. That they will comply with all Federal, State and local anti-discrimination laws that are applicable to the **PROVIDER**.
- C. That they will administer their programs under procedures, supervision, safeguards, and such other methods as may be necessary to prevent fraud and abuse, and that it will target its services to those who most need them.
- D. That if clients are to be transported under this contract, the **PROVIDER** will comply with the provisions of Chapter 427, Florida Statutes, which requires the coordination of transportation for the disadvantaged.
- E. That any products or materials purchased with contract funds shall be procured in accordance with the provisions of Chapter 403.7065, Florida Statutes, which refers to the procurement of products or materials with recycled content.
- F. That they will comply with Chapter 39.201, Florida Statutes, that any person who knows, or has reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, as defined in this chapter, shall report such knowledge or suspicion to the Central Abuse Hotline (1-800-342-3720).
- G. That they will comply with Chapter 415.1034, Florida Statutes, that any person who knows or has reasonable cause to suspect that a vulnerable and or disabled adult has been abused, neglected, or exploited, shall immediately report such knowledge or suspicion to the National Center on Elder Abuse Hotline (1-800-962-2873).
- H. That if personnel in programs under this contract work directly with children or youths

and vulnerable or disabled adults, the **PROVIDER** will comply with the provisions of Chapters 435.03 and 435.04, Florida Statutes, which requires employment screening.

- . That they will comply with Chapter 216.347, Florida Statutes, which prohibits the expenditure of contract funds for the purpose of lobbying the legislature, State or county agencies.
- . That they will notify the **COUNTY** immediately of any funding source changes and/or additions from other sources that are different from that shown in the **PROVIDER'S** application. This notification must include a statement as to how this change in funding affects provision of service as well as the use of and continued need for **COUNTY** funds.
- . That they will acknowledge support for activities funded wholly or in part by **COUNTY** funds.
- . That they will notify the **COUNTY** of any SIGNIFICANT changes to the **PROVIDER** organization to include Articles of Incorporation and Bylaws within ten (10) working days of the effective date.

**ARTICLE X            HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**

St. Johns County, pursuant to the Federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a "covered entity" as the law defines that term. Any "personal health information" ("PHI") as defined by the law that the **COUNTY** receives pursuant to this Agreement is subject to the disclosure and security requirements of HIPAA. Transfer of information to the **COUNTY** sufficiently "de-identified" to no longer be considered PHI is encouraged as being in the best interest of client PHI confidentiality to the extent that client services are unaffected. Particular methods to accomplish the highest levels of client service coupled with PHI confidentiality shall be an on-going task of the effected staffs of the **COUNTY** and **PROVIDER**.

**ARTICLE XI            NOTICES**

Official notices concerning this Contract shall be directed to the following authorized representatives:

**PROVIDER:**

Name: Gary Bruce  
Title: Executive Director  
Agency: Project Special Care  
Address: 2155 Old Moultrie Rd. Ste. 101  
St. Augustine, FL 32086  
Telephone: (904) 797-0600  
Fax: (904) 797-0608  
Email : mti2200@aol.com

**COUNTY:**


Name: Ann Henry  
Title: Contracts Coordinator  
SJC Social Services/HHS Dept.  
Address: 1955 US 1 South, Suite D9  
St. Augustine, FL 32086  
Telephone: (904) 209-6142  
Fax: (904) 209-6141  
Email: ahenry@co.st-johns.fl.us

The signatures of the **two** persons shown below are designated and authorized by the **Provider** to sign all applicable reports:

**Gary Bruce**

OR **Denise Rosa**

  
Signature

  
Signature

**Executive Director**

Title:

**Administrative Director**

Title:

In the event that either party designates different representatives after execution of this contract, notice of the name and address of the new representative will be rendered in writing by authorized officer of **PROVIDER** to the **COUNTY**. The notification shall be attached to originals of this Contract.

**ARTICLE XII      SPECIAL PROVISIONS**

If needed, **PROVIDER** may be called upon to assist **COUNTY** during a natural disaster or emergency.

