Division of Public Health
Agreement Addendum
FY 25-26

Durham County Department of Public Health **Local Health Department Legal Name**	Epidemiology / Communicable Disease **DPH Section / Branch Name**
583 Refugee Health Assessments **Activity Number and Description**	Jennifer Morillo, 919-546-1634 jennifer.morillo@dhhs.nc.gov **DPH Program Contact** (name, phone number, and email)
06/01/2025 – 05/31/2026 **Service Period**	**DPH Program Signature** **Date** (only required for a negotiable Agreement Addendum)
07/01/2025 – 06/30/2026 **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[1], refugees arrive to the U.S. and North Carolina from all around the globe. In fiscal year 2024, the largest numbers have arrived in North Carolina from the Democratic Republic of the Congo, Venezuela, Syria, Afghanistan, Burma and Guatemala. Additionally, North Carolina has received large numbers of Afghan Special Immigrant Visa holders as well as Humanitarian Parolees[2] from Cuba, Haiti and Ukraine.

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 infectious and non-infectious, not commonly seen in the U.S.-born population.

All those arriving through the Refugee Admissions Program undergo a required immigration medical examination, usually 3 to 6 months before departure for the U.S. Other Office of Refugee Resettlement (ORR)-eligible populations bound for the U.S. do not usually undergo this medical examination prior to arrival but may have health requirements either after immediately after arrival and/or at the time of

[1] About Us — Refugee Processing Center (wrapsnet.org)
[2] https://www.uscis.gov/CHNV, https://www.uscis.gov/FRP, https://www.uscis.gov/ukraine

DocuSigned by:
Rodney Jenkins
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Health Director Signature (use blue ink or verifiable digital signature)

3/4/2025 | 3:20 PM EST
Date

LHD to complete:
[For DPH to contact in case follow-up information is needed.]

LHD program contact name: Shenell Little

Phone and email address: 919-560-7574 slittle@dconc.gov

Signature on this page signifies you have read and accepted all pages of this document.

adjusting their status to request residency. 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.

Another assessment, the domestic refugee health assessment (also commonly known as the domestic refugee medical screening examination or initial screening), is conducted soon after U.S. arrival and is recommended but not legally required. This assessment offers a timely opportunity to identify acute and chronic health conditions. Incomplete vaccination status, tuberculosis infection, elevated blood lead levels in children, 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 an 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 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 initial screening can help refugees develop a sense of trust in the U.S. medical system and healthcare providers. It is also an opportunity to introduce the importance of preventative medicine and routine physical examinations, as well as how and when to access emergency medical care. 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. The source of funding for this service is from the Office of Refugee Resettlement's Cash and Medical Assistance Program.[3]

Throughout this document, for ease of use, the term "refugee" or "refugees" is used to refer to all humanitarian-based newcomers eligible for the screening program: refugees, asylees, certain Amerasians, Cuban/Haitian entrants (including Cuban/Haitian humanitarian parolee), certain victims of trafficking, Afghan and Iraqi Special Immigrant Visa (SIV) holders, 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. [Office of Refugee Resettlement (ORR) guidance around the status and documentation requirements for eligibility of benefits and services.[4]]

II. Purpose:

This Agreement Addendum provides funds to local health departments that have consistent and significant numbers of refugee arrivals to assist with (1) administrative costs which includes personnel, language interpretation, and transportation costs, and costs associated with providing refugee health assessments; (2) expenses related to providing this service to eligible clients that may not be covered by any medical program or insurance; and (3) interpretation and transportation costs for limited follow-up communicable disease/immunization services.

[3] https://www.acf.hhs.gov/orr/programs/refugees/cma
[4] https://www.acf.hhs.gov/orr/policy-guidance/status-and-documentation-requirements-orr-refugee-resettlement-program

These specialized supportive funds for dedicated staff and other administrative supports are crucial to help ensure the assessment is completed in a timely manner, appropriate referrals to specialized care are provided, and refugees with newly diagnosed conditions are connected to individual case support. Dedicated staff and funding are important as refugees have unique needs (e.g., logistical, language, cultural) and components of the refugee health assessment are generally beyond the scope of typical local health department services.

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:

Durham County is one of the top refugee resettlement counties in North Carolina, with the state receiving approximately 7,000 arrivals each year. Durham County anticipates screening approximately 800 new refugee arrivals for State Fiscal Year 2025-2026.

The Local Health Department shall meet the following program requirements to ensure new refugee arrivals have access to timely medical screening.

1. Staff

The Local Health Department (LHD) shall:

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

b. 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 and discuss logistics.

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

d. When there are any changes of key refugee health staff, inform the DPH Program Contact within one month of the change.

e. When new staff are hired and upon request, provide the DPH Program Contact with 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.

f. Require key refugee health staff to:

   1. Attend relevant trainings and conferences sponsored by the North Carolina Refugee Assistance Program and the North Carolina Refugee Health Program,
   2. Communicate regularly with local resettlement agencies to coordinate local refugee services, and
   3. Attend the Quarterly Consultation meetings with local partners.

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

1. The Minnesota Department of Health's Center of Excellence in Newcomer Health trainings.[5]
2. The University of Minnesota's Department of Medicine's free, comprehensive introductory course in immigrant and refugee health for those new to the field.[6]
3. Working with Interpreters - The University of Minnesota's Department of Medicine medical interpreter training module which is directed at healthcare workers using interpreters in the clinical setting as well as Switchboard interpretation trainings.[7]
4. Switchboard onboarding guide resources[8] - cultural humility, awareness and competency; cultural backgrounders on common populations; partner collaboration; and other basics for new staff.

2. Assessments and Screening Services. There are **t**hree general categories of the assessment: Communicable Disease Screening, Physical Exam, and Laboratory Testing.

