Agency With Choice Financial Management Services

MANAGING EMPLOYER/SURROGATE AGREEMENT FORM

*I understand that "Participant Direction" means that the individual or their surrogate has the ability to exercise decision-making authority over some or all of the individual's supports and services authorized in the Person-Centered Individual Support Plan (ISP). The individual participant or surrogate elects and accepts the responsibility for self-directing or managing those supports and services and is, therefore, recognized as the "**Managing Employer**."*

Name of Participant *(please print)* _____
(Participant Name)

Address: _____
(Number) *(Street)* *(Unit/Apt)*

_____
(City) *(State)* *(Zip Code)*

Cell phone: ( ) _____ Home phone: ( ) _____

Email: _____

Will the participant have a surrogate acting as the Managing Employer? Yes No
(circle one)

If yes:

Managing Employer/Surrogate name _____
(Managing Employer/Surrogate Name)

Address: _____
(Number) *(Street)* *(Unit/Apt)*

_____
(City) *(State)* *(Zip Code)*

Cell phone: ( ) _____ Home phone: ( ) _____

Email: _____

Requirements:

Managing Employers and surrogates are responsible for working collaboratively to ensure:

- Individuals receive high quality services.
- Individuals receive needed support services from qualified workers.
- Services are provided in accordance with the guiding principles of self-determination, state and federally funded program requirements and in accordance with the approved and authorized ISP.

I recognize that my involvement in this program as a Managing Employer/Surrogate is contingent upon the participant's enrollment in the Participant Direction Services Program (PDS). If the participant is no longer in the Waiver or the PDS Program, my involvement under this agreement will end. I further acknowledge I have received and understand the orientation, training, and written information provided to me regarding the use of self-directed support services under the Medicaid Waiver. I understand my role as a "Managing Employer" of qualified Support Service Workers (SSWs) and how to work with the identified Agency With Choice Financial Management Service (AWC FMS) provider. I understand that the AWC FMS will make payments for the services that are rendered in accordance with the approved and authorized ISP.

You must meet the following requirements to become a Managing Employer:

- Be at least 18 years of age or older.
- Must not have been convicted of a felony or a crime that would disqualify you from becoming the Managing Employer. A list of the disqualifying crimes can be requested by contacting the Agency With Choice Financial Management Service organization.
- Participate in all required training sponsored by the Office of Developmental Programs and the AWC FMS.
- Sign any and all agreements with the Office of Developmental Programs and the AWC FMS related to the AWC FMS option.
- Agree to perform all the tasks outlined in Section A of Bulletin 00-08-08.
- Agree to work with the Supports Coordinator (SC) to develop and revise the individual's ISP as needed and required and participate in the required ISP monitoring.

Responsibilities:

The Managing Employer of the qualified Support Service Workers is responsible to:

1. Determine whether the individual, surrogate or both will have signature authority and serve as the Managing Employer of qualified Support Service Workers.
2. Recruit and refer qualified Support Service Workers to the AWC FMS provider for hire and assignment back to the individual. In cooperation with the AWC FMS provider, a copy of the Documentation of Support Service Worker (SSW) Qualification Form (DP 1008) must be completed and verified prior to the Support Service Worker rendering service. This form is located in the Pennsylvania Guide to Participant-Directed Services and should be completed on each Support Service Worker by the individual or surrogate and the AWC FMS. The original signed copy will be maintained in the file at the AWC FMS office and a copy will be given to the individual or surrogate.
3. Negotiate wage and benefit allowances for Support Service Workers within the established wage range.
4. Recruit qualified vendors, small unlicensed providers[1] and individuals or providers to render transportation (mile)[2] services in accordance with the approved and authorized ISP.
5. Provide or participate in the provision of qualified Support Service Worker orientation and training.
6. Determine the work schedule of his or her Support Service Workers up to a maximum of 40 hours per week, based upon the approved and authorized ISP.
7. Determine tasks to be performed by qualified Support Service Workers and where and when they are to be performed in accordance with the approved and authorized ISP.

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1 For the purposes of this bulletin, a small provider is defined as: an individual or agency that provides unlicensed services to a maximum of four individuals statewide.

2 This transportation service is provided by providers, family members and other licensed drivers for using vehicles to transport the person to services, resources and activities specified in the person's ISP. The unit of service is one mile. The mileage reimbursement rate may not exceed the current reimbursement rate established for commonwealth employees for such purposes.

