Division of Public Health
Agreement Addendum
FY 22-23

Wake County Health & Human Services **Local Health Department Legal Name**	Epidemiology / Communicable Disease **DPH Section / Branch Name**
583 Refugee Health Assessments **Activity Number and Description**	Jennifer Morillo, 919-755-3181 jennifer.morillo@dhhs.nc.gov **DPH Program Contact** (name, phone number, and email)
06/01/2022 – 05/31/2023 **Service Period**	**DPH Program Signature** **Date** (only required for a negotiable Agreement Addendum)
07/01/2022 – 06/30/2023 **Payment Period**	

☒ Original Agreement Addendum
☐ Agreement Addendum Revision # ___

I. Background:

Refugees are individuals who are unable to return to their home countries due to a well-founded fear of persecution on account of race, religion, nationality, political opinion, or membership in a particular social group. Mostly via the United States (U.S.) Refugee Admissions Program, refugees arrive to the U.S. and North Carolina from all around the globe. In fiscal year 2021, the largest numbers have arrived in North Carolina from the Democratic Republic of the Congo, Afghanistan, and Syria.

Refugees are a high-risk and vulnerable population that face special health challenges due to their exposure to deteriorating conditions usually attributed to circumstances such as war, trauma, and forced migration. In many refugee camps, sanitation, food supplies, and health care services are limited, which can have implications for malnutrition, infectious diseases, and chronic conditions. Therefore, depending on their country of origin, refugees are at an increased risk for many diseases, both communicable and noncommunicable, not commonly seen in the native U.S.-born population. All U.S.-bound refugees undergo a required medical examination, usually 3 to 6 months before departure for the U.S.; however, the main purpose of this medical examination is to identify the presence or absence of certain disorders that could result in exclusion from the U.S. under the provisions of the Immigration and Nationality Act, rather than a comprehensive medical examination that screens for a wide range of infectious diseases and non-communicable conditions. Incomplete vaccination status, tuberculosis infection, and chronic conditions are some of the most common and immediate health issues seen in newly arrived refugees. It is important for refugees to receive medical screenings upon arrival to identify conditions that threaten their path to self-sufficiency or risk the general public's health.

Beyond initial health screening, accessing general medical, dental, and mental health services can be significantly challenging for many refugees due to cultural differences, lack of transportation, language

DocuSigned by:
Nannette M. Bowler
Health Director Signature (use blue ink or verifiable digital signature)

4/27/2022
Date

LHD to complete: [For DPH to contact in case follow-up information is needed.]	LHD program contact name:	Karen Best
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Signature on this page signifies you have read and accepted all pages of this document. Template rev. August 2021

interpretation issues, and limited understanding of the U.S. healthcare system. Serving this unique segment of our society is rewarding but comes with challenges. Attempting to manage complex medical conditions while at the same time working to overcome cultural, language and socio-economic barriers to deliver high quality care with respect, is a challenge. The refugee health assessment is a valuable tool to identify health issues, promote wellbeing, orient new arrivals to the U.S. healthcare system and connect them with routine and specialty care to provide that continuum of care from overseas to arrival in the U.S.

The primary goal of the North Carolina Refugee Health Program is to ensure that health problems of newly arrived refugees that could pose a threat to public health or interfere with the effective resettlement of the refugees are promptly identified and treated. Health problems are identified through health assessments provided to refugees generally in their county of resettlement and in the local health department.

Throughout this document, the term "refugee" refers to all the following federal immigration categories: refugee, asylee, certain Amerasians, Cuban/Haitian entrant (including Cuban/Haitian humanitarian parolee), certified victim of trafficking, Iraqi & Afghan Special Immigrant (SIV), Afghan Special Immigrant lawful permanent resident, Afghan Special Immigrant conditional permanent resident, Afghan humanitarian non-special immigrant parolee, and any population/status determined eligible by the U.S. Department of Health and Human Services Administration for Children and Families Office of Refugee Resettlement. [The Office of Refugee Resettlement (ORR) has a summary of the ORR Benefits and Services to Eligible Populations sheet available at https://www.acf.hhs.gov/sites/default/files/documents/orr/orr_fact_sheet_benefits_at_a_glance.pdf].

II. Purpose:

This Agreement Addendum provides funds to local health departments that have consistent and significant numbers of refugee arrivals to (1) assist with administrative costs, including language interpretation costs, associated with providing refugee health assessments and (2) assist with the expenses related to providing this service to eligible clients that may not be covered by any medical program or insurance.

The Refugee Health Assessment is provided soon after arrival to identify any communicable diseases of public health concern and any health conditions that might impede resettlement and achieving self-sufficiency. In addition to early identification of health conditions, the assessment focuses on preventing the spread of communicable diseases, and referral to health providers for further medical evaluation, treatment, and follow-up care. One intrinsic purpose of the Refugee Health Assessment is to introduce new refugee arrivals to the U.S. healthcare system and to guide them in establishing a medical home.

III. Scope of Work and Deliverables:

Wake County is one of the top ten refugee resettlement counties in North Carolina, with the state receiving approximately 5,850 arrivals each year. Wake County anticipates screening approximately 1,000 new refugee arrivals for State Fiscal Year 2022-2023.

The Local Health Department shall meet the following program requirements to ensure new refugee arrivals have access to timely assessments based on North Carolina Refugee Health Program guidelines provided in the *Technical Guidance for Local Health Departments* document.

