



IDAHO DEPARTMENT OF
HEALTH & WELFARE

**PARTICIPANT-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 (Department), and _____,
a Community Support Worker (CSW).

Participant's Name

CSW's Name

The Participant desires to engage CSW for services under the SDCS Option. In exchange, the CSW desires to be paid 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.

To these mutual purposes, the parties promise and agree as follows:

1. CSW services are to be provided in accordance with the Participant's SDCS Support and Spending Plan, and the SDCS rules, outlined in IDAPA 16.03.13, "Consumer-Directed Services."
2. It is mutually understood that CSW is the employee of the Participant, and that the Participant directs, controls and approves the CSW's work.
3. The CSW is hired to assist the Participant and assumes no legal liability for the Participant's conduct.
4. The CSW promises that he/she meets the following minimum qualifications to be a CSW, as outlined in Section 136 of IDAPA 16.03.13, "Consumer-Directed Services."
5. The parties mutually agree that CSW is an employee of the Participant and is not an employee of the SDCS Option or the Fiscal Employer Agent (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 or health insurance.
6. The CSW agrees to notify the Participant immediately in the event he/she 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. The Participant shall train the CSW on the duties and responsibilities of the CSW and shall be responsible for approving the accuracy of CSW's time records.



8. The CSW agrees to provide services in a safe, courteous and professional manner. The CSW 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.

9. The CSW agrees to report any observed physical, sexual or mental abuse, exploitation or neglect of Participant to adult protection authorities immediately.

10. The CSW understands and agrees that they cannot provide or bill for services until:

- an authorized Support and Spending Plan has been submitted to the FEA,
- the signed Employment Agreement has been submitted to the FEA
- the signed Medicaid-CSW Agreement has been submitted to the FEA

11. The CSW understands and agrees that no payment for services will be made until both the CSW and the Participant have signed the appropriate time sheets, acknowledging their accuracy, and have submitted them to the FEA.

12. It is mutually understood that Medicaid funding can only pay for services rendered. Under the Self Direction Waiver option, the CSW will not receive payment for any vacation time, holiday time, overtime or sick time. Medicaid will not pay wages at an hourly amount in excess of this agreement.

Please check this box if the employer is requiring the Community Support Worker to specifically document activities that support billable time in writing in a manner agreed upon between the employer and the Community Support Worker.

More than forty (40) hours per week of paid work are allowed only if the CSW meets the criteria for employees that are exempted from overtime pay and minimum wage requirements as per the Fair Labor Standards Act.

The participant must obtain and follow guidance from the Idaho Department of Labor and Commerce to determine if the CSW is exempt from these requirements. It is the responsibility of the participant to ensure that the CSW is exempt if the participant requires the CSW to work more than forty (40) hours per week.

The CSW will be paid only for the specific services authorized as per the Support and Spending Plan.

The signing of this Employment Agreement by the participant and the CSW signifies that the parties acknowledge that the criteria for exemption from overtime and minimum wage requirements will be met prior to scheduling work hours in excess of forty (40) hours per week or agreeing to wages less than minimum wage standards.



13. Terms and conditions of work. **Effective Date:** _____.

COLUMN A Service needed	B Type of Support <input checked="" type="checkbox"/> only one box per row	C Number of hours per year OR Number of miles/year	D Wage per hour OR Wage per mile		E Annual Cost
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR)			x	= \$
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code			x	= \$ Sub-Total
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code			x	= \$ Sub-Total
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code			x	= \$ Sub-Total
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code			x	= \$ Sub-Total
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Job JSS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Transportation TSS (hourly) <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Transportation Mileage Reimbursement (MR) <input type="checkbox"/> Code for second rate of pay/hour _____ Fill in code <input type="checkbox"/> Code for third rate of pay/hour _____ Fill in code			x	= \$ Sub-Total
Total Cost of Agreement:					\$

04888



14. The CSW must meet the following specific qualifications in order to provide the following services including attaching copy of certification/licensure, if applicable, as outlined in IDAPA 16.03.13 Subsections 120.05 and 110.03:

Age Criteria for CSWs:

- CSWs 17 years of age and older may provide supervision, direct services or chore type services
- CSWs under 17 years of age may provide chore type services

I am under 17 and the support I provide aligns with the Department's guidance.

