OHEL CHILDREN' S HOME AND FAMILY SERVICES
BAIS EZRA

CORPORATE COMPLIANCE PLAN

Adopted by the OHEL Children's Home and Family Services Bais Ezra Board on January 19, 2010- Revised

Introduction

Message to Ohel Children's Home and Family Services Employees and Vendors

This manual provides guidance to Ohel's employees, Board and vendors on its Corporate Compliance Program. We have developed this Program to ensure that we comply with federal, state and city laws governing our work and that we adhere to the highest ethical standards in doing so.

The Board of Directors and Executive Management are committed to complying with this Program. As part of this commitment, we will educate and train you on the compliance program's standards, assist you to comply with its provisions and provide an environment in which you can comply without fear of retaliation. In addition, we have provided several methods for you to request assistance or report suspected violations of the compliance policies, including a confidential Hotline at **(718) 438-0941**.

In all of our work, we are committed to conducting ourselves with integrity, both in the delivery of services and in obtaining payment for those services. This commitment cannot be achieved without your commitment and help. We hope you will join us in this endeavor.

Mel Zachter and Jay Kestenbaum
Co-Presidents

David Mandel
Chief Executive Officer

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Code of Conduct

As an integral member of Ohel's team, all individuals and entities that participate in or do business with Ohel including but not limited to all of Ohel's employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers ("Affected Individuals") are expected to accept certain responsibilities, adhere to acceptable business principles in matters of personal conduct, and exhibit a high degree of personal integrity at all times. This not only involves sincere respect for the rights and feelings of others but also demands that both in an employee's business and in their personal life they refrain from any behavior that might be harmful to themselves, their coworkers, contractors, and/or the agency, or that might be viewed unfavorably by current or potential customers or by the public at large.

Whether Affected Individuals are on or off duty, their conduct reflects on Ohel. They are, consequently, encouraged to observe the highest standards of professionalism at all times.

Listed below are some of the rules and regulations of the Agency. This list should not be viewed as being all-inclusive. Types of behavior and conduct that Ohel considers inappropriate and which could lead to disciplinary action up to and including immediate termination of employment or business relationships, without prior warning include but are not limited to, the following:

- Falsifying employment or other Agency records, including, but not limited to, billing documentation, progress notes and contact records;
- Knowingly presenting or causing to be presented a false or fraudulent claim to the Federal government for payment;
- Knowingly making, using, or causing to be made or used, a false statement to get a false or fraudulent claim paid by the Federal government;
- Improper or fraudulent billing for health care services;
- The preparation of inaccurate or incomplete cost reports;
- The payment or receipt of kickbacks in return for client referrals;
- The unauthorized or misuse of Agency funds or supplies;
- Untimely, incomplete or inaccurate documentation;
- Violating the Agency's nondiscrimination and/or sexual harassment policy;
- Soliciting or accepting gratuities from customers or clients;
- Establishing a pattern of excessive absenteeism or tardiness;
- Reporting to work intoxicated or under the influence of nonprescribed drugs;
- Illegally manufacturing, possessing, using, selling, distributing, or transporting drugs;

- Bringing or using alcoholic beverages on the Agency's property or using alcoholic beverages while engaged in the Agency's business off Agency premises, except where authorized;
- Fighting or using obscene, abusive, or threatening language or gestures;
- Stealing property from coworkers, customers, or clients of the Agency;
- Having unauthorized firearms on Agency premises or while on Agency business;
- Disregarding safety or security regulations;
- Engaging in insubordination;
- Failing to maintain the privacy and security of the Agency, customer, or client information;
- Use of corporal punishment or inhumane treatment on consumers;
- Engaging in any activity that constitutes abuse or neglect of consumers as defined in state and federal regulations;
- Modeling inappropriate or unacceptable behavior to a client;
- Failing to maintain client information as confidential and failing to utilize such information in a professional manner at all times. To the extent Affected Individuals obtain HIV related information concerning a client, such information shall be maintained in confidence as required by applicable law;
- Entering into financial transactions between Affected Individuals and clients except with the express written authorization of the Corporate Compliance Officer;
- Leaving clients alone or unsupervised in their residence unless there is specific, written permission for them to be left alone as per their plan of service; and
- Smoking in non-designated agency program sites.

If an Affected Individual's performance, work habits, overall attitude, conduct, or demeanor becomes unsatisfactory in the judgment of the Agency, based on violations either of the above or of any other Agency policies, rules, or regulations, the Affected Individual will be subject to disciplinary action, up to and including dismissal.

Ohel is committed to providing quality residential and non-residential services for individuals with developmental and/or psychiatric disabilities and other services to its clients, while observing the highest standards of professional, clinical, legal and business ethics. Affected Individuals are expected and trained to treat all clients with dignity and respect and comply with all applicable privacy and security laws, including the Health Information Portability and Accountability Act (HIPAA). Training on these items, among others, is provided as part of our orientation process and detailed in Agency policy and procedure. Ohel is committed and obligated to comply with all applicable federal and state legal and regulatory standards and requirements, including any Medicaid program policies and procedures, as specified in subdivision (d) of section 18 NYCRR Part 521-1.3. Ohel's Compliance Program forms the foundation of Ohel's overall compliance efforts, which seek to ensure continuing compliance with all applicable laws, rules, regulations and contractual obligations that govern Ohel's operations.

Ohel developed its Compliance Program, including its Code of Conduct and policies and procedures that address key risk areas, to guide its best efforts to operate under ethical and legal standards. Ohel expects that all aspects of patient care and business conduct will be performed in compliance with this Compliance Program, professional standards and applicable governmental laws, rules and regulations.

To demonstrate that Ohel has developed an effective compliance program, Ohel must demonstrate that it has (1) developed standards, procedures, and a Code of Conduct in order to reduce the prospect of improper conduct; (2) designated a Compliance Officer and Compliance Committee to oversee compliance; (3) taken steps to train and communicate the standards to Affected Individuals as appropriate; (4) established a reporting system by which Affected Individuals can report potential misconduct without fear of intimidation, retaliation, or retribution; (5) developed disciplinary policies to encourage good faith participation in the Compliance Program by all Affected Individuals and taken appropriate disciplinary measures against individuals found to have violated the Compliance Program or related policies and procedures; (6) engaged in internal auditing of documentation, billing and other compliance obligations; and (7) taken reasonable steps to respond to and prevent future violations. The following Compliance Program Overview establishes the steps Ohel has implemented to ensure the effectiveness of its Program.

Policies and Procedures Overview

Ohel's compliance philosophy is expressed within this Compliance Program and related documents, including the Code of Conduct and policies and procedures related to compliance, clinical operations, human resources and fiscal management. Collectively, these documents establish standards and procedures that must be followed by Ohel employees and, as applicable, its contractors and the Board. Following these standards will reduce the prospect of unethical, illegal and criminal conduct.

The Code of Conduct emphasizes the shared common values and culture Ohel seeks to cultivate that guide Ohel's operations each day. As part of the hiring and appointment process, Ohel will disseminate the Plan to new employees and Board members and train them on such. Ohel also requires that a copy of the Ohel Compliance Program and Code of Conduct be provided to all contractors that are required to receive such by applicable law.

Ohel will review, revise and develop new policies and procedures, as necessary, to ensure that Ohel operations are conducted in accordance with any changes in law or newly identified areas of significant risk.

Compliance Program Structure and Oversight Responsibilities

Corporate Compliance Officer

Ohel has designated a Compliance Officer with overall responsibility for the day-to-day management and oversight of the development, implementation, operations and revision of the Compliance Program. The Compliance Officer reports directly to the Chief Administrative Officer ("CAO"), and periodically to the Board of Directors or its Risk Management Committee. The Compliance Officer may be reached at 718-686- 3320 or through the confidential Compliance Hotline at **(718) 438-0941**. The duties and responsibilities of the Corporate Compliance Officer include:

With the assistance of the Corporate Compliance Committee, developing, overseeing and monitoring implementation of the Compliance Program, including the Code of Conduct and the Hotline, and ensuring that the effectiveness of the Compliance Program is maintained at all times so that Ohel may certify annually to the Department of Health that this Program meets the requirements of 18 NYCRR Part 521;

Developing, coordinating and participating in a multifaceted educational and training program that focuses on the key elements of the Compliance Program and seeks to ensure that all Ohel Affected Individuals are knowledgeable of, understand, and comply with, all applicable federal and state legal and regulatory standards and requirements;

Developing and implementing specific written policies and procedures that establish processes to facilitate regulatory compliance, as well as disciplinary guidelines for violations of the Compliance Program, and that require Ohel Affected Individuals to report suspected fraud and other improprieties without fear of retaliation;

Assessing areas of risk for the organization and tailoring the operations of the Program (policies, training, auditing) to those risk areas;

Directing and coordinating activities related to regular internal audits to investigate and monitor compliance with standards and procedures under the Compliance Program and applicable laws and regulations;

Drafting, implementing and updating an annual compliance work plan;

Reporting directly to the Chief Executive Officer, the Compliance Committee and the Board of Directors' Risk Management Committee and/or the Board leadership, on the progress of adopting, implementing and maintaining the compliance program.

Corporate Compliance Committee

Ohel has established a Corporate Compliance Committee to assist the Compliance Officer in the development, implementation, oversight and evaluation of the effectiveness of its compliance program. The members of the Compliance Committee will be appointed by the CEO of Ohel. In appointing members of the Compliance Committee, the CEO shall include senior management representatives from a broad cross section of departments, including, at a minimum, finance, human resources and clinical. The primary responsibility of the Compliance Committee, which will be chaired by the Chief Operating Officer, is to assist the Compliance Officer in the development, implementation, oversight and evaluation of the effectiveness of the Compliance Program, to assist in the annual review of the Compliance Program and its activities and to provide feedback to the CEO and to the Board of Directors, or the Risk Management Committee of the Board, on the effectiveness of the Compliance Officer and the Compliance Program.

The Compliance Committee will receive reports from the Compliance Officer on issues, incidents and reports that are under investigation, will assist the Compliance Officer in developing recommendations for corrective action to be presented to the [Executive Director/CEO], the Board and, as appropriate, senior management. The reports will evaluate the effectiveness of the corrective actions, once implemented, in preventing any occurrence of the problems or behaviors targeted.

