

## **AGREEMENT**

STATE OF TEXAS       §

COUNTY OF WEBB     §

This agreement is made by and between the City of Laredo Public Health Department (“Department”) and Dental Odyssey, (“Provider”).

In consideration of the promises and of the mutual covenants and agreements contained in this Agreement, the parties hereby agree as follows:

### **SCOPE OF SERVICES**

The Provider agrees to render all dental services necessary within the scope of practice for appropriate treatment of patients as defined and described by rules and guidelines and applicable laws and standards followed by the South Texas Development Council (STDC), and National Guidelines followed by the Department’s HIV Ryan White Program. See Attachment A “Specific Duties and Responsibilities”, Attachment B “Provider’s Insurance Checklist”, Attachment C “HIPAA Business Associate Agreement”, Attachment D “Insurance Provisions”, and Attachment E “Federal and State Assurances”, incorporated herein by reference as if set out in full for all intents and purposes.

### **TERM**

This agreement will commence on April 1, 2026 and will continue until March 31, 2027; either party may terminate this agreement by giving seven days written notice to the other party. This contract maybe renewed for another two (2) years, contingent on funding ability.

### **COMPENSATION**

The total cumulative payment to the Provider under this agreement shall not exceed \$150,000.00 per year. Reimbursement will be paid on a monthly basis upon receipt of an invoice. All original invoice(s) for services rendered must be submitted by the 5th working day after the end of the month in which services were rendered. Any invoices not submitted within this timeline will not be paid by the Department’s HIV Ryan White Program. Invoices should be sent to 2600 Cedar, Attn: HIV Services Program.

### **RELATIONSHIP OF THE PARTIES**

It is understood and agreed that the relationship of the Provider to the Department is that of an independent contractor. Each party is interested only in the results obtained under this Agreement.

Under no circumstances shall either party be deemed an employee of the other, nor shall either party act as an agent of the other party. Any and all joint venture or partnership status is hereby expressly denied and the parties expressly state that they have not formed, either express or impliedly, a joint venture or partnership.

## **INSURANCE AND INDEMNIFICATION**

**IT IS THE INTENTION OF THE PARTIES THAT THE PROVIDER BE AN INDEPENDENT CONTRACTOR AND NOT AN EMPLOYEE UNDER THIS AGREEMENT. IN ORDER TO PROTECT THE DEPARTMENT FROM LIABILITY, THE PROVIDER MUST MAINTAIN A POLICY OF INSURANCE AND COMPLY WITH ALL REQUIREMENTS SET FORTH IN ATTACHMENT D AND WILL FURTHER INDEMNIFY AND HOLD THE DEPARTMENT HARMLESS FROM ANY AND ALL CLAIMS ARISING OUT OF THE PERFORMANCE OF THE REQUIRED SERVICES.**

**THE PROVIDER FURTHER AGREES TO FURNISH THE DEPARTMENT WITH A COPY OF HIS/HER TEXAS MEDICAL LICENSE(S), PROOF OF LIABILITY INSURANCE, AND TO GIVE NOTICE OF ANY CHANGES IN THE MALPRACTICE INSURANCE COVERAGE OR INSURER, AND TO PROVIDE UPDATED RENEWAL COPIES OF LICENSE AND PROOF OF INSURANCE TO THE DEPARTMENT, AS WELL AS PROOF OF IMMUNIZATION STATUS.**

## **QUALITY ASSURANCE**

The Department and Provider, in receiving funding from Ryan White must adhere to the requirements and quality assurance of the Texas Department of State Health Services (DSHS) Standards of Care for any provision of services. These include the Universal Standards as well as the specific Ryan White Part B standard for each service category, including supervision and oversight of SUBCONTRACTOR services. Oral Health Care (OHC) can be found at <https://www.dshs.texas.gov/hivstd/taxonomy/oral.shtm>. A copy of the OHC SOC is attached.

The Department and Provider will maintain a medical record/client file on the premises of City of Laredo Public Health Department for each Dental Odyssey patient seen and make the record available for quality management review by City of Laredo Public Health Department program staff and for audit by the South Texas Development Council, HIV Services Administrative Agency Staff, and the Texas Department of State Health Services Staff upon request.

