

PROFESSIONAL SERVICES CONTRACTS	TYPE OF SERVICE	DESCRIPTION OF SERVICES	MAXIMUM CONTRACT AMOUNT
Disability Consultants, LLC	Psychologist	\$65.00 per hour, 50 hours a month not exceeding 600 hours and \$39,000.00/ year	\$ 39,000.00
Distinctive Smiles of Baton Rouge, LLC	Dentist	12 on-site clinics, \$755.00 per clinic, not to exceed \$9,060.00 per year	\$ 9,060.00
D. Thomas Curtis, MD	Physician	52 on-site medical clinics and related services, \$365.00/clinic not to exceed \$18,980.00/year, \$65.00 per licensed bed on-campus, 92 beds, not to exceed \$5,980/year, \$498.33/month	\$ 18,980.00
First Choice Medical Staffing, Inc.	Nursing Contract	2 or 3 shifts per day, \$28.00/ hour for LPN's, \$45.00/hour for RN's not to exceed 705 hours and \$19,740.00/year.	\$ 19,740.00
Timothy F. Himel, MD	Neurologist	12 on-site neurological clinics, \$600.00/clinic, not to exceed \$7,200.00/year	\$ 7,200.00
ML Concepts, Inc.	Dietitian	\$45.00/hour, not exceed 240 hours/year	\$ 10,800.00
Robert L. McManus, MD	Physician	52 on-site clinics, \$365.00/clinic, not to exceed \$18,980.00/year	\$ 18,980.00
Doris Pitre	Advocacy Training/Consultation	\$16.00/hour, 600 hours/year,	\$ 9,600.00
The Psychiatric Center, LLC	Psychologist	CST \$150.00/hour,(Maximum of 4 or 6 hours per week), not to exceed 312 hours/year.	\$ 46,800.00
Mitchell Sonnier, DDS, LLC	Dentist	12 on-site clinics, \$755.00/clinic, not to exceed \$9,060.00/year	\$ 9,060.00
Susan Thompson, LPT	Physical Therapy	\$50.00/hour, average of 60 hours/month,not to exceed 720 hours/year	\$ 36,000.00
Vincent Internal Medicine, LLC	Physician	52 on-site clinics, \$365.00/clinic, not to exceed \$18,980.00/year	\$ 18,980.00
Bob Winston, MD	Psychologist	CST \$150.00/hour (minimum of 4 hours & maximum of 6 hours per week) not to exceed 312 hours/year \$150.00/per hour, 4 hours/month, not to exceed 48 hours/year	\$ 46,800.00
			\$ 7,200.00

INVOICE
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Name and Address of Contractor

Disability Consultants, LLC
 17211 North Lakeway Avenue
 Baton Rouge LA 70810
 225-752-5924

CFMS# 690184 **VENDOR #**72146251200 **INVOICE#** _____ (CFMS# + 6 digits)

REGION: IV **PROGRAM:** 340 8000Acadiana Region Supports & Services Center

DATE INVOICE COMPLETED: _____

DATE OF SERVICES	DESCRIPTION OF SERVICES	AMOUNT
	Provide behavioral evaluations/consultation to individuals served by ARSSC, staff training, and technical assistance. Services performed under the supervision of a licensed psychologist. Provider to be paid at a rate of \$65.00 per hour, for approximately 50 hours/month, not to exceed the maximum amount 600 hours and \$39,000.00/year.	
TOTAL		\$

CONTRACTOR'S/RESPONSIBLE PARTY'S CERTIFICATE

"This is to certify that the information contained on this form is true, accurate and complete and that expenditures shown above were made for the furtherance of and in conformity with contractual agreement with DHH/OCDD."

