

EXHIBIT A - SCOPE OF WORK
(Changes to be made by Seminole County Community Health)

Seminole County Community Health

| | | |
|---|---|-----------------------|
| Agency Name: Health Council of East Central Florida | OG# TBD | Vendor# 301762 |
| Point of Contact: Jeff Feller, Executive Director | BU: 00100.069100.530340.3400660103 | |
| Address: 5931 Brick Court, Ste 164 Winter Park, FL 32792 | Contract Term: 10/1/2025 - 4/30/2026 | |
| Contact Phone Number: 869-991-3652 | Total Contracted Amount: \$71,000 | |
| Contact Email: jfeller@wellflorida.org | | |

SCOPE OF WORK

| Budget Categories | | Total Approved Budget | Total Approved Unit | Approved Price Per Unit |
|------------------------------------|--|-----------------------|---------------------|-------------------------|
| Healthcare Navigation (Healthlink) | Intake, assessment and eligibility services, case plan development, linking residents to needed services and maintaining case notes. | \$25,000.00 | 12 | \$2,083.33 |
| Prescription Assistance Services | Assisting residents with obtaining free or reduced prescriptions and coordination with medical staff, pharmacies and medication manufacturers to link client with medically needed prescriptions, including assisting in the application for indigent prescription programs. | \$15,000.00 | 12 | \$1,250.00 |
| Medication/Prescriptions | Direct assistance to Seminole residents to obtain and pay for medically needed prescription assistance. | \$15,500.00 | | |
| Medical Procedures | Referral and payment for vouchers for minor medical procedures (outpatient procedures not requiring hospitalization, diagnostic testing, etc.) | \$15,500.00 | | |
| Total | 0.00 | \$ - | \$ 71,000 | \$ (71,000) |

Note: Please attach documentation substantiating expenditures. Supporting documentation must be submitted with each payment request. Failure to submit required documentation may result in denial of invoice or delayed payments.

I certify that the goods and/or services covered by this request have been provided to Seminole County in accordance with the terms and conditions of the contracts and are documented by the attachment(s).

Authorized Signature: _____

Date: _____

EXHIBIT B - PERFORMANCE REPORT

Seminole County Community Health

Agency Name: Health Council of East Central Florida
Point of Contact: Jeff Feller, Executive Director
Address: 5931 Brick Court, Ste 164 Winter Park, FL 32792
Contact Phone Number: 869-991-3652
Contact Email: jfeller@wellflorida.org

OG# TBD
BU: 00100.069100.530340.3400660103
Vendor# 301762

Invoice #:

Reporting Period:

Performance Report

Healthcare Navigation Services

| Unique Client ID | Date of Service | Type of Service | Service Category | Minutes | Notes/Comments |
|---|-----------------|-----------------|--|---------|----------------|
| | | | | | |
| | | | | | |
| | | | | | |
| Total # of Seminole Residents Served (unduplicated): | | 0 | Total # of Healthcare Navigation Units: | | 0 |

Prescription Assistance

| Unique Client ID | Date of Service | Service Category | Minutes | Notes/Comments | |
|---|-----------------|------------------|--|----------------|----------|
| | | | | | |
| | | | | | |
| | | | | | |
| Total # of Seminole Residents Served (unduplicated): | | 0 | Total # of Healthcare Navigation Units: | | 0 |

Prescription Payment (Valid receipts must accompany invoice)

| Unique Client ID | Date of Script | Pharmacy | Name of Script | Cost | Notes/Comments |
|----------------------------------|----------------|----------|------------------------------|--------------------|----------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Total # of Prescriptions: | | 0 | Total # of Residents: | | 0 |
| | | | | Total Cost: | \$0.00 |

Medical Procedure Payment (Valid receipts must accompany invoice)

| Unique Client ID | Date of Procedure | Provider/Clinic | Cost | Name & Description of Procedure | |
|---------------------------------------|-------------------|-----------------|------------------------------|--|---------------|
| | | | | | |
| | | | | | |
| | | | | | |
| Total # of Referrals/Vouchers: | | 0 | Total # of Residents: | | 0 |
| | | | | Total Cost of Referrals/Vouchers: | \$0.00 |

Note: Please attach documentation substantiating expenditures. Supporting documentation must be submitted with each payment request. Failure to submit required documentation may result in denial of invoice or delayed payments.

I certify that the goods and/or services covered by this request have been provided to Seminole County in accordance with the terms and conditions of the contracts and are documented by the attachment(s).

Authorized Signature: _____

Date: _____

EXHIBIT C - REQUEST FOR PAYMENT

Seminole County Community Health

Agency Name: Health Council of East Central Florida
Point of Contact: Jeff Feller, Executive Director
Address: 5931 Brick Court, Ste 164 Winter Park, FL 32792
Contact Phone Number: 869-991-3652
Contact Email: jfeller@wellflorida.org

OG# 2656 **Vendor#** 301762
BU: 00100.069100.530340.3400660103
Reporting Period: October 1, 2025 - October 31, 2025
Invoice #: 0

Budget Summary Report

Expenditures

| Budget Categories | Total Approved Budget | Total Approved Unit | Approved Price Per Unit | Previous Billed Units | Previous Billed Amount | Current Units Requested | Current Payment Request | Payments Requested to Date | Units Remaining | Remaining Balance |
|------------------------------------|-----------------------|---------------------|-------------------------|-----------------------|------------------------|-------------------------|-------------------------|----------------------------|-----------------|--------------------|
| Healthcare Navigation (Healthlink) | \$25,000.00 | 12 | \$2,083.33 | | \$0.00 | 0.00 | \$0.00 | \$0.00 | 12 | \$25,000.00 |
| Prescription Assistance Services | \$15,000.00 | 12 | \$1,250.00 | | \$0.00 | 0.00 | \$0.00 | \$0.00 | 12 | \$15,000.00 |
| Medication/Prescriptions | \$15,500.00 | | | | | 0.00 | \$0.00 | \$0.00 | | \$15,500.00 |
| Medical Procedures | \$15,500.00 | | | | | 0.00 | \$0.00 | \$0.00 | | \$15,500.00 |
| Total | \$71,000.00 | | | 0.00 | \$0.00 | 0.00 | 0.00 | 0.00 | \$ 24 | \$71,000.00 |

Note: Please attach documentation substantiating expenditures. Supporting documentation must be submitted with each payment request. Failure to submit required documentation may result in denial of invoice or delayed payments.

I certify that the goods and/or services covered by this request have been provided to Seminole County in accordance with the terms and conditions of the contracts and are documented by the attachment(s).

Authorized Signature: _____ Date: _____



