NCDHHS DIVISION OF SOCIAL SERVICES
STATE MATERNITY FUND – Alternative Living Arrangement

Housing Assessment and Provider Agreement

ASSESSMENT

Name of Individual providing housing: Does Individual live in home? Date of On-Site Visit: Address:
Describe physical environment. Include information on sleeping arrangement, client's privacy, space for storage of personal items, access to bathroom facilities, heating/cooling, etc.
Describe the food and nutrition plan for the client along with access to laundry facility services.
Describe transportation resources for emergency needs, medical needs, accessibility to resources, etc.
Describe how placement meets any emotional support needs or addresses other special needs.
Based on policy, how does this placement meet the adequate needs of the client?
Does the Caseworker have confidence in the placement's ability to meet the needs of the client?

AGREEMENT

1. This Agreement is entered into between (Supporting Agency supervising Pregnancy Services case, hereinafter the "Agency") and (the Alternative Housing Provider, hereinafter "Care Provider"), located at for the delivery of room and board under the provisions of the North Carolina Maternity Fund as set forth in Title 10A, Chapter 71L of the North Carolina Administrative Code and in accordance with the policies standards in Child Welfare Services Section 021 Appendix 4 Pregnancy Services Manual. https://policies.ncdhhs.gov/wp-content/uploads/appendix-4-pregnancy-services.pdf

2. The Service Agency agrees to initiate contact with the State Maternity Fund to facilitate reimbursement to the Care Provider **$27.00** per day for room, board and the services described herein on behalf of , an approved State Maternity Fund client, commencing on the date of SMF Client's move to placement on (admission date), or the approved admission date, whichever is the latter. Reimbursable expenses will cease to accrue as of the date the SMF Client leaves the Care Provider or the date the pregnancy concludes, whichever occurs first. In any event, reimbursements will not exceed 183 days.

3. The Service Agency agrees to keep the Care Provider informed of anticipated or actual changes in the service plan for the SMF Client that might affect the terms of this Agreement and will consult with the Care Provider as needed. The Service Agency will be responsible for the arrangement and coordination of medical care and social services for the SMF Client.

4. The Care Provider shall collect no fee or other payment from the SMF client for the services provided under this Agreement. Any other fees required for specialized services or needs (outside of pregnancy services) must be specifically listed under this section: Other fees will require the approval of the SMF Coordinator and may reduce the daily fee indicated.
5. The Care Provider agrees to furnish appropriate sleeping accommodations, at least three nutritionally balanced meals per day, linens, laundry, and utilities for the SMF Client from (admission date) until the date the SMF Client leaves the Care Provider or pregnancy is concluded, whichever occurs first.
6. The Care Provider further agrees to immediately notify the Service Agency of any of the following, and to obtain any necessary waivers or releases from the SMF Client in advance to be able to provide such notice:
   a.) when the SMF Client leaves the Care Provider;
   b.) of any conditions of which the Care Provider is or becomes aware that might negatively affect the SMF Client's pregnancy or the completion of this agreement; and/or
   c.) of any medical emergency involving the SMF Client.
7. The Care Provider is not responsible for medical care and/or social services for the SMF Client. The Care Provider is aware of G.S. § 131D-1 governing maternity home licenses. The Care Provider is not required to hold such a license. The Care Provider is aware of G.S. § 48-10-101 and § 48-10-102 governing prohibited activities and unlawful payments relating to adoption and agrees to obey these laws.
8. This Agreement may be terminated by either party upon five days' notice, or immediately upon mutual consent.

SIGNATURES & CONTACT	**Service Agency**	**Care Provider**
Signature		
Title		
Contact Number		
Other Contact Info or preferred method/times		
Date		
W-9 Form will be required for any State Payments - Service Agency should provide a copy, indicate here if completed form attached.		