The LHD shall:

a. **Inform newly arrived refugees** in the county about the availability of assessments and screening services.

b. **Schedule screening assessments for the newly arrived refugees**, 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 90 days from eligibility to assure reimbursement through Medicaid or Refugee Medical Assistance (RMA). (Medicaid's Clinical Coverage Policy 1D-1[9] is specific to local health departments providing the entire assessment including a physical examination.)

c. For those newly arrived refugees who are residing in **nearby counties for which there is no health department refugee screening clinic**, if the LHD determines it has capacity in its clinic to do so, attempt to schedule screening assessments as described in Paragraph 2.b. above.

d. **Follow the North Carolina Refugee Health Assessment Protocol guidelines, listed in Attachments A, B and C,** for the assessment, which are generally based on recommendations from the Centers for Disease Control and Prevention (CDC)[10] and the Office of Refugee Resettlement (ORR).[11] (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. As CDC guidance changes frequently, local health departments may adjust the protocol accordingly and prior to Agreement Addendum revision execution upon consultation with the DPH Program Contact.).

e. In determining which screening tests to use and what other preventive care to provide, consider using:

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[5] https://www.health.state.mn.us/communities/rih/coe/index.html
[6] https://med.umn.edu/dom/education/global-medicine/courses-certificates/online/introduction-immigrant-refugee-health-course
[7] https://med.umn.edu/dom/education/ global-medicine/courses-certificates/online/medical-interpreter-training; https://learning.switchboardta.org/collections/eLearning-Courses
[8] https://www.switchboardta.org/resource/sample-intensive-case-management-onboarding-guide/; https://www.switchboardta.org/resource/service-and-health-care-provider-collaboration-promoting-clients-health-through-improved-coordination/; https://www.switchboardta.org/resource/an-introduction-to-refugee-health/; https://live-irc-switchboard.pantheonsite.io/wp-content/uploads/2023/05/Assisting-Newcomers-PDF.pdf
[9] https://medicaid.ncdhhs.gov/providers/program-specific-clinical-coverage-policies; https://medicaid.ncdhhs.gov/1d-1-refugee-health-assessments-provided-health-departments/download?attachment
[10] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/index.html
[11] https://www.acf.hhs.gov/orr/policy-guidance/revised-medical-screening-guidelines-newly-arriving-refugees

1. CareRef[12], the CDC-funded interactive tool, based on the demographic and geographic factors that contribute to risk.
2. A CDC-funded project[13] 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.
3. The American Academy of Pediatrics Immigrant Health Toolkit[14] for those screening children.

f. As some of the recommended testing may be done overseas prior to the refugee's arrival, consider whether there is appropriate documentation of that testing and the timeliness of when the testing was conducted. Clinics have the discretion to rescreen if there is a clinical indication (e.g., an infection where the client is potentially at risk of exposure for a prolonged period before re-presenting, such as TB). Additionally, clinics have the discretion to rescreen if there are anomalies with the reported results or other concerns. If discrepancies are noted with any results, please notify the DPH Program Contact.

g. There are **three general categories of the assessment: Communicable Disease Screening, Physical Exam, and Laboratory Testing**. When screening asymptomatic refugees:
   1. The Communicable Disease portion of the assessment should generally include the activities listed in the table in **Attachment A — Communicable Disease Screening of Asymptomatic Refugees.** 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 Attachments B and C.
   2. The Physical Exam portion of the assessment should generally include the activities listed in the table in **Attachment B — Physical Exam of Asymptomatic Refugees**.
   3. The Laboratory Testing portion of the assessment should generally include the activities listed in the table in **Attachment C — Laboratory Testing of Asymptomatic Refugees**.

h. Determine whether there are significant concerns around the mental status of each refugee. 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.

i. 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] https://careref.web.health.state.mn.us/
[13] https://policylab.chop.edu/project/providing-tools-clinicians-better-support-immigrant-health
[14] https://downloads.aap.org/AAP/PDF/cocp_toolkit_full.pdf

j. 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. [The Office of Refugee Resettlement (ORR) provides guidance around the status and documentation requirements for eligibility of benefits and services].[15] Contact the DPH Program Contact if a client's eligibility for service is uncertain.

3. Referrals

The LHD shall:

a. Refer or link refugees to a primary care facility or provider for on-going follow-up and treatment.
    1. 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.

b. Refer the refugee to a medical provider to receive the components that the LHD is unable to provide to the refugee. (Medical providers include hospital clinics, private clinics, or federally qualified health centers.) At minimum, the LHD shall provide the Communicable Disease Screening portion of the assessment. (There are **t**hree general categories of the assessment: Communicable Disease Screening; Physical Exam, and Laboratory Testing.)
    1. If the LHD does not also 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 1D-1[16].

c. When appropriate, 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.

d. 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.

e. 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.

4. Fees and Payments from Clients

The LHD shall:

a. Not assess the refugee any fees for this screening if <u>all</u> the following criteria are met:
    1. 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,
    2. The refugee has confirmed that he or she has applied for Medicaid/Refugee Medical Assistance (RMA) prior to receiving the service, <u>and</u>
    3. The refugee follows through with all the Medicaid/RMA 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

[15] https://www.acf.hhs.gov/orr/policy-guidance/status-and-documentation-requirements-orr-refugee-resettlement-program
[16] https://medicaid.ncdhhs.gov/1d-1-refugee-health-assessments-provided-health-departments/download?attachment

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 12 months in the U.S. if the client is known to be on RMA.

b. Not assess any copayments for this service if the 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.

5. Performance Standards

The LHD shall:

a. 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 may have been screened previously in another county or state.

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

c. 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.

d. 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.[17]

e. Maintain an updated list of behavioral health resources to ensure prompt referral of patients who require urgent follow-up care for mental health needs and/or to be provided as part of routine intake.

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

6. Subcontracting

The LHD shall:

a. Request and receive prior written approval from the DPH Program Contact to subcontract any of these services.

b. Ensure any subrecipients adhere to all the same conditions of this Agreement Addendum with careful attention to client eligibility, monthly reporting requirements and funding guidelines.

c. Monitor all subrecipients through monthly desk reviews and a minimum of one site visit during the Agreement Addendum service period to assure that their operations are in adherence to the conditions of this Agreement Addendum.

d. Establish and submit to the DPH Program Contact a copy of Memorandums of Agreement or Understanding (MOAs or MOUs) and subcontracts (for all service providers identified as a subrecipient) within 30 days of signature, documenting the following:

1. Subrecipient contact information.
2. The services to be provided.
3. How client eligibility will be determined.
4. How and when monthly reporting will be communicated.
5. That funding guidelines are understood.

