



IDAHO DEPARTMENT OF
HEALTH & WELFARE

**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 (Department),

and _____, an agency.

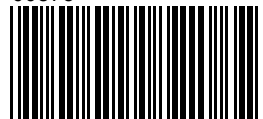
It is mandatory to identify specific Community Support Worker(s) who will be supplying services under this agreement.

The names of the individual(s) who will provide Community Support services under this agreement are:

The Participant desires to engage the agency to provide Community Support Worker(s) (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.

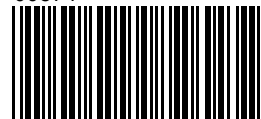
The CSW will remain employee(s) of the agency and the agency agrees to provide services which might otherwise be the responsibility of the Participant, as detailed in the "Additional Terms" section. To these mutual purposes, the parties promise and agree as follows:

1. 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. It is mutually understood that 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 assist 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 parties mutually agree that CSW is an employee of the agency and is not an employee of the SDCS Option or the Fiscal/Employer Agent, and agree that the CSW 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.
6. The agency agrees to 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 shall train the CSW on the duties and responsibilities of the CSW.
8. The agency shall be responsible for ensuring the accuracy of CSW's time records.
9. The agency agrees to train 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 agrees to train and require the CSW to report any observed physical, sexual or mental abuse, exploitation or neglect of Participant to adult protection authorities immediately.
11. The agency understands and agrees that they cannot provide or bill for services until:
 - a.) An authorized Support and Spending Plan has been submitted to the FEA.
 - b.) The Community Support Workers have either cleared the criminal history background check or have Waivers signed by the Participant.
12. The agency understands they will not be paid for services until:
 - a.) A time sheet has been submitted to and signed by the participant.
 - b.) An invoice which correlates to the CSW's time sheet has been supplied by the agency and signed by the participant.
 - c.) The invoice has been submitted to the FEA.
13. It is mutually understood that Medicaid funding can only pay for services rendered. 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 forty (40) hours per week or works for less than minimum wage has met the criteria for exemption from the requirements for overtime and minimum wage, as per 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 <input checked="" type="checkbox"/> only one box	Number of hours/year OR Number of Miles/year	Wage per hour Or Rate per Mile	Annual Cost
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Job JSS <input type="checkbox"/> Transportation TSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Transportation Mileage Reimbursement		x	= \$ Sub-Total
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Job JSS <input type="checkbox"/> Transportation TSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Code for second rate of pay/hour <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Transportation Mileage Reimbursement _____ Fill in code		x	= \$ Sub-Total
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Job JSS <input type="checkbox"/> Transportation TSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Code for second rate of pay/hour <input type="checkbox"/> Code for third rate of pay/hour <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Transportation Mileage Reimbursement _____ Fill in code _____ Fill in code		x	= \$ Sub-Total
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Job JSS <input type="checkbox"/> Transportation TSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Code for second rate of pay/hour <input type="checkbox"/> Code for third rate of pay/hour <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Transportation Mileage Reimbursement _____ Fill in code _____ Fill in code		x	= \$ Sub-Total
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Job JSS <input type="checkbox"/> Transportation TSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Code for second rate of pay/hour <input type="checkbox"/> Code for third rate of pay/hour <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Transportation Mileage Reimbursement _____ Fill in code _____ Fill in code		x	= \$ Sub-Total
	<input type="checkbox"/> Personal PSS <input type="checkbox"/> Job JSS <input type="checkbox"/> Transportation TSS <input type="checkbox"/> Learning LSS <input type="checkbox"/> Code for second rate of pay/hour <input type="checkbox"/> Code for third rate of pay/hour <input type="checkbox"/> Emotional ESS <input type="checkbox"/> Skilled Nursing SNS <input type="checkbox"/> Relationship RSS <input type="checkbox"/> Transportation Mileage Reimbursement _____ Fill in code _____ Fill in code		x	= \$ Sub-Total
	Total Cost of Agreement:			= \$



14. The CSW 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:

15. Additional terms of this agreement are as follows:

Unless the Criminal History Background Check is Waived, the Community Support Worker has applied for a Criminal History Background Check through the Department of Health and Welfare. The employer/agency identification number to use on the application for the criminal history check is: 1710. The process to apply for a criminal history background check is found on the Idaho state website: <https://chu.dhw.idaho.gov/>

Alternately – If the CSW has had a criminal history background check in the past three years, the CSW can apply for an IDAHO STATE NAME CHECK through the IDAHO STATE POLICE. Information on this is also found on the criminal history web site.

The CSW 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.

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.

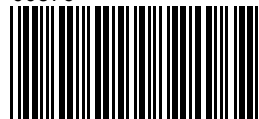
The provisions of this agreement represent the entirety of the agreement between the parties. It may be amended only in writing with both parties consenting by their signatures. It is mutually understood that this is employment at will. Either party may terminate the employment relationship without cause 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

AGENCY IF APPLICABLE Date

00876





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)

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



