Participant- Agency / Community Support Worker Employment Agreement

This agreement is hereby made between ____________________________, a participant of the Self-Directed Community Supports (SDCS) Option, a Medicaid option administered by the Department of Health and Welfare (the department), and ________________________________, an agency.

It is mandatory to identify specific community support workers (CSW) who will be supplying services under this agreement.

The names of the individuals who will provide community support services under this agreement are:

____

____

The participant wants to hire the agency to provide a CSW for services under the SDCS Option. In exchange, the agency will bill for and provide payment to the CSW for services provided to the participant. Both parties understand and agree that payment is made through a fiscal employer agent (FEA), using Medicaid monies and based on time sheets submitted by the CSW and approved by the participant.

The CSW will remain an employee of the agency and the agency agrees to provide services that might otherwise be the responsibility of the participant, as detailed in the “Additional Terms” section. To these mutual purposes, the parties promise and agree as follows:

1. The CSW services are to be provided in accordance with the participant’s SDCS Option Support and Spending Plan, and the SDCS Option rules, outlined in *IDAPA 16.03.13*, “Consumer-Directed Services.”
2. The CSW remains the employee of the agency but will provide services as directed, controlled, and approved by the participant.
3. The CSW is hired to help the participant and assumes no legal liability for the participant’s conduct.
4. The agency will ensure that the CSW meets the minimum qualifications to be a CSW, as outlined in Section 136 of *IDAPA 16.03.13*, “Consumer-Directed Services.”
5. The CSW is an employee of the agency and is not an employee of the SDCS Option or the FEA, and agree that the CSW is not entitled to nor will make claim for any employee benefits from the SDCS Option or the FEA, including but not limited to worker’s compensation, disability, life insurance, or health insurance.

6. The agency will notify the participant immediately in the event the CSW is unable to provide the agreed services due to sickness, injury, or personal emergency. The CSW must obtain the participant's written approval in advance for any pre-planned absence.
7. Unless the participant specifies otherwise in the “Additional Terms” section of this agreement, the agency will train the CSW on the duties and responsibilities of a CSW.
8. The agency will be responsible for ensuring the accuracy of CSW’s time records.
9. The agency will train the CSW and require the CSW to provide services in a safe, courteous, and professional manner. The agency acknowledges that any physical, sexual, or mental abuse or neglect of the participant by the CSW will result in the immediate termination of this agreement and a report being made according to the requirements in Section 39-5303, *Idaho Code*.
10. The agency will train the CSW and require the CSW to report any observed physical, sexual, or mental abuse, and any exploitation or neglect of the participant to adult protection authorities immediately.
11. The agency cannot provide or bill for services until:
    - An authorized “Support and Spending Plan” has been submitted to the FEA.
    - The CSW has either cleared the criminal history background check or has a waiver signed by the participant.
12. The agency will not be paid for services until:
    - A time sheet has been submitted to and signed by the participant.
    - An invoice that correlates to the CSW’s time sheet has been supplied by the agency and signed by the participant.
    - The invoice has been submitted to the FEA.
13. Medicaid funding can only pay for services that are provided. Under the SDCS option, Medicaid will not reimburse the agency or the CSW for any vacation time, holiday time, overtime, or sick time. Medicaid will not pay wages at an hourly amount in excess of this agreement.

    The agency will ensure that any CSW who performs paid work in excess of 40 hours a week or works for less than minimum wage has met the criteria for exemption from the requirements for overtime and minimum wage, according to the Fair Labor Standards Act and the Idaho Department of Commerce and Labor.