The Local Health Department (LHD) shall:

1. Maintain LHD capacity to appropriately provide refugee health assessment services to newly arriving refugee populations, to provide follow-up and referral services, and to report services and findings to the DPH Program Contact.

2. Designate, at minimum, one Refugee Health Liaison to coordinate refugee health assessments for whom local refugee resettlement agencies and the DPH Program Contact may contact to schedule appointments.

3. Designate, at minimum, one staff member who will maintain an active account with CDC's Electronic Notification System (EDN) and where new arrival information (history, examination findings, vaccinations, chest x-ray and facial images and pre-departure treatment) shall be accessed.

4. Inform the DPH Program Contact if there are any changes of key refugee health staff within one month of the change.

5. Inform newly arrived refugees in the county (as well as clients residing in neighboring and nearby counties where the county health department does not have a refugee screening clinic) about availability of the assessment services and schedule assessment ideally within 30 days but no later than 90 days after arrival or eligibility begins. Exams must be completed within 90 days of arrival or when eligibility begins to assure reimbursement through Medicaid or Refugee Medical Assistance (RMA). Note that the 90-day requirement is waived through September 30, 2022. See Medicaid Clinical Coverage Policy 1D-1 at https://files.nc.gov/ncdma/documents/files/1D-1.pdf.

6. Contact the DPH Program Contact if there are concerns or questions regarding client eligibility for this activity due to uncertainty of eligible immigration status, eligibility period, Medicaid/RMA eligibility, or whether client was previously assessed in another county or state.

7. Provide the assessment based on North Carolina Refugee Health Assessment Protocol guidelines which are generally based on Centers for Disease Control and Prevention (CDC) recommendations http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/domestic-guidelines.html and Office of Refugee Resettlement (ORR) recommendations https://www.acf.hhs.gov/orr/resource/state-letter-12-09. (Note: These recommendations are designed for use when screening asymptomatic refugees. Refugees with clinical complaints should receive diagnostic testing or referral as guided by their signs, symptoms, and exposure history).

   Consider using the CDC-funded interactive tool, CareRef, to assist in determining screening tests and other preventive care based on the demographic and geographic factors that contribute to risk: https://careref.web.health.state.mn.us. Another consideration is a CDC-funded project that provides a suite of clinical decision support tools designed to embed in electronic health records systems and provides clinicians with up-to-date CDC guidance and recommendations, using order sets and associated documentation templates: https://policylab.chop.edu/project/providing-tools-clinicians-better-support-immigrant-health.

   The assessment can be divided into three categories: a Communicable Disease Screening, a Physical Exam, and Laboratory Testing. The LHD shall, at minimum, provide the communicable disease portion of the assessment.

   If the LHD cannot provide the physical exam and/or laboratory testing portions, the LHD must refer the refugee to a hospital clinic or private clinic or physician (preferably to a medical home) for the physical exam and laboratory testing. The LHD may also refer the refugee (preferably via refugee resettlement agency staff) to the local Division of Social Services/Medicaid office for referral to a participating provider and/or to the provider on the Medicaid card. The LHD must work closely with providers in the community to work out the logistics such as which clinic is performing which parts and the timing issues, how medical information will be communicated, and how reporting will be completed to ensure clients receive all the necessary parts.

If the LHD does not provide the entire physical exam and laboratory testing portions of the assessment, it is not eligible to bill Medicaid/RMA for the complete refugee health assessment as described in Medicaid Clinical Coverage Policy 1 D-1.

a. When screening asymptomatic refugees, the Communicable Disease portion of the assessment should generally include the following:

Communicable Disease Screening of Asymptomatic Refugees	
Activity	**Summary**
History and records review	Complete medical records may be obtained from a combination of CDC's Electronic Notification System (EDN) and the client's International Organization for Migration (IOM) bag.
Immunization assessment and update	Assess and update adults and children as per U.S. and North Carolina schedules. Serological screening of refugee adults for varicella immunity before vaccinating is generally recommended and cost-effective. Most refugees are from hepatitis B endemic countries and are at risk of infection and therefore should be vaccinated against hepatitis B if not chronically infected or immune (adults). Hepatitis A vaccination series is recommended for children without a history of vaccination. All adult refugees should be vaccinated or tested for serologic evidence of immunity for HAV, whichever is most cost-effective.
Tuberculosis screening	Review history, screen for signs, symptoms and risk, and conduct: • tuberculin skin tests (TST) [for children aged <2 years] or • Interferon-Gamma Release Assays (IGRA) [aged ≥ 2 years] unless overseas IGRA testing was performed within 6 months prior to domestic exam and results are available. If overseas or domestic IGRA is positive, LTBI treatment should be considered after TB disease is ruled out (if not previously treated for LTBI or TB disease).
HIV testing	Routinely test all refugees unless they opt out. For children ≤12 years old, test unless HIV status of mother is confirmed as negative, and child's risk is assessed as low. 1) Repeat screening 3-6 months following resettlement for those who had recent exposure or are high risk. 2) Screen all pregnant refugee women as part of their routine post arrival and prenatal medical screening and care. 3) Refer all confirmed to be HIV-infected for care, treatment, and preventative services.
Hepatitis B testing	Routinely test all refugees coming from countries or populations where the population infection rate is ≥2%, unless a negative HBsAg test result is documented on the overseas medical forms and was performed within 6 months of U.S. evaluation. 1) For children < 18 years test HBsAg 2) For adults ≥ 18 years test HBsAg, HBsAb, and HBcAb 3) Anyone who tests negative should be offered HBV vaccine For those that had overseas HBsAg test that was negative: • If patient has record of complete vaccination, no further testing or vaccination is necessary unless patient has a high risk of future exposure; in which case it is reasonable to check serology for evidence of immunity.