[17] https://www.ncbon.com/myfiles/downloads/position-statements-decision-trees/standing-orders.pdf

6. Agreements for sharing client data.

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. Initiate care for at least:
   a. 50% of refugee arrivals within 30 days after arrival,
   b. 70% of refugee arrivals within 60 days after arrival, and
   c. 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 will communicate regularly and consistently with local partners.

4. Report to the DPH Program Contact when the refugee is found to not reside in the LHD's jurisdiction. In instances where the refugee is found to have moved, the LHD shall report to the DPH Program about the residency status, including any known address/contact information, as soon as possible but no later than 10 days after the determination was made.

5. Submit clinical services data via the LHD-HSA P3 Refugee Health Form within the LHD's electronic health record as soon as possible following the clinical appointment.

6. Provide the following reports to the DPH Program Contact for the North Carolina Refugee Health Program:
   a. **Monthly Financial Reports**
   b. **Monthly Client Line Listing Reports**

7. In the submitted data reports, include the following:
   a. Medical Screening (MS) Administration 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.

      Monthly client line listing reports are to be prepared per eligible client and are due according to the table in Paragraph 6, below.

      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 is being billed (i.e., $0).

b. Medical Screening (MS) Uninsured 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 insurance 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.

This client line listing report 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.

c. Refugee Medical Assistance (RMA) Administration Post-assessment 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 what service was provided, and the amount being billed for administration.

d. Reporting in Smartsheet: Total expenses for each monthly Financial Report are to be broken out in the following manner and submitted each month via Smartsheet.[18]

1. MS Administration interpreter expenses being charged (AMU 2B08100)
2. MS Administration transportation expenses being charged (AMU 2B08100)
3. MS Administration translation expenses being charged (AMU 2B08100)
4. MS Administration personnel expenses being charged and list the names of relevant staff (AMU 2B08100)
5. MS Administration subrecipient expenses being charged (AMU 2B08100)
6. All MS Administration expenses (from numbers 1 through 5 above)
7. MS Uninsured expenses (AMU 2B08110)
8. RMA Administration Post-assessment expenses (AMU 2B08120)

Within Smartsheet, the Local Health Department shall be asked to agree to the following statement each month:

As Health Department Director or designee, I hereby certify that the cost or units billed to NCDHHS on this Monthly Expenditure Report have been delivered in accordance with the conditions of the Agreement Addendum, and that to the best of my knowledge and belief, we have complied with all laws, regulations and contractual provisions that are conditions of payment under this Agreement Addendum.

8. Provide reports according to the following schedule:

Screening Month	Monthly Reports Due	Screening Month	Monthly Reports Due
June	July 15	December	January 15
July	August 15	January	February 15
August	September 15	February	March 15
September	October 15	March	April 15
October	November 15	April	May 15
November	December 15	May	June 15

Monthly Client Line Listing reports may be submitted either on paper (through fax or mail) or preferably electronically (through encrypted email).

9. **Reporting Required Subcontract Information**
In accordance with revised NCDHHS guidelines effective October 1, 2024, the LHD must provide the information listed below for every subcontract receiving funding from the LHD to carry out any or all of this Agreement Addendum's work.

[18] https://app.smartsheet.com/b/publish?EQBCT=82018408e7b44ef9b44e113b6e536ffb

This information is not to be returned with the signed Agreement Addendum (AA) but is to be provided to DPH when the entities are known by the LHD.

a. Subcontracts are contracts or agreements issued by the LHD to a vendor ("Subcontractor") or a pass-through entity ("Subrecipient").
    1. Subcontractors are vendors hired by the LHD via a contract to provide a good or service required by the LHD to perform or accomplish specific work outlined in the executed AA. For example, if the LHD needed to build a data system to satisfy an AA's reporting requirements, the vendor hired by the LHD to build the data system would be a Subcontractor. (However, not all Vendors are considered Subcontractors. Entities performing general administrative services for the LHD (e.g., certified professional accountants) are not considered Subcontractors.
    2. Subrecipients of the LHD are those that receive DPH pass-through funding from the LHD via a contract or agreement for them to carry out all or a portion of the programmatic responsibilities outlined in the executed AA. (Subrecipients are also referred to as Subgrantees in NCAC.)

The following information must be submitted via Smartsheet for review prior to the entity being awarded a contract or agreement from the LHD:

- Organization or Individual's Name (if an individual, include the person's title)
- EIN or Tax ID
- Street Address or PO Box
- City, State and ZIP Code
- Contact Name
- Contact Email
- Contact Telephone
- Fiscal Year End Date (of the entity)
- State whether the entity is functioning as a pass-through entity Subcontractor or Subrecipient of the LHD.

V. Performance Monitoring and Quality Assurance:

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

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, some 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. **Federal Funding Requirements**: where federal grant dollars received by the Division of Public Health (DPH) are passed through to the Local Health Department (LHD) for all or any part of this Agreement Addendum (AA).
    a. Requirements for Pass-through Entities: In compliance with 2 CFR §200.331 – *Requirements for pass-through entities*, DPH provides Federal Award Reporting Supplements (FASs) to the LHD receiving federally funded AAs.

1. Definition: An FAS discloses the required elements of a single federal award. FASs address elements of federal funding sources only; state funding elements will not be included in the FAS. An AA funded by more than one federal award will receive a disclosure FAS for each federal award.
2. Frequency: An FAS will be generated as DPH receives information for federal grants. FASs will be issued to the LHD throughout the state fiscal year. For a federally funded AA, an FAS will accompany the original AA. If an AA is revised and if the revision affects federal funds, the AA Revision will include an FAS. FASs can also be sent to the LHD even if no change is needed to an AA. In those instances, the FAS will be sent to provide newly received federal grant information for funds already allocated in the existing AA.

b. Required Reporting Certifications: Per the revised Uniform Guidance, 2 CFR 200, if awarded federal pass-through funds, the LHD as well as all subrecipients of the LHD must certify the following whenever 1) applying for funds, 2) requesting payment, and 3) submitting financial reports:

> "I certify to the best of my knowledge and belief that the information provided herein is true, complete, and accurate. I am aware that the provision of false, fictitious, or fraudulent information, or the omission of any material fact, may subject me to criminal, civil, or administrative consequences including, but not limited to violations of U.S. Code Title 18, Sections 2, 1001, 1343 and Title 31, Sections 3729-3730 and 3801-3812."