**ARTICLE XIII      ALL TERMS AND CONDITIONS INCLUDED**

This contract and its attachments, and any exhibits referenced in said attachments, together with any documents incorporated by reference, contain all the terms and conditions agreed upon by the parties. There are no provisions, terms, conditions, or obligations other than those contained herein, and this contract shall supersede all previous communications, representations, or agreements, either verbal or written between the parties. If any term or provision of this contract is legally determined unlawful or unenforceable, the remainder of the contract shall remain in full force and effect and such terms or provisions shall be stricken.

**ARTICLE XIV GOVERNING LAW**

This contract shall be construed according to the laws of the State of Florida. Venue for any State administrative and/or legal action arising under this contract shall be in St. Johns County, Florida. Venue for any federal legal action arising under this contract shall be in the United States District Court, Middle District of Florida.

**ARTICLE XV SEVERABILITY**

If any word, phrase, sentence, part, section, subsection, or other portion of this contract, or any application thereof, to any person or circumstance is declared void, unconstitutional, or invalid for any reason, then such word, phrase, sentence, part, section, subsection, other portion, or the proscribed application thereof, shall be severable, and the remaining portions of this contract, and all applications thereof, not having been declared void, shall remain in full force, and effect.

**IN WITNESS THEREOF, PROVIDER and COUNTY** have caused this 12-page contract and all Contract Exhibits and Attachments as indicated on next page to be executed by their undersigned officials as duly authorized.

**PROVIDER:**

By: Gary Bruce

(Signature of authorized officer)

Title: Executive Director

10-11-07

Date

**COUNTY: ST. JOHNS COUNTY**

By: Ben Rich

(Signature of authorized officer)

Title: Chair, Board of County Commissioners

Date

**STATE OF FLORIDA  
COUNTY OF ST. JOHNS**

**ATTEST: CLERK OF CIRCUIT COURT**

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

The foregoing instrument was acknowledged before me this 11 day of OCTOBER, 2007,

by GARY BRUCE, who is personally known to me or who has produced \_\_\_\_\_ as identification and who  did  did not take an oath.

**APPROVED AS TO FORM:  
COUNTY ATTORNEY'S OFFICE**

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

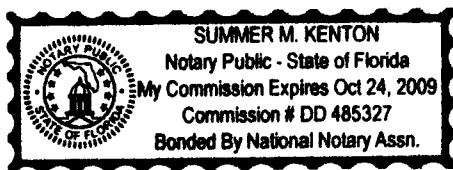
**NOTARY:**

By: \_\_\_\_\_

Notary of Public (Signature)

SUMMER KENTON

Name (Typed/Printed)



By: Michael J. Hunt

Title: Deputy County Attorney

Date: 10/13/07

## Attachment I

**"To the extent not in conflict with, or violative of, any applicable County, State, or Federal ordinance, statute, law, policy, rule, or regulation, and further, to the extent that such action promotes a public purpose, then the Provider may request, in writing, that any unused, and/or unallocated funds may be transferred to a different project task, or transferred to different accounting code, in order to be used by the Provider, for a purpose and/or task, not noted in the existing Contract, or an under funded project task that is noted in the existing Contract.**

**"In its written request, the Provider shall specifically state that the funds sought to be transferred and/or redirected, are funds that have not been allocated for another task, or pledged/committed for services already performed. Additionally, the Provider must state, in writing, the scope and/or nature of the public purpose that will be achieved/obtained by transferring/re-directing such funds.**

**"The County is not obligated to approve such a request. However, the County shall examine and/or evaluate the Provider's request, and issue a written or electronic opinion within 10 days of the request, either approving, approving with conditions, or denying the request.**

**"The County shall consider the following factors when evaluating/examining the Provider's request to transfer funds: (1) whether the transfer of funds to a different project task will promote a public purpose--if so, what? (2) will the transfer of funds to a different project task, duplicate services provided through existing projects, (3) if applicable, whether provisions in a matching State or Federal Contract prevent, or severely restrict the transfer of funds to a different project task; and (4) any other factor deemed relevant by the County.**

**"It is explicitly understood, that should the County approve such a transfer of funds, the Provider is liable for any financial shortfalls, or associated penalties, or costs in the original project task fund.**

**"Should the County approve such a transfer of funds, the County and the Provider shall execute an Amendment to the Contract that sets forth the rationale for the approval of the transfer of such funds."**