	• If patient has no previous doses of vaccine, test for immunity. It is reasonable to start the HBV vaccine series while awaiting results. • If vaccination series has been initiated, the series should be completed according to ACIP schedule.
Hepatitis D	Test for HDV infection for all HBsAg-positive new arrivals.
Hepatitis C testing	Routinely test all adults (≥ 18 years of age). Test any child (< 18 years of age) with risk factors, which include history of traditional tattooing or female genital mutilation or cutting.
Syphilis testing	Nontreponemal testing (VDRL or RPR) for ≥15 years old if no overseas results available or for <15 years old with risk factors. Conduct confirmatory testing for all positives.
Chlamydia and Gonorrhea testing	Test (NAAT) females <25 years old who are sexually active or females ≥25 years old who have risk factors who do not have documented pre-departure testing. Also test/refer anyone with signs and symptoms.
Follow-up	Provide health education, anticipatory guidance, treatment, and referrals as appropriate.

The LHD may also be able to provide intestinal and tissue invasive parasite testing and treatment, malaria presumptive treatment and evaluation, pregnancy testing, and blood lead level testing. For the purposes of funding for interpretation, these are not required as part of the communicable disease portion of the assessment, particularly if private providers serving refugees in the community are able and willing to provide them as part of the physical exam and laboratory testing portions or part of primary care services. More information about these activities can be found in the tables in subparagraphs (b) and (c) below.

b. When screening asymptomatic refugees, the Physical Exam portion of the assessment should include the following:

Physical Exam of Asymptomatic Refugees	
Activity	**Summary**
History and records review	Complete medical records may be obtained from a combination of EDN and the client's IOM bag.
Blood pressure	Screen all refugees ≥3 years old.
Nutritional status and growth	Take dietary history and collect anthropometric measurements of weight and height/length, head circumference for young children, micronutrient deficiency assessment, and nutritional counseling.
Physical exam	Review of systems including vision (>3 years old), dental and hearing (Note: genital exam could be delayed for a subsequent visit or after primary care and/or trust is established).
Mental status examination and screening	The goal is to identify and evaluate patients in need of mental health support and assistance. The screening is not designed to diagnose mental health conditions. • Ask directly about symptoms, functionality, and suicidal ideation as part of an integrated history and physical examination, minimizing stigmatization. • Screen with a single standardized tool for a range of symptoms associated with diverse potential diagnoses or a combination of tools (adults) — must screen for PTSD, anxiety, and depression — or screen with an age-appropriate structured or semi-structured assessment, integrated into the overall health assessment (children and adolescents).

Physical Exam of Asymptomatic Refugees	
Activity	**Summary**
	• Screen for substance abuse and provide education and appropriate referrals. For those in need of mental health support and assistance, develop an impairment-related action plan with associated management and/or referral. Possible tools: PHQ9/GAD7, RHS-15, RHS-14, RHS-13, Harvard Trauma, or Minnesota RH Screener. Information about suggested tools can be found in the CDC domestic screening guidelines.
Female genital mutilation/ cutting (FGM/C) screening	Eventual external genital exams are important, including for pediatric patients from countries where FGM/C is practiced; however, trust and a relationship should be built starting with early, non-judgmental, straightforward discussions about FGM/C. Deferral of the genital exam for a future visit could be requested/granted, with assurance that timely follow-up will occur. Culturally sensitive counseling and education should be offered and, when necessary, referrals provided. At the discretion of the clinician, consider providing information to especially mothers with daughters that this practice is illegal in the U.S. and it is also illegal to send their child outside the U.S. to have FGM/C performed ("vacation cutting"). Victims are not prosecuted. Clear and detailed documentation of physical findings and ICD-10 coding of FGM/C soon after arrival in the U.S., may help protect families against future suspicions of "vacation cutting" or abuse accusations.
Multivitamin	Recommend to 1) all children 6-59 months of age, and 2) children and adults with clinical evidence of poor nutrition.
Malaria presumptive treatment and evaluation	Refugees from sub-Saharan Africa who have received pre-departure treatment with a recommended antimalarial drug or drug combination do not need further evaluation or treatment for malaria unless they have signs or symptoms of disease. Presumptive malaria treatment should be given to all refugees originating from sub-Saharan Africa who received no pre-departure treatment prior to departure (typically this would be some pregnant women and children weighing less than 5 kg at the time of evaluation for whom presumptive treatment was contraindicated). Refugees from areas other than sub-Saharan Africa who are asymptomatic generally do not need routine presumptive treatment or testing.
Intestinal and tissue invasive parasite testing and treatment	Soil-transmitted helminth infections: 1) Most refugees receive overseas presumptive treatment (Albendazole) — no further screening/treatment recommended. 2) Asymptomatic refugees who did not receive presumptive treatment may be presumptively treated after arrival or screened (2 or more separate stool ova and parasite samples collected 12-24 hours apart). Generally testing not recommended in non-symptomatic children under 6 months old as they are low risk. *Strongyloides*: 1) Most refugees receive overseas presumptive treatment (Ivermectin) — no further screening/treatment recommended. 2) Asymptomatic refugees who did not receive presumptive treatment may be presumptively treated after arrival or screened (*Strongyloides* IgG serology) if contraindications to presumptive treatment exist.