Members of the Compliance Committee will treat confidential and sensitive information that it has disclosed to the Compliance Committee in a manner that secures and protects it from further disclosure outside the direct activities of the Compliance Committee. The members of the Committee will act individually in their various responsibilities as employees to promote compliance, to encourage employee participation in the Compliance Program, to answer questions about the scope and purpose of the program, to receive reports of concerns, incidents and inappropriate behaviors, and to

bring these reports to the prompt attention of the Compliance Officer.

Written minutes will be kept of all Compliance Committee meetings and actions, which minutes will be made available to the members of the Board of Directors upon request.

The Compliance Committee will operate pursuant to a Committee Charter, which shall be reviewed annually and updated as needed.

Board of Directors

The Ohel Board of Directors, including the Board's Risk Management Committee and the Board leadership, will be knowledgeable about the content and operation of the Compliance Program, and will be updated by Agency staff, including the Compliance Officer, regarding the implementation and effectiveness of the Compliance Program. The training for the Board of Directors is further discussed in the Compliance Training policy. The Board will exercise oversight of the effectiveness of the Program.

Due Care in Assignment of Responsibilities – Background Checks

Ohel will use due care not to employ, contract with or delegate substantial discretionary authority to any individual with a propensity to engage in illegal activities. To maintain the integrity of services and financial and business operations, it is critical that Ohel hire and contract with individuals and entities that have the same respect for applicable legal and ethical obligations that Ohel has. This standard applies to personnel in positions with "substantial" control over Ohel, including, but not limited to those having the ability to affect and determine policy and to negotiate contracts. Each prospective employee will be required to disclose whether he or she has been convicted of committing a crime.

As per the Exclusion Screening Policy, Ohel will determine if prospective Affected Individuals have been excluded from participation in the federal healthcare programs by checking the LEIE, EPLS, and OMIG Exclusion Lists; Ohel will not hire or utilize the services of any individual or entity which has been excluded.

Ohel will also comply with any requirements promulgated under applicable state law with respect to background checks and appropriate screening activities to the extent those requirements apply to personnel within Ohel's operations, including reviewing criminal history (fingerprints), motor vehicle records, and child abuse and neglect information. Ohel may rely on third parties for this information.

Education and Training

As per the Compliance Training policy, all Affected Individuals will be informed about regulatory requirements, the operation of the Compliance Program, and Ohel policies and procedures that implement these requirements, as they apply to each individual. Therefore, Ohel will discuss the Plan with all Affected Individuals.

New employees, including executive-level employees, and the Board will receive training on the Ohel Code of Conduct, this Compliance Program and those policies and procedures relevant to their duties as part of an orientation program. Ohel will tailor its training based on the roles and responsibilities of each group of individuals and in a manner that the individual can understand.

Auditing and Reporting

Internal Auditing and Monitoring

As per the Internal Auditing Policy, Ohel is committed to routinely identifying compliance risk areas and conducting internal audits of identified areas of significant risk. Appropriate individuals in key management positions will be responsible for engaging in self-monitoring processes conducted within specific departments/divisions. The Agency's Department of Quality Improvement will be primarily responsible for internally auditing Agency programs to identify compliance risk areas, ensure credentialing of providers and persons associated with providers, as appropriate, mandating reporting, governance, and quality of care of medical assistance program beneficiaries. Generally, the Department will conduct random case record reviews to ensure that the programs are complying with all regulatory and contractual requirements, in addition to verifying the accuracy of the billing information. Staff will compile a report based upon the internal review, which will be shared with appropriate supervisory staff. Department staff will conduct a follow-up review, as appropriate, to ensure that corrective action was taken to address issues of concern.

The Compliance Officer may engage external auditors to conduct additional reviews where appropriate.

Reporting by Affected Individuals

As per the Mandatory Reporting policy, each employee, vendor, and Board member has a responsibility to report through Ohel's compliance processes any activity by any colleague, clinician, independent contractor or vendor that appears to violate applicable laws, rules, regulations, accreditation standards, standards of medical practice or the Compliance Program. We encourage a culture in which all feel free to report behaviors or actions which they believe should be reported. Therefore, the effectiveness of Ohel's Compliance Program depends on the willingness and commitment of the Affected Individuals in all parts and at all levels of Ohel to step forward, in good faith, with questions and concerns. Likewise, Ohel is committed to making every effort to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports a concern in good faith.

It is an expected good practice, when one is comfortable with it and thinks it is appropriate under the circumstances, for concerns to be raised first with a supervisor or the Human Resources Department. If this is not comfortable or not a viable option, then Affected Individuals always have the option to contact the Compliance Officer directly. Affected Individuals and clients can also call the Corporate Compliance Hotline at **(718) 438- 0941** where reports may be made anonymously.

As per the Non-retaliation policy, any and all Affected Individuals who, in good faith, participate in the compliance program, including, but not limited to, reporting potential issues, investigating issues, self-evaluations, audits and remedial actions, and reporting to appropriate officials, will be protected against any retaliation or intimidation. Any Affected Individual who intentionally makes a false accusation with the purpose of harming or retaliating against any individual or the Agency will be subject to appropriate disciplinary action, up to and including termination.

Disciplinary Action and Incentives

As per the Discipline policy, failure to comply with the Compliance Program, the Code of Conduct and/or laws and regulations applicable to Ohel and its operations may result in disciplinary action, up to and including termination. Among other things, this relates to an employee's failure to report suspected problems, participation in non- compliant behavior or encouraging, directing, facilitating or permitting, either actively or passively, non-compliant behavior. Retraining of staff will occur if misconduct is based on a lack of awareness or understanding of a regulatory obligation, policy or procedure. Resolution of disciplinary issues will be determined through the Human Resources Department in direct cooperation with the appropriate manager and, as appropriate, other management personnel of Ohel. The degree of discipline may range from counseling, verbal warnings, written warnings, recommended change or discontinuation of privileges, salary reduction, termination of employment or removal from a particular position or function – and the Agency will endeavor to be consistent in its approach to discipline with the same disciplinary action for similar offenses. In instances of a vendor's failure to comply with the Plan, Ohel reserves the right to terminate the contract and/or seek other relief under the law. Ohel will also seek to reward employees who foster a culture of compliance through merit-based increases, as appropriate.

Detection and Response

As per the Internal Auditing and Mandatory Reporting policy, Ohel is committed to fostering a culture of compliance through detecting, correcting and preventing non-compliant behaviors. Through the process of corporate compliance reporting structure and the articulation of compliance-related roles and responsibilities at every level of Ohel's operations, detection and correction of problems is expedited. If an internal investigation substantiates a reported violation, then it is Ohel's policy to engage in a

two-fold process: (1) to initiate corrective action, including, as appropriate, making prompt restitution of any overpayment amounts, notifying the appropriate governmental Agency, instituting whatever disciplinary action is necessary; and (2) implementing systemic changes to prevent a similar violation from recurring in the future.

Government Investigations

As per the Government Investigations policy, Ohel will comply with all government investigations as per applicable law.

	SECTION: Corporate Compliance					NO: 2
	TITLE: EMPLOYEE DISCIPLINE					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Purpose

The purpose of this policy is to promote compliance with applicable legal requirements by ensuring that Affected Individuals are appropriately disciplined if they commit fraud, fail to comply with applicable law or do not adhere to Ohel Children's Home and Family Services, Inc. (hereinafter Agency) policies, including those related to the prevention, detection and reporting of fraud and abuse.

Definitions

Fraud means any type of intentional deception carried out or misrepresentation made by a person with the knowledge that the deception or misrepresentation could result in the receipt of an unauthorized benefit by such person, Agency or another individual or entity.

Abuse means activities that are inconsistent with sound fiscal, business, client care or medical practices and result in (i) an unnecessary cost to the state or federal government or Agency or (ii) the reimbursement of services that are not medically necessary or fail to meet professionally recognized standards for health care or (iii) the violation of client rights, including the physical or sexual abuse of a client, inappropriate supervision of a client, client neglect, and/or any failure to reasonably carry out the job responsibilities and Agency policies.

Statement of Policy

Conduct Subject to this Policy

Affected Individuals will be subject to discipline under this policy for (i) engaging in, encouraging, directing, facilitating or permitting fraud or abuse, (ii) failing to report suspected fraud or abuse committed by others in accordance with Agency's Fraud and Abuse Reporting Policy or (iii) violating Agency's Code of Conduct or any other Agency policy, including those designed to detect or prevent fraud and abuse, failing to provide appropriate care to clients, or breaching privacy and security requirements. Nothing in this policy will restrict Agency from disciplining Affected Individuals for offenses not referenced above under other Agency policies.

Administration of Disciplinary Measures

The Compliance Officer will promptly notify the Chief Administrative Officer of any improper conduct by an employee that may warrant discipline under this policy. The Chief Administrative Officer will be responsible for determining the appropriate sanction, if any, in accordance with Agency's standard employment policies, taking into account escalating actions and the special considerations set forth in this policy. Chief Administrative Officer will consult with the Compliance Officer, human resources, and legal counsel as necessary throughout the disciplinary process. Discipline will be imposed consistently with that taken in similar instances of non-compliance regardless of the level of employee involved.

Types of Discipline

Any conduct punishable under this policy will be subject to the following disciplinary actions, which will be based on the nature of the violation:

- Unintentional Violations. Unintentional violations of Agency policies or legal requirements may occur if an employee is unaware of the relevant standards of conduct or inadvertently fails to adhere to such standards. Although unintentional violations do not generally constitute fraud or abuse, depending on the circumstances, they may be grounds for discipline. The key factors to be considered in determining the appropriate type of discipline, if any, for such violations include (i) the degree of the employee's carelessness, (ii) the extent to which the conduct involved an isolated incident or an ongoing pattern of activity, (iii) a history of any prior violations by the employee, (iv) the effect of the conduct on Agency's clients, (v) whether the conduct resulted in improper billing by Agency to government agencies and (vi) the extent to which the conduct exposed Agency to regulatory sanctions, other liabilities or adverse publicity. Disciplinary action will typically involve counseling, an oral warning, a written warning or modification of duties, but in certain circumstances (especially in the case of repeat offenses) may also include suspension or termination.
- Intentional Misconduct That Does not Constitute a Crime. An employee engages in intentional misconduct if the employee knows his or her conduct violates Agency policies or legal requirements, or acts with reckless disregard of applicable standards of conduct. "Reckless disregard" may occur, for example, if an employee knows there is a relevant standard of conduct and fails to seek appropriate guidance as to the nature of that standard or compromises client safety or well-being. Non-compliance, with intentional or reckless behavior will be subject to more significant sanctions. If an employee's intentional misconduct is a first offense and does not constitute a crime, depending on the circumstances, disciplinary action may involve counseling, an oral or written warning, modification of duties, suspension or termination. Any subsequent offense, related or unrelated, to the prior offense, will involve counseling, an oral warning, a written warning or modification of duties, suspension or termination.