2. Some refugee health funds are directly related to the number of eligible clients served and to what extent they are served. The federal funding guidelines are very specific and must be strictly followed. Funds may not be drawn down except according to the following guidelines:

a. **Medical Screening Administration (AMU 2B08100)**:

1. A once-in-a-lifetime maximum amount of $70 per eligible client for administration/ language interpretation for the Communicable Disease portion of the refugee health assessment and any follow-up.
    a. Vaccinations only: maximum amount limited to $30.
    b. Tuberculosis screening only: maximum amount limited to $30.
    c. On a pre-approved basis only, LHD may ask for a waiver for a limited number of clients needing interpretation services for a rare language, which may be significantly more expensive. Documentation of the need may be requested.
2. A once-in-a-lifetime maximum amount of $70 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 12 months or when it has been more than 12 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. Transportation: If LHD has had an emergency need to assist a client with transportation to or from the Refugee Health Assessment appointment, a maximum of $60 per eligible client may be charged with DPH Program Contact approval. Requests for this need are expected to be very limited.

5. Translation: On a pre-approved basis only, LHD may request to charge for costs associated with translation of foreign historical vaccination records. Documentation and quotes may be requested. Requests for this need are expected to be very limited.
6. Personnel charges are allowable only 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.
7. Allocation of funds in this AMU cover the following: (a) per client charges for interpretation, transportation, or translation; (b) personnel charges; and (c) subrecipient. The funds allocated for each are not interchangeable and each have the following limits:

Service Period	Payment Period	Interpretation/ Transportation/ Translation	Personnel*	Subrecipient	Total
June-September	July-October	$21,000	$71,600	$0	$92,600
October-May	November-June	$39,750	$143,200	$0	$182,950
*Based on an estimated need of $17,900 per month for personnel costs.					

b. **Medical Screening (AMU 2B08110)**:

1. A once-in-a-lifetime maximum amount of up to $500 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. Services must have been initiated within 90 days of eligibility. These funds are not available for any otherwise eligible client when:
   a) the refugee has been in the U.S. for more than 90 days, **or**
   b) it has been more than 90 days since the final grant date of asylum for asylees, **or**
   c) it has been more than 90 days since the certification/eligibility letter's date for trafficking victims.

Service Period	Payment Period	Uninsured	Total
June–September	July–October	$4,000	$4,000
October–May	November–June	$4,000	$4,000

c. Refugee Medical Assistance (RMA) Administration Post-assessment (AMU 2B08120)

A maximum amount of $30 per eligible client to assist with administration/language interpretation and/or transportation for limited follow-up communicable disease/immunization services.

Service Period	Payment Period	Interpretation / Transportation	Total
June–September	July–October	$0	$0
October–May	November–June	$0	$0

3. This Activity's funds should not be used 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.

4. This Activity's funds should not be used if another entity is providing the service at no charge to the Local Health Department.

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

Attachment A — **Communicable Disease Screening of Asymptomatic Refugees**

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[19]	Complete medical records may be obtained from a combination of CDC's Electronic Disease Notification System (EDN) and the client's International Organization for Migration (IOM) bag. Records include the overseas medical examination which includes a medical history and physical examination to determine the presence and severity of Class A or Class B conditions.
Vaccination assessment and update[20]	Historical vaccination records must be reviewed and may include refugee camp vaccination cards and records or booklets from other programs and clinics. Some vaccinations will only be documented on the DS-3025 (Vaccination Worksheet) while at times, vaccinations given immediately before travel may only be documented on the Pre-departure Medical Screening (PDMS) forms. Accessing the clients' records in EDN and in the IOM bag is critical. It is important to review the historical vaccinations and schedule appropriately. Two live injectable vaccines such as MMR and varicella should be given on the same day or separated by a minimum of 28 days. Tuberculosis testing may be administered simultaneously with live vaccines or deferred for 28 days after vaccination of a live virus vaccine. Serological testing may be an acceptable alternative for certain antigens and dependent on client's age. Cost-effectiveness should be considered. Assess and update adults and children as per North Carolina Immunization Program requirements and the CDC's Advisory Committee on Immunization Practices (ACIP) immunization guidelines. Especially for adults, consider the vaccination requirements needed for adjusting their status from refugee to permanent residence. Special considerations: • Hepatitis B Virus (HBV) – Most U.S.-bound refugees are tested for HBV infection overseas using HBsAg. HBsAg-positive persons do not receive HBV vaccination overseas. HBsAg-negative persons are offered the hepatitis B vaccine. Most receive 2 doses before departure and may be due a third dose after arrival. See the Hepatitis B testing section below for additional information. • Varicella serology - Serological screening of refugee adults for varicella immunity before vaccinating is generally recommended and cost-effective. • Hepatitis A Virus (HAV) - 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. • Polio vaccination (IPV) – Adults who are known or suspected to be unvaccinated or incompletely vaccinated against polio should receive and complete the polio vaccination

[19] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/history-and-physical.html and https://www.cdc.gov/immigrant-refugee-health/php/case-reporting-edn/index.html

[20] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/immunizations.html; https://www.cdc.gov/immigrant-refugee-health/hcp/civil-surgeons/vaccination.html; and https://www.cdc.gov/polio/hcp/vaccine-considerations/index.html