**EXHIBIT 1**

**PAYMENT REQUEST  
UNIT COST CONTRACT**

Mail to: Attn: Ann Henry, Contracts Coordinator  
 SJC Social Services/HHS Department  
 1955 US 1 South, Suite D9  
 St. Augustine, FL 32086

Contract No. \_\_\_\_\_  
 Funding Source \_\_\_\_\_  
 Fiscal Year \_\_\_\_\_  
 Reporting period: \_\_\_\_\_

Agency: \_\_\_\_\_  
 Project Special Care \_\_\_\_\_  
 Mailing Address: 2155 Old Moultrie Road, Suite 101  
 St. Augustine, FL 32086

Please call Social Services with any questions:  
 Tel: (904) 209-6142 Fax: (904) 209-6141  
 E-Mail: ahenry@co.st-johns.fl.us

Check appropriate line:

Regular Payment  
 (due 20th of month following)

Final Payment  
 (due Oct. 10, 2009)

Phone: (904) 797-0600  
 E-MAIL: mh2200@aol.com  
 FAX: (904) 797-0608

a. NAME OF EACH PROGRAM RECEIVING FUNDING FROM ST. JOHNS COUNTY	ANNUAL BUDGET				CURRENT MONTH			YEAR-TO-DATE				
	b. TOTAL NUMBER SERVICE UNITS PROJECTED FOR PROGRAM	c. TOTAL NUMBER SERVICE UNITS TO BE FUNDED BY ST. JOHNS COUNTY	d. UNIT COST FUNDED BY ST. JOHNS COUNTY	e. TOTAL FY2006 BUDGET AMOUNT	f. # TOTAL UNITS PROVIDED IN PROGRAM CURRENT MONTH	g. # UNITS BILLED TO ST. JOHNS COUNTY CURRENT MONTH	h. AMOUNT BILLED TO ST. JOHNS COUNTY CURRENT MONTH (col. D x col. g)	i. # UNITS BILLED TO ST. JOHNS COUNTY YEAR TO DATE	j. TOTAL UNITS PROVIDED IN PROGRAM YEAR TO DATE	k. AMOUNT BILLED TO ST. JOHNS COUNTY YEAR TO DATE	l. NUMBER OF ST. JOHNS COUNTY FUNDED UNITS REMAINING (col. c-col. j)	m. FUNDS REMAINING (col. e-col. k)
Adult Day Training	1580.00	197.50	\$66.45	\$13,123.88			\$0.00				197.50	\$13,123.88
Respite Care	14000.00	1011.97	\$16.45	\$16,646.91			\$0.00				2200.00	\$16,646.91
							\$0.00				0.00	\$0.00
							\$0.00				0.00	\$0.00
<b>TOTAL</b>	<b>15,580.00</b>	<b>1,209.47</b>		<b>\$29,770.78</b>	<b>0.00</b>	<b>0.00</b>	<b>\$0.00</b>	<b>0.00</b>	<b>0.00</b>	<b>\$0.00</b>	<b>2,397.50</b>	<b>\$29,770.78</b>

I certify that all services on this report have been performed in compliance with applicable statutes and regulations, and in accordance with the approved County contract.

TOTAL REQUEST

\$0.00

Signature of authorized representative \_\_\_\_\_

DATE \_\_\_\_\_

FOR ST. JOHNS COUNTY USE ONLY	
CERTIFIED BY:	_____
DATE:	_____
AUTHORIZED BY:	_____
DATE:	_____

**Exhibit 2**  
**DEMOGRAPHICS REPORT** (Demographics of Clients Served in Program)

*DEMOGRAPHICS OF CLIENTS SERVED IN PROGRAM Program Name: Project Special Care Respite Care*