- Criminal Activity. Any employee who engages in criminal activity in the course of his or her employment will be immediately suspended pending the outcome of the investigation. For Affected Individuals employed in an ACS, OCFS, OMRDD, or OMH program, they are required, pursuant to applicable law, to submit to a criminal history check. The Agency is notified by governmental authorities of the employee's past criminal record and is notified of any subsequent arrests. The Compliance Officer, in conjunction with the Agency's Safety Assessment Committee, will determine whether the particular conviction or pending arrest should result in, among other things, termination of the employee, suspension pending the outcome of the criminal proceeding, or reinstatement subject to certain conditions, based upon the nature of the charge and the employee's job responsibilities. The Agency's Safety Assessment Committee will make such determination, pursuant to applicable law.

Disciplinary measures will be imposed within two weeks of the receipt of all relevant information unless the Chief Administrative Officer determines there are unusual circumstances warranting a longer review period.

Employee Evaluations

Employee evaluations when administered will include questions relating to ethics and/or compliance with applicable Agency policies and legal requirements. Agency supervisors and managerial staff will provide accurate and complete information in response to such question(s) when preparing employee evaluations, as appropriate.

Disciplinary action for non-employed Affected Individuals will be administer in accordance with the terms of the documents governing their relationship including but not limited to statutory provisions, Board Bylaws, Contracts, etc.

Record Retention

All records relating to the Agency's adoption, implementation, and operation of the compliance program will be retained for a period of six years.

	SECTION: Corporate Compliance					NO: 3
	TITLE: COMPLIANCE TRAINING					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Purpose

The purpose of this policy is to promote Ohel Children's Home and Family Services, Inc. (hereinafter Agency) compliance with applicable laws and regulations by ensuring that all Agency Affected Individuals receive appropriate training regarding the operations of the Compliance Program and the prevention, detection and reporting of fraud and abuse.

Ohel will maintain an annual training plan that outlines:
1. required subjects or topics;
2. timing and frequency of training;
3. which affected individuals are required to attend;
4. how attendance is tracked; and
5. how the effectiveness of the training is periodically evaluated.

Statement of Policy

Basic Compliance Training

All newly hired employees must receive basic compliance training within 30 days of the initial date of employment. Training will be scheduled by the employees' respective supervisor as part of his or her responsibility to oversee general orientation for new employees.

The curriculum for basic compliance training will be developed and updated as necessary by the Compliance Officer in consultation, as appropriate, with program staff and outside counsel. The curriculum will be designed to provide Affected Individuals with an overview of key compliance issues faced by Agency.

Basic compliance training will provide guidance regarding, among other things, the Agency's Compliance Plan and the role of the Office of the Medicaid Inspector General, as well as the federal False Claims Act. In addition, Affected Individuals will be advised of their obligation to report suspected fraud or abuse, the opportunity for anonymous reporting through Agency's compliance hotline and the prohibition on retaliating against Affected Individuals for making reports in good faith. Employees will receive a copy of the Agency's Code of Conduct, which is included in the Personnel Handbook, at the time of hire. The Compliance Officer will also train staff on the above topics at New Hire Orientation.

Documentation will be maintained regarding the provision of the compliance training. All Affected Individuals will be required to sign a written form acknowledging the receipt of the Code of Conduct. Such forms will be retained in Affected Individuals' personnel/contract files for no less than six years. In the case of Contractors, a dated training distribution letter may substitute as evidence of an acceptable self-study program.

The Compliance Officer will determine the format of basic compliance training (e.g., in-person, on-line, video, etc.) and is authorized to retain outside vendors to provide training

components.

Annual Refresher Training

The Compliance Officer will prepare an annual refresher compliance training curriculum, which will reinforce the key principles covered by basic compliance training and summarize any changes in Agency's Code of Conduct, Compliance Program or applicable government standards during the prior year. The information will be disseminated to program supervisory staff, who will train their respective supervisees and maintain documentation of such.

Bulletins and Updates

The Compliance Officer will be responsible for preparing and distributing to relevant Affected Individuals bulletins and updates addressing new fraud and abuse or other compliance issues of which the Compliance Officer becomes aware. These bulletins and updates will cover, among other things, changes in government contracts, new interpretations of existing laws or rules, revisions to Agency policies or procedures, relevant OMIG initiatives, and industry trends or developments. Department directors will notify the Compliance Officer of any significant matters they deem appropriate for inclusion in such bulletins and updates.

Board Member Training

All members of Agency's Board of Directors will receive a compliance training upon joining the Board and annually thereafter. The Compliance Officer will be responsible for developing this training program. The training may take place in person or through the dissemination of written materials.

Contractors, Agents, Subcontractors, and Independent Contractors Training

All contractors, agents, subcontractors, and independent contractors shall receive annual training on Ohel's compliance program to the extent it is related to their contracted role and responsibilities within the Ohel's identified risk areas.
The training and education shall include, at a minimum, the following topics:

(i) the required provider's risk areas and organizational experience;
(ii) the required provider's written policies and procedures identified in subdivision (a) of this section;
(iii) the role of the compliance officer and the compliance committee;
(iv) how affected individuals can ask questions and report potential compliance-related issues to the compliance officer and senior management, including the obligation of affected individuals to report suspected illegal or improper conduct and the procedures for submitting such reports; and the protection from intimidation and retaliation for good faith participation in the compliance program;
(v) disciplinary standards, with an emphasis on those standards related to the required provider's compliance program and prevention of fraud, waste and abuse;
(vi) how the required provider responds to compliance issues and implements corrective

action plans;

(vii) requirements specific to the MA program and the required provider's category or categories of service;
(viii) coding and billing requirements and best practices, if applicable;
(ix) claim development and the submission process, if applicable;

All affected individuals are required to receive compliance training and education that includes all required topics; however, some affected individuals require additional training related to their job functions.

Enforcement
Affected Individuals who do not comply with this policy will be subject to disciplinary action by Agency. Depending on the facts and circumstances of each case, Agency may reprimand, suspend, dismiss, or terminate any Affected Individual who fails to comply with this policy.

	SECTION: Corporate Compliance					NO: 4
	TITLE: MANDATORY REPORTING					
Effective Date: 1/19/2010	**Revised:** 3/28/2023	9/22/2023				

Purpose

The purpose of this policy is to promote Ohel Children's Home and Family Services, Inc. (hereinafter Agency) compliance with applicable laws and government standards by requiring all Affected Individuals to report violation of compliance policies or suspected fraud or abuse and ensuring that all reports are investigated and otherwise handled in an appropriate manner.

Definitions

Affected Individuals means all individuals and entities that participate in or do business with Ohel including but not limited to all of Ohel's employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.

Fraud means any type of intentional deception carried out or misrepresentation made by a person with the knowledge that the deception or misrepresentation could result in the receipt of an unauthorized benefit by such person, Agency or another individual or entity.

Abuse means activities that are inconsistent with sound fiscal, business, client care or medical practices and result in (i) an unnecessary cost to the state or federal government or Agency or (ii) the reimbursement of services that are not medically necessary or fail to meet professionally recognized standards for health care or (iii) the violation of client rights, including the physical or sexual abuse of a client, inappropriate supervision of a client, client neglect, and/or any failure to reasonably carry out the job responsibilities and Agency policies.

Statement of Policy

Reporting Responsibilities

It is the responsibility of all Affected Individuals to report suspected fraud, abuse or other improper activity relating to the operation of Agency, whether committed by Agency employees, vendors, clients or others. Examples of the types of activity that must be reported by Affected Individuals include, but are not limited to, the following:

- Billing Medicaid or other third-party payers for clients to whom Agency has not rendered services.
- Billing Medicaid as a primary payor for clients also covered by Medicare or private insurance when not permitted by Medicaid rules.
- Inflating or otherwise misrepresenting Agency's costs on cost reports filed with government agencies or private funders.
- Submitting inaccurate or misleading data or reports to government agencies.

- Using grant funds from government agencies such the Office of Mental Health or Office of Mental Retardation and Developmental Disabilities in a manner that is inconsistent with these agencies' requirements.
- Theft or misuse of client funds held in trust.
- Client abuse or neglect, including physical or sexual abuse, failure to properly supervise, and otherwise failure to discharge job responsibilities.
- Breach of client confidentiality.

Reporting Mechanisms

Affected Individuals have several options for reporting fraudulent, abusive or other improper conduct. Affected Individuals may file reports with their supervisor or department director or the Compliance Officer or any other member of the Compliance Committee with whom the reporter feels comfortable.

Agency has also established a telephone hotline (**718-438-0941**) that Affected Individuals, clients and their families/advocates may call to file reports anonymously. The Compliance Officer will be responsible for overseeing the operation of the hotline and responding to complaints filed through the hotline. The number for the hotline is listed on the Agency's website, in the personnel manual, and in the Compliance Plan, among other locations.

Affected Individuals are protected from retaliation for filing, in good faith, reports of suspected fraud, abuse or other improper conduct under Agency's Non-Retaliation Policy. Reporter's identity shall be maintained unless the matter is subject to a disciplinary proceeding, referred to, or under investigation by, MFCU, OMIG or law enforcement, or disclosure is required during a legal proceeding,

The Compliance Officer will maintain a log of all compliance-related reports, including reports filed through the hotline and other means that are brought to his or her attention by Board members, staff, volunteers or clients. The log will specify the nature of the report, the date of the report, the reporting method (hotline, etc.), the name of the person filing the report (if the report was not filed anonymously), and any subsequent follow-up. The log information will be maintained by the Compliance Officer for six years. These documents will be kept confidential and will be shared with Affected Individuals or advisors only as necessary to comply with this policy or to otherwise carry out Agency operations.

Internal Investigations

All reports of fraudulent, abusive or other improper conduct, if not made to the Compliance Officer or through the hotline, will be promptly forwarded to the Compliance Officer for review. The Compliance Officer, in consultation with other Agency staff and legal counsel as appropriate, will determine whether the report warrants an investigation. The Compliance Officer will use best efforts to make this determination within two weeks of the receipt of the report.

