

TOWNSHIP OF SCHAUMBURG  
ONE ILLINOIS BLVD.  
HOFFMAN ESTATES, IL 60169

Agreement for Purchase of Services

DISABILITY SERVICES

1. Agency \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Parent Organization  
(If Applicable) \_\_\_\_\_

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

2. Funds Requested:
- A. Total Grant Requested \_\_\_\_\_
- B. Charge requested per unit of service by each classification of services provided.
- | Service | Charge | Per Hour or Per Day |
|---------|--------|---------------------|
| _____   | _____  | _____               |
| _____   | _____  | _____               |
| _____   | _____  | _____               |
- C. Additional programs for which you are requesting funds  
Attach a detailed statement \_\_\_\_\_

3. Are all program, services, activities and facilities provided by your Agency available to residents of Schaumburg Township?  
Yes \_\_\_\_\_ No \_\_\_\_\_ (If no, attach a detailed statement)
4. Does your agency serve the entire Schaumburg Township area?  
Yes \_\_\_\_\_ No \_\_\_\_\_ (If no, attach a detailed statement)
5. Does your agency serve any other Township other than Schaumburg Township?  
Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, please list Townships served.)

**6. Units of Service:**

**A. How many units of service did your agency provide by classification of service for the past three years, and what do you project for next year.**

Classification of Services	20__	20__	20__	20__

**B. Provide the same information for the residents of Schaumburg Township.**

Classification of Services	20__	20__	20__	20__

**7. Please attach a detailed account of the exact number of residents served on a monthly basis for the current Township fiscal year beginning March 1<sup>st</sup>, to the end of the most recent month.**

**8. What percentage of your operational funding comes from the following sources?**

Other Township(s)\_\_\_ Village(s)\_\_\_ County \_\_\_ State \_\_\_ Federal\_\_\_

Private: Endowments \_\_\_ United Way \_\_\_ Fund Raising Drives \_\_\_ Other \_\_\_

**9. If no funding from United Way, please explain:**

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10. How are your fund raising efforts different from last year?

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11. If you have received funds from Schaumburg Township, beginning with the most current year, list the amounts requested and the amount actually received for the past three years.

Year:	Amount Requested	Amount Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. What was total budgeted cost for your agency, for the past fiscal year? \_\_\_\_\_

What was the actual cost? \_\_\_\_\_

13. The Agency understands and agrees that the following conditions are incorporated into and considered with this agreement before a distribution will be made by the Township. The Agency further agrees to comply with the provisions hereinafter set forth in the event it receives the purchase of services grant from the Township.

A Service Charge

1. The Agency agrees not to request from the Township more than the total annual funds allowed under the purchase of services grant.
2. The Agency agrees that any charges of the Township for services rendered shall be in conformance with the per client charge negotiated at the time of the Agency's annual grant.
3. The Agency agrees to submit a statement of services rendered to the Township on a monthly basis. Said charges for services shall be drawn from the total funds available in the annual purchase of services grant to that Agency. Each monthly statement of services must include the following:

- a. Every Township resident rendered services must be identified with an I.D. number. For those Agencies reporting to the Department of Mental Health (DMH) to the Department of Developmental Disabilities (DD) the assigned I.D. number will be the same as the DMH and DD numbers.:
- b. The monthly billing statement will include a list of clients served identified with their I.D. numbers and the number of contacts provided. Only direct service contacts will be accumulated monthly for each client. Collateral hours are not to be accumulated, nor reported on the monthly statement.:
- c. The monthly statement will indicate what type of services were provided the clients: individual, group, family, marital, residential, day treatment, rehab, etc. If more than one member of a family or marital group- ing has an I.D. number, only one I.D. number will be reported unless these members are seen individually during the month.:
- d. Other costs will be charged to the Township according to the negotiated fee. Bills for these costs shall be detailed as to date, actual cost, to whom, by whom, etc.

**B Services Provided**

1. The Agency agrees to provide the appropriate professional services to the residents of the Township.
2. The Agency agrees to provide the Township a specific description of new programs, services, activities or facilities which are initiated subsequently to the annual grant by the Township for the purchase of services.

**C Inspection**

The Agency agrees that all financial records and client files shall be open for inspection at any time to the Township Officials and to their representatives pursuant to Section 7 of the Mental Health and Development Disabilities Confidentiality Act (Article I, Section 1, et seq. Effective January 1, 1979). The exception to this condition are the records of alcoholic clients/patients whose confidentiality is protected by the COMPREHENSIVE ALCOHOLIC ABUSE AND ALCOHOLIC PREVENTION, TREATMENT AND

**REHABILITATION ACT OF 1970, and related federal laws governing the treatment of alcoholic clients/patients.**

**D Agency Representative**

**The undersigned Agency Representative has been empowered by the Agency and is responsible for ensuring compliance to this agreement. The Agency will provide the name of a successor in the event that the undersigned is no longer associated with the Agency: such successor will be empowered for ensuring compliance to this agreement.**

**E Source of Funds**

**The Agency understands that all funds for the purchase of services shall be distributed from the Township in the manner specified by the Township.**

**F Required Documents**

**All attached documents are to be considered part of this agreement.**

**The Agency agrees to submit to the Township the following documents.**

- 1 A specific description of any new programs, services, activities or facilities which are proposed or contemplated by your Agency.**
- 2 The specific purposes for which Township funds would be used by your Agency.**
- 3 Audit of the past fiscal year.**
- 4 Proposed budget for the coming year.**
- 5. A copy of I.R.S. 501 C.**

We of \_\_\_\_\_ agree to the above  
(Name of Agency)  
provisions for the purchase of services grant from Schaumburg Township.

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Agency Representative

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Title

**CORPORATE SEAL**

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Date

**10/2000**