Communicable Disease Screening of Asymptomatic Refugees	
Activity	**Summary**
	series with IPV. Adults who completed their polio vaccination but who are at increased risk of exposure to poliovirus may receive one lifetime IPV booster.
Tuberculosis screening[21]	Review history, screen for signs, symptoms and risk, and conduct: • Interferon-Gamma Release Assays (IGRA) or tuberculin skin test (TST) [for children aged <2 years] or • IGRA [aged ≥2 years] Unless overseas IGRA testing was performed within 6 months prior to domestic exam and results are available. Per the NC Tuberculosis Control Program Policy Manual, emerging evidence suggests that IGRAs may reduce false-positive tests among BCG-vaccinated children, so an IGRA is a reasonable alternative for such children. The Manual also discusses the growing evidence supporting the use of IGRAs in children <2 years old; therefore, IGRAs are acceptable alternatives to the TST for LTBI screening in children <2 years old. 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). IGRA or TST tuberculosis test may be administered simultaneously with live vaccines or deferred for 28 days after vaccination.
HIV testing[22]	Routinely test all refugees unless they decline (opt out). For children <13 years old, test unless HIV status of mother is confirmed as negative, and child's risk is assessed as low. • Repeat screening 3-6 months following resettlement for those who had recent exposure or are high risk. • Screen all pregnant refugee women as part of their routine post arrival and prenatal medical screening and care. • Refer all confirmed to be HIV-infected for care, treatment, and preventative services.
Hepatitis B testing[23]	Most U.S.-bound refugees are tested for HBV infection overseas using HBsAg. HBsAg-positive persons do not receive HBV vaccination overseas. HBsAg-negative persons are offered the hepatitis B vaccine. Most receive 2 doses before departure and may be due for the third dose after arrival. In this situation, serologic testing should not be performed. If serologic testing is performed, results should be interpreted with caution, as vaccination may cause temporary seroconversion (anti-HBs), which does not predict long-term protection. In addition, HBsAg testing should be delayed for at least 4 weeks after the final hepatitis B vaccination because the vaccine can cause a false positive HBsAg for up to 30 days. Therefore, serologic results can be difficult to interpret (and generally avoided) when an individual has received an incomplete hepatitis B vaccine series.

[21] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/tuberculosis.html and https://epi.dph.ncdhhs.gov/cd/lhds/manuals/tb/Chapter%20II%20Tuberculin%20skin%20testing%20and%20IGRA.pdf?ver=1.1

[22] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/hiv-infection.html

[23] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/immunizations.html and https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/viral-hepatitis.html

Communicable Disease Screening of Asymptomatic Refugees	
Activity	**Summary**
	All newly arriving adult refugees (≥18 years of age) should be screened for hepatitis B, if not previously tested. Review overseas records (pre-departure testing for infection and vaccination) to determine if further management is needed. • If not previously tested for hepatitis B infection, triple panel screening should be performed for hepatitis B surface antigen (HBsAg), total hepatitis B core antibody (anti-HBc), and hepatitis B surface antibody (anti-HBs). • If previously tested for hepatitis B virus infection overseas: - If testing was positive for HBV infection (HBsAg-positive), then additional evaluation and treatment options, or referral to a specialist, is recommended. - If HBsAg was negative, and the refugee has a record of complete vaccination before arrival, then no further testing or vaccination is necessary. [In refugees with high risk of future exposure, it is reasonable to check serology for evidence of immunity.] - If HBsAg was negative, vaccination records indicate that the vaccination series is complete, the refugees is in a high-risk group, or there is a concern for high-risk exposure since the original screen or in the future, then it is reasonable to repeat testing following arrival. - If HBsAg was negative and no previous doses of vaccine were received, then the refugee should be tested for immunity by serology with HBsAg, anti-HBc, and anti-HBs. It is reasonable to start the hepatitis B vaccines series while awaiting results. If serologic testing returns negative, then the series should be completed. If serology for both anti-HBc and anti-HBs are positive, then no further vaccine doses are needed. **All pregnant refugees** should be screened during each pregnancy, preferably in the first trimester regardless of vaccination status or history of testing. **All refugee children and adolescents <18 years of age** should be tested for HBsAg, if not previously tested and they have an incomplete vaccination history. Review overseas records (pre-departure testing for infection and vaccination) to determine if further management is needed. • If not previously tested for hepatitis B virus infection, triple panel screening should be performed for hepatitis B surface antigen (HBsAg), total hepatitis B core antibody (anti-HBc), and hepatitis B surface antibody (anti-HBs). • If previously tested for hepatitis B virus infection overseas: - If testing was positive for HBV infection (HBsAg-positive), then additional evaluation and treatment options, or referral to a specialist, is recommended. - If HBsAg was negative, and vaccination series has been initiated, the vaccine series should be completed according to the ACIP schedule. - If HBsAg was negative, vaccination is not complete, and the patient is high-risk, or there is concern for a risk exposure since the original screen, it is reasonable to repeat testing. - If HBsAg was negative, and the refugee has a record of complete vaccination before arrival and at appropriate intervals, then no further testing or vaccination is necessary. [In refugees with high risk of future exposure, it is reasonable to check serology for evidence of immunity.]

Communicable Disease Screening of Asymptomatic Refugees	
Activity	**Summary**
	Hepatitis B vaccination is not indicated for those whose serologic testing indicates prior HBV infection. Further evaluation and management should be considered.
Hepatitis C testing[24]	Routinely test all adults (≥18 years of age). Test any child (<18 years of age) with risk factors, including, but not limited to those with a history of traditional tattooing or female genital mutilation or cutting.
Syphilis testing[25]	Nontreponemal testing (VDRL or RPR), and confirmatory testing for all positives, for refugees in the following categories: • All refugees aged 18 years to those aged less than 45 years, if no overseas results are available. • Refugees 45 years and older, if there is reason to suspect infection. Syphilis testing should also be considered for those younger than 18 years of age who are at risk for congenital syphilis, who disclose sexual activity, or have been sexually assaulted.
Chlamydia and Gonorrhea testing[26]	Nucleic Acid Amplification Tests (NAAT) are recommended for the following: • All refugees aged 18 to 24 years who do not have documented pre-departure testing. • All refugees with signs or symptoms. • All refugees aged less than 18 years or greater than 24 years if there is reason to suspect infection or if there are risk factors.
Pregnancy and STI prevention[27]	Discuss family planning and available contraceptive methods, including accessibility, efficacy, and cost. Consider offering condoms to avoid unintended pregnancy and sexually transmitted infections (STIs).
Follow-up and Referrals	Provide health education, anticipatory guidance, treatment, and referrals as appropriate. All refugees should be referred to a primary care provider and a dental provider.