## **TRANSITION OF CLIENTS**

The Department and Provider will execute the following process and timely plan to transition client(s) to a new provider if the current provider is no longer able to continue services.

Outline Process:

- a. Notification to the Department and the HIV Administrative Agency if Provider is no longer able to continue services as per contract, contract termination or transition of service providers.

- b. Notification to clients of service changes not limited to medical care facility, medical provider and case management services.
- c. Collaboration between existing service provider and the new service provider.
- d. Participate in Transition Plan to continue to provide services to clients, with minimal disruption, during transition of service providers or change/loss of agency services.
- e. Provider will handle all of client's information in accordance with DSHS HIV-STD Security Policies and Procedures which can be found at <https://www.dshs.texas.gov/hivstd/policy/security.shtm>.

## **NOTICES**

Notices under this agreement shall be in writing and shall be hand delivered or sent by registered mail or certified mail, return receipt request, postage prepaid, properly addressed, to the respective parties at the addresses set forth below in this agreement. Notice actually received shall be deemed for all purposes to have been in writing and shall, for all purposes, be deemed to have been fully given and received.

Dental Odyssey  
Salvador Muñoz-Flores, DDS  
5901 McPherson Rd  
Laredo, Texas 78041

City of Laredo Public Health Department  
Richard A. Chamberlain, DrPH, MPH,  
DipACLM, CPM, CHW, LCI, RS  
Director of Public Health  
2600 Cedar Avenue  
Laredo, TX 78040

## **DISPUTE OR CONTEST**

In the unlikely event that a dispute which is litigated or a cause of action in law or equity is filed concerning the operation, construction, interpretation, or enforcement of this agreement the losing party shall bear the cost of the attorney's fees incurred by the prevailing party and any and all costs applicable thereto.

## **CORPORATE AUTHORITY**

If any party of this agreement is a legal entity, including, but not limited to, an association, corporation, joint venture, limited partnership, or trust, that party represents to the other that this agreement and the transactions contemplated in this agreement and the execution and delivery hereof have been duly authorized by all necessary corporate, partnership, or trust proceedings and actions including, but not limited to, actions on the part of the directors, officers, and agents of the entity.

Furthermore, a corporate party represents that all appropriate corporate meetings were held to authorize the aforementioned obligations and certified copies of all corporate meetings or minutes and corporate resolutions authorizing this transaction have been delivered to all parties to this agreement prior to or at the time of execution of this agreement.

## **FUNDING**

This agreement is contingent upon funding being available for the term designated in this agreement. The Provider shall have no right of action against the Department in the event that the Department is unable to perform its obligations under this agreement as a result of suspension, termination, withdrawal or failure of funding to the Department.

## **PROFESSIONAL STANDARDS**

The Provider agrees to abide by and perform his/her duties accordance with the applicable ethics of his/her profession, and all applicable federal, state, and municipal laws, regulations and ordinances regulating his/her profession.

## **AMENDMENT OR MODIFICATION**

This agreement represents the entire agreement by and between the parties except as otherwise provided in this agreement. It may not be changed except by written agreement duly executed by all of the parties.

The Department and Provider will follow any changes in local, state and federal rules, regulations or laws applicable hereto may occur during the term of this Agreement and that any such changes shall be automatically incorporated into this Agreement without written amendment hereto, and shall become a part hereof as the effective date of the rule, regulation or law.

## **HIPAA AGREEMENT**

(See attached Addendum for Contractors under the Health Insurance Portability and Accountability Act of 1996)

## **ASSIGNMENT**

Neither this agreement nor any duties or obligations under it are assignable by the Provider without the prior written consent of the Department.

## **ENTIRE AGREEMENT**

This agreement supersedes any and all other agreements, either oral or in writing, between the parties to this agreement with respect to this subject matter. No other agreement, statement, or promise relating to this subject matter will be valid or binding unless in writing and signed by both parties.

**PARAGRAPH HEADINGS**

The paragraph headings used in the agreement are descriptive only and shall have no legal force or effect whatsoever.