Signature of Contractor Date _____

 Administrator or Designee Approval **Signature** Date _____ (337) 824-6250
Contact Phone#

AGENCY 340 **EFFECTIVE DATE:** ____ / ____ (MO/YR)

ORG#	OBJECT	REPORTING#	AMOUNT	REMARKS
244S	3460			

INVOICE
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Name and Address of Contractor

Distinctive Smiles of Baton Rouge, L.L.C.
 8894 Airline Hwy, Suite M
 Baton Rouge LA 70815
 225-218-9218

CFMS# 690180

VENDOR #20454117800 INVOICE# _____ (CFMS# + 6 digits)

REGION: IV

PROGRAM: 340 8000Acadiana Region Supports & Services Center

DATE INVOICE COMPLETED: _____

DATE OF SERVICES	DESCRIPTION OF SERVICES	AMOUNT
	Contractor will conduct up to twelve on-site dental clinics and related services for an assigned caseload of Acadiana Region Support and Services Center clients at a rate of \$755.00/clinic, not to exceed \$9,060.00/year.	
TOTAL		\$

CONTRACTOR'S/RESPONSIBLE PARTY'S CERTIFICATE

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Signature of Contractor

 Date

6250
 Administrator or Designee Approval **Signature**

 Date

 Contact Phone# (337) 824-

AGENCY 340

EFFECTIVE DATE: ____ / ____ (MO/YR)

ORG#	OBJECT	REPORTING#	AMOUNT	REMARKS
244S	3440			

INVOICE
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Name and Address of Contractor

D. Thomas Curtis, M.D.
 717 Curtis Drive
 Rayne LA 70578
 337-334-7551

CFMS# 690437 **VENDOR #**43127538900 **INVOICE#** _____ (CFMS# + 6 digits)
REGION: IV **PROGRAM:** 340 8000Acadiana Region Supports & Services Center

DATE INVOICE COMPLETED: _____

DATE OF SERVICES	DESCRIPTION OF SERVICES	AMOUNT
	Contractor will serve as Primary Care Physician & will conduct up to 52 on-site medical clinics & related services for an assigned caseload of ARSSC clients at a rate of \$365.00/clinic , not to exceed \$18,980.00/year. Contractor will serve as Agency Medical Director & will provide Coordinated Case Mgt. for ALL residential clients of ARSSC, as well as consultation with agency health care & management team regarding agency health care services, policy and procedure. Medical Director Services will be compensated at a fixed rate of \$65 per licensed bed annually for each licensed ICF-DD bed on-campus up to a maximum of 92 beds (not to exceed \$5,980/year).	\$498.33
TOTAL		\$

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 Administrator or Designee Approval **Signature** Date _____ Contact Phone# (337) 824-6250

AGENCY **340** EFFECTIVE DATE: ____ / ____ (MO/YR)

ORG#	OBJECT	REPORTING#	AMOUNT	REMARKS
244S	3440			

INVOICE
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Name and Address of Contractor

Timothy F. Himel, M.D.
 602 North Lewis Street, Suite 500
 New Iberia LA 70563
 337-364-3653

CFMS# 690540 **VENDOR #**72151579200 **INVOICE#** _____
 REGION: IV PROGRAM: 340 8000Acadiana Region Supports & Services Center (CFMS# + 6 digits)

DATE INVOICE COMPLETED: _____

DATE OF SERVICES	DESCRIPTION OF SERVICES	AMOUNT
	Contractor will conduct up to twelve on-site neurological clinics and related services for an assigned caseload of ARSSC clients at a rate of \$600.00/clinic, not to exceed \$7,200.00/year.	
TOTAL		\$

CONTRACTOR'S/RESPONSIBLE PARTY'S CERTIFICATE

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 Administrator or Designee Approval **Signature** Date _____ Contact Phone# (337) 824-6250

AGENCY 340 EFFECTIVE DATE: ____ / ____ (MO/YR)

ORG#	OBJECT	REPORTING#	AMOUNT	REMARKS
244S	3440			

INVOICE
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Name and Address of Contractor

M L Concepts, Inc.
 Post Office Box 305
 Broussard LA 70518
 337-232-5363

CFMS# 690320 **VENDOR #**72145012800 **INVOICE#** _____
 REGION: IV **PROGRAM:** 340 8000Acadiana Region Supports & Services Center (CFMS# + 6 digits)