**UNDUPLICATED CLIENT CHARACTERISTICS**

Reporting Period : <input type="checkbox"/> October 1, 2008 through March 31, 2008 <input type="checkbox"/> April 1, 2008 through September 30, 2008		# of Clients served in Program	
<b>AGE GROUP</b>			
5 and under			
6 - 12 years			
13 - 17 years			
18 - 59 years			
60 -64 years			
65 & over			
Not collected			
<b>Total</b>		0	
<b>GENDER</b>		<b>Children (0-17)</b>	<b>Adults (18 &amp; up)</b>
Male			
Female			
Not collected			
<b>Total</b>		0	0
<b>RACE</b>			
American Indian or Alaska Native			
Asian			
Black or African American			
Native Hawaiian or Pacific Islander			
White			
Unknown			
Not collected			
<b>Total</b>		0	0
<b>ETHNICITY</b>			
Hispanic or Latino			
Haitian			
Other			
Unknown			
Not collected			
<b>Total</b>		0	0
<b>LEGAL RESIDENCE AT REFERRAL</b>			
32033			
32145			
32080			
32082			
32084			
32085			
32086			
32092			
32095			
32259			
Out of County			
Not Collected			
<b>Total</b>		0	0
\$0-\$19,152.00 Annually			
\$19,153.00-\$			
\$23,491.00-\$			
\$28,729.00-\$			
\$33,517.00-\$38,304.00 Annually			
\$38,305.00-\$43,092.00 Annually			0



**Exhibit 2**  
**DEMOGRAPHICS REPORT** (Demographics of Clients Served in Program)

*DEMOGRAPHICS OF CLIENTS SERVED IN PROGRAM Program Name: Project Special Care Adult Day Training*  
**UNDUPLICATED CLIENT CHARACTERISTICS**

Reporting Period : ___ October 1, 2008 through March 31, 2008 ___ April 1, 2008 through September 30, 2008		# of Clients served in Program	
<b>AGE GROUP</b>			
	5 and under		
	6 - 12 years		
	13 - 17 years		
	18 - 59 years		
	60 -64 years		
	65 & over		
	Not collected		
	<b>Total</b>	0	
<b>GENDER</b>		<b>Children (0-17)</b>	<b>Adults (18 &amp; up)</b>
	Male		
	Female		
	Not collected		
	<b>Total</b>	0	0
<b>RACE</b>			
	American Indian or Alaska Native		
	Asian		
	Black or African American		
	Native Hawaiian or Pacific Islander		
	White		
	Unknown		
	Not collected		
	<b>Total</b>	0	0
<b>ETHNICITY</b>			
	Hispanic or Latino		
	Haitian		
	Other		
	Unknown		
	Not collected		
	<b>Total</b>	0	0
<b>LEGAL RESIDENCE AT REFERRAL</b>			
	32033		
	32145		
	32080		
	32082		
	32084		
	32085		
	32086		
	32092		
	32095		
	32259		
	Out of County		
	Not Collected		
	<b>Total</b>	0	0
	\$0-\$19,152.00 Annually		
	\$19,153.00-\$		
	\$23,491.00-\$		
	\$28,729.00-\$		
	\$33,517.00-\$38,304.00 Annually		
	\$38,305.00-\$43,092.00 Annually		0

**EXHIBIT 3**

**PERFORMANCE OUTCOME REPORT**

Page 1 of 3

**Provider Name: Project Special Care**

**Reporting Period: 10/01/07-03/31/08**

**04/01/08-09/30/08**

**Program: Adult Day Training**

**Outcome # 1: 100% of participants will increase their basic life skills.**

**Service Description: Individualized training plans; supervision, coaching and assistance with activities of daily living.**

**Required Documentation: Weekly, monthly and annual reports; client case files; service logs.**

<b>(Column 1)</b>	<b>(Column 2)</b>	<b>(Column 3)</b>	<b>(Column 4)</b>
<b>Projected # Served Annually</b>	<b>Actual # Served Year to Date</b>	<b>Total # Achieving Outcome Year to Date</b>	<b>% Clients Achieving Outcome (Column 2/Column 3)</b>
15			

**Outcome # 2: 100% of participants will increase their communication ability.**

**Service Description: Individualized training plans; supervision, coaching and assistance with activities of daily living.**

**Required Documentation: Weekly, monthly and annual reports; client case files; service logs**

<b>(Column 1)</b>	<b>(Column 2)</b>	<b>(Column 3)</b>	<b>(Column 4)</b>
<b>Projected # Served Annually</b>	<b>Actual # Served Year to Date</b>	<b>Total # Achieving Outcome Year to Date</b>	<b>% Clients Achieving Outcome (Column 2/Column 3)</b>
15			

**Outcome #3:** 100% of participants will increase their health, well being and personal hygiene.

**Service Description:** Individualized training plans; supervision, coaching and assistance with activities of daily living.

