

SCOPE OF WORK

Name of Contractor (Person/Agency Rendering Service): _____

Address: _____

Email: _____ Phone: _____

The following section must be completed by Contractor:

1. Is the Contractor currently employed at CCCS, CCCOnline, or at any of CCCS's community colleges? _____ Yes _____ No
 - a. If yes, where? _____
Note: A MOU must be completed if contractor employed at any of the State Community Colleges and payment will be made by the appropriate college through the CCCS payroll system. If employed at CCCS, MOU not required.

2. Is the Contractor a PERA retiree? _____ Yes _____ No
 - b. If yes, is the Contractor either a sole proprietor/individual or employed by a business entity that is owned or operated by a PERA retiree? _____ Yes _____ No
Note: If yes to b, purchase requisition must include a completed, original Retiree Working for a PERA Employer form. Once work begins, each individual invoice submission must include a Disclosure of Compensation form.

The contractor is required to produce in a satisfactory manner the following:

As full payment for services rendered, the contractor shall be paid:

Payment request should be submitted by monthly invoice to:

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Proposed Travel Expenses must be approved by the Fiscal/Purchasing Department before the Scope of Work (SOW) is signed by the CCCS Department Director. Reimbursement for travel expenses, if approved, must be consistent with applicable IRS and Colorado State Travel and Fiscal Rules and must receive prior approval by the System Designee.

(Any approved mileage will be reimbursed at the current state rate of _____ and is subject to change to match the prevailing state rate at time of invoicing. Any other approved travel expenses will be reimbursed upon submission of an invoice including original itemized receipts, not to exceed the established Colorado State per diem rates in effect at the time of invoicing.)

Expenses that will be considered for reimbursement:

Fiscal Approval: _____

Contractor Name (Print): _____

S# or Tax ID or last 4 digits of SSN: _____

Signature: _____ Date: _____

Department Director Name (Print): _____

Signature: _____ Date: _____