15. The CSW agrees to take all actions necessary to become Participant's employee, and to maintain the employment relationship by submitting necessary documents to the FEA, including:

- Completion of W-4, I-9 and other IRS required forms
- A copy of this agreement
- Time sheets approved by Participant recording hours worked.
- A completed criminal history check, including clearance in accordance with IDAPA 16.05.06, "Rules Governing Mandatory Criminal History Checks"
 - Unless the Criminal History Background Check is Waived, the CSW has applied for a Criminal History Background Check through the Department of Health and Welfare. **The CSW will list the Department as the agency/employer, using identification number WLQUFX.**

The CSW gives permission to the fiscal employer agent to notify the Participant (Employer) of the results of the Criminal History Background Check. _____

CSW Signature

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 the CSW cannot receive Medicaid dollars if he is on a federal or state Medicaid exclusion list. _____

Participant or Legal Guardian Signature

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 CSW performance.

PARTICIPANT

Date

LEGAL GUARDIAN (IF APPLICABLE)

Date

CSW

Date

04889





EMPLOYEE-EMPLOYER RELATIONSHIP DETERMINATION

(Determine if employee is exempt from some payroll taxes)

Employee Name	Participant (Employer of Record) Name

Background: Employees providing domestic services may be exempt from some payroll taxes. This is based on the Employee’s age and relationship to the Employer of Record (Employer). Consumer Direct Care Network (CDCN) will apply any exemptions based on the relationships identified below. **Incorrectly filling this form out may result in inaccurate tax withholdings.**

Note: If the Employee and Employer qualify for tax exemptions, they must be taken. Exemptions cannot be waived. If the Employee’s earnings are exempt from these taxes, they may not qualify for related benefits. An example is unemployment insurance.

Employee-Employer Relationship

Employee select one relationship below.

<input type="checkbox"/> I am the spouse of the Employer. <i>Not allowed to be an employee by Idaho Medicaid rules.</i>
<input type="checkbox"/> I am the parent of the Employer (including adoptive and stepparent). If parent checked, check <u>any</u> of the following that apply: <ul style="list-style-type: none"> <input type="checkbox"/> I provide care for the Employer’s child or stepchild that lives in the home. <input type="checkbox"/> The Employer’s child or stepchild is less than 18 years old or requires personal care of an adult for at least 4 straight weeks in 3 months. <input type="checkbox"/> The Employer is a widow, widower, divorced or married and lives with a spouse, but the spouse has a physical or medical condition that prevents them from caring for the child at least 4 straight weeks in 3 months. <i>Exempt from FUTA¹ and SUTA². Subject to FICA³ if all three boxes checked above; else FICA exempt.</i>
<input type="checkbox"/> I am the child of the Employer. If child checked, check <u>one</u> option below: <ul style="list-style-type: none"> <input type="checkbox"/> I am 21 years of age or older. <i>Subject to FICA, FUTA, and SUTA.</i> <input type="checkbox"/> I am less than 21 years old. <i>Exempt from FICA, FUTA, and SUTA.</i>
<input type="checkbox"/> I am not related to the Employer or my relationship is not described above. <i>Subject to FICA, FUTA, and SUTA.</i>

Acknowledgement: The Employee and Employer agree the relationship selected above is accurate. If this information changes, the Employee must notify CDCN. If CDCN is not notified of changes, the Employee may have to pay back money that should have been withheld from pay.

Employee Signature	Date	Participant or Legal G. Signature	Date
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¹FUTA – Federal Unemployment Tax Act
²SUTA – State Unemployment
³FICA – Federal Insurance Contributions Act (Social Security and Medicare)