Physical Exam of Asymptomatic Refugees	
Activity	**Summary**
	3) Refugees who have lived in a *Loa loa*-endemic country should be tested for the presence of *Loa loa* microfilaremia BEFORE being treated with Ivermectin. *Schistosoma*: 1) Most sub-Saharan African (SSA) refugees receive overseas presumptive treatment (Praziquantel) — no further screening/treatment recommended. Asymptomatic SSA refugees who did not receive presumptive treatment may be presumptively treat after arrival or screened (*schistosoma* IgG serology) if contraindications to presumptive treatment exist.
Follow-up	Provide health education, anticipatory guidance, treatment, and referrals as appropriate.

c. When screening asymptomatic refugees, the Laboratory Testing portion of the assessment should include the following:

Laboratory Testing of Asymptomatic Refugees	
Activity	**Summary**
Hematology	CBC with RBC indices, WBC differential to include eosinophil counts, and platelet count.
Urinalysis	Recommended for all who are old enough to provide a clean-catch urine specimen.
Pregnancy testing	For females of childbearing age when clinically indicated prior to administration of vaccines or medications which may present a risk. Recommend prenatal vitamins and referral if positive.
Serum chemistries and glucose	Basic panel including blood urea nitrogen and creatinine should be considered if indicated by signs, symptoms, or comorbidities.
Blood lead level testing	For all children 6 months to 16 years old. Repeat testing recommended for children 6 months to 6 years old within 3-6 months of arrival regardless of initial result. All pregnant or lactating women should be assessed for lead exposure risk and tested if found to be at risk https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Lead-Screening-During-Pregnancy-and-Lactation.
Infant metabolic screening	For infants < 1 year old, according to state guidelines: https://publichealth.nc.gov/wch/families/newbornmetabolic.htm.
Cardiovascular and lipid disorder screening	Hypertension screening and non-fasting serum lipid testing of adults in accordance with the U.S. Preventive Services Taskforce (USPSTF) guidelines and as appropriate. Lipid screening may be addressed at patient's medical home. If screening clinic will be medical home, then can consider lipid panel at the initial screening visit. Other cardiovascular and lipid disorder screening tests recommended by the USPSTF could be postponed to future visits.
Cancer preventive screening	The first visit may not be the most appropriate time and place; however, promoting the importance of primary care and annual preventive care visits would be appropriate topics of discussion during initial screening visit.

8. Provide vaccination assessment and upgrades based on the North Carolina Immunization Program requirements and the CDC's Advisory Committee on Immunization Practices (ACIP) immunization guidelines. CDC's refugee-specific guidelines should be encouraged and considered [http://www.cdc.gov/immigrantrefugeehealth/guidelines/domestic/immunizations-guidelines.html] along with the requirements for refugees applying for permanent U.S. residency [http://www.cdc.gov/immigrantrefugeehealth/exams/ti/civil/vaccination-civil-technical-instructions.html]. Serological testing may be an acceptable alternative for certain antigens and dependent on client's age. Cost-effectiveness should be considered.

9. Determine whether there are significant concerns around the mental status. If so, clinical judgement and availability of services will determine whether emergency referral or routine follow-up care is needed and how quickly these services need to be accessed. If symptoms of depression or PTSD affect daily function, more urgent follow-up care is recommended. Referral for emergency follow-up should be made as appropriate.

10. Use a qualified and language-appropriate interpreter for clinical encounters. Telephonic interpretation may be appropriate.

11. Provide education, treatment, and referral for all conditions identified overseas or domestically. Provide culturally and linguistically appropriate health education based on individual refugee's needs and risk factors. Provide treatment or referral, if necessary, for conditions identified during overseas medical examination, tuberculosis, and other communicable diseases within 30 days of arrival or 14 days of domestic diagnosis. Provide referrals to WIC, OB/family planning, and disability services, as appropriate.

12. Refer or link refugees to a primary care facility or provider for on-going follow-up and treatment.

13. Ensure that the primary care facility or provider receives the results of the overseas medical screening including overseas presumptive treatment and the results of the domestic medical screening/refugee health assessment.

14. Not assess the refugee any fees for this screening if the following criteria are met:
    a. The screening is provided within 90 days of the date of his or her arrival into the U.S. or within 90 days since eligibility began,
    b. The refugee has confirmed that he or she has applied for Medicaid/Refugee Medical Assistance (RMA) prior to receiving the service, and
    c. The refugee follows through with all the Medicaid application requirements.

    If the refugee fails to schedule and attend screening appointments within 90 days after eligibility begins and does not already have approved insurance such as Medicaid or RMA, the refugee should be notified of any possible fees before the service is provided. Public funds may be used if the refugee is eligible for selected screening due to individual or group risk factors. Fees including copayments should also be waived for initial screening and related follow-up visits for the client's first eight months in the U.S. if the client is known to be on RMA.

15. Not assess any copayments for this service if client is on Refugee Medical Assistance (RMA, coded as RRF/MRF) which is for single individuals (21-64 years of age) and married couples without minor children. Copayments are for NC Medicaid program beneficiaries and not RMA beneficiaries.