**Required Documentation:** Weekly, monthly and annual reports; client case files; service logs; staff observation of physical condition and receipt of personal care.

(Column 1)	(Column 2)	(Column 3)	(Column 4)
Projected # Served Annually	Actual # Served Year to Date	Total # Achieving Outcome Year to Date	% Clients Achieving Outcome (Column 2/Column 3)
15			

**Outcome #4:** 100% of participants will increase their self knowledge and movement toward independence.

**Service Description:** Individualized training plans; supervision, coaching and assistance with activities of daily living.

**Required Documentation:** Weekly, monthly and annual reports; client case files; service logs

(Column 1)	(Column 2)	(Column 3)	(Column 4)
Projected # Served Annually	Actual # Served Year to Date	Total # Achieving Outcome Year to Date	% Clients Achieving Outcome (Column 2/Column 3)
15			

**Outcome #5:** 100% of participants will increase their integration within the community.

**Service Description:** Individualized training plans; supervision, coaching and assistance with activities of daily living; use of public transportation and community resources.

**Required Documentation:** Daily and weekly, reports; client case files; service logs

(Column 1)	(Column 2)	(Column 3)	(Column 4)
Projected # Served Annually	Actual # Served Year to Date	Total # Achieving Outcome Year to Date	% Clients Achieving Outcome (Column 2/Column 3)
15			

**Outcome # 6:** 100% of participants will have a decrease in abuse or neglect.

**Service Description:** Physical inspection of individuals for trauma by staff; staff observation of behavior.

**Required Documentation:** Daily and weekly reports; client case files

(Column 1) Projected # Served Annually	(Column 2) Actual # Served Year to Date	(Column 3) Total # Achieving Outcome Year to Date	(Column 4) % Clients Achieving Outcome (Column 2/Column 3)
15			

**Outcome # 7:** 100% of participants will have a decrease in out of home placement.

**Service Description:** Enrollment and attendance in adult day training program; support provided by independent support coordinator.

**Required Documentation:** Completion and review of support plan; client case files

(Column 1) Projected # Served Annually	(Column 2) Actual # Served Year to Date	(Column 3) Total # Achieving Outcome Year to Date	(Column 4) % Clients Achieving Outcome (Column 2/Column 3)
15			

**Instructions:** *Outcome:* What is the desired result of the program? *Service Description:* How is the result being accomplished? *Required Documentation:* What written documentation is being collected to support the results?  
**Column 1** – Total annual number of clients projected to be served in this program per proposal. **Column 2** – Actual number of clients served in program year to date. **Column 3** – Total number of clients served that met outcome. **Column 4** – Percent of clients served that met outcome (column 2 divided by column 3)

**EXHIBIT 3**

**PERFORMANCE OUTCOME REPORT**

Page 1 of 3

**Provider Name: Project Special Care**

**Reporting Period:** 10/01/07-03/31/08  
04/01/08-09/30/08

**Program: Respite Care for Children With Special Needs**

**Outcome # 1:** 100% of participants will have an increase in their level of care.

**Service Description:** All participants are to be assessed twice daily for personal appearance and physical health; personal care assistance provided by staff.

**Required Documentation:** Attendance logs; service data; client case files; incident reports,

(Column 1)	(Column 2)	(Column 3)	(Column 4)
<b>Projected # Served Annually</b>	<b>Actual # Served Year to Date</b>	<b>Total # Achieving Outcome Year to Date</b>	<b>% Clients Achieving Outcome (Column 2/Column 3)</b>
15			

**Outcome # 2:** 90% of participants will have improved hygiene.

**Service Description:** All participants are to be assessed twice daily for personal hygiene; personal care assistance provided by staff.