**NO WAIVER**

A failure or delay in the enforcement of the rights detailed in this agreement by either party shall not constitute a waiver of rights or be deemed a basis for estoppel. The parties may exercise their rights under this agreement despite delay or failure to enforce those rights.

**TEXAS LAW**

This agreement shall be subject to and governed by the laws of the State of Texas. Any and all obligations or payments are due and payable in Webb County, Texas.

SIGNED, accepted, and agreed to this \_\_\_ day of \_\_\_\_\_, 2026, by the undersigned parties, executed in duplicate by authorized representatives.

**CITY OF LAREDO**

**PROVIDER**

By: \_\_\_\_\_  
Joseph W. Neeb                      Date  
City Manager

By: \_\_\_\_\_  
Salvador Muñoz-Flores, DDS      Date  
Dental Odyssey

**RECOMMENDED**

By: \_\_\_\_\_  
Richard A. Chamberlain      Date  
DrPH, MPH, DipACLM, CPM, CHW, LCI, RS  
Director of Public Health

Address to where reimbursement will be sent:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**APPROVED AS TO FORM**

Doanh T. Nguyen, City Attorney

By: \_\_\_\_\_  
Amber R. Holmes                      Date  
Assistant City Attorney

Tax ID Number:

\_\_\_\_\_

**ATTESTED**

By: \_\_\_\_\_  
Mario I. Maldona, Jr.                      Date  
City Secretary

## ATTACHMENT A

### SPECIFIC DUTIES AND RESPONSIBILITIES

This attachment is hereby considered part of the agreement by and between the Provider **Dental Odyssey**, and the Department's HIV Program, for the term beginning April 1, 2026 to March 31, 2027.

In fulfilling the terms of this agreement the Provider hereby agrees to carry out the duties and responsibilities as follows:

#### **1. THE PROVIDER AGREES:**

A. To provide necessary medical services to HIV/AIDS clients that are referred in writing by the Department.

Provider shall comply with the new Standards of Care for funded service category (OAMC- Outpatient Ambulatory Medical Care) implemented as of June 2015 which are accessible <http://www.dshs.state.tx.us/hivstd/taxonomy/default.shtm>. A waiver on behalf of Provider was executed by the "Department" for approval by DSHS so that service may be rendered by Provider via subcontract Agreement with "Department". Provider will also adhere to all of the current Universal Standards, HIV Core and Support Service Categories expected practices.

Provider will adhere to any policy changes made during the life of the current contract with at least 15 days written notice of expected change.

Provider, when provided with appropriate written request by STDC/DSHS, will make available any pertinent documents related to the service being rendered for review and monitoring purposes for STDC and/or DSHS staff. Provider will comply with DSHS guidance on sample size requirements for monitoring purposes of records and such records will be maintained on file for annual reviews by DSHS and STDC staff.

Documents will consist of outlined documents in the OAMC monitoring tool issued out by DSHS such as required and supporting documents related to services rendered, personnel training records, chart reviews, licensure, continuing education, assessments as well as any related services subcontracted out i.e. radiology tests, etc.

None of the services outlined in this contract/agreement may be outsourced to another entity at any point. Services are to solely be provided by "Provider" under this contract.

Medical progress notes should be submitted to case management agency/unit no later than 10 business days after the date of visit that highlight the nature of the services conducted as part of the medical consultation being billed. The progress note should at a minimum contain the following information:

- Client Name
- Client Date of Birth

- Doctor Name (Print) and Signature
- Date of Medical Visit
- CDC Disease Stage
- Co-Morbidities
- Current Medications
- Current Anti-Retroviral Drugs
- Last CD-4 Count (date and result)
- Last Viral Load (date and result)
- All other Laboratory results applicable
- Last STD screening (date and result)
- Summary of reason for visit and outcome

No ambulatory/outpatient medical care visit will be reimbursed by the Department if a medical progress note is not submitted to the case management agency/unit along with request for payment.