If the Compliance Officer determines an investigation is warranted, he or she or the designee will promptly coordinate the investigation. The Compliance Officer may obtain the assistance of other Agency staff and outside legal and financial advisors as necessary to carry out a proper investigation. All Affected Individuals will be required to cooperate in such investigations. The Compliance Officer will monitor the activities of any outside advisors performing investigative services for Agency. Agency will make reasonable efforts to protect the identity of any individuals filing non-anonymous reports except when disclosure of the individual's identity is necessary to conduct an effective investigation.

The Compliance Officer will provide the Chief Executive Officer and the Board with regular reports of all pending investigations. The Compliance Officer, in consultation with the Chief Executive Officer, will have the authority to order the temporary suspension of any Agency activity that is the subject of a pending investigation.

Upon completion of an investigation, the Compliance Officer shall document its investigation of the compliance issue which shall include any alleged violations, a description of the investigative process, copies of interview notes and other documents essential for demonstrating that the required provider completed a thorough investigation of the issue. The Compliance Officer will prepare a written report of the investigation's findings, which will indicate whether fraudulent, abusive or other improper conduct was committed. If such conduct is found, the Compliance Officer will recommend to the Chief Executive Officer and Human Resources Director, if appropriate, any corrective or disciplinary action deemed appropriate.

Notification of Government Authorities

Ohel complies with requirements regarding to reporting, returning and explaining overpayments, fraud, abuse, or other improper activity. The Compliance Officer, in consultation with the Chief Executive Officer and general counsel (if other than the compliance officer), as well as outside legal counsel, if deemed necessary and appropriate, will determine when and in what manner to report to federal, state or local government agencies. Such reporting may involve, depending on the circumstances, refunding overpayments to Medicaid or other government payers, making a self-disclosure, whether full or abridged, as established by the appropriate government Agency and in accordance with OMIG guidelines, and/or other formal or informal protocols as the case may be, or alerting law enforcement authorities.

Enforcement

Affected Individuals who do not comply with this policy will be subject to disciplinary action by Agency. Depending on the facts and circumstances of each case, Agency may reprimand, suspend or dismiss any employee who fails to comply with this policy.

	SECTION: Corporate Compliance					NO: 5
	TITLE: NON-RETAILITATION					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Purpose

The purpose of this policy is to promote Ohel Children's Home and Family Services, Inc. (hereinafter Agency) compliance with applicable law by prohibiting any form of intimidation or retaliation against Affected Individuals or others filing reports of suspected fraud or abuse in good faith or otherwise participating in Agency's compliance program.

Definitions

Affected Individuals means all individuals and entities that participate in or do business with Ohel including but not limited to all of Ohel's employees, the chief executive and other senior administrators, managers, contractors, agents, subcontractors, independent contractors, and governing body and corporate officers.

Fraud means any type of intentional deception carried out or misrepresentation made by a person with the knowledge that the deception or misrepresentation could result in the receipt of an unauthorized benefit by such person, Agency or another individual or entity.

Abuse means activities that are inconsistent with sound fiscal, business, client care or medical practices and result in (i) an unnecessary cost to the state or federal government or Agency or (ii) the reimbursement of services that are not medically necessary or fail to meet professionally recognized standards for health care or (iii) the violation of client rights, including the physical or sexual abuse of a client, inappropriate supervision of a client, client neglect, and/or any failure to reasonably carry out the job responsibilities and Agency policies.

Statement of Policy

Reporting and Other Responsibilities

All Affected Individuals are required to report suspected fraud, abuse or other improper conduct in accordance with Agency's Fraud and Abuse Reporting Policy. Affected Individuals are also required to cooperate in all other aspects of Agency's Compliance Program, including audits, investigations and remedial actions.

Prohibition on Retaliation

No employee who files a report of suspected fraud, abuse or other improper conduct in good faith or otherwise participates in Agency's Compliance Program may be subject to retaliation in any form for such activity. It is also prohibited to retaliate against an employee for refusing to carry out any activity that is the subject of a good faith report of suspected fraud, abuse or other improper conduct. No employee may threaten to retaliate against another employee for filing such a report.

Prohibited retaliation includes, but is not limited to:

- Termination
- Suspension
- Demotion
- Failure to consider for promotion
- Harassment
- Reduction in compensation
- Adverse change in working conditions other than for legitimate Agency needs

Retaliation is prohibited even if it is determined that the allegedly improper conduct covered by a report was proper or did not occur, provided that the report was made in good faith. Agency reserves the right to take disciplinary action against any employee who maliciously files a report he or she knows to be untrue.

Any actual or threatened retaliation should be reported by the affected employee or any other employee to the Compliance Officer. The Compliance Officer will investigate such allegations in the same manner as other investigations carried out under Agency's Fraud and Abuse Reporting Policy.

Enforcement

Affected Individuals who do not comply with this policy will be subject to disciplinary action by Agency. Depending on the facts and circumstances of each case, the Agency may reprimand, suspend or dismiss any employee who fails to comply with this policy.

	SECTION: Corporate Compliance					NO: 6
	TITLE: GOVERNMENT INVESTIGATIONS					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Purpose

The purpose of this policy is to establish a mechanism for the orderly response to government investigations of Ohel Children's Home and Family Services, Inc. (Agency) or its Affected Individuals, and to ensure that all Agency personnel and contractors cooperate appropriately with such investigations.

Statement of Policy

Types of Government Agencies that May Investigate Agency

A variety of federal, state and local government agencies may be involved in investigating Agency. These agencies include, but are not limited to, the U.S. Department of Health and Human Services' Office of Inspector General (DHHS OIG), Centers for Medicare and Medicaid Services (CMS), Federal Bureau of Investigation (FBI), United States Attorney's Office, New York State Office of the Medicaid Inspector General (NYS OMIG), New York State Attorney General's Medicaid Fraud Control Unit (NYS MFCU), New York State Department of Health NYS DOH), New York State Office of Mental Health NYS OMH), New York State Office for Persons with Developmental Disabilities (NYS OPWDD), county social services and mental health departments and District Attorneys' offices.

General Guidelines for Responding to Government Investigators

If contacted by government investigators, Affected Individuals are expected to be polite and to request the following information: (1) the name, agency affiliation, business telephone number and address of all investigators; (2) the reason for the contact; and (3) if the investigator visits in person, the investigator's identification and business card. Except as specified otherwise in this policy, Affected Individuals will direct investigators to Agency's General Counsel, who will be exclusively responsible for responding to any requests for information or documents. If an employee is not contacted by an investigator but learns of a government investigation through other means, the employee shall immediately notify counsel.

Subpoenas and Other Requests for Documents

If an employee receives a subpoena or any other written request for documents from a government agency, the employee will immediately forward the request to Agency's General Counsel. General Counsel will be responsible for reviewing the request, verifying its authenticity and confirming that the production of documents or witnesses is not restricted by any applicable laws, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") or other confidentiality statutes. If there is no such restriction, General Counsel will coordinate the production of documents with the investigating agency. It is Agency's policy to fully cooperate with all appropriate requests for documents issued by government agencies. All documents will be provided by Agency without charge.

Government investigators may seek documents by contacting Affected Individuals by telephone or in person at Agency's offices. It is Agency's policy to cooperate with these requests in an orderly manner. Any employee who is contacted by a government investigator to provide documents will immediately notify Agency's General Counsel, who will coordinate the provision of any requested information. It is Agency's general policy to provide documents to government investigators only in response to a written request. However, General Counsel, after verifying the authority of the requesting official, may waive this requirement on a case-by-case basis as appropriate and permitted by law.

Requests for Interviews and Other Testimony

Agency will cooperate fully with government investigators in making its employees available in person for private interviews, consultations, grand jury proceedings, pre-trial conferences, hearings and trials. Agency's contractors will be required to cooperate in the same manner by making their own employees available.

All Affected Individuals are required to make themselves available for interviews requested by government investigators. Although individuals have a constitutional right not to incriminate themselves, any failure by an employee to provide an interview, testify or otherwise cooperate in a government investigation of Agency will constitute a violation of the employee's employment obligations and may be grounds for termination.

All requests by government agencies to interview Affected Individuals, whether by a subpoena or in any other written or oral form, will be directed to Agency's General Counsel. General Counsel will be responsible for scheduling all such interviews at appropriate times and locations.

In some cases, investigators may contact Affected Individuals at their homes or other locations outside of Agency's premises, in person or by telephone, to request an interview. Affected Individuals are encouraged in such circumstances to advise the investigator of their willingness to cooperate in an interview scheduled by Agency's General Counsel during normal business hours at Agency's offices or another appropriate location. Affected Individuals should request the investigator's business card and promptly report the contact to their supervisor, who will inform General Counsel. General Counsel will be responsible for coordinating the scheduling of interviews with investigators.

Agency will generally seek to have in-house or outside counsel attend an employee's interview to the extent permitted by the investigating agency. Agency's counsel will represent the interests of Agency and not the individual employee. Any privilege attaching to information provided to Agency's counsel will belong to Agency and not to the employee. An employee may consult with an attorney of his or her own choosing to represent his or her individual interests.

During the interview, Affected Individuals will be expected to adhere to the following guidelines:

- Always tell the truth. It is a crime to lie under oath or obstruct a government criminal investigation.
- Be clear. In talking with a government investigator, Affected Individuals should be very careful to answer questions completely, accurately and concisely so that there will be no misunderstanding as to what is said.
- Explain the source of information. It is important for Affected Individuals to make clear to the government representative whether the information he or she is providing is first-hand knowledge, or information that the employee has heard or otherwise obtained from another individual.
- Do not speculate. If Affected Individuals do not recall something or have no knowledge or insufficient knowledge about the topic, they should say so.

If, during the course of the interview, the investigator requests copies of any Agency documents, the employee will forward the request to Agency's General Counsel, who will handle all requests for documentation. It is essential that General Counsel review all documents prior to submission to government investigators to ensure that they are fully responsive to the investigator's request and that they are not protected by the attorney-client or any other legal privilege.

If General Counsel is not present during the interview, the employee should contact the counsel promptly after the interview to conduct a debriefing. Affected Individuals are encouraged to make detailed notes during the interview or, if permitted, record the interview

Searches of Agency's Premises

If representatives of an investigative agency appear at Agency's offices and request to search the premises, the employee receiving the request will immediately contact Agency's General Counsel and request that the investigator wait in the reception area for counsel to appear. Counsel or his or her designee will immediately appear in person or direct other staff on the premises as to how to handle the request. Counsel or his or her designee will not be required to permit the search unless a duly authorized search warrant is presented. Counsel or his or her designee will request to see a copy of the warrant and any supporting affidavit, and confirm that the search and any documents seized are within the scope of the warrant. If no search warrant is presented, counsel or his or her designee may determine, in his or her discretion, whether to permit the search.