16. Maintain a copy of the client's U.S. Customs and Border Protection's Form I-94 or other acceptable documentation demonstrating a client's eligibility for this service [see Division of Social Services

Refugee Assistance Manual at https://policies.ncdhhs.gov/divisional/social-services/refugee-assistance]. Contact the DPH Program Contact if a client's eligibility for service is uncertain.

17. Record and submit refugee health assessment results and follow-up activities (treatment or referrals) for each refugee arrival using the Program's Refugee Health Assessment Data Collection Form or through another Program-approved and confidential method. Contact the DPH Program Contact to acquire this form or to request approval for recording and submitting through another method. Maintain assessment results and follow-up activities in the client's record.

18. If the LHD is not able to provide part of or the entirety of a refugee health assessment for one or more clients, set up a communication and sharing process with hospital clinics, private clinics, or physicians to obtain refugee medical screening information, preferably using the Program's Refugee Health Assessment Data Collection Form or similar approved format, that can be submitted to the DPH Program Contact.

19. Upon request of the DPH Program Contact, complete and submit an Annual Refugee Health Assessment Survey by the requested due date.

20. Ensure that all standing orders or protocols developed for nurses in support of Refugee Health Assessments are in the North Carolina Board of Nursing required format [http://www.ncbon.com/vdownloads/position-statements-decision-trees/standing-orders.pdf].

21. Require key refugee health staff to:

    a. Attend relevant trainings and conferences sponsored by the North Carolina Refugee Assistance Program and the North Carolina Refugee Health Program,

    b. Meet regularly with local resettlement agencies to coordinate local refugee services, and

    c. Attend at least one North Carolina State Refugee Advisory Council meeting per year. Representatives of most North Carolina refugee service providers attend these meetings. Meetings generally occur quarterly, with each meeting's location alternating between Raleigh, Greensboro, and Charlotte. During the COVID-19 pandemic, these are being held as virtual meetings.

22. Encourage refugee health staff and other staff encountering refugee clients to participate in the following trainings:

    a. The Minnesota Department of Health's Center of Excellence in Newcomer Health training available at https://www.health.state.mn.us/communities/rih/about/coe.html.

    b. The University of Minnesota's Department of Medicine's free, comprehensive introductory course in immigrant and refugee health for those new to the field https://med.umn.edu/dom/education/global-medicine/courses-certificates/online/introduction-immigrant-refugee-health-course.

    c. The University of Minnesota's Department of Medicine medical interpreter training module available at https://med.umn.edu/dom/education/ global-medicine/courses-certificates/online/medical-interpreter-training which is directed at healthcare workers using interpreters in the clinical setting.

IV. Performance Measures / Reporting Requirements:

Upon being notified by the North Carolina Refugee Health Program or the local refugee resettlement agencies about new refugee arrivals needing health assessments, the LHD shall:

1. Inform at least 95% of refugee arrivals within 30 days after arrival, in each refugee's own language, regarding the availability, importance, and content of the health screening.

2. Only for those who have federal immigration category as a refugee and are primary arrivals (not for asylees, parolees, SIVs, or secondary migrants):
   a. Initiate care for at least 50% of refugee arrivals within 30 days after arrival,
   b. Initiate care for at least 70% of refugee arrivals within 60 days after arrival, and
   c. Initiate care for at least 90% of refugee arrivals within 90 days after arrival.

3. Provide all the appropriate components of the refugee health assessment according to state, CDC and ORR recommendations and based on country of origin, age, gender, history, risk factors and symptoms.

   Strong communications among LHD staff, other clinics/physicians, and refugee resettlement agency staff are extremely important and are encouraged to help ensure refugees receive all necessary components of the assessment. Strong communications may also prevent duplication in services, prevent clinical activities that conflict in timing, and result in better health outcomes. It is expected that LHD staff communicate regularly and consistently with partners.

4. Document and include in their submitted data reports to the DPH Program Contact about the efforts they have made to contact and schedule each new refugee arrival and if the refugee refuses assessment services. In instances where the refugee is found to not reside in their jurisdiction, the LHD shall report to the DPH Program Contact about the residency status, including address/contact information, as soon as possible but no later than 10 days after the determination was made.

5. Submit monthly client line listing reports to the North Carolina Refugee Health Program for the following:
   a. Refugee Health Assessment Administration/Interpretation expenses

      The reports must include the refugee's last name, first name, birth date, alien number, date of arrival or eligibility date, date the service was initiated, statement of which part or parts of the refugee health assessment have been completed, and the amount being billed for administration/interpretation. For the Program to have timely accounting of all refugee health services by the Local Health Department, include all refugee clients receiving a refugee health assessment even if no cost for administration/interpretation is being billed (i.e., $0).

   b. Refugee Health Assessment Medical Screening expenses

      This fund is for refugees that have applied for Medicaid and RMA, but who are subsequently denied and not covered for medical screening by any medical program. It is highly recommended that the LHD immediately contact the DPH Program Contact as soon as possible when it is suspected there may be a client in this situation.

      The monthly client line listing reports must include the refugee's last name, first name, birth date, alien number, date of arrival or eligibility date, date the service was initiated, date the service was completed, and the cost for assessment.

      Monthly client line listing reports are to be prepared per eligible client and are due according to the table in the following Paragraph, below.