**Required Documentation:** Attendance logs; service data; client case files; incident reports,

(Column 1)	(Column 2)	(Column 3)	(Column 4)
<b>Projected # Served Annually</b>	<b>Actual # Served Year to Date</b>	<b>Total # Achieving Outcome Year to Date</b>	<b>% Clients Achieving Outcome (Column 2/Column 3)</b>
15			

**Outcome # 3:** 80% of participants will increase their attitude and degree of participation.

**Service Description:** Individualized training plans; supervision, coaching and assistance with activities of daily living; peer interaction in appropriate, supervised activities;

**Required Documentation:** Staff observations; parent satisfaction surveys; case notes.

(Column 1) Projected # Served Annually	(Column 2) Actual # Served Year to Date	(Column 3) Total # Achieving Outcome Year to Date	(Column 4) % Clients Achieving Outcome (Column 2/Column 3)
15			

**Outcome # 4:** 80% of family members will increase their knowledge of care issues and resources available.

**Service Description:** Distribution of information, attendance of programs and referrals given to other providers.

**Required Documentation:** Monthly reports, with annual reviews.

(Column 1) Projected # Served Annually	(Column 2) Actual # Served Year to Date	(Column 3) Total # Achieving Outcome Year to Date	(Column 4) % Clients Achieving Outcome (Column 2/Column 3)
50			

**Outcome # 5:** 90% of participants will have a decrease in abuse or neglect.

**Service Description:** Physical inspection of individuals for trauma by staff; staff observation of behavior.

**Required Documentation:** Daily and weekly reports; client case files; incident reports.

(Column 1) Projected # Served Annually	(Column 2) Actual # Served Year to Date	(Column 3) Total # Achieving Outcome Year to Date	(Column 4) % Clients Achieving Outcome (Column 2/Column 3)
15			

**Outcome # 7:** 90% of participants will have a decrease in out of home placement.

**Service Description:** Enrollment and attendance in adult day training program; support provided by independent support coordinator.

**Required Documentation:** Completion and review of support plan; client case files

(Column 1) Projected # Served Annually	(Column 2) Actual # Served Year to Date	(Column 3) Total # Achieving Outcome Year to Date	(Column 4) % Clients Achieving Outcome (Column 2/Column 3)
15			

**Outcome # 8:** 90% of participants and their families will increase their recreational activities.

**Service Description:** Enrollment and attendance in respite program; participation at events.

**Required Documentation:** Attendance logs; service data; daily tracking.

(Column 1) Projected # Served Annually	(Column 2) Actual # Served Year to Date	(Column 3) Total # Achieving Outcome Year to Date	(Column 4) % Clients Achieving Outcome (Column 2/Column 3)
50			

**Instructions:** *Outcome:* What is the desired result of the program? *Service Description:* How is the result being accomplished? *Required Documentation:* What written documentation is being collected to support the results?  
**Column 1** – Total annual number of clients projected to be served in this program per proposal. **Column 2** – Actual number of clients served in program year to date. **Column 3** – Total number of clients served that met outcome. **Column 4** – Percent of clients served that met outcome (column 2 divided by column 3)

S:\INTSVCS\STANDARD FORMS\PFR Outcomes Report 2006.doc





**EXHIBIT 4**  
**ST. JOHNS COUNTY HEALTH & HUMAN SVCS. DEPARTMENT**  
**AGENCY: Project Special Care**  
**PROGRAM: Adult Day Training**  
**QUARTERLY UNIT RATE REPORT**