Agency's General Counsel or his or her designee will accompany the investigator on the search. Counsel or his or her designee will keep a record of the search, including, but not limited to: (1) the date and time period of the search; (2) the names and positions of all the investigators; (3) the areas and files searched; (4) which files were seized; (5) the names of any Affected Individuals questioned by the investigators and (6) the subjects covered by any questioning.

If permitted by the investigator, a copy will be made of all documents that are seized. If this is not permitted, an inventory of the seized documents will be requested from the investigator. Any requests during the search to speak with Affected Individuals will be handled in accordance with the provisions of this policy governing employee interviews.

If Agency's General Counsel cannot be contacted promptly when a search warrant is presented, the Affected Individuals receiving the warrant will contact another senior manager of Agency to oversee the search. The manager overseeing the search will carry out all of the functions of General Counsel specified in this policy and report back to General Counsel as soon as possible.

Record Retention

Once Agency's General Counsel becomes aware of a government investigation, he or she will promptly notify all relevant Agency Affected Individuals that, until further notice is issued, they are prohibited from altering, removing or destroying any paper or electronic documents or records of Agency relating to the subject matter of the investigation. Counsel will define with sufficient specificity the range of documents subject to the notice. The provision of notice by counsel will supersede any record destruction that would otherwise be carried out under Agency's ordinary record retention policies. Counsel will notify all relevant Affected Individuals upon completion of the investigation and direct how records relating to the investigation should be handled.

Enforcement

Affected Individuals who do not comply with this policy will be subject to disciplinary action by Agency. Depending on the facts and circumstances of each case, Agency may reprimand, suspend or dismiss any employee who fails to comply with this policy.

	SECTION: Corporate Compliance					NO: 7
	TITLE: INTERNAL AUDITING					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Purpose

The purpose of this policy is to prevent fraud, abuse and other improper conduct by establishing a framework for regular internal audits of Ohel Children's Home and Family Services, Inc. (hereinafter Agency) operations.

Statement of Policy

Oversight of Auditing Process

The Compliance Officer will be responsible for overseeing Agency's internal auditing system. The Compliance Officer is authorized to delegate auditing duties to members of the Compliance Committee or other Agency personnel as well as outside attorneys, accountants and vendors as necessary and appropriate.

Subjects for Auditing

Internal audits will cover at least the following subjects:

- The maintenance of adequate documentation to support claims for payment submitted by Agency to Medicare, Medicaid and other government health care programs.
- The accuracy and completeness of the cost reports submitted by Agency to federal, New York State or local regulatory agencies.
- The medical necessity and quality of the health care services provided by Agency.
- The credentialing of health care professionals, as appropriate, providing services at Agency facilities.
- The screening of Agency Affected Individuals against government program exclusion lists.
- Coordination of benefits between Medicare, Medicaid and other third-party payers.
- Annual Effectiveness Review of Ohel's Compliance Program.

The Compliance Officer, in consultation with the Compliance Committee as appropriate, will identify other issues that should be covered by the internal auditing program.

Audit Procedures

The Compliance Officer or his designee will develop audit tools and procedures for carrying out the audits required by this policy. The Compliance Officer, with the approval of the Chief Executive Officer, may contract with outside companies to perform certain auditing functions.

In the event the Compliance Officer determines it is in the best interests of Agency to keep the contents and/or findings of any audit confidential, the Compliance Officer will arrange for in-house or outside legal counsel to conduct and/or supervise the audit. In such event, Affected Individuals will be advised that the audit is being conducted under theattorney-client privilege and the audit report will indicate that such privilege is applicable.

Audit Plan

Audit subjects will be selected from among the topics specified in this policy and will include any other topics deemed appropriate by the Compliance Officer. The Compliance Officer will select audit subjects based on the level of risk associated with the subject, any prior history of violations, the length of time that has passed since the most recent audit on the same subject and the cost of performing the audit. The Compliance Officer will ensure that any internal audits mandated by law or contract be carried out on a schedule consistent with such requirements. Nothing in this policy is intended to require internal auditing on all of the matters specified herein each year or on any other specific schedule. The Compliance Officer will use best efforts to minimize any disruption of Agency's business activities caused by internal audits.

Audit Reports

Upon completion of an audit, the Compliance Officer or his designee will arrange for the preparation of a written audit report. The report will set forth the subject of the audit, the audit methodology and the audit findings. The report will be provided to the respective program supervisor and program director and, as appropriate, the Chief Executive Officer and Chief Operating Officer, as well as the Compliance Committee and members of the Board's Risk Management Committee. The Compliance Officer or his designee will work with the relevant department director to ensure that all appropriate follow-up is taken. Any overpayments or fraud or abuse activity discovered through an audit will be handled in accordance with Agency's Fraud Reporting Policy. All audit reports will be maintained by Agency for six years.

Enforcement

Affected Individuals who do not comply with this policy will be subject to disciplinary action by Agency. Depending on the facts and circumstances of each case, Agency may reprimand, suspend or dismiss any employee who fails to comply with this policy.

	SECTION: Corporate Compliance					NO: 8
	TITLE: EMPLOYEE SCREENING; CREDENTIALING					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Purpose

The purpose of this policy is to establish safeguards to prevent the employment of individuals who have been excluded from participation in government health care programs or have otherwise engaged in improper conduct.

Definitions

EPLS means the U.S. General Services Administration Excluded Parties List System.
LEIE means the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities.
OMIG Exclusion List means the List of Restricted, Terminated or Excluded Individuals or Entities maintained by the New York State Office of Medicaid Inspector General.

Statement of Policy

Responsibility for Screening

All candidates for employment by Ohel Children's Home and Family Services, Inc. (Agency) or to serve as a member of their Board will be subject to pre-employment screening. The screening process will commence when an applicant has been identified by the appropriate department director as a final candidate whose employment is conditioned only upon the successful completion of pre-employment screening. The Department of Human Resources will promptly carry out the below screening activities under this policy. The Department of Human Resources and Department directors are not restricted from imposing additional screening requirements that are consistent with this policy on candidates for employment within their department. No individual may be offered employment until the screening process has been completed.
The Director of Human Resources will consult with the Compliance Officer as necessary to carry out his or her responsibilities under this policy. The Director of Human Resources may delegate certain screening functions to outside vendors as deemed efficient and appropriate pursuant to written agreements with such vendors.

Basic Screening

All final candidates for employment/Board members will be subject to basic screening to determine whether they are reliable and trustworthy, and qualified for employment. Basic screening will consist of at least the following:

- Verification of previous employment;
- Reference checks;
- Verification of education and/or licensure if certain educational and/or licensing qualifications are stated criteria of employment; and
- Review of completed application

Government Program Exclusion Screening

All application forms will require applicants to indicate whether they have been excluded from participation in Medicare, Medicaid or any other government health care program. Applicants will certify on such forms that the information they have provided regarding such exclusions is accurate and complete. While a prior exclusion that is not in effect at the time of the application does not automatically bar an applicant from employment by Agency, no offer of employment may be made to such an applicant without the approval of the Compliance Officer.

The Human Resources Department screens all final candidates for employment against the LEIE, the EPLS and the OMIG Exclusion List. Agency is prohibited from offering employment or membership on the Board to any individual who is included on the LEIE, EPLS or OMIG Exclusion List at the time of such offer.

Upon receipt of notification from the U.S. Department of Health and Human Services Office of Inspector General or the New York State Office of Medicaid Inspector General that an employee has been excluded from a state or federal health care program, Agency will promptly terminate the employee's employment. If any employee obtains information indicating that another employee is subject to such an exclusion, the employee who obtained such information will promptly notify the Compliance Officer, who will be responsible for investigating the matter.

Criminal Background and Credit History Checks

As required by state law, Affected Individuals who will have regular and substantial unsupervised or unrestricted physical contact with people receiving services through programs funded by the New York State Office of Mental Retardation and Developmental Disabilities, New York State Office of Mental Health, New York City Department of Mental Health and Hygiene, and New York City Administration for Children's Services, among others, must undergo an investigation regarding their criminal history.

All applicants must additionally sign a statement revealing any and all convictions for felonies and/or misdemeanors in this state or any other jurisdiction. The applicant's prior conviction record will be reviewed on a case by case basis in the hiring process, and an applicant can only be denied employment based on the conviction, if that felony or misdemeanor is related to the proposed employment. All information will be kept confidential.

The Director of Human Resources, in consultation with the Compliance Officer, will designate those positions for which Agency must conduct a pre-employment criminal background and/or credit history check pursuant to application regulations. All criminal background and credit history checks will be carried out by the Director of Human Resources or his or her designee.

As part of the employment application, Agency will obtain the prior written authorization of any candidate who is to be the subject of a criminal background or credit history check. Agency will provide the candidate with the name, address and telephone number of the consumer reporting agency retained by Agency, if applicable, together with a complete and accurate disclosure of the nature and scope of the investigation requested by Agency as well as a written summary of the candidate's rights under the Fair Credit Reporting Act.

Before taking any adverse action with respect to a candidate based, in whole or in part, on information in a consumer report, the Director of Human Resources will provide the candidate with a copy of the report, along with a written description of his or her rights under applicable law. Candidates will be afforded a reasonable time period to review the report for errors that might affect an adverse employment decision.

All job applicants who have the potential for regular and substantial contact with children must sign a statement as to whether they have been the subject of a founded report to the State Central Child Abuse Registry or similar registry in any other jurisdiction and under penalty of perjury, that the information they provide is accurate. Such applicants must also undergo an investigation by the New York State Central Register of Child Abuse and Maltreatment. All information and findings will be kept confidential.

Applicants who will drive a vehicle for Agency business, either their own vehicle or an Agency vehicle, must undergo a Motor Vehicle Registry check regarding their past driving history.

Credentialing

Licensed health care professionals employed by Agency will be subject to credentialing prior to employment, as required, and such credentialing will be reviewed every two years by the respective supervisor.

Record Retention

All records relating to government program exclusion screening, and criminal background and credit checks will be retained by the Director of Human Resources. These records will be treated as confidential and may be disclosed only with the approval of the Director of Human Resources, consistent with applicable law. Records will be retained for a period of six years.