- B. To bill Medicaid, Medicare, or any other private insurance that the client may be enrolled in, before billing the Department. Billing the Department will take place on a last resort basis. (See Attachment B- Insurance Checklist of Providers)
- C. To sign and submit the documents indicated below to the Department **if applicable** to the Provider.
  1. HIV Workplace Guidelines Form
  2. Certification Regarding Lobbying Form
  3. Articles of Incorporation
  4. Non-Profit Status letter
  5. Clients sliding fee schedule
  6. Confidentiality Statement
- D. All original invoice(s) for services rendered must be submitted by the 5th working day after the end of the month in which services were rendered. Any invoices not submitted within this timeline will not be paid by the Department's HIV Ryan White Program. Invoices should be sent to 2600 Cedar, Attn: HIV Services Program.
- E. Any referral provided by **THE DEPARTMENT** contains a date when it was issued out to the client. If the client does not keep his/her appointment on the scheduled date noted on the referral and the **PROVIDER** chooses to honor the referral at a later date, the **PROVIDER** will only get reimbursed for any services rendered to the client if it falls within the same month as the date on the original referral.

**2. THE DEPARTMENT AGREES:**

- A. To reimburse the Provider for services being rendered. The fee is to be paid monthly by the City of Laredo on an invoice basis.
- B. To reimburse the Provider for Co-Pays. Co-Pays will vary depending on the insurance of the client.

**3. THE PARTIES AGREE:**

The City of Laredo Public Health Department shall not be responsible for payment of services beyond the scope of this contract. In the event the client is charged for services outside the scope of this agreement, a sliding fee schedule must be used with co-payment to provider based on a client's poverty income status.

Total Fees charged to client must conform to the limitations on annual aggregate charges described in the chart below.

<u>INDIVIDUAL/FAMILY ANNUAL GROSS INCOME</u>	<u>TOTAL ALLOWABLE ANNUAL CHARGES TO CLIENTS</u>
Equal to or below the official poverty line	No charges permitted
101 to 200 percent of the official poverty line	5 percent or less of gross income level
201 to 300 percent of the official poverty line	7 percent or less of gross income level
More than 300 percent of the official poverty line	10 percent or less of gross income level

**4. U.S. PUBLIC HEALTH STANDARDS:**

All Ryan White ambulatory/outpatient medical care sub-contractors providing HIV medical care services to our CLHD's LETS Program clients will be expected to adopt and enforce U.S. Public Health Standards. Each sub-contractor will be responsible for reviewing and maintaining a copy of the standards in their office and ensure that all involved staff in the care of the client is familiar with the information.

**ATTACHMENT B**

**PROVIDER INSURANCE CHECKLIST**

**Provider accepts Medicaid, Medicare or other insurance(s) and third party payers?**  
(Please check "Yes" or "No")

\_\_\_\_\_ **YES**                      \_\_\_\_\_ **NO**

**Provider accepts the following types of Insurance(s)**  
(Please check Insurance(s) accepted)

- |   |                        |
|---|------------------------|
| _____ <b>AARP</b>                               | <b>Other Insurance</b> |
| _____ <b>AETNA</b>                              | _____                  |
| _____ <b>Amerigroup</b>                         | _____                  |
| _____ <b>APWU Health Plan</b>                   | _____                  |
| _____ <b>Assurant Healthcare</b>                | _____                  |
| _____ <b>Baker Benefits</b>                     | _____                  |
| _____ <b>CIGNA</b>                              | _____                  |
| _____ <b>Hartford</b>                           | _____                  |
| _____ <b>Healthspring</b>                       | _____                  |
| _____ <b>Humana</b>                             | _____                  |
| _____ <b>Medicaid of Texas</b>                  | _____                  |
| _____ <b>Medicare</b>                           | _____                  |
| _____ <b>Mercy Health Plan</b>                  | _____                  |
| _____ <b>Mutual of Omaha</b>                    | _____                  |
| _____ <b>Physician Mutual Insurance</b>         | _____                  |
| _____ <b>Principial Mutual Life</b>             | _____                  |
| _____ <b>Provident American Life and Health</b> | _____                  |
| _____ <b>Pyramid Life</b>                       | _____                  |
| _____ <b>Railroad Medicare</b>                  | _____                  |
| _____ <b>Secure Horizons</b>                    |                        |
| _____ <b>Sierra Health &amp; Life Insurance</b> |                        |
| _____ <b>Superior Health Plan of Texas</b>      |                        |
| _____ <b>Texas True Choice</b>                  |                        |
| _____ <b>Tricare for Life</b>                   |                        |
| _____ <b>UMR</b>                                |                        |
| _____ <b>Unicare</b>                            |                        |
| _____ <b>BC&amp;BS</b>                          |                        |