[24] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/viral-hepatitis.html
[25] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/sexual-and-reproductive-health.html
[26] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/sexual-and-reproductive-health.html
[27] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/sexual-and-reproductive-health.html

Attachment B — **Physical Exam of Asymptomatic Refugees**

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

Physical Exam of Asymptomatic Refugees	
Activity	**Summary**
History and records review[28]	Complete medical records may be obtained from a combination of CDC's Electronic Disease Notification System (EDN) and the client's International Organization for Migration (IOM) bag. Records include the overseas medical examination which includes a medical history and physical examination to determine the presence and severity of Class A or Class B conditions.
Blood pressure	Screen all refugees ≥3 years old.
Nutritional status and growth[29]	The main goal of nutritional status screening of refugees after arrival is to identify those with nutritional deficiencies that require further evaluation and/or treatment. Refugee populations may be increasingly at risk for both undernutrition, a condition associated with development and cognitive delays, and overweight/obesity, a condition associated with chronic medical conditions, including hypertension, diabetes, and cardiovascular disease. 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[30]	Review of systems including oral health, vision (≥3 years) and hearing (≥4 years). Use of alternate vision charts may be needed if the individual cannot identify letters of the English alphabet. Conduct a thorough, head-to-toe physical examination as permitted by the patient, as this may reveal undiagnosed underlying diseases and other medical issues. (Note: genital exam could be delayed for a subsequent visit or after primary care and/or trust is established).
Mental status examination and screening[31]	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, but rather to identify individuals who should be referred for appropriate mental health diagnosis and management. Timely referrals to mental health services may assist refugees in living more productive and healthier lives following resettlement. Ask directly about symptomology, functionality, and suicidal ideation as part of an integrated history and physical examination, helping to minimize stigmatization. Screen adults using either 1) a single standardized tool for a wide range of symptoms associated with diverse potential Diagnostic and Statistical Manual of Mental Disorders

[28] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/history-and-physical.html
[29] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/nutrition-and-growth.html
[30] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/history-and-physical.html
[31] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/mental-health.html;
https://www.health.state.mn.us/communities/rih/guide/10mentalhealth.html;
https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp;
https://hprt-cambridge.org/screening/hopkins-symptom-checklist;
https://hprt-cambridge.org/screening/harvard-trauma-questionnaire;
https://www.refugeehealthta.org/wp-content/uploads/2012/09/RHS15_Packet_PathwaysToWellness-1.pdf; and
https://youthinmind.com/products-and-services/sdq/

Physical Exam of Asymptomatic Refugees	
Activity	**Summary**
	(DSM) diagnoses, or 2) a combination of tools (must screen for PTSD, anxiety, and depression), with each geared to a narrow range of symptoms and likely diagnoses. Screen children and adolescents with an age-appropriate structured or semi-structured assessment, integrated into the overall health assessment. In addition to behavioral health screeners already used as part of clinic workflow (e.g., PHQ-2, PHQ-9), clinicians may also want to consider refugee and/or conflict-affected specific screeners such as WE-Check Minnesota Wellness and Emotions Check, RHS-15, PC-PTSD-5, PCL-5, HSCL-25, and HTQ. For youth aged 14 and under, consider screeners such as SDQ (ages 2–17 years), PHQ-2 (ages ≥13 years), and PHQ-9 (ages ≥12 years). Screen for substance abuse and educate about possible legal consequences of these behaviors in the U.S. Make appropriate referrals if refugee is interested, and services are available. Possible tool: CAGE. For those in need of mental health support and assistance, develop an impairment-related action plan with associated management and/or referral.
Early childhood developmental screening[32]	Age-appropriate developmental screening may be initiated during the domestic medical screening or at a subsequent well-child visit, provided culturally, and linguistically appropriate care is not delayed.
Female genital mutilation/ cutting (FGM/C) screening[33]	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, especially to mothers with daughters, that this practice is considered child abuse and is illegal in the U.S.; and it is also illegal to take/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[34]	Recommend to: • all children 6–59 months of age, and • children (≥6 years) with clinical or laboratory evidence of poor nutrition, and • adults with clinical or laboratory evidence of poor nutrition.

[32] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/history-and-physical.html
[33] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/sexual-and-reproductive-health.html
[34] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/nutrition-and-growth.html

Physical Exam of Asymptomatic Refugees	
Activity	**Summary**
Malaria presumptive treatment and evaluation[35]	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[36]	Soil-transmitted helminth infections: • Most refugees receive overseas presumptive treatment (Albendazole) — no further screening/treatment recommended. • Asymptomatic refugees who did not receive presumptive treatment may be presumptively treated after arrival or screened if contraindications to presumptive treatment exist (2 or more separate stool ova and parasite samples collected 12-24 hours apart). Generally testing is not recommended in asymptomatic children under 6 months old as they are low risk. *Strongyloides*: • Most refugees receive overseas presumptive treatment (Ivermectin) — no further screening/treatment recommended. • 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. • 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. Alternatively, these refugees may be offered a *Strongyloides* serologic test. *Schistosoma*: • 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 treated after arrival or screened (*schistosoma* IgG serology) if contraindications to presumptive treatment exist.
Follow-up and Referrals	Provide health education, anticipatory guidance, treatment, and referrals as appropriate. All refugees should be referred to a primary care provider and a dental provider.

[35] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/malaria.html
[36] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/intestinal-parasites.html

Attachment C — **Laboratory Testing of Asymptomatic Refugees**

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

Laboratory Testing of Asymptomatic Refugees	
Activity	**Summary**
Hematology[37]	• CBC with RBC indices, WBC differential to include eosinophil counts, and platelet count. • ZPP/H (zinc protoporphyrin to heme ratio).
Pregnancy testing[38]	Urine pregnancy testing should be performed for all females of childbearing age and pubescent girls. It is especially important to test prior to administration of vaccines or medications which may present a risk. Recommend prenatal vitamins and referral if positive.
Hemoglobin electrophoresis[39]	Screen for hemoglobinopathies in individuals from high prevalence areas. Screening should include hemoglobin electrophoresis, particularly in individuals with anemia, red blood cell abnormalities, and/or morbidity suggestive of disease.
Blood Lead Level (BLL) testing[40]	For all refugee infants and children ≤16 years old and those >16 years old if there is a high index of suspicion, or clinical signs/symptoms of lead exposure. Repeat testing recommended for all refugee infants and children ≤6 years old within 3-6 months after initial testing, regardless of initial screening BLL result. Repeat testing is also recommended for refugee children and adolescents 7-16 years of age who had elevated BLL (EBLL) at initial screening. Repeat testing is also warranted in adolescents >16 years of age with specific risk factors (e.g., sibling with EBLL, environmental risk factors). Note the blood lead reference value is 3.5 micrograms per deciliter. Capillary screening results at or above 3.5 micrograms per deciliter should be confirmed with blood drawn by venipuncture. All pregnant or lactating women and adolescent girls should be assessed for lead exposure risk and tested if found to be at risk.
Thyroid screening[41]	For all infants and children <6 years of age. Thyroid-stimulating hormone (TSH) and free T4 should be used when screening for thyroid disease.
Infant metabolic screening[42]	For infants <1 year old, according to state guidelines.

