**SUB DELEGATION APPROVAL AND REQUIREMENTS**

# Sub-Delegation of contract requirements from:

|  |  |  |  |
| --- | --- | --- | --- |
|  | CBCIH to CBC Lead Agency |  | CBC Lead Agency to other Entity |

# SUB DELEGATION: REQUEST FOR APPROVAL

In accordance with Vendor Agreement #3 “Sub Delegation”, advanced approval is required from the Health Plan to sub-delegate care coordination responsibilities to the following entity:

|  |  |  |
| --- | --- | --- |
| Name: |  |  |
| TIN/EIN: |  |  |
| Submit Date: |  |  |
| Effective Date: |  | (*Note: Must be 120 days later than “Submit Date”*) |

In accordance with Vendor Agreement #3 “Sub Delegation”, this written request must include an objective evaluation of the sub-delegate’s ability to perform the functions and comply with applicable state and federal statutes and rules, and accreditation requirements. The following is the objective evaluation of the agency’s ability to perform the functions:

CBCIH and/or the CBC Lead Agency shall provide documentation and demonstrate oversight of the sub-delegate which includes:

* Contract – An executed agreement, that defines the delegated responsibilities of the Vendor and sub-delegate, reporting requirements consistent with those outlined in this agreement, the process by which the Vendor evaluates the sub-delegate’s compliance with performance requirements in this Agreement at least every twelve (12) months, and the remedies, including revocation of the sub-delegation, available to the Vendor if the sub-delegate does not fulfill its obligations
* Capacity Evaluation – Evaluation of the sub-delegate’s capacity to perform the delegated activities prior to the execution of the contract
* Annual Monitoring – Annual evaluation of performance in accordance with Health Plan’s, accreditation,  
  regulatory and statutory standards

|  |  |  |  |
| --- | --- | --- | --- |
| **Evaluation**: | |  | |
| Signature: | |  | |
| Name: | |  | |
| Title: | |  | |
| Company: | | CBCIH | |
| Date: | |  | |

**HEALTH PLAN RESPONSE**

Approved

Denied Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Note: If the Health Plan denies the request, the sub-delegate may not be brought forward for consideration as a potential sub-delegate until nine (9) months after the denial decision is rendered.)*

|  |  |
| --- | --- |
| Signature: |  |
| Name: |  |
| Title: |  |
| Company: | Sunshine Health |
| Date: |  |