SHIAWASSEE HEALTH AND WELLNESS

Choice Voucher

EMPLOYMENT AGREEMENT FOR ADULT`S STAFF

This agreement is made on _____(date) between _____(Consumer/"employer") and _____("Employee") to describe the supports that the employee will provide to the employer and the terms and conditions of employment.

Article I

EMPLOYEE RESPONSIBILITIES

I, _____ (employee) acknowledge and agree that employment is conditioned on my employer's participation in the Choice Voucher System administered by Shiawassee Health And Wellness ("SHW"). If my employer ends participation in the Choice Voucher System, my employment may end.

I agree to the following terms of employment:

1. I am at least 18 years of age at the beginning of my employment.
2. I am not the guardian, parent, spouse or primary caregiver of _____ (employer).
3. During the term of this Agreement, I shall provide support to my employer by performing the duties outlined in this agreement and any attachments to it.
4. I agree to assist my employer in maintaining the documentation and records required by my employer and/or the SHW. I agree to:
    a. Complete all necessary paperwork to secure mandatory payroll deductions from my pay.
    b. I agree to document the services I deliver on the **CLS/RESPITE PROGRESS NOTE** which will be provided to me by my employer or obtained directly from the SHW case manager. The documentation I complete must completed by the end of my shift.
    c. All records I may have or assist in maintaining are the property of my employer. I will keep these records confidential, complying with all HIPAA requirements. I will release them only with the consent of employer and return them to my employer if my employment ends.
    d. Complete illness and incident reports when necessary as required or requested by the SHW policy and/or my employer.
5. I shall immediately notify _____ (emergency contact) if my employer experiences a medical emergency or illness. I will also notify the emergency contact before taking my employer to the physician, except in case of an emergency.
6. I agree to participate in any meetings if requested to do so by my employer.

7. I agree to execute a Provider Agreement with the SHW (Host Agency) and acknowledge that this agreement does not alter the fact that the Host Agency is only the project administrator of the Self-Determination Initiative, and that my employer is _____consumer/employer). (**ATTACHMENT A**)

8. I, _____ (employee) agree to abide by all my employer's rules and all SHW regulations and policies while performing my employment duties, and I acknowledge receipt of the following rules and regulations:

    a. **ATTACHMENT B** to this Agreement, which outlines the supports that I will provide to my employer.
    b. Recipient Rights and all other trainings:

        i. I acknowledge receipt of the Booklet entitled "Your Rights" published by the State of Michigan. (**ATTACHMENT G**)
        ii. I understand that Recipient Rights rules and regulations apply to self-determination employment arrangements. The SHW's Recipient Rights Officer has the same jurisdiction in self-determination arrangements as with any other service provider.
        iii. I agree to complete and submit to a recipient rights background check, criminal records and driver`s license check. I will complete the Authorization to Disclose Employee Information form. (**ATTACHMENT F)**
        iv. I agree to attend and complete all mandatory trainings, including but not limited to, Recipient Rights, CPI, (if necessary), PCP annual and individual plan of Service, 1st Aid & CPR, Gentle Teaching, (if necessary)HIPAA, Corporate Compliance, Deficient Reduction Act, False Claims Act, LEP, Cultural Competency, Grievance and Appeals, Medication Administration (if necessary) trauma informed care and Environmental Safety.

            1. I further understand that if I do not show up for my scheduled training and/or I do not call to cancel at least **24 hours prior** to the start of class, my employer will be charged a **$50 no-show fee by the SHW.**
            2. My employer may require me to reimburse him/her for the no-show fee. ***By my signature below, I*** _____(employee) & _____(employer) ***authorize my employer to deduct $50 from my payroll check to reimburse my employer's budget for each no-show fee I incur.***
            3. I agree I **MUST** stay current with all trainings. If I don`t stay current with all trainings **I CAN NOT be scheduled to work until my trainings are current.**

        v. I agree to assist my employer in filing right complaints upon request. I also understand that I have a responsibility to report rights violations of which I am aware or any potential abusive or neglectful situations I observe. I understand that I may be requested to cooperate with a recipient rights investigation and/or assist my employer with exercising his or her rights.

c. I agree to adhere to my employer's specific rules while in my employer's home as outlined in **ATTACHMENT C**.
d. I agree to record my hours worked as instructed in **ATTACHMENT D.** I further understand that it is solely my responsibility to turn in my timecard on time. If I fail to do so I will not receive payment for my services until the next pay cycle (generally 1 week).