Enforcement

Affected Individuals who do not comply with this policy will be subject to disciplinary action by Agency. Depending on the facts and circumstances of each case, Agency may reprimand, suspend or dismiss any employee who fails to comply with this policy.

	SECTION: Corporate Compliance					NO: 9
	TITLE: EMPLOYMENT APPLICATIONS					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Purpose

Ohel relies upon the accuracy of all information provided by Affected Individuals in their application and during their hiring process and course of employment. All information provided is subject to verification.

Any misrepresentation, falsification, or material omission may result in removal of the individual from further consideration for employment or, if already hired termination of employment.

	SECTION: Corporate Compliance					NO: 10
	TITLE: BACKGROUND INVESTIGATIONS					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Purpose

As a condition of employment, all employees are required to submit to a background investigation as part of the hiring process. Any information provided is subject to verification. This includes, but is not limited to, personal and employment references and verification of credentials, licenses, permits and education.

All job applicants who have the potential for regular and substantial contact with children must sign a statement as to whether they have been the subject of a founded report to the State Central Child Abuse Registry or similar registry in any other jurisdiction and under penalty of perjury, that the information they provide is accurate. Such applicants must also undergo an investigation by the New York State Central Register of Child Abuse and Maltreatment. All information and findings will be kept confidential. Applicants must also sign a "Fair Credit Report Act" and may be subject to fingerprinting, depending on the program.

As required by state law, employees who will have regular and substantial unsupervised or unrestricted physical contact with people receiving services through programs funded by the New York State Office for Persons with Developmental Disabilities, New York State Office of Mental Health, New York City Department of Mental Health and Hygiene, and New York City Administration for Children's Services, among others, must undergo an investigation regarding their criminal history.

All job applicants must additionally sign a statement revealing any and all convictions for felonies and/or misdemeanors in this state or any other jurisdiction. The applicant's prior conviction record will be reviewed on a case by case basis in the hiring process, and an applicant can only be denied employment based on the conviction, if that felony or misdemeanor is related to the proposed employment. All information will be kept confidential.

Applicants who will drive a vehicle for Agency business, either their own vehicle or an Agency vehicle, must undergo a Motor Vehicle Registry check regarding their past driving history.

All employment application forms will require applicants for employment to indicate whether they have been excluded from participation in Medicare, Medicaid or any other government health care program. Applicants will certify on such forms that the information they have provided regarding such exclusions is accurate and complete.

While a prior exclusion that is not in effect at the time of the application does not automatically bar an applicant from employment by Agency, no offer of employment may be made to such an applicant without the approval of the Compliance Officer.
The Director of Human Resources will screen all final candidates for employment against the LEIE, the EPLS and the OMIG Exclusion List. Agency is prohibited from offering employment to any individual who is included on the LEIE, EPLS or OMIG Exclusion List at the time of such offer.

If an applicant does not successfully complete the hiring process background investigation, then the conditional offer of employment will be rescinded if he/she has not yet commenced work, or will be terminated if he/she already commenced work.

	SECTION: Corporate Compliance					NO: 11
	TITLE: EMPLOYEE REFERENCE CHECKS					
Effective Date: 1/19/2010	**Revised** 3/28/2023					

Purpose

As part of the hiring process, employees will be required to provide the Agency with past employment references. To ensure that individuals who join Ohel / Bais Ezra / Lifetime Care Foundation are appropriately qualified and have strong potential to be productive and successful, it is Agency policy to verify the employment and personal references of all applicants for employment with the Agency. This may be done by telephone, mail or both. If the Agency does not receive satisfactory references, and / or if references are not received in a timely manner, the hiring process is deemed to be incomplete and the individual's services will be subject to termination.

	SECTION: Corporate Compliance					NO: 12
	TITLE: REQUESTS FOR REFERENCES ON CURRENT OR FORMER EMPLOYEES					
Effective Date: 1/19/2010	**Revised** 3/28/2023					

Purpose

Only the Human Resources Department is authorized to respond to reference check inquiries that are received by the Agency regarding current or former employees. The Human Resources Department will only respond to written inquiries and will only confirm the dates of employment, final wage rate, and position(s) held.

If an employee receives a reference inquiry regarding a current or former employee, then it should be referred to the Human Resources Department.

	SECTION: Corporate Compliance					NO: 13
	TITLE: EMPLOYEE MEDICAL EXAMINATIONS					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Purpose

As part of the Agency's employment procedures, an applicant is required to undergo a post offer, medical examination and, upon the Agency's request, a drug or alcohol screening, within 5 to 10 business days of employment that is conducted by a physician designated by the Agency. Employees may elect to be examined by their own physician at their own e expense. Any offer of employment that an applicant receives from the Agency is contingent upon, among other things, satisfactory completion of this examination and a determination by the Agency and the physician that the applicant is capable of performing the essential functions of the position that has been offered, with or without a reasonable accommodation. Cooks, food handlers and others as required by law, must successfully complete the post-offer physical examination prior to commencing employment and periodically thereafter as required by the Agency. Costs for any additional tests or examinations that are ordered by the examining physician, beyond the initial screening, is the financial responsibility of the employee.

As a condition of continued employment, employees may also be required to undergo periodic medical examinations, and/or alcohol and drug screenings, at times specified by the Agency. In connection with these examinations, employees are required to provide the Agency with access to their medical records, if requested. Further, it should be understood that the Agency receives a full medical report from its examining physicians regarding the applicant or employee's state of health. All Agency required medical examinations and alcohol and drug screenings are paid for in full by the Agency.

	SECTION: Corporate Compliance					NO: 14
	TITLE: OPEN DOOR					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Purpose

Misunderstandings or conflicts can arise in any organization. To ensure effective working relations, it is important that such matters be resolved before serious problems develop. Most incidents will resolve themselves naturally; however, if a situation persists that an employee believes is detrimental to themselves or to the Agency, free discussion with the employee's immediate supervisor, department head, or a member of the human resources department is encouraged. These individuals will endeavor to work out a satisfactory solution to the problem.

The Agency is committed to compliance in all aspects of the organization. As such, the Agency maintains a confidential hotline for Affected Individuals, clients and their families/advocates to report any compliance concerns, including inappropriate documentation and billing. The hotline's number is **718-438-0941**. To best respond to all calls and issues raised in a timely basis, it is most helpful if the reporter provide as much information as possible (contact name and phone number, residence, name of client, name of staff,). While staff are welcome to leave an anonymous message, it may be difficult to follow-up on anonymous calls. Ohel will make every effort in good faith to maintain, within the limits of the law, the confidentiality of the identity of any individual who reports a concern. No adverse action will be taken against such individuals who report concerns in good faith. Reporters also have the option of calling the Agency's Human Resources or Quality Assurance Department directly at 718-851-6300.

	SECTION: Corporate Compliance					NO: 15
	TITLE: FALSE CLAIMS ACT COMPLIANCE					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Summary

Ohel Children's Home and Family Services, Inc. ("Ohel") is committed to complying with the requirements of Section 6032 of the Federal Deficit Reduction Act of 2005 and to preventing and detecting any fraud, waste, or abuse in its organization. To this end, Ohel maintains a compliance program and strives to educate its work force on fraud and abuse laws, including the importance of submitting accurate claims and reports to the Federal and State governments. Ohel's compliance policies and procedures are set forth in detail in our Compliance Program, which is available on Ohel's website and through the Department of Quality Assurance.

In furtherance of this policy and to comply with the Deficit Reduction Act, Ohel provides the following information about its policies and certain relevant Federal and State laws.

In particular, Ohel prohibits the knowing submission of a false claim for payment from a Federally or State funded health care program. Such a submission is a violation of Federal and State law and can result in significant administrative and civil penalties under the Federal False Claims Act, a Federal statute that allows private persons to help reduce fraud against the United States government. Please see more information about the Federal False Claims Act below.

In addition, in New York State the submission of a false claim can result in civil and criminal penalties under portions of the New York State Social Services Law and Penal Law, among other State statutes. Please see more information about these New York State laws below.

OHEL'S POLICIES AND PROCEDURES

To assist Ohel in meeting its legal and ethical obligations, any Affected Individual, client or family member/advocate who reasonably suspects or is aware of the preparation or submission of a false claim or report or any other potential fraud, waste, or abuse related to a Federally or State funded health care program is required to report such information to his/her supervisor, Ohel's compliance officer, or by calling the Compliance Hotline at 718-438-0941. Any employee of Ohel who reports such information in good faith will be protected against retaliation for coming forward with such information both under Ohel's internal compliance policies and procedures and Federal and State law. The anonymity of callers will be respected to the extent possible in conducting a thorough investigation. Ohel retains the right to take appropriate action against an employee who has participated in a violation of Federal or State law or Agency policy or who has made a report that was not made in good faith.

As an organization, Ohel commits itself to investigate any suspicions of fraud, waste, or abuse swiftly and thoroughly and requires all Affected Individuals to assist in such investigations. If an Affected Individual believes that Ohel is not responding to his or her report within a reasonable period of time, the Affected Individual shall bring these concerns about Ohel's perceived inaction to Ohel's compliance officer. Failure to report and disclose or assist in an investigation of fraud and abuse is a breach of the Affected Individual's obligations to Ohel and may result in disciplinary action.

FEDERAL AND STATE STATUTES

The following is a summary of the Federal False Claims Act, the Program Fraud Civil Remedies Act and certain relevant State laws.

Federal False Claims Act

The Federal False Claims Act, 31 USC §3729-3733, et seq, establishes liability for any person who engages in certain acts, including:

- knowingly presenting or causing to be presented a false or fraudulent claim to the Federal government for payment or approval or statements that are material to the government's decision to pay a claim;
- knowingly making, using, or causing to be made or used, a false statement to get a false or fraudulent claim paid by the Federal government; or
- conspiring to defraud the Federal government by getting a false or fraudulent claim allowed or paid.

Under the Federal False Claims Act, a person acts "knowingly" if s/he:

- has actual knowledge of the information;
- acts in deliberate ignorance of the truth or falsity of the information; or
- acts in reckless disregard of the truth or falsity of the information.

There is no requirement that the person specifically intended to defraud the government through his or her actions.

Under the Federal False Claims Act, a "claim" is any request or demand for money or property if the Federal government provides any portion of the money or property in question. This includes requests or demands submitted to a contractor of the Government and includes Medicaid and Medicare claims.

