IDAHO DEPARTMENT OF
HEALTH & WELFARE

PARTICIPANT- INDEPENDENT CONTRACTOR

WORK 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 (Department), æ} å

____ , an independent contractor, hereafter referred to as 'Contractor.'

The Participant desires to engage Contractor to provide services under the SDCS Option. In exchange, Contractor will bill 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 invoices submitted by Contractor and approved by the Participant. To these mutual purposes, the parties promise and agree as follows:

1. Contractor 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. It is mutually understood that Contractor is an independent worker and not the employee of the participant and as such, is responsible for filing tax information with the Internal Revenue Service.

3. Contractor will provide services as directed, controlled and approved by the participant.

4. Contractor is hired to assist the Participant and assumes no legal liability for the Participant's conduct.

5. Contractor ensures that he/she meets the minimum qualifications to be a support worker, as outlined in Section 136 of IDAPA 16.03.13, "Consumer-Directed Services."

6. The parties mutually agree that Contractor is not an employee of the SDCS Option or the Fiscal/Employer Agent, and agree that Contractor is not entitled to nor will make claim for any employee benefits from the SDCS Option or the Fiscal Employer Agent, including but not limited to, worker's compensation, disability, life or health insurance.

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7. Contractor agrees to notify the Participant immediately in the event the he/she is unable to provide the agreed services due to sickness, injury or personal emergency.

8. Contractor agrees to provide services in a safe, courteous and professional manner. Any physical, sexual or mental abuse or neglect of the Participant by the contractor will result in the immediate termination of this Agreement and a report being made according to the requirements in Section 39-5303, Idaho Code.

9. Contractor agrees to report any observed physical, sexual or mental abuse, exploitation or neglect of Participant to Adult Protection Services authorities immediately.

10. Contractor understands and agrees that he/she cannot provide or bill for services until:

a.) An authorized Support and Spending Plan has been submitted to the FEA.
b.) Contractor has either cleared the criminal history background check or has had a Waiver signed by the Participant.

11. Contractor understands he/she will not be paid for services until:

a.) An invoice has been submitted to and signed by the participant.

b.) The invoice has been submitted to the FEA.

c.) The Participant's Support and Spending Plan authorizes the service that Contractor has completed.

12. It is mutually understood that Medicaid funding can only pay for services rendered. Under the SDCS option, Medicaid will not reimburse Contractor for any vacation time, holiday time, overtime or sick time. Medicaid will not pay wages at an amount in excess of this agreement.

Contractor will provide the following service(s) to the Participant:

Service needed	**Type of Support** ☑ only one box	Frequency How often or how many hours:		Duration: How long a period of time will the service be offered:		Annual Cost
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS		x		=	$ Sub-Total
Service needed	**Type of Support** ☑ only one box					Annual Cost
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS		x		=	$

	☐ Learning LSS					Sub-Total
Service needed	Type of Support ☑ only one box					Annual Cost
	☐ Personal PSS ☐ Emotional ESS ☐ Job JSS ☐ Skilled Nursing SNS ☐ Transportation TSS ☐ Relationship RSS ☐ Learning LSS		x		=	$ Sub-Total
	TOTAL COST OF AGREEMENT				=	$ TOTAL

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

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Additional terms of this agreement are as follows:

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Unless the Criminal History Background Check is Waived, the Community Support Worker or Contractor has applied for a Criminal History Background Check through the Department of Health and Welfare. **The Employer Identification Number for the Criminal History Background Check is 1710. Use this number when applying for the background check. This number allows the Department of Health and Welfare, Division of Medicaid, and its contracting fiscal intermediary to access results of the background check.**

Contractor gives permission to the Department of Health and Welfare, Division of Medicaid, to notify the Participant (Employer) of the results of the Criminal History Background Check.

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Signature.

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☐ I am waiving the Criminal History Check requirement. I have completed the attached Waiver of Liability form. I understand that even if CHC is waived Contractor cannot receive Medicaid dollars if he is on a federal or state Medicaid exclusion list.

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

PARTICIPANT Date

LEGAL GUARDIAN (IF APPLICABLE) Date

INDEPENDENT CONTACTOR Date

IDAHO DEPARTMENT OF
HEALTH & WELFARE

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:

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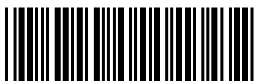
Signature of Support Broker Date



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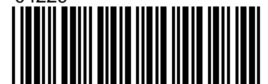

Criminal History Check
Waiver of Liability - Assumption of Risk – Failed Criminal History Check

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: ____

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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