9. I understand that this is an at-will employment relationship, which can be terminated by me or by my employer at any time. However, my employer cannot terminate my employment based on my race, religion, sex, disability or other protected status under federal or Michigan law. In addition, **if I decide to terminate my employment, I agree to give written notice at least 14 calendar days** before my last scheduled day of work.
10. I understand and acknowledge that my employer is my sole employer and that I am not an employee of the SHW, which authorizes the supports I provide, or the fiscal intermediary, which is the financial administrator of the Choice Voucher System funds used to pay me.
11. I agree not to sue the fiscal intermediary for its role as the financial administrator of my employer's Choice Voucher System funds or SHW for its role in administering the Choice Voucher System.
12. I agree to read, sign and adhere to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) summary. (**ATTACHMENT D**)

Article II

EMPLOYER RESPONSIBILITIES

I, _____ ("Employer") agree to the following:

1. I will provide my fiscal intermediary with the necessary documentation to assure timely compensation of my employee so long as my employee has met the condition set forth in Article I.8.d and described in **ATTACHMENT D**.
2. I will compensate my employee in the manner described in Article I.13 of this agreement. Payroll will be handled by my fiscal intermediary, who will withhold all necessary tax and other withholdings from the employee's paychecks.
3. I will assure my employee(s) receives all appropriate training and remain current in all trainings.
4. I will evaluate the performance of my employee and provide appropriate feedback to assure that I am receiving quality supports. Evaluation will be prepared annually.
5. I will assure that my employee(s) executes a Provider Agreement with the specified Waiver Agency Organization (SHW). (**ATTACHMENT A**)
6. Shiawassee Health and Wellness can terminate a Choice Voucher Agreement when the welfare of the consumer is in jeopardy due to the failure of the employer to direct services and supports or when the employer consistently fails to comply with the contractual responsibilities laid out in this agreement.
7. It is the employer's responsibility to ensure authorized hours of service are covered by fully trained staff. We understand the difficulty in hiring qualified staff. If staff are working more than 40 hours per week you must notify your case worker within 2 business days. After four (4) pay periods SHW will re-assess the choice voucher agreement to ensure all possible option are being used to hire qualified staff. If it is discovered the employer is not diligently working to hire new staff the choice voucher agreement can be terminated.
8. As the employer it is the expectation a 30-day notice is given if the self-determination site will be ending. This will allow SHW time to complete a smooth transition to another service provider.

By signing below, both parties agree to the terms and conditions set forth in this Employee Agreement.

_____	_____
Employee	Date
_____	_____
Employer	Date
_____	_____
Employer's Guardian/Legal Representative (if applicable)	Date

Article III

SHARED LIVING ARRANGMENTS

In this section you will see that you have "shared" wages and benefits. This means that your employer has a shared living arrangement with another/other consumer(s) who have agreed to share service costs. You will have a separate employee agreement with the other consumer(s) and all your wage and benefit expenses are shared by your employers.

1. I, _____ (employee), agree to the following compensation for the services I shall perform:
    a. Shared Hourly Wage: Wage is variable depending on the staff-to-consumer ratio as follows:
        i. 1:1 hourly wage: $_____ per hour
        ii. 1:2 hourly wage: $_____ per hour (the second consumer will pay the other 1/2 of the hourly wage).
        iii. 1:3 hourly wage: $_____ per hour (the second and third consumer will pay the other 2/3 of the hourly wage).
    b. Average number of hours to be scheduled each week appears below. Every attempt will be made to schedule you for at least these hours per week, however there is no guaranteed of the number of hours scheduled as your employer's need can change from week to week. Full-Time Employment is considered to be 35 – 40 hours worked per week.
        i. Est. weekly hours scheduled: _____ AVERAGE HOURS PER WEEK
    c. Shared Holiday's for which I will receive "time-and-half" hourly wages if I am scheduled to work, and actually work, on any of these days: <u>New Year's Day, Good Friday, Easter Sunday, Memorial Day, 4th of July, Labor Day, Thanksgiving Day, Christmas Day.</u>
    d. Paid Vacation:
        i. Only Full-Time Staff are eligible to receive vacation pay. Full-Time is defined as working an average of 35-40 per week.
        ii. Vacation hours that may be offered to you by your employer must be used before the end of the employer's fiscal year (October 1 to September 30 of each year).
        iii. Vacation hours cannot be carried forward or "banked" beyond September 30th of each year.
        iv. There is no provision for "vacation buy out". If the employer has offered vacation hours, the intent is for you to take a break from your job.
        v. If your employment terminates for any reason, all remaining vacation hours are forfeited.
    e. Number of Paid Vacation Hours per Year: _____ paid vacation hours per year.
    f. Number of Paid Training Hours per Year: 20 hours to be used for the mandatory training at SHW (Rights Training, CPI Training, CPR Training, Gentle Teaching,

