**Contractors/Providers**: Complete this form and submit it to the assigned contract manager for review, along with the Recipient-Subrecipient and Contractor-Vendor Determination Checklist for State-Federal Funds, Conflict of Interest form(s), and a copy of the subcontract.

1. Subcontractor’s legal name and address:

|  |  |
| --- | --- |
| Legal Name: |  |
|  |  |
| Street Address: |  |
| City, State, Zip Code: |  |

1. Complete Recipient-Subrecipient and Contractor-Vendor Determination Checklist to determine subcontractor relationship:

[ ]  Recipient/Subrecipient [ ]  Contractor/Vendor

1. Brief Description of the subcontract scope of work:
2. Amount of the subcontract: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Percentage of subcontract allocated from primary agreement: \_\_% (amount of subcontract ÷ amount of contract = percentage)
4. Does the subcontractor currently employ current or former DOH employees? Yes [ ]  No [ ]
5. If yes to F, please provide the name(s) and the role(s).

|  |  |
| --- | --- |
| Name: | Role: |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

1. Did any subcontractor staff participate in the Department’s procurement of this contract?

Yes [ ]  No [ ]

1. If yes to H, please provide the name(s) and the role(s).

|  |  |
| --- | --- |
| Name: | Role: |
|  |  |
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1. Does the subcontractor have any contracts or subcontracts with DOH?

Yes [ ]  No [ ]

1. If yes, please provide the contract number(s).

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1. Did the Provider's subcontracting agreement include the requirement to comply with the prohibition of indoor smoking, pursuant to the Pro-Child Act of 1994? (Federal Funding Only - use N/A if contract does not consist of federal funds)

Yes [ ]  No [ ]  N/A [ ]

1. Did the Provider's subcontracting agreement include the provisions for Audits, Records (including electronic storage media) and Records Retention?

Yes [ ]  No [ ]

1. Did the Provider's subcontracting agreement include the provision of independent capacity of contractor?

Yes [ ]  No [ ]

1. Did the Provider's subcontracting agreement adequately identify the financial assistance award information? (CFDA/CSFA# and title, award year, name of awarding agency, award name/title - Subrecipient Only - use N/A if Provider was not determined as a subrecipient relationship)

Yes [ ]  No [ ]  N/A [ ]

1. Did the Provider's subcontracting agreement advise the subrecipient of financial assistance of applicable laws, rules, regulations? (Subrecipient Only - use N/A if Provider was not determined as a subrecipient relationship)

Yes [ ]  No [ ]  N/A [ ]

1. Did the Provider's subcontracting agreement include the requirement that a financial and compliance audit be submitted to the Provider per §215.97 (FL Single Audit Act), F.S. and/or OMB 2 CFR Part F? (Fed Single Audit Act - Subrecipient Only - use N/A if Provider was not determined as a subrecipient relationship)

Yes [ ]  No [ ]  N/A [ ]

1. Did the Provider’s subcontracting agreement include the requirement to submit the Annual Executive Compensation Report including the most recent Internal Revenue Services (IRS) Form 990 by January 31 of each contract year? (Use N/A if Provider was not determined as a subrecipient relationship or if Provider is exempt from the Annual Compensation requirement)

Yes [ ]  No [ ]  N/A [ ]

1. Did the Provider’s subcontracting agreement include the USDA WIC Services Assurance of Civil Rights Compliance requirement approved by the U.S. Department of Agriculture? (Use N/A if contract is unrelated to services or commodities being provided to WIC applicants or participants)

Yes [ ]  No [ ]  N/A [ ]

1. Did the Provider’s subcontracting agreement include background and drug screening requirements?

Yes [ ]  No [ ]

1. Did the Provider’s subcontracting agreement include the Employment Eligibility Verification which requires subcontractors performing work or providing services pursuant to the contract use the E-Verify system to verify employment eligibility of all employees used by the subcontractor for the performance of service.

Yes [ ]  No [ ]

**Attestation and Signature of Provider Representative/Authority**

“I, (Printed/Typed Name of Provider Representative) certify that the provided information is true and correct; the applicable provisions above have been incorporated in the subcontract agreement. I understand that the Department of Health reserves the right to review the subcontract agreement and additional documentation as needed.”

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Signature: |  | Date: |  | Contract #: |  |

 Title of Representative/Authority

**Department of Health Approval**

I, (contract manager) have reviewed the information above and consulted with management. The request is:

 Approved **[ ]**  Not Approved **[ ]**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Signature: |  | Date: |  | Contract #: |  |

 Contract Manager

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |   | Date: |  |

 Contract Manager’s Supervisor

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |   | Date: |  |

 Division Director/CHD Health Officer/Administrator