A violation of the Federal False Claims Act results in a civil penalty between $5,500 and $11,000 for each false claim submitted, plus up to three times the amount of the damages sustained by the Government because of the violation. In addition, the United States Department of Health and Human Services (HHS) Office of the Inspector General (OIG) may exclude the violator from participation in Federal health care programs.

The False Claims Act allows a private person to file a qui tam lawsuit on behalf of the Federal government. This person, also called a relator or whistleblower, must file his or her lawsuit under seal in a federal district court. The government may decide to intervene with the lawsuit, in which case the United States Department of Justice will direct the prosecution. If the government does not decide to intervene, the relator may still continue the lawsuit independently.

If a qui tam lawsuit is successful, the relator may receive between 10 to 30% of the recovery, depending on the level of the government's participation and other factors, as well as reasonable attorney's fees and costs. In addition, there can be no retaliation against the relator for filing or participating in the lawsuit in good faith. At the same time, however, any person who brings a clearly frivolous case can be held liable for the defendant's attorney's fees and costs.

Federal Program Fraud Civil Remedies Act of 1986

The Program Fraud Civil Remedies Act of 1986, 31 USC §§3801, et seq, is similar to the False Claims Act, establishing an administrative remedy against any person who presents or causes to be presented a claim or written statement that the person knows or has reason to know is false, fictitious, or fraudulent to certain Federal agencies, including HHS, and again, includes Medicaid and Medicare claims.

Similar to the False Claims Act, a person who "knows or has reason to know" is defined as one who:

- has actual knowledge of the information;
- acts in deliberate ignorance of the truth or falsity of the information; or
- acts in reckless disregard of the truth or falsity of the information.

Once again, there is no necessary proof of specific intent to defraud the government.

A violation of the Program Fraud Civil Remedies Act can result in a civil monetary penalty of up to $5,000 per false claim and an assessment of twice the amount of the false claim. The penalty can be imposed through an administrative hearing after investigation by HHS and approval by the United States Attorney General.

New York State Laws

New York's false claims laws fall into two categories: civil and administrative; and criminal laws. Some apply to recipient false claims and some apply to provider false claims, and while most are specific to healthcare or Medicaid, some of the "common law" crimes apply to areas of interaction with the government.

A. Civil And Administrative Laws

NY False Claims Act (State Finance Law, §§187-194)

The NY False Claims Act closely tracks the federal False Claims Act. It imposes penalties and fines on individuals and entities that file false or fraudulent claims for payment from any state or local government, including health care programs such as Medicaid. The penalty for filing a false claim is $6,000-$12,000 per claim and the recoverable damages are between two and three times the value of the amount falsely received. In addition, the false claim filer may have government's legal fees.

The Act allows private individuals to file lawsuits in state court, just as if they were state or local government parties. If the suit eventually concludes with payments back to the government, the person who started the case can recover 25-30% of the proceeds if the government did not participate in the suit of 15- 25% if the government did participate in the suit.

Social Services Law §145-b False Statements

It is a violation to knowingly obtain or attempt to obtain payment for items or services furnished under any Social Services program, including Medicaid, by use of a false statement, deliberate concealment or other fraudulent scheme or device. The State or the local Social Services district may recover three times the amount incorrectly paid. In addition, the Department of Health may impose a civil penalty of up to $2,000 per violation. If repeat violations occur within 5 years, a penalty up to $7,500 per violation may be imposed if they involve more serious violations of Medicaid rules, billing for services not rendered or providing excessive services.

Social Services Law §145-c Sanctions

If any person applies for or receives public assistance, including Medicaid, by intentionally making a false or misleading statement, or intending to do so, the person's, the person's family's needs are not taken into account for 6 months if a first offense, 12 months if a second (or once if benefits received are over $3,900) and live years for 4 or more offenses.

B. Criminal Laws

Social Services Law $145 Penalties

Any person who submits false statements or deliberately conceals material information in order to receive public assistance, including Medicaid, is guilty of a misdemeanor.

Social Services Law § 366-b, Penalties for Fraudulent Practices

a. Any person who obtains or attempts to obtain, for himself or others, medical assistance by means of a false statement, concealment of material facts, impersonation or other fraudulent means is guilty of a Class A misdemeanor.
b. Any person who, with intent to defraud, presents for payment and false or fraudulent claim for furnishing services, knowingly submits false information to obtain greater Medicaid compensation or knowingly submits false information in order to obtain authorization to provide items or services is guilty of a Class A misdemeanor.

Penal Law Article 155, Larceny

The crime of larceny applies to a person who, with intent to deprive another of his property, obtains, takes or withholds the property by means of trick, embezzlement, false pretense, false promise, including a scheme to defraud, or other similar behavior. It has been applied to Medicaid fraud cases.

a. Fourth degree grand larceny involves property valued over $1,000. It is a Class E felony.
b. Third degree grand larceny involves property valued over $3,000. It is a Class D felony.
c. Second degree grand larceny involves property valued over $50,000. It is a Class C felony.
d. First degree grand larceny involves property valued over $1 million. It is a Class B felony.

Penal Law Article 175, False Written Statements

Four crimes in this Article relate to filing false information or claims and have been applied in Medicaid fraud prosecutions:

a. §175.05, Falsifying business records involves entering false information, omitting material information or altering an enterprise's business records with the intent to defraud. It is a Class A misdemeanor.
b. § 175.10, Falsifying business records in the first degree includes the elements of the §175.05 offense and includes the intent to commit another crime or conceal its commission. It is a Class E felony.

c. §175.30, Offering a false instrument for filing in the second degree involves presenting a written instrument (including a claim for payment) to a public office knowing that it contains false information. It is a Class A misdemeanor.
d. §175.35, Offering a false instrument for filing in the first degree includes the elements of the second degree offense and must include an intent to defraud the state or a political subdivision. It is a Class E felony.

Penal Law Article 176, Insurance Fraud

Applies to claims for insurance payment, including Medicaid or other health insurance and contains six crimes.

a. Insurance Fraud in the 5th degree involves intentionally filing a health insurance claim knowing that it is false. It is a Class A misdemeanor.
b. Insurance fraud in the 4th degree is filing a false insurance claim for over $1,000. It is a Class E felony.
c. Insurance fraud in the 3rd degree is filing a false insurance claim for over $3,000. It is a Class D felony.
d. Insurance fraud in the 2nd degree is filing a false insurance claim for over $50,000. It is a Class C felony.
e. Insurance fraud in the 1st degree is filing a false insurance claim for over $1 million. It is a Class B felony.
f. Aggravated insurance fraud is committing insurance fraud more than once. It is a Class D felony.

Penal Law Article 177, Health Care Fraud

Applies to claims for health insurance payment, including Medicaid, and contains five crimes:

a. Health care fraud in the 5th degree is knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions. It is a Class A misdemeanor.
b. Health care fraud in the 4th degree is filing false claims and annually receiving over $3,000 in aggregate. It is a Class E felony.
c. Health care fraud in the 3rd degree is filing false claims and annually receiving over $10,000 in the aggregate. It is a Class D felony.
d. Health care fraud in the 2nd degree is filing false claims and annually receiving over $50,000 in the aggregate. It is a Class C felony.
e. Health care fraud in the 1st degree is filing false claims and annually receiving over $1 million in the aggregate. It is a Class B felony.

Whistleblower Protection

Federal False Claims Act (31 U.S.C. S3730(h))

The FCA provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the FCA. 31 U.S.C. 3730(h). Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

NY False Claim Act (State Finance Law §191)

The False Claim Act also provides protection to *qui tam* relators who are discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of their employment as a result of their furtherance of an action under the Act. Remedies include reinstatement with comparable seniority as the *qui tam* relator would have had but for the discrimination, two times the amount of any back pay, interest on any back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees.

New York Labor Law §740

An employer may not take any retaliatory action against an employee if the employee discloses information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that the employer is in violation of a law that creates a substantial and specific danger to the public health and safety or which constitutes health care fraud under Penal Law §177 (knowingly filing, with intent to defraud, a claim for payment that intentionally has false information or omissions). The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

New York Labor Law §741

A health care employer may not take any retaliatory action against an employee if the employee discloses certain information about the employer's policies, practices or activities to a regulatory, law enforcement or other similar agency or public official. Protected disclosures are those that assert that, in good faith, the employee believes constitute improper quality of patient care. The employee's disclosure is protected only if the employee first brought up the matter with a supervisor and gave the employer a reasonable opportunity to correct the alleged violation, unless the danger is imminent to the public or patient and the employee believes in good faith that reporting to a supervisor would not result in corrective action. If an employer takes a retaliatory action against the employee, the employee may sue in state court for reinstatement to the same, or an equivalent position, any lost back wages and benefits and attorneys' fees. If the employer is a health provider and the court finds that the employer's retaliatory action was in bad faith, it may impose a civil penalty of $10,000 on the employer.

Procedure

A. **General Principles**

1. Ohel shall provide information in this policy to all its Board, employees, contractors and agents, to the extent required by the Federal Deficit Reduction Act, regarding this policy.

2. Billing activities are to be performed in a manner consistent with Medicare, Medicaid and other payer regulations and requirements and in accordance with Ohel's billing and corporate compliance policies.

3. To assist in its efforts to detect and prevent fraud, waste and abuse, Ohel conducts regular audit and monitoring procedures as described in our auditing procedure policy.

B. **Reporting Non-Compliance**

If a Ohel employee, Board member, contractor or agent has any reason to believe that anyone is engaging in false billing practices, that individual shall immediately report the practice in accordance with Ohel's reporting policy. The Compliance Hotline telephone number is **(718) 438-0941**.

C. **Non-Retaliation**

Ohel will not retaliate against any employee for taking any lawful action under the False Claims Act. Moreover, it will not retaliate against any employee, contractor or agent for reporting any potential compliance concern, as described in this policy.

D. **Employee Handbooks and Contractor Agreements**
This Policy shall be included in all employee handbooks and attached to any contracts with outside contractors or agents, as required by the False Claims Act.

E. **Records of Compliance with the Policy**
This written policy and any revision to it, and the employee handbooks containing this policy shall be retained for a period of six (6) years from the date of the submission of the certification.

	SECTION: Corporate Compliance					NO: 16
	TITLE: VENDOR RELATIONS AND CONFLICTS OF INTEREST					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Purpose
The purpose of this policy is to ensure that Ohel complies with all applicable laws governing its relationships with vendors and that all such relationships are carried out with honesty and integrity and without conflicts of interest.