PERIOD	REPORT DUE	CHECK PERIOD
OCT-DEC	1/31/2008	
JAN-MAR	4/30/2008	
APR-JUNE	7/31/2008	
JULY-SEPT	10/31/2008	

(A) EXPENSE CATEGORY	(B) BUDGET Per Proposal	BUDGET Revised	(C) EXPENSES FIRST QT. 10/01/07-12/31/07	(D) EXPENSES SECOND QT. 1/1/08-3/31/08	(E) EXPENSES THIRD QT. 4/01/08-6/30/08	(F) EXPENSES FOURTH QT. 7/01/08-9/30/08	(G) EXPENSES TOTAL	(H) PERCENT OF BUDGET
Salaries	\$65,520.00						\$0.00	0.00%
Payroll Taxes	\$11,259.00						\$0.00	0.00%
Employee Benefits	\$1,100.00						\$0.00	0.00%
Employee Leasing (including fees)	\$0.00						\$0.00	0.00%
Advertising	\$900.00						\$0.00	0.00%
Audit	\$2,850.00						\$0.00	0.00%
Bonding Insurance	\$2,710.00						\$0.00	0.00%
Contract Labor	\$0.00						\$0.00	0.00%
Dues and Subscriptions	\$220.00						\$0.00	0.00%
Equipment Rental	\$0.00						\$0.00	0.00%
Mileage	\$0.00						\$0.00	0.00%
Office Expense	\$852.00						\$0.00	0.00%
Professional Services	\$750.00						\$0.00	0.00%
Rent/Mortgage	\$9,122.00						\$0.00	0.00%
Repairs and Maintenance	\$957.00						\$0.00	0.00%
Telephone	\$1,520.00						\$0.00	0.00%
Training Expense/Travel	\$626.00						\$0.00	0.00%
Utilities	\$0.00						\$0.00	0.00%
Food	\$6,812.00						\$0.00	0.00%
TOTAL EXPENSES	\$105,198.00		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	0.00%
NO. OF UNITS	1580							
TOTAL UNIT COST	\$	66.58	#VALUE!	#VALUE!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

I certify that the information submitted on this report is, to the best of my knowledge, correct and accurate.

Signed By: \_\_\_\_\_ Position: \_\_\_\_\_ Date: \_\_\_\_\_

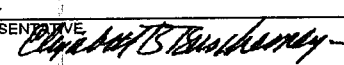
<b>ACORD CERTIFICATE OF LIABILITY INSURANCE</b>		OP ID B3 PROJE-2	DATE (MM/DD/YYYY) 09/21/07
PRODUCER  <b>Harden &amp; Associates, Inc.</b> 806 Riverside Ave. Jacksonville FL 32204 Phone: 904-354-3785 Fax: 904-634-1302		THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.	
INSURED  <b>Project Special Care, Inc.</b> <b>Gary Bruce/Exec. Director</b> 2155 Old Moultrie Rd, #101 St. Augustine FL 32086		INSURERS AFFORDING COVERAGE  INSURER A. <b>Colony Insurance Co.</b> NAIC # <b>39993</b> INSURER B. <b>United States Liability Ins. Co</b> NAIC # <b>25895</b> INSURER C: INSURER D: INSURER E:	

**COVERAGES**

THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS

INSR	ADD'L	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS
A	X	<b>GENERAL LIABILITY</b>	AP509987	03/26/07	05/01/08	EACH OCCURRENCE \$ <b>1,000,000</b>
		<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input checked="" type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR <input checked="" type="checkbox"/> <b>Professional Liab</b> GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC				DAMAGE TO RENTED PREMISES (Ea occurrence) \$ <b>100,000</b> MED EXP (Any one person) \$ <b>Excluded</b> PERSONAL & ADV INJURY \$ <b>1,000,000</b> GENERAL AGGREGATE \$ <b>1,000,000</b> PRODUCTS - COMP/OP AGG \$ <b>1,000,000</b>
		<b>AUTOMOBILE LIABILITY</b>				COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
		<b>GARAGE LIABILITY</b>				AUTO ONLY - EA ACCIDENT \$ OTHER THAN AUTO ONLY EA ACC AGG \$
		<b>EXCESS/UMBRELLA LIABILITY</b>				EACH OCCURRENCE \$ AGGREGATE \$ DEDUCTIBLE \$ RETENTION \$
		<b>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</b>				ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? If yes, describe under SPECIAL PROVISIONS below OTHER
B		<b>Directors &amp; Officers Liability</b>	NDO1020033F	03/13/07	03/13/08	WC STATUTORY LIMITS OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - EA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$ Per Claim <b>1,000,000</b> Aggregate <b>1,000,000</b>

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS  
**Certificate Holder is named as an Additional Insured for General Liability.**

<b>CERTIFICATE HOLDER</b>  STJOHN8  St. Johns County 4010 Lewis Speedway St. Augustine FL 32085	<b>CANCELLATION</b>  SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL <u>10</u> DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.  AUTHORIZED REPRESENTATIVE 
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