DATE INVOICE COMPLETED: _____

DATE OF SERVICES	DESCRIPTION OF SERVICES	AMOUNT
	Provide dietitian services to insure the health and well-being of individuals with developmental disabilities served by Acadiana Region Supports & Services Center. Provide dietary consultation services in the area of quality assurance, menu planning, food purchasing, diet preparation, and food service, as well as program/diet planning for individuals served. Provider to be paid at a rate of \$45.00 per hour, not to exceed 240 hours/yr.	
TOTAL		\$

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Signature of Contractor Date _____

 Administrator or Designee Approval **Signature** Date _____ (337) 824-6250
Contact Phone#

AGENCY 340 **EFFECTIVE DATE:** ____ / ____ (MO/YR)

ORG#	OBJECT	REPORTING#	AMOUNT	REMARKS
244S	3460			

INVOICE
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Name and Address of Contractor

Doris Pitre
 939 Landreneau Road
 Eunice LA 70535
 337-457-8792

CFMS# 690057 VENDOR #51046924300 INVOICE# _____ (CFMS# + 6 digits)

REGION: IV PROGRAM: 340 8000Acadiana Region Supports & Services Center

DATE INVOICE COMPLETED: _____

DATE OF SERVICES	DESCRIPTION OF SERVICES	AMOUNT
	Provide advocacy training and consultation services as needed to individuals with developmental disabilities, often complicated with mental illness, challenging behaviors, or lack of family support served by Acadiana Region Supports & Services Center and its affiliated programs. Services include attending Individual Life Planning meetings, training and assisting staff and other resource personnel in rights of these individuals and in efforts to transition persons into other living and working arrangements. Provider to be paid at a rate of \$16.00 per hour, not to exceed 600 hours/yr.	
TOTAL		\$

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Signature of Contractor

 Date

6250
 Administrator or Designee Approval **Signature**

 Date

 Contact Phone#

(337) 824-

AGENCY **340**

EFFECTIVE DATE: ____ / ____ (MO/YR)

ORG#	OBJECT	REPORTING#	AMOUNT	REMARKS
244S	3460			

INVOICE
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Name and Address of Contractor

The Psychiatric Center, L.L.C.
 324 West Hale
 Lake Charles, LA 70601
 337-433-9177

CFMS# 690542 VENDOR # 27146726400 INVOICE# _____
 (CFMS# + 6 digits)
 REGION: IV PROGRAM: 340 8000Acadiana Region Supports & Services Center

DATE INVOICE COMPLETED: _____

DATE OF SERVICES	DESCRIPTION OF SERVICES	AMOUNT
	Provide quality and timely psychiatric services in evaluating, assessing and medication management for individuals in the Community Support Team caseload. Provider to be paid at a rate of \$150.00 per hour, (a minimum of 4 hrs and maximum of 6 hrs per week) not to exceed 312 hours/yr.	
TOTAL		\$

CONTRACTOR'S/RESPONSIBLE PARTY'S CERTIFICATE

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Signature of Contractor Date _____

 Administrator or Designee Approval **Signature** Date _____ Contact Phone# (337) 824-6250

AGENCY 340 EFFECTIVE DATE: ____ / ____ (MO/YR)

ORG#	OBJECT	REPORTING#	AMOUNT	REMARKS
2445	3741			
2445	3440			

INVOICE
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Name and Address of Contractor

Mitchell Sonnier, D.D.S., LLC
 109 Cary Avenue
 Jennings LA 70546
 337-824-9090

CFMS# 690524 VENDOR #20337877700 INVOICE# _____

REGION: IV PROGRAM: 340 8000Acadiana Region Supports & Services Center (CFMS# + 6 digits)

DATE INVOICE COMPLETED: _____

DATE OF SERVICES	DESCRIPTION OF SERVICES	AMOUNT
	Contractor will conduct up to twelve on-site dental clinics and related services for an assigned caseload of ARSSC clients at a rate of \$755.00/clinic, not to exceed \$9,060.00/year.	
TOTAL		\$