Corporate Compliance, HIPAA, Cultural Competency, LEP, Grievance and Appeals, Medication Administration, Ext.)

Article IV

MILEAGE REIMBURSEMENT:

1. If my employer has staff mileage reimbursement included in his/her Self-Determination budget I may submit a mileage reimbursement request for transportation I provide to my employer during my scheduled shift.
2. Maximum Annual mileage reimbursement is $ 600.00 per year.
3. Mileage will be reimbursed at $0.25 per mile and tracked on the travel reimbursement form.

ATTACHMENT A

PROVIDER AGREEMENT

The parties of this contract are Shiawassee Health and Wellness ("herein referred to as the Host Agency"), and _____ (employee - "herein referred to as Provider".)

The purpose of this agreement is to define the roles and responsibilities of the above-named parties. This agreement shall remain in effect until such time is must be terminated or modified. Any party can initiate a termination or modification, by providing written notice to the other of the desire to terminate or modify this agreement.

The Host Agency Agrees to the following:

1. Upon receipt of this agreement, to certify the Provider as available to provide services to individuals who receive services and supports through arrangements authorized by the Host Agency or one of its subcontractors, and financed through Michigan's Medicaid Specialty Pre-Paid Mental Health Plan where the individual is seeking or requesting services and/or supports in accordance with their person-centered plan.

The Provider Agrees to the following:

1. To keep any records necessary to disclose the extent of services the provider furnishes to recipients of services.
2. On request, to furnish any information maintained under paragraph (1) of this section and any information regarding payments claimed by the Provider for furnishing services under the person-centered plan to the Host Agency, the State Medicaid Agency, the Secretary of the Department of Health and Human Services or the State Medicaid fraud control unit.
3. To comply with the disclosure requirements specified in 42 CFR 455, subpart B, as applicable.
4. To comply with the advance directives requirements specified in 42 CFR 489, Subpart 1 and 42 CFR 417.436(b), as applicable.

Both parties expressly acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. Further both parties recognize and reaffirm that the Host Agency is not the employer of the Provider of Services, and that the Participant is the sole employer of the Provider of Services.

This agreement sets forth the entire understanding between the parties with respect to the subject matters, and supersedes any and all other agreements, either oral or in writing between the parties, pertaining to these matters.

No change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties.

The parties agree to terms and conditions of this agreement as specified on the foregoing pages, and so signify by affixing their signatures below.

_____	_____
Self Determination Coordinator	Date
_____	_____
Employee	Date

17.3. B. COMMUNITY LIVING SUPPORTS (this is only the relevant portion from the Medicaid Manual Section: 17.3. B. – See Medicaid Manual for full text.)

Community Living Supports are used to increase or maintain personal self-sufficiency, facilitating an individual's achievement of his goals of community inclusion and participation, independence or productivity. The supports may be provided in the participant's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting, reminding, observing, guiding and/or training in the following activities:
  - Meal preparation
  - Laundry
  - Routine, seasonal, and heavy household care and maintenance
  - Activities of daily living (e.g., bathing, eating, dressing, personal hygiene)
  - Shopping for food and other necessities of daily living

CLS services may not supplant state plan services, e.g., Personal Care (assistance with ADLs in a certified specialized residential setting) and Home Help or Expanded Home Help (assistance in the individual's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance is needed, the beneficiary, with the help of the PIHP case manager or supports coordinator **must** request Home Help and, if necessary, Expanded Home Help from the Department of Human Services (DHS). CLS may be used for those activities while the beneficiary awaits determination by DHS of the amount, scope and duration of Home Help or Expanded Home Help.