6. Provide the final refugee health assessment results (including results from other providers in the community providing refugee health assessment services) and follow-up activities to the DPH Program Contact by the end of the month following the month when the assessment was completed.

Exceptions can be given when all findings and results are not available by the due date. Exception requests can be sent to the DPH Program Contact through email, telephone, or fax; however, all results must be submitted within 90 days of the exam date, per the following table:

Screening Month	Client Line List Due	Final Refugee Health Assessment Results Due	Screening Month	Client Line List Due	Final Refugee Health Assessment Results Due
June	July 10	July 31	December	January 10	January 31
July	August 10	August 31	January	February 10	February 28
August	September 10	September 30	February	March 10	March 31
September	October 10	October 31	March	April 10	April 30
October	November 10	November 30	April	May 10	May 31
November	December 10	December 31	May	June 10	June 30

These reports may be submitted either on paper (through fax or mail) or preferably electronically (through encrypted email). In the event changes are made to the reporting form, the LHD will be given several months to adjust to any new procedures.

7. Ensure that all communications that include any Personally Identifiable Information (PII) are sent in a confidential manner. All reports must be submitted in a HIPAA-compliant manner.

8. Provide to the DPH Program Contact by July 1, 2022, when new staff are hired, and upon request:
   a. copies of résumés, licenses, certifications, and job descriptions of staff providing direct management of refugee health assessment whose salary is being funded through this Agreement Addendum, and
   b. a detailed breakdown of expenses being funded through this Agreement Addendum.

V. Performance Monitoring and Quality Assurance:

The DPH Program Contact will monitor the LHD's performance through monthly reviews of monthly reports, in quarterly telephone conferences, and through email correspondence. Site visits may also be conducted as needed.

If the performance is below expectations, the Communicable Disease Branch may request a corrective action plan. Funding may be reduced if performance does not improve.

In the event that 1) there is an ongoing delay longer than 90 days in which the LHD provides refugee health assessments or 2) if the number of refugee arrivals to a particular county or the number of completed refugee health assessments decreases by more than 10% of the anticipated number during this Agreement Addendum's Service Period, funds may be reverted and redistributed if another county or counties are experiencing an increase in refugee arrivals and/or refugee health assessments.

VI. Funding Guidelines or Restrictions:

1. Requirements for pass-through entities: In compliance with 2 CFR §200.331 – *Requirements for pass-through entities*, the Division of Public Health provides Federal Award Reporting Supplements to the Local Health Department receiving federally funded Agreement Addenda.
   a. Definition: A Supplement discloses the required elements of a single federal award. Supplements address elements of federal funding sources only; state funding elements will not be included in the Supplement. Agreement Addenda (AAs) funded by more than one federal award will receive a disclosure Supplement for each federal award.

b. Frequency: Supplements will be generated as the Division of Public Health receives information for federal grants. Supplements will be issued to the Local Health Department throughout the state fiscal year. For federally funded AAs, Supplements will accompany the original AA. If AAs are revised and if the revision affects federal funds, the AA Revisions will include Supplements. Supplements can also be sent to the Local Health Department even if no change is needed to the AA. In those instances, the Supplements will be sent to provide newly received federal grant information for funds already allocated in the existing AA.

2. Some refugee health funds are directly related to the number of eligible clients served and to what extent they are served. Funds may not be drawn down except according to the following guidelines:

   a. **Refugee Health Medical Screening Administration/Interpretation (RCC 8100)**:

      1. A once-in-a-lifetime maximum amount of $60 per eligible client for administration/language interpretation for the Communicable Disease portion of the refugee health assessment and any follow-up.
      2. A once-in-a-lifetime maximum amount of $60 per eligible client for administration/language interpretation for the Physical Exam portion of the refugee health assessment and any follow-up.
      3. These funds are not available for any otherwise eligible client that has been in the U.S. for more than eight months or when it has been more than eight months since the date of final grant of asylum for asylees or date of certification/eligibility letter for trafficking victims. To avoid including ineligible clients and incorrect billing, it is recommended that the LHD submit line listing reports to the DPH Program Contact for review and approval prior to expenditure report submission to Aid-to-Counties database.
      4. Personnel charges are only allowable for staff working directly on refugee health assessment services and only for the time that such staff work on refugee health assessment services as described in the above Scope of Work and Deliverables section.

   b. **Refugee Health Medical Screening (RCC 8110)**:

      1. A once-in-a-lifetime maximum amount of $400 for refugee health assessment services provided to an eligible client that has applied for, but not been found eligible for, Medicaid nor Refugee Medical Assistance, and who is not covered for medical screening by any other medical program or insurance. The LHD is required to contact the DPH Program Contact when there is a client that may be in this situation prior to submitting any refugee health assessment expense reports and prior to expenditure report submission to Aid-to-Counties database.
      2. These funds are not available for any otherwise eligible client that has been in the U.S. for more than 90 days or when it has been more than 90 days since the date of final grant of asylum for asylees or date of certification/eligibility letter for trafficking victims. Services must have been initiated within 90 days of eligibility.

3. Funds should not be requested if another source of funding is available to cover the expenses such as Medicaid, state or local public health programs, county funds, or other non-Refugee Medical Assistance resources. Funds should not be requested if another entity is providing the service at no charge to the Local Health Department.