[37] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/nutrition-and-growth.html and https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/laboratory-testing.html
[38] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/sexual-and-reproductive-health.html
[39] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/laboratory-testing.html
[40] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/lead.html and https://ehs.dph.ncdhhs.gov/hhccehb/cehu/lead/resources.htm
[41] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/laboratory-testing.html
[42] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/laboratory-testing.html and https://www.ncdhhs.gov/divisions/child-and-family-well-being/whole-child-health-section/genetics-and-newborn-screening

Laboratory Testing of Asymptomatic Refugees	
Activity	**Summary**
Hepatitis D testing[43]	Test or refer for testing for HDV infection for all HBsAg-positive new arrivals. The NC State Laboratory of Public Health (SLPH) does not offer this testing; however, the SLPH can facilitate this testing at CDC, as CDC can perform serology for total anti-body on both serum and plasma. The DHHS-3445 (Special Serology Form) and CDC 50.34 DASH Form should be completed and sent to the SLPH. Note: This testing may be more appropriate in a primary care setting.
Cancer preventive screening[44]	Refugees should receive preventive screening according to USPSTF Cancer Screening Guidelines. 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 the initial screening visit. In addition, behavioral risks can be addressed, such as avoiding the use of tobacco, alcohol, and other substances (e.g., khat, betel nut) that predispose toward cancer. Clinicians should maintain a heightened awareness of cancers related to infectious diseases and environmental exposures and adjust clinical practices accordingly.

[43] https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/viral-hepatitis.html and https://slph.dph.ncdhhs.gov/forms.asp

[44] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9209943/; https://www.uspreventiveservicestaskforce.org/uspstf/home and https://www.cdc.gov/immigrant-refugee-health/hcp/domestic-guidance/cancer-screening.html

FY26 - FAS federal award supplement

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

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

Assistance Listing Nbr + Name: **93.566** Refugee and Entrant Assistance State Administered Programs

Is award R&D?: no FAIN: **2401NCRCMA** IDC rate: n/a Fed awd total amt: $ 32,578,481

Fed award project description: GY2024 ORR Refugee Cash and Medical Assistance

Fed awd date + awarding agency: 09-09-24 HHS, Administration for Children and Families

Subrecipient	Subrecipient's UEI	Federal funds from grant listed above	Total federal funds for entire Activity	Subrecipient	Subrecipient's UEI	Federal funds from grant listed above	Total federal funds for entire Activity
Alamance	F5VHYUU13NC5	$ 44,910	$ 129,980	Jackson	X7YWWY6ZP574		
Albemarle	WAAVS51PNMK3			Johnston	SYGAGEFDHYR7		
Alexander	XVEEJSNY7UX9			Jones	HE3NNNUE27M7		
Anson	PK8UYTSNJCC3			Lee	F6A8UC99JWJ5		
Appalachian	CD7BFHB8W539			Lenoir	QKUFL37VPGH6		
Beaufort	RN1SXFD4LXN6			Lincoln	UGGQGSSKBGJ5		
Bladen	TLCTJWDJH1H9			Macon	LLPJBC6N2LL3		
Brunswick	MJBMXLN9NJT5			Madison	YQ96F8BJYTJ9		
Buncombe	W5TCDKMLHE69	$ 64,000	$ 186,750	MTW	ZKK5GNRNBBY6		
Burke	KVJHUFURQDM5			Mecklenburg	EZ15XL6BMM68	$ 87,000	$ 258,800
Cabarrus	RXDXNEJKJFU7			Montgomery	E78ZAJM3BFL3		
Caldwell	HL4FGNJNGE97			Moore	HFNSK95FS7Z8		
Carteret	UC6WJ2MQMJS8			Nash	NF58K566HQM7		
Caswell	JDJ7Y7CGYC86			New Hanover	F7TLT2GMEJE1	$ 29,000	$ 86,500
Catawba	GYUNA9W1NFM1			Northampton	CRA2KCAL8BA4		
Chatham	KE57QE2GV5F1			Onslow	EGE7NBXW5JS6		
Cherokee	DCEGK6HA11M5			Orange	GFFMCW9XDA53	$ 4,600	$ 10,600
Clay	HYKLQVNWLXK7			Pamlico	FT59QFEAU344		
Cleveland	UWMUYMPVL483			Pender	T11BE678U9P5		
Columbus	V1UAJ4L87WQ7			Person	FQ8LFJGMABJ4		
Craven	LTZ2U8LZQ214	$ 29,500	$ 91,500	Pitt	VZNPMCLFT5R6		
Cumberland	HALND8WJ3GW4	$ 4,000	$ 10,000	Polk	QZ6BZPGLX4Y9		
Dare	ELV6JGB11QK6			Randolph	T3BUM1CVS9N5		
Davidson	C9P5MDJC7KY7			Richmond	Q63FZNTJM3M4		
Davie	L8WBGLHZV239			Robeson	LKBEJQFLAAK5		
Duplin	KZN4GK5262K3			Rockingham	KGCCCHJJZZ43		
Durham	LJ5BA6U2HLM7	$ 96,600	$ 283,550	Rowan	GCB7UCV96NW6	$ 19,400	$ 57,200
Edgecombe	MAN4LX44AD17			Sampson	WRT9CSK1KJY5		
Foothills	NGTEF2MQ8LL4			Scotland	FNVTCUQGCHM5		
Forsyth	V6BGVQ67YPY5	$ 53,500	$ 152,300	Stanly	U86MZUYPL7C5		
Franklin	FFKTRQCNN143			Stokes	W41TRA3NUNS1		
Gaston	QKY9R8A8D5J6			Surry	FMWCTM24C9J8		
Graham	L8MAVKQJTYN7			Swain	TAE3M92L4QR4		
Granv-Vance	MGQJKK22EJB3			Toe River	JUA6GAUQ9UM1		
Greene	VCU5LD71N9U3			Transylvania	YLN4BFCJCP39		
Guilford	YBEQWGFJPMJ3	$ 107,000	$ 301,500	Union	LHMKBD4AGRJ5	$ 12,000	$ 20,000
Halifax	MRL8MYNJJ3Y5			Wake	FTJ2WJPLWMJ3	$ 95,000	$ 270,250
Harnett	JBDCD9V41BX7			Warren	TLNAU5CNHSU5		
Haywood	DQHZEVAV95G5			Wayne	DACFHCLQKMS1		
Henderson	TG5AR81JLFQ5			Wilkes	M14KKHY2NNR3		
Hoke	C1GWSADARX51			Wilson	ME2DJHMYWG55		
Hyde	T2RSYN36NN64			Yadkin	PLCDT7JFA8B1		
Iredell	XTNRLKJLA4S9			Yancey	L98MCUHKC2J8		

