Vendor Fiscal/Employer Agent (VF/EA)
Financial Management Services (FMS)

DIRECT CARE WORKER (DCW) AGREEMENT

Name of Participant: ____ Participant ID: ______

Name of DCW: ____ DCW ID: __________

Address:
____

County Name:
____

Phone Number:
____

E-mail Address:
____

A child under the age of 18 resides in the home of the **Participant**? ☐ Yes ☐ No

I have continuously lived in the state of PA for the past 2 years? ☐ Yes ☐ No

Are you a spouse of the Participant? ☐ Yes ☐ No

I am at least 18 years of age? ☐ Yes ☐ No

I recognize that my employment is contingent upon the Participant's enrollment in the Participant Directed Service Program (PDS). If the Participant is no longer in the waiver or the PDS program, I may no longer be employed. In order to acknowledge the terms of my employment, I agree to the following:

1. I understand and consent to having State Police criminal background checks, Child Abuse clearances (when required), and Federal criminal history records (when required) completed on me and that my employment is contingent upon the results.
2. I understand that the results of my background checks will be made available to my prospective employer and other program administrators as necessary and/or required.

SAMPLE

3. I understand that I cannot begin providing services in this program before I have successfully cleared the background checks.
4. To provide the supports as identified and authorized in the Individual Service Plan (ISP) in accordance with the outcomes and health and safety requirements identified.
5. To complete the required training and met all necessary qualifications as required and identified in the ISP and Office of Long-Term Living (OLTL) policies and procedures.
6. I understand that I may not submit time records for any time period for which a Participant is admitted to a hospital, nursing home, rehabilitation facility or for any period for which the Participant is not eligible for waiver services.
7. To maintain the necessary documentation and records as required by the PDS program and by my employer. All records I may have or assist in maintaining will be kept confidential.
8. I agree to report incidents to my Participant's service coordinator, including suspected abuse, neglect, exploitation or any event involving personal error in service/support implementation, critical events involving personal injury, illness, medical emergency or any event determined to be atypical as required by OLTL, or my employer.
9. I agree to take part in any meetings if requested by and/or regarding the Participant.
10. I agree to abide by all applicable rules, regulations and policies pertaining to providing support services through the PDS program.
11. I hereby acknowledge that I have received, read, and understand all of the following:
    a. OLTL program policies and procedures regarding PDS
    b. The Individual Service Plan (ISP)
12. I agree to review any/all programmatic updates made available to me by my employer.
13. I understand that ____________________ *(Selected Offeror)* will verify that I do not appear on the Office of the Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). In the event I appear on this list, I will not be permitted to work or be paid in this program.
14. I understand that in consideration of the above stated Agreement, I shall be compensated through this program for only those services approved by my employer and authorized in the ISP.
15. I understand and acknowledge that the VF/EA is not my employer.
16. I understand that the Participant or their appointed representative is my employer. My employer is not the VF/EA, OLTL or any other entity involved with the PDS program.
17. I understand that my paychecks will be processed by the Vendor Fiscal/Employer Agent (VF/EA). The VF/EA is considered a Financial Management Service (FMS) Organization. I understand that the VF/EA is not authorized to pay for any service not approved and authorized in the ISP or any request that exceeds the Participant's budget and funds for the PDS program as stated in the ISP.
18. I agree to correctly complete all required paperwork and be approved prior to providing any service under this PDS program.
19. I understand and acknowledge that any false claims or untruthful submission of services provided, statements, or documents, or concealment of material facts in an attempt to obtain improper payment is reportable as Medicaid Fraud and subject to investigation. Medicaid Fraud is a felony and can lead to substantial penalties and/or imprisonment.

SAMPLE

20. In accordance with 55 PA. Code§52.28, I agree to self-disclose a conflict of interest to the Department of Human Services (DHS).

    I am self-disclosing a potential conflict with:

    ____

    By signing below, I attest that I have read this Agreement in its entirety. I understand I must sign and return this form as a condition of employment in this program, and that I cannot begin working until this form is completed and returned to the VF/EA. I further attest that by signing below, that I understand what is being requested of me, and I agree to abide by these terms and conditions. I further understand and agree that violation of any of the terms and/or conditions of this Agreement may result in termination of this Agreement and payment for employment to any Medicaid Recipient of this program.

____

DCW Employee Signature Date

____

Common Law Employer Signature Date

NOTE: Please ensure both you and the employer sign this form before sending it to _______________________ *(Selected Offeror)*.

MAIL FORMS TO:

Selected Offeror

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SAMPLE