PROVIDER

By: \_\_\_\_\_  
Salvador Muñoz Flores, DDS    Date  
Dental Odyssey

## **ATTACHMENT C**

### **HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)** **BUSINESS ASSOCIATE AGREEMENT**

This is a HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (Hereinafter "HIPAA") Business Associate Agreement made between Dental Odyssey, Business Associate (hereinafter "BA") and the undersigned City of Laredo through its City of Laredo Public Health Department-Covered Entity, (hereinafter "CE"), in consideration of the use and disclosure of Protected Health Information (hereinafter "PHI") on behalf of the CE, in accordance with the Standards for Privacy of Individually Identifiable Health Information pursuant to the Health Insurance Portability Act of 1996 (HIPAA).

#### **RECITALS**

That it is the desired intention of the CE to disclose certain information to the BA pursuant to the terms of the Underlying Agreement, some of which may constitute PHI.

Other than limitations set forth in this agreement, the forthwith BA may use or disclose PHI solely to perform the agreed upon services contracted with the CE.

The HIPAA Regulations, 45 C.F.R. § 164.502 (e)(2), requires the CE to enter into an agreement with the BA prior to disclosure of PHI that contains the specific requirements set forth in 45 C.F.R. §§ 164.502(e) and 164.504(e). In accordance with the HIPAA Regulations, these specific requirements are contained in this Business Associate Agreement.

#### **OBLIGATIONS OF BUSINESS ASSOCIATE**

Business Associate (BA) Agrees to the following:

1. Except as otherwise limited in this Agreement, the BA may not use or disclose PHI other than what is permitted or required by this Agreement or is required by law.
2. To use all of the necessary and essential safeguards in a permitted disclosure in no other manner that would not constitute a violation of the Privacy Rule if disclosed by the BA..
3. To report to the CE any use or disclosure of the PHI not provided for by this Agreement within five (5) days of becoming aware of such disclosure.
4. To ensure that the BA make a proper accounting of all information of the PHI and maintain all of its internal practices, books and records relating to the use and disclosure of PHI received from or created; or received by the BA on behalf of the CE and make available to the Secretary of Health and Human Services 200 Independence Avenue, S.W., Washington D.C., 20201 or by telephone at (800) 368-1019, so as to determine the CE's HIPAA compliance status.
5. The BA shall take the appropriate safeguards necessary to prevent the use or disclosure of PHI.

6. All agents of the BA shall additionally comply and agree in writing to comply with the same restrictions and conditions incumbent upon the BA with respect to the PHI. As additional assurance of this compliance, the BA shall implement and impose sanctions against any agents or subcontractors who violate these restrictions or conditions of any such violation.

### **OBLIGATIONS OF COVERED ENTITY (CE)**

That the CE shall be responsible for using all necessary and appropriate safeguards in order to ensure and maintain confidentiality, privacy and the utmost security of PHI transmitted to the BA pursuant to this Business Associate Agreement and furthermore shall notify the BA of any existing restrictions as to the use or disclosure of any PHI including any known changes in or revocations of permission by any individual whose PHI is transmitted to such extent that such changes may affect the BA use or disclosure of this PHI.

### **TERM AND TERMINATION**

The term of this Agreement shall be effective and shall remain in force for the duration of the professional services agreement between the parties. Upon any material breach by the BA where a cure is not possible the CE may immediately terminate this Agreement. Thereafter all PHI shall be returned to the CE by the BA.

In WITNESS WHEREOF, the parties hereto have duly executed this Business Associate Agreement as of the following directive.