Gifts and Gratuities
Employees and Board members are prohibited from accepting gifts or gratuities of any kind from vendors or prospective vendors of Agency. Gifts include, but are not limited to, the provision of any item or service to an employee at less than fair market value. The only exception to this prohibition is that employees and Board members are permitted to accepted unsolicited gifts of nominal value (e.g., candy during the holiday season) from existing vendors of Agency. Employees and Board members must contact the Compliance Officer if they have any questions about whether a gift from the vendor violates this policy.

Employees and Board members may not permit vendors or potential vendors to pay for business related meals, entertainment or travel having a value of more than $100 per year without the prior approval of the Compliance Officer*. Meals, entertainment and travel are considered business related only if they are used predominantly to facilitate business related discussions.

Screening of Vendor entities
Ohel will not enter into any contract where vendor entities, who are subject to the Federal False Claims Act, are included on the LEIE, EPLS or OMIG exclusion list, or have been convicted of a crime relating to the provision of or billing for healthcare services. Screenings of Vendors are performed by the Human Resources Department before the contract is executed and on a monthly basis.

Information About the False Claims Act
The Compliance Officer or his designee will ensure that vendors, who are subject to the Federal False Claims Act, receive information about the False Claims Act in accordance with Agency's False Claims Act Policy.

Contract Language
All contracts with vendors/contractors shall include the following language:

In accordance with New York State Social Services Law Section 363(d) and corresponding regulations found at 18 NYCRR Part 521-1, Contractor is required to take all reasonable steps to understand and comply with Provider's: (a) Compliance Plan; (b) related policies and procedures; and (c) compliance initiatives (collectively referred to as the Provider's "Compliance Program") to the extent that Contractor's duties and obligations under the Contract are related to Provider's risk area(s). Contractor's compliance duties and requirements shall include but not be limited to adherence with all

Provider training requirements, reporting obligations, and other good-faith participation in Provider's compliance initiatives. Any questions related to whether Contractor is affected by Provider's risk areas shall be directed to Provider's Compliance Officer.

Contractor's failure to adhere to Provider's Compliance Program requirements shall be grounds for immediate termination for cause of the Contract by Provider following three (3) days' prior written notice and opportunity to cure, if curable.

Bid Requirements

Level 1- For transactions with an estimated unit price between $3,000 and $5,000, a price quote or a price check should be made when buying unfamiliar products with at least one other vendor. Additionally, staff should check the price of familiar items with historical information to ensure that a consistent price is being agreed upon. These verbal quotes should be duly recorded with relevant documentation maintained in the respective manager's files and appropriate copies provided to fiscal staff. In the case of proprietary items, more than one price is often not possible and should be so noted. A photocopy of the items and delivery costs from a current catalog is an acceptable alternative when soliciting bids for transactions estimated between $3,000 and $5,000.

Level 2- For transactions with an estimated unit price of $5,000 or more, written bids may be required from a minimum of three vendors. Generally these types of purchase are made through the Administrative Services Department ("ASD") and staff must put these requests to ASD or the Fiscal department. ASD will determine if bids are required as they have the purchasing experience.

Level 3- All purchases over $15,000 should be reviewed and approved in writing by the Chief Financial Officer after approval by the ASD. All purchase transactions over $50,000 require the additional written approval of the Chief Executive Officer.

Exceptions To Bid Requirement

Level 1 and Level 2- Exceptions to policy to waive this requirement may be approved only with the written authorization of the CEO **or** the CFO. Exceptions will be considered in instances where: the product or service is unique, the product, vendor or service provider is exclusive, the supplier is a contract vendor, prior experience dictates, or in instances where timeliness is a critical factor.

Level 3- Exceptions to policy to waive this requirement may be approved only with the written authorization of the CEO **and** the CFO. Exceptions will be considered in instances where: the product or service is unique, the product, vendor or service provider is exclusive, the supplier is a contract vendor, prior experience dictates, or in instances where timeliness is a critical factor.

Acceptance of Bids

Every effort should be made to solicit bids only from vendors with a proven, professional quality, track record. The following factors, in combination, will be considered in accepting a bid:

- Lowest cost/Greatest value
- Payment terms
- Bidder's previous record of performance and service
- Ability of the bidder to render satisfactory service or deliver the goods in a timely manner
- Quality and conformance to specifications
- Warranty

Ohel Bais Ezra reserves the right to reject any and all bids, and to award the purchase or contract as the best interest of the agency may require.

Conflicts of Interest

Conflicts of interest on the part of Ohel Bais Ezra staff members and Board members shall be avoided. A conflict is deemed to exist if any of the following conditions apply in connection with an employee or board member of either Ohel Bais Ezra, or an immediate member of their families:

- Has a propriety interest in a supplier or vendor doing business with Ohel Bais Ezra
- Does business with Ohel Bais Ezra
- Accepts any form of payment to influence the decision

Should a potential conflict exist, it is the responsibility of the employee or Board member to disclose this immediately to the CEO, CFO, or President of the Board of Directors.

Any exception to the conflict of interest provision requires the approval of the Board Executive or Finance Committee and should be disclosed at an upcoming board meeting. A Board member will recuse himself (herself) from voting on the matter it involves him and/or his interests in a company. The Board member may be involved in the discussion but shall not attempt to improperly influence a decision on the matter. The minutes shall reflect the recusal of the Board member from the vote.

If the conflict of interest involves a member of the Board of Directors, the matter shall be reviewed by the Board President. The President, in consultation with members of the Executive or Finance Committee, has the discretion to waive this provision and approve such a transaction involving a Board member. When a determination is made that waiting until the next meeting of the Executive or Finance Committee or full Board of Directors is

not in the agency's best interest, this decision should be appropriately documented. Alternatively, this information may be recorded as minutes of a Board Committee teleconference.

Check Signing Procedures

All Checks in excess of $5,000 will require dual signatures, which can be evidenced by either dual signing of the check or the dual initialing of the supporting documentation by any combination of the CEO or CFO, and the Controller or Assistant Controller(s). Normal recurring monthly, quarterly, semi-annual or annual items in excess of $5,000, specifically mortgage payments, insurance premiums, rents, intercompany balances, amounts defined per an approved contract, (i.e. monthly bus transportation) are not subject to the dual signature requirement.

The Chief Financial Officer should ensure that appropriate information is provided to agency staff to solicit bids and maintain documentation. The CFO should additionally conduct periodic reviews and spot check to ensure that conformance with this policy is maintained.

*The Compliance Officer is appointed by the Chief Executive Officer. At this time, the Compliance Officer is Aryeh B. Schneider, Esq. (718) 686-3360.

* EPLS- U.S. General Services Administration Excluded Parties List System
* LEIE- U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals/Entities
* OMIG- List of Restricted, Terminated or Excluded Individuals or Entities maintained by the New York State Office of Medicaid Inspector General

	SECTION: Corporate Compliance					NO: 17
	TITLE: BILLING AND REIMBURSEMENT					
Effective Date: 1/19/2010	**Revised:** 3/28/2023					

Purpose
The purpose of this policy is to promote compliance with applicable legal requirements as they relate to billing for services and the treatment of any improper or inaccurate payments.

Statement of Policy on Billing
All claims submitted by Ohel, whether to government entities or private payors, must meet the following criteria:

- The claim must be accurate and submitted timely;
- The claim must only be for items and services that are medically necessary as such standard is established by the applicable payor and/or prevailing community standards, and, where required, as ordered by the client's physician;
- The claim must fall within all coverage guidelines contained in applicable laws, regulations, manual provisions and contracts; and
- The client's medical record must contain all documentation required in connection with the claim.
- Claims must be submitted to the other applicable payers prior to being submitted to Medicaid as Medicaid is the payer of last resort.

Claims for reimbursement of any kind that are false, fraudulent and accurate or fictitious are prohibited. Falsified medical records, timecards, or any other record used as the basis for submitting claims will not be permitted. For services that must be coded, use of a code that does not accurately describe the documented service when there is a more accurate code that could have been used are prohibited. This includes post- dating orders or signatures. Late entries should include an explanation of reason for delay or entry. Ohel does not permit the filing of claims for the same item or services to more than one payor source where that organization will receive duplicate or double payments.

Treatment of Credit Balances
Ohel will determine the validity of all credit balances and resolve all credit balances in accordance with applicable law and/or contract requirements. The billing office will timely file an adjusted claim from the date an overpayment is confirmed for any Medicaid or other government funded payor. Any overpayment that is determined to be result of a payment by a client must be refunded to the client promptly. If the credit balance is determined to be an overpayment by a commercial payor, Ohel will comply with applicable state law, regulatory guidance and contract requirements in the reporting, explaining and returning of the overpayment.

	SECTION: Corporate Compliance	NO: 17
	TITLE: MEDICAL NECESSITY AND QUALITY OF CARE	
Effective Date: 1/19/2010	**Revised:** 3/28/2023	

Purpose

Ohel Children's Home and Family Services, Inc. ("Ohel") provides a broad array of social and health care support programs to the communities we serve. Many of our services are reimbursed by government agencies. Regardless of payor source, payors require strict compliance with their rules addressing medical necessity, including physician certification and recertification requirements. For some services, Ohel is required to obtain a medical necessity determination for the appropriate level of care by the Office of Mental Retardation and Developmental Disabilities ("OMRDD") or Office of Mental Health ("OMH"), among other federal, state, and city agencies, prior to rendering services. The purpose of this policy is to ensure that all such rules are followed throughout Ohel's programs.

Statement of Policy on Reimbursement

To ensure that Ohel is reimbursed only for services to eligible consumers, each Ohel program will understand, follow and document its compliance with the medical necessity requirements applicable to such program. The Department of Quality Assurance will conduct periodic audits of each program to determine whether applicable medical necessity rules are being followed and timely documented.

For those programs reimbursed by Medicaid, medical necessity requirements are generally established in the applicable Medicaid manual. The New York Medicaid manuals are available at http://www.emedny.org/ProviderManuals/index.html.

For those services that require a determination by OPWDD, OMH, or other agencies as to the appropriate level of care, Ohel will seek this determination in accordance with OPWDD, OMH, or any other agency's requirements and will seek periodic reevaluations as required by OPWDD, OMH, or any other applicable agency.

Any material failure to follow medical necessity rules will be reported to the Compliance Officer for further evaluation and remediation.