4. Funds received through this Activity must be used for the administrative and interpretation costs directly associated with refugee health screening provision and provider management of refugee health screening services and follow-up.

FY23 - FAS federal award supplement

Activity Nbr + Name: **583** **Refugee Health Assessments**

FAS Nbr + Reason: **1** This FAS is accompanying an AA+BE or an AA Revision+BE Revision.

CFDA Nbr + Name: **93.566** Refugee and Entrant Assistance_State Administered Programs IDC rate: n/a

FAIN: **2201NCRCMA** Is award R&D?: no Fed awd's total amt: $ 2,327,490

Fed award project description: Refugee Cash and Medical Assistance Program

Fed awd date + awarding agency: 11-17-21 HHS, Administration for Children and Families

Subrecipient	Subrecipient SAM UEI	Subrecipient DUNS UEI	Funds from the federal grant listed above	For the entire Activity, the of all total federal funds
Alamance	MBM7W225N3W8	965194483		
Albemarle	WAAVS51PNMK3	130537822		
Alexander	XVEEJSNY7UX9	030495105		
Anson	PK8UYTSNJCC3	847163029		
Appalachian	CD7BFHB8W539	780131541		
Beaufort	RN1SXFD4LXN6	091567776		
Bladen	TLCTJWDJH1H9	084171628		
Brunswick	MJBMXLN9NJT5	091571349		
Buncombe	W5TCDKMLHE69	879203560	$ 35,335	$ 96,599
Burke	G855APCNL591	883321205		
Cabarrus	RXDXNEJKJFU7	143408289		
Caldwell	HL4FGNJNGE97	948113402		
Carteret	UC6WJ2MQMJS8	058735804		
Caswell	JDJ7Y7CGYC86	077846053		
Catawba	GYUNA9W1NFM1	083677138		
Chatham	KE57QE2GV5F1	131356607		
Cherokee	DCEGK6HA11M5	130705072		
Clay	HYKLQVNWLXK7	145058231		
Cleveland	UWMUYMPVL483	879924850		
Columbus	V1UAJ4L87WQ7	040040016		
Craven	LTZ2U8LZQ214	091564294	$ 31,470	$ 79,598
Cumberland	HALND8WJ3GW4	123914376	$ 3,000	$ 9,000
Dare	ELV6JGB11QK6	082358631		
Davidson	C9P5MDJC7KY7	077839744		
Davie	L8WBGLHZV239	076526651		
Duplin	KZN4GK5262K3	095124798		
Durham	LJ5BA6U2HLM7	088564075	$ 61,310	$ 166,499
Edgecombe	MAN4LX44AD17	093125375		
Foothills	NGTEF2MQ8LL4	782359004		
Forsyth	V6BGVQ67YPY5	105316439	$ 48,170	$ 132,998
Franklin	FFKTRQCNN143	084168632		
Gaston	QKY9R8A8D5J6	071062186		
Graham	L8MAVKQJTYN7	020952383		
Granville-Vance	MGQJKK22EJB3	063347626		
Greene	VCU5LD71N9U3	091564591		
Guilford	YBEQWGFJPMJ3	071563613	$ 66,270	$ 197,198
Halifax	MRL8MYNJJ3Y5	014305957		
Harnett	JBDCD9V41BX7	091565986		
Haywood	DQHZEVAV95G5	070620232		
Henderson	TG5AR81JLFQ5	085021470		
Hoke	X9C3V658CUM4	091563643		
Hyde	T2RSYN36NN64	832526243		
Iredell	XTNRLKJLA4S9	074504507		

FY23 - FAS federal award supplement

Activity Nbr + Name: **583** **Refugee Health Assessments**

FAS Nbr + Reason: **1** This FAS is accompanying an AA+BE or an AA Revision+BE Revision.

CFDA Nbr + Name: **93.566** Refugee and Entrant Assistance_State Administered Programs IDC rate: n/a

FAIN: **2201NCRCMA** Is award R&D?: no Fed awd's total amt: $ 2,327,490

Fed award project description: Refugee Cash and Medical Assistance Program

Fed awd date + awarding agency: 11-17-21 HHS, Administration for Children and Families