The agency will provide the following services to the participant:

COLUMN A	B	C		D		E
Service Needed	**Type of Support** ☑ only one box	**Number of hours/ year OR Number of miles/year**		**Wage per hour Or Rate per mile**		**Annual Cost**
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement		x		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **Code for second rate of pay/hour** _______ **Fill in code**		x		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **Code for second rate of pay/hour** ______ **Fill in code** ☐ **Code for third rate of pay/hour** ______ **Fill in code**		x		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **Code for second rate of pay/hour** ______ **Fill in code** ☐ **Code for third rate of pay/hour** _______ **Fill in code**		x		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **Code for second rate of pay/hour** ______ **Fill in code** ☐ **Code for third rate of pay/hour** ______ **Fill in code**		x		=	$ Sub-Total
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS ☐ Transportation Mileage Reimbursement ☐ **Code for second rate of pay/hour** ______ **Fill in code** ☐ **Code for third rate of pay/hour** ______ **Fill in code**		x		=	$ Sub-Total
	Total Cost of Agreement:					$

The CSW must meet the following specific qualifications in order to provide the above services including attaching a copy of the certification/licensure, if applicable, as outlined in subsections 120.05 and 150.01:

____

____

____

15. Additional terms of this agreement are as follows:

____

____

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The provisions of this agreement represent the entirety of the agreement between the parties. It can be amended only in writing with both parties consenting by their signatures. It is mutually understood that this is employment at will. Either party can terminate the employment relationship without cause with two weeks notice. This agreement can be terminated at any time by the participant due to unsatisfactory worker or contractor performance.

____
Participant Date

____
Legal Guardian (if applicable) Date

____
Agency if Applicable Date

Criminal History Check
Waiver of Liability - Assumption of Risk

Participant Name: _______________________________**MID #** ______________ **Date:** _______________

Waiver: I do not want (name of community support worker) ________________________ to be subject to Criminal History Check requirements.

Relationship to the Participant: ____

Description of Service: ____

Reason:

____

____

____

I Will Make Sure I am Healthy and Safe by: ____

____

Release of Liability means that I am giving up my right to sue the Department of Health and Welfare or make them pay for any costs associated with things such damages, liabilities, and attorney fees that happen because of my choice.

Assumption of Risk means that I understand that there things such as personal injury, property loss, abuse, neglect and exploitation that could happen in my life as a result of my choice even if I try to prevent them from happening.

I have read the definitions above and have talked to my Support Broker and/or Circle of Support and I understand the risks of what could happen if I decide not to make the provider of my Self-Directed services have a Criminal History Check. I agree that my choice is voluntary and that I knowingly assume all such risks.

_______________________________________ _______________________________________

Signature of Individual Date Signature of Legal Guardian (if applicable) Date

I have provided education and counseling to _____________________________ **regarding the risks of waiving a criminal history check for this individual.**

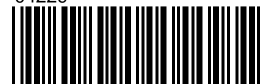
Comments:

____

____

Signature of Support Broker Date

IDHW SDCS CSW Agreement Revised 02/2014



IDAHO DEPARTMENT OF HEALTH & WELFARE

Criminal History Check
Waiver of Liability - Assumption of Risk – Failed Criminal History Check

Participant Name: ______________________________ **MID #** ______________ **Date:** ______________

Waiver: I choose to hire (name of community support worker) ________________________ as my community support worker. I understand that they have failed the criminal history check per requirements at IDAPA 15.05.06, "Rules Governing Mandatory Criminal History Checks".

Relationship to the Participant: ____

Description of Service: ____

Reason: ____

____

____

I Will Make Sure I am Healthy and Safe by: ____

____

____

Release of Liability means that I am giving up my right to sue the Department of Health and Welfare or make them pay for any costs associated with things such damages, liabilities, and attorney fees that happen because of my choice.

Assumption of Risk means that I understand that there things such as personal injury, property loss, abuse, neglect and exploitation that could happen in my life as a result of my choice even if I try to prevent them from happening.

I have read the definitions above and have talked to my Support Broker and/or Circle of Support and I understand the risks of what could happen if I decide to hire a provider of my Self-Directed services who has a criminal history that would be precluded from providing services in the Idaho Medicaid program. I agree that my choice is voluntary and that I knowingly assume all such risks.

______________________________________ ______________________________________

Signature of Individual Date Signature of Legal Guardian (if applicable) Date

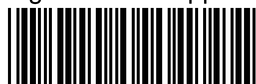
I have provided education and counseling to ______________________________ **regarding the risks of waiving a criminal history check for this individual.**

Comments:

____

____

Signature of Support Broker Date



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