**COVERED ENTITY:**  
City of Laredo Public Health Department

**BUSINESS ASSOCIATE:**

\_\_\_\_\_  
Richard A. Chamberlain,  
DrPH, MPH, CPHA, CPM, CHW, RS  
Director of Public Health

\_\_\_\_\_  
Salvador Muñoz Flores, DDS  
Dental Odyssey

Date: \_\_\_\_\_

Date: \_\_\_\_\_

## ATTACHMENT D

### CITY OF LAREDO INSURANCE PROVISIONS FOR PROFESSIONAL SERVICE CONTRACTS

The following insurance provisions shall provide additional clarification to the “INSURANCE AND INDEMNIFICATION” Section of the contract, and the Contractor shall comply with each and every condition contained herein. The Contractor shall provide and maintain, until the work covered in the contract is completed and accepted by The City of Laredo, the minimum insurance coverages as follows:

1. Commercial General Liability insurance at minimum combined single limits of \$1,000,000 per-occurrence and \$2,000,000 general aggregate for bodily injury and property damage, which coverage shall include products/completed operations (\$1,000,000 products/completed operations aggregate), and XCU (Explosion, Collapse, Underground) hazards. Coverage must be written on an occurrence form. Without limitation, the commercial general liability coverage must cover all operations required in the contract, as well as contractual liability for the indemnity obligations assumed by the Contractor in the contract.
2. Workers Compensation insurance at statutory limits, including Employers Liability coverage a minimum limits of \$1,000,000 each-occurrence each accident/\$1,000,000 by disease each-occurrence/\$1,000,000 by disease aggregate.
3. Professional Liability (Medical Malpractice/Errors and Omissions) for professional services,
  - a) With minimum limits of \$200,000 per occurrence/\$600,000 annual aggregate; limits required depend on the type and scope of services provided.
  - b) This coverage must be maintained for at least two (2) years after the project is completed. If coverage is written on a claims-made basis, a policy retroactive date equivalent to the inception date of the contract (or earlier) must be maintained during the full term the contract.

PLEASE NOTE: The required limits may be satisfied by any combination of primary, excess, or umbrella liability insurances, provided the primary policy complies with the above requirements and the excess umbrella is following-form. The Contractor may maintain reasonable and customary deductibles, subject to approval by the City of Laredo.

Any Subcontractor(s) hired by the Contractor shall maintain insurance coverage equal to that required of the Contractor. It is the responsibility of the Contractor to assure compliance with this provision. The City of Laredo accepts no responsibility arising from the conduct, or lack of conduct, of the Subcontractor.

With reference to the foregoing insurance requirement, Contractor shall specifically endorse applicable insurance policies as follows:

1. City of Laredo shall be named as an additional insured on a primary and non-contributory basis, regardless of the application of other insurance, with respect to all liability coverages, except for the professional liability and workers' compensation.
2. All liability policies shall contain no cross-liability exclusions or insured versus insured restrictions.
3. A waiver of subrogation in favor of City of Laredo shall be contained in all applicable policies.
4. All insurance policies shall be endorsed to require the insurer to immediately notify the City of Laredo of any material change in the insurance coverage.
5. All insurance policies shall be endorsed to the effect that City of Laredo will receive at least sixty (60) days' notice prior to cancellation or non-renewal of the insurance.
6. Insurance must be purchased from insurers that are financially acceptable to City of Laredo.

All insurance must be written on standard ISO or equivalent forms. Certificates of insurance shall be prepared and executed by the insurance company, or its authorized agent, shall be furnished to City of Laredo within five (5) business days of being notified of the award of the contract, and shall contain provisions representing and warranting the following:

1. Shall set forth all endorsements and insurance coverages according to requirements and instructions contained herein.
2. Shall specifically set forth the notice-of-cancellation or termination provisions to City of Laredo.
3. Copies of all required endorsements must be attached to the certificate of insurance. The certificates of insurance must be updated and resubmitted to the City of Laredo to show renewal coverages, as applicable, at least thirty (30) days prior to expiration of any one or more policies.

Upon request, Contractor shall furnish City of Laredo with certified copies of all insurance policies.

All contractors and subcontractors must be meeting minimum OSHA safety requirements as applicable to their operations.

**ATTACHMENT E**

**FEDERAL AND STATE ASSURANCES**