Subrecipient	Subrecipient SAM UEI	Subrecipient DUNS UEI	Funds from the federal grant listed above	For the entire Activity, the of all total federal funds
Jackson	X7YWWY6ZP574	019728518		
Johnston	SYGAGEFDHYR7	097599104		
Jones	HE3NNNUE27M7	095116935		
Lee	F6A8UC99JWJ5	067439703		
Lenoir	QKUFL37VPGH6	042789748		
Lincoln	UGGQGSSKBGJ5	086869336		
Macon	LLPJBC6N2LL3	070626825		
Madison	YQ96F8BJYTJ9	831052873		
MTW	EZ15XL6BMM68	087204173		
Mecklenburg	E78ZAJM3BFL3	074498353	$ 62,270	$ 185,198
Montgomery	HFNSK95FS7Z8	025384603		
Moore	ZKK5GNRNBBY6	050988146		
Nash	NF58K566HQM7	050425677		
New Hanover	F7TLT2GMEJE1	040029563	$ 4,000	$ 8,800
Northampton	CRA2KCAL8BA4	097594477		
Onslow	EGE7NBXW5JS6	172663270		
Orange	JL7PLQJA2PE3	139209659	$ 4,800	$ 10,400
Pamlico	FT59QFEAU344	097600456		
Pender	T11BE678U9P5	100955413		
Person	FQ8LFJGMABJ4	091563718		
Pitt	VZNPMCLFT5R6	080889694		
Polk	QZ6BZPGLX4Y9	079067930		
Randolph	T3BUM1CVS9N5	027873132		
Richmond	Q63FZNTJM3M4	070621339		
Robeson	LKBEJQFLAAK5	082367871		
Rockingham	KGCCCHJJZZ43	077847143		
Rowan	GCB7UCV96NW6	074494014		
Sampson	WRT9CSK1KJY5	825573975		
Scotland	FNVTCUQGCHM5	091564146		
Stanly	U86MZUYPL7C5	131060829		
Stokes	W41TRA3NUNS1	085442705		
Surry	FMWCTM24C9J8	077821858		
Swain	TAE3M92L4QR4	146437553		
Toe River	JUA6GAUQ9UM1	113345201		
Transylvania	W51VGHGM8945	030494215		
Union	LHMKBD4AGRJ5	079051637		
Wake	FTJ2WJPLWMJ3	019625961	$ 74,935	$ 223,199
Warren	TLNAU5CNHSU5	030239953		
Wayne	DACFHCLQKMS1	040036170		
Wilkes	M14KKHY2NNR3	067439950		
Wilson	ME2DJHMYWG55	075585695		
Yadkin	PLCDT7JFA8B1	089910624		

DPH-Aid-To-Counties For Fiscal Year: 22/23 Budgetary Estimate Number : 0

Activity 583 Service Period Payment Period		AA	1370 8100 68 06/01-09/30 07/01-10/31	Total Allocated	1370 8100 68 10/01-05/31 11/01-06/30	Total Allocated	1370 8110 68 10/01-05/31 11/01-06/30	Total Allocated	1370 8110 68 06/01-09/30 07/01-10/31	Total Allocated	Proposed Total	New Total
01 Alamance			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
D1 Albemarle			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
02 Alexander			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
04 Anson			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
D2 Appalachian			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
07 Beaufort			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
09 Bladen			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
10 Brunswick			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
11 Buncombe	*	0	33,735	$0.00	59,664	$0.00	1,600	$0.00	1,600	$0.00	96,599	96,599
12 Burke			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
13 Cabarrus			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
14 Caldwell			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
16 Carteret			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
17 Caswell			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
18 Catawba			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
19 Chatham			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
20 Cherokee			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
22 Clay			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
23 Cleveland			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
24 Columbus			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
25 Craven	*	0	29,870	$0.00	46,528	$0.00	1,600	$0.00	1,600	$0.00	79,598	79,598
26 Cumberland	*	0	3,000	$0.00	6,000	$0.00	0	$0.00	0	$0.00	9,000	9,000
28 Dare			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
29 Davidson			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
30 Davie			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
31 Duplin			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
32 Durham	*	0	59,710	$0.00	103,589	$0.00	1,600	$0.00	1,600	$0.00	166,499	166,499
33 Edgecombe			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
D7 Foothills			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
34 Forsyth	*	0	46,570	$0.00	83,228	$0.00	1,600	$0.00	1,600	$0.00	132,998	132,998
35 Franklin			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
36 Gaston			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
38 Graham			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
D3 Gran-Vance			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
40 Greene			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
41 Guilford	*	0	64,670	$0.00	129,328	$0.00	1,600	$0.00	1,600	$0.00	197,198	197,198
42 Halifax			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
43 Harnett			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
44 Haywood			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
45 Henderson			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
47 Hoke			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
48 Hyde			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
49 Iredell			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
50 Jackson			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
51 Johnston			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
52 Jones			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
53 Lee			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
54 Lenoir			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
55 Lincoln			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
56 Macon			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
57 Madison			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
D4 M-T-W			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
60 Mecklenburg	*	0	60,670	$0.00	121,328	$0.00	1,600	$0.00	1,600	$0.00	185,198	185,198
62 Montgomery			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
63 Moore			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
64 Nash			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
65 New Hanover	*	0	4,000	$0.00	4,800	$0.00	0	$0.00	0	$0.00	8,800	8,800
66 Northampton			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
67 Onslow			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
68 Orange	*	0	4,000	$0.00	4,800	$0.00	800	$0.00	800	$0.00	10,400	10,400
69 Pamlico			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
71 Pender			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
73 Person			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
74 Pitt			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0

75 Polk			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
76 Randolph			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
77 Richmond			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
78 Robeson			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
79 Rockingham			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
80 Rowan			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
82 Sampson			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
83 Scotland			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
84 Stanly			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
85 Stokes			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
86 Surry			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
87 Swain			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
D6 Toe River			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
88 Transylvania			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
90 Union			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
92 Wake	*	0	73,335	$0.00	146,664	$0.00	1,600	$0.00	1,600	$0.00	223,199	223,199
93 Warren			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
96 Wayne			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
97 Wilkes			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
98 Wilson			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
99 Yadkin			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
Totals			379,560	0	705,929	0	12,000	0	12,000	0	1,109,489	1,109,489

Sign and Date - DPH Program Administrator 12-2-21

Sign and Date - DPH Section Chief 12-2-21

Sign and Date - DPH Contracts Office - ATC Coordinator Budget 12/2/2021

Sign and Date - DPH Budget Officer 12/07/2021

NT 12/3/2021