CONTRACTOR'S/RESPONSIBLE PARTY'S CERTIFICATE

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Signature of Contractor

 Date

 Administrator or Designee Approval **Signature**

 Date

 Contact Phone#

(337) 824-

AGENCY 340

EFFECTIVE DATE: ____ / ____ (MO/YR)

ORG#	OBJECT	REPORTING#	AMOUNT	REMARKS
244S	3440			

INVOICE
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Name and Address of Contractor

Susan Thompson, LPT
 Post Office Box 96
 Basile LA 70515
 337-432-5725

CFMS# 690035

VENDOR #43572596200 INVOICE# _____

(CFMS# + 6 digits)

REGION: IV

PROGRAM: 340 8000Acadiana Region Supports & Services Center

DATE INVOICE COMPLETED: _____

DATE OF SERVICES	DESCRIPTION OF SERVICES	AMOUNT
	Provide physical therapy & physical management services to insure the physical well-being & active treatment for individuals at Acadiana Region Supports & Services Center and satellites. Provide consultation to & education with designated staff in accordance with recognized physical therapy techniques. Provider to be paid at a rate of \$50.00 per hour for an average of 60 hours per month, not to exceed 720 hours/yr.	
TOTAL		\$

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Signature of Contractor

 Date

 6250

 (337) 824-

 Administrator or Designee Approval **Signature** Date

 Contact Phone#

AGENCY 340

EFFECTIVE DATE: ____ / ____ (MO/YR)

ORG#	OBJECT	REPORTING#	AMOUNT	REMARKS
244S	3440			

INVOICE
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Name and Address of Contractor

Vincent Internal Medicine, LLC
 136 Tower Road
 Post Office Box 871
 Crowley LA 70527-0871
 337-783-4043

CFMS# 690748 VENDOR #20342802300 INVOICE# _____

REGION: IV PROGRAM: 340 8000Acadiana Region Supports & Services Center (CFMS# + 6 digits)

DATE INVOICE COMPLETED: _____

DATE OF SERVICES	DESCRIPTION OF SERVICES	AMOUNT
	Contractor will conduct up to 52 on-site medical clinics and related services for an assigned caseload of ARSSC clients at a rate of \$365.00/clinic, not to exceed \$18,980.00/year.	
TOTAL		\$

CONTRACTOR'S/RESPONSIBLE PARTY'S CERTIFICATE

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Signature of Contractor Date _____

 Administrator or Designee Approval **Signature** Date _____ Contact Phone# (337) 824-6250

AGENCY 340 EFFECTIVE DATE: ____ / ____ (MO/YR)

ORG#	OBJECT	REPORTING#	AMOUNT	REMARKS
244S	3440			

INVOICE
DEPARTMENT OF HEALTH AND HOSPITALS
OFFICE FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Name and Address of Contractor

Bob Winston, M.D.
 234 Rue Beauregard, Suite 100
 Lafayette LA 70508
 337-593-0830

CFMS# 690445 **VENDOR #**61118381100 **INVOICE#** _____
 (CFMS# + 6 digits)
REGION: IV **PROGRAM:** 340 8000Acadiana Region Supports & Services Center

DATE INVOICE COMPLETED: _____

DATE OF SERVICES	DESCRIPTION OF SERVICES	AMOUNT
	Provide quality and timely psychiatric services in evaluating, assessing and medication management for individuals in the Community Support Team caseload. Provider to be paid at a rate of \$150.00 per hour, (a minimum of 4 hrs and maximum of 6 hrs per week) not to exceed 312 hours/yr.	
	Provide quality and timely psychiatric services in evaluating, assessing and medication management for individuals receiving services from ARSSC and its satellites. Provider to be paid at a rate of \$150.00 per hour, (4 hrs per month) not to exceed 48 hours/year.	
TOTAL		\$

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Signature of Contractor Date _____

 6250 (337) 824-_____
 Administrator or Designee Approval **Signature** Date _____ Contact Phone# _____

AGENCY 340 **EFFECTIVE DATE:** ____ / ____ (MO/YR)

ORG#	OBJECT	REPORTING#	AMOUNT	REMARKS
2445	3741		46,800.00	
244S	3440		7,200.00	