UEI = Unique Entity Identifier

DPH-Aid-To-Counties **For Fiscal Year: 25/26** **Budgetary Estimate Number : 0**

Activity 583 Service Period Payment Period		AA	133501 2B08100 20G0122001 06/01-09/30 07/01-10/31	Total Allocated	133501 2B08100 20G0122001 10/01-05/31 11/01-06/30	Total Allocated	133501 2B08110 20G0122001 06/01-09/30 07/01-10/31	Total Allocated	133501 2B08110 20G0122001 10/01-05/31 11/01-06/30	Total Allocated	133501 2B08120 20G0122001 06/01-09/30 07/01-10/31	Total Allocated	133501 2B08120 20G0122001 10/01-05/31 11/01-06/30	Total Allocated	Proposed Total	New Total
01 Alamance	*	0	42,910	$0.00	83,070	$0.00	2,000	$0.00	2,000	$0.00	0	$0.00	0	$0.00	129,980	129,980
D1 Albemarle			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
04 Anson			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
07 Beaufort			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
10 Brunswick			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
11 Buncombe	*	0	62,000	$0.00	120,750	$0.00	2,000	$0.00	2,000	$0.00	0	$0.00	0	$0.00	186,750	186,750
12 Burke			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
14 Caldwell			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
17 Caswell			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
19 Chatham			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
22 Clay			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
24 Columbus			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
25 Craven	*	0	27,500	$0.00	60,000	$0.00	2,000	$0.00	2,000	$0.00	0	$0.00	0	$0.00	91,500	91,500
26 Cumberland	*	0	2,000	$0.00	4,000	$0.00	2,000	$0.00	2,000	$0.00	0	$0.00	0	$0.00	10,000	10,000
28 Dare			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
30 Davie			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
32 Durham	*	0	92,600	$0.00	182,950	$0.00	4,000	$0.00	4,000	$0.00	0	$0.00	0	$0.00	283,550	283,550
33 Edgecombe			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
34 Forsyth	*	0	51,500	$0.00	96,800	$0.00	2,000	$0.00	2,000	$0.00	0	$0.00	0	$0.00	152,300	152,300
35 Franklin			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
38 Graham			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
40 Greene			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
41 Guilford	*	0	103,000	$0.00	190,500	$0.00	4,000	$0.00	4,000	$0.00	0	$0.00	0	$0.00	301,500	301,500
42 Halifax			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
44 Haywood			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
47 Hoke			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
49 Iredell			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
51 Johnston			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
53 Lee			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
55 Lincoln			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
57 Madison			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
60 Mecklenburg	*	0	78,000	$0.00	157,800	$0.00	4,000	$0.00	4,000	$0.00	5,000	$0.00	10,000	$0.00	258,800	258,800
62 Montgomery			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
64 Nash			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
65 New Hanover	*	0	27,000	$0.00	55,500	$0.00	2,000	$0.00	2,000	$0.00	0	$0.00	0	$0.00	86,500	86,500
66 Northampton			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
68 Orange	*	0	2,600	$0.00	4,000	$0.00	2,000	$0.00	2,000	$0.00	0	$0.00	0	$0.00	10,600	10,600
69 Pamlico			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
73 Person			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
75 Polk			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
77 Richmond			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
79 Rockingham			0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	$0.00	0	0
80 Rowan	*	0	17,400	$0.00	35,800	$0.00	2,000	$0.00	2,000	$0.00	0	$0.00	0	$0.00	57,200	57,200
82 Sampson			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0
84 Stanly			0	$0.00	0	$0.00	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	$0.00	0	$0.00	0	0

86 Surry			0	**$0.00**	0	**$0.00**	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	**$0.00**	0	**$0.00**	0	0
D6 Toe River			0	**$0.00**	0	**$0.00**	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	**$0.00**	0	**$0.00**	0	0
90 Union	*	**0**	10,000	**$0.00**	6,000	**$0.00**	2,000	**$0.00**	2,000	**$0.00**	0	**$0.00**	0	**$0.00**	20,000	20,000
92 Wake	*	**0**	91,000	**$0.00**	171,250	**$0.00**	4,000	**$0.00**	4,000	**$0.00**	0	**$0.00**	0	**$0.00**	270,250	270,250
93 Warren			0	**$0.00**	0	**$0.00**	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	**$0.00**	0	**$0.00**	0	0
97 Wilkes			0	**$0.00**	0	**$0.00**	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	**$0.00**	0	**$0.00**	0	0
99 Yadkin			0	**$0.00**	0	**$0.00**	0	**$0.00**	0	**$0.00**	0	**$0.00**	0	**$0.00**	0	0
00 Yancey			0	**$0.00**	0	**$0.00**	0	**$0.00**	0	**$0.00**	0	**$0.00**	0	**$0.00**	0	0
Totals			607,510	0	1,168,420	0	34,000	0	34,000	0	5,000	0	10,000	0	1,858,930	1,858,930

Sign and Date - DPH Program Administrator Christopher M. Kippes 12/05/24	Sign and Date - DPH Section Chief Mac Kemer 12/05/24
Sign and Date - DPH Budget Office – ATC Coordinator Sarah Griffin 12/5/2024	Sign and Date - DPH Budget Office S. Nosdil 12/6/2024

NT 12/6/24