8. Manage the day-to-day activities of qualified Support Service Workers.
9. Verify time worked by qualified Support Service Workers and approve and sign timesheets.
10. Approve and assure submission of Support Service Worker timesheets, and all other invoices, to the AWC FMS provider for processing in accordance with the AWC FMS annual payment cycle and Department of Labor & Industry standards. ISPs are developed and updated to ensure authorized services and supports are reflective of an individual's current, assessed needs. Therefore, if a timesheet or invoice is submitted to the AWC FMS provider by the individual or their surrogate that includes services or supports not authorized for the person or that includes units and costs in excess of those authorized for the individual, the individual or their surrogate will be responsible for reimbursing the AWC FMS provider for the costs required to cover the excess amount(s) related to payment of the Support Service Workers. Invoices related to units and costs in excess of the authorized ISP when the entity (provider or vendor) providing the service is not an employee of the AWC FMS provider will be paid directly to the entity by the Managing Employer. In these situations, the Managing Employer must pay the AWC FMS provider or the appropriate entity for any excess amount(s) through the use of their own personal funds or other non-ODP funds.
11. Report work-related injuries incurred by qualified Support Service Workers to the AWC FMS.
12. Complete an individual or surrogate satisfaction survey within 90 calendar days after first receiving Financial Management Services and annually thereafter. This survey will be distributed by the AWC FMS provider.
13. Receive initial Managing Employer skills training and additional skills training, as needed and requested, from the AWC FMS provider to perform as the Managing Employer of qualified Support Service Workers.[3]
14. Develop an emergency worker back-up plan in case a substitute Support Service Worker is ever needed on short notice or as a back-up (short-term replacement worker). Back-up Support Service Workers must meet all of the qualification criteria applicable to regular qualified Support Service Workers.
15. Ensure all outcomes for Waiver services are documented by Support Service Workers or the Managing Employer as required in Bulletin 00-07-01, "*Provider Billing Documentation Requirements for Waiver Services.*" Although this bulletin refers to providers or organizations, the requirements outlined in this bulletin also apply to Waiver services rendered by Support Service Workers providing Waiver services through an AWC FMS provider. ODP recommends the same documentation requirement for outcomes and progress for base-funded individuals.
16. Evaluate whether qualified Support Service Workers can perform necessary job functions as described in the person's approved and authorized ISP.
17. Ensure that the individual's outcomes are being addressed by qualified Support Service Workers.
18. Inform the AWC FMS provider of any changes in the status of qualified Support Service Workers, such as hours worked and change of address or telephone number, if known.
19. Inform the AWC FMS provider that the individual wishes to dismiss the worker from working for him or her prior to the individual or surrogate dismissing the worker.
20. Inform the AWC FMS provider of any changes in the status of the Managing Employer or surrogate, such as the individual's or surrogate's address, telephone number or if the individual is hospitalized.
21. Inform the AWC FMS provider of satisfaction or concerns regarding the administrative services received from the AWC FMS provider. Examples of administrative services include orientation and Managing Employer training Support Services Worker training, processing of potential workers for hire, timely payment of Support Service Workers.
22. Track utilization of services and budget by reviewing standard reports provided by the AWC FMS provider to ensure services are rendered in accordance with the authorized ISP.
23. Participate in the required ISP monitoring visits with the individual's Supports Coordinator.
24. Sign all Office of Developmental Programs' standard agreements and forms with the AWC FMS provider and the Office of Developmental Programs.
25. I understand that if I am no longer able to act as the Managing Employer, I may be assisted to select a surrogate or another model of service management and that I will fully cooperate with any transition plan so the needs in the ISP continue to be met.
26. I hereby acknowledge that I have received, read, and understand the following information:
    - ODP and Participant Direction program policies and procedures
    - Individual Support Plan (ISP)
27. I understand and acknowledge that any untruthful submission of services provided in an attempt to obtain improper payment is subject to investigation as Medical Assistance Fraud. Medical Assistance Fraud is a felony and can lead to substantial penalties and/or imprisonment.

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3 Managing Employer training must include instructions in the proper completion of required forms and progress notes.

I, _____, have received and understand the orientation, training, and written information provided to me related to using self-directed support services under the Medicaid Waiver, my role as a Managing Employer of qualified Support Service Workers (SSWs), and how to work with the Agency With Choice Financial Management Service (AWC FMS) organization.

(Name of Managing Employer or Surrogate)

I understand I have the right to choose, refer to the AWC FMS for hire, and once hired, direct my qualified Support Services Workers, be their Managing Employer, and perform the tasks as described on Pages 2 – 3 under ***Responsibilities****.*

I understand and agree with my role and responsibilities as the Managing Employer of my qualified Support Service Workers and that of the AWC FMS organization I will use.

I understand that my support services must be provided in accordance with my approved and authorized Individual Support Plan (ISP). I understand that if I allow services to be rendered in excess of my approved and authorized ISP, I will be responsible for payment of those services.

I agree to abide by applicable Office of Developmental Programs' Waiver and non-Waiver policies, and _____ and Administrative Entity procedures and requirements.

(Name of AWC FMS)

By signing below, I attest that I have read this Managing Employer/Surrogate Agreement in its entirety (four pages). I understand that I must sign and return the form as a condition of the program and that I cannot begin enrollment in the Participant Direction Services Program until this form is completed and returned to AWC FMS. I further attest by signing below that I understand what is being required of me and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms or conditions of this Agreement may result in termination of this Agreement.

Signatures:

_____ _____

Individual *Date*

_____ _____

Surrogate, if applicable *Date*

_____ _____

Agency With Choice Financial Management Service Director/Designee *Date*