_____ (employee)

ATTACHMENT C

EMPLOYER HOME RULES:

1. Smoking: _____

   _____

2. Use of Employer's Home Telephone: _____

   _____

3. Other(s): _____

   _____

   _____

   _____

   _____

   _____

   _____

_____ (employee)

ATTACHMENT D

PAYROLL PROCEDURES

1. Procedures for recording time worked:
    a. You will indicate a Start Time and a Stop Time each time your work.
    b. If a shift runs over midnight, you must record the portion of the shift work on each day (for example if you start work 10:00 PM on Monday evening until 6:00 AM Tuesday morning, you will record your time as follows:

i. Monday:	Start Time	10:00 PM
	End time	12:00 AM
ii. Tuesday:	Start Time	12:01 AM
	End Time	6:00 AM

2. It is your responsibility to turn your timecards in on time to meet the payroll processing deadlines. Your employer will let you now what day and time your timecards are due.
3. If you fail to turn in your time sheet by the deadline stated above, you will not receive your paycheck on the normal pay day. You will have to wait until the next scheduled pay day to receive the wages owed to you.
4. All time which you put on your time sheet must be backed up by an entry on the CLS log for that day (commonly called the 15-minute sheets) which is used as proof of you providing Medicaid Services to your employer.
    a. Only Face-to-Face services are billable.
    b. Only one staff may provide services at a time. Doubled up staff, even for training purposes is not billable and must be recorded on the lower portion of your time sheet. You will be paid for non-billable time if you received prior approval from your employer.
    c. Approved training time must be recorded on the lower portion of your time sheet as well.
5. Falsifying time sheets is not only violation of this employee agreement, it is a violation of State and Federal Medicaid Laws. Your employer and the SHW will prosecute Medicaid fraud to the fullest extent of the law.

By Signing Below all parties acknowledge that they have read and understood the procedure for recording the time worked each week.

_____	_____
Employee	Date
_____	_____
Employer	Date
_____	_____
Employer's Guardian/Legal Representative (if applicable)	Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA)

HIPPA is a federal law that mandates how people handle protected health care information. As a personal assistant or community supports staff, you will most likely have access to this type of information for the person/people for whom you work. HIPAA mandates that if you have access to this type of information, you must take reasonable steps to protect it and keep it private from others who do not have a legitimate reason for knowing the information.

Examples of the type of information you may become aware of include, but are not limited to, the following:

1. Past, present, or future mental health issues.
2. Information about the care, treatment and/or services a person receives.
3. Information about who pays for care, treatment and/or services.
4. Records or documentation that you create during the course of your work.

The consumer(s) for whom you work have the expectation that you will share their private information with others only as necessary for treatment or for payment of services (including your salary). It is understood that you may share information with others who help the SHW operate, such as accreditation, licensing or quality assurance inspectors. The expectation is that you only provide information on a "need to know" basis.

Remember these simple rules to help keep in HIPAA compliance:

1. Shred any paper that may contain personal health information.
2. Do not leave papers laying around where others might see them.
3. Remember to discuss health information in a private area where others cannot overhear.
4. When it is appropriate to share information limit the shared information to "need to know".

Also remember that the HIPAA law is serious! The HIPAA law allows for criminal and civil penalties which could include fines and/or jail time.

If you have questions about whether it is appropriate to share personal health information about a consumer you are working with, feel free to call the consumer's supports coordinator/case manager for guidance. You may also call the SHW and ask for the HIPPA Officer (989-723-6791).

MY SIGNATURE BELOW INDICATES I HAVE READ AND RECEIVED A COPY OF THIS FORM AND UNDERSTAND MY RESPONSIBILITIES RELATED TO THE HIPAA LAW.

_____ (employee) _____ (date)

_____ (witness) _____ (date)

ATTACHMENT F

ACKNOWLEDGMENT RECEIVING "YOUR RIGHTS" BOOK.

I have received a copy of the "Your Rights" booklet from my employer.

_____ (employee) _____ (date)

_____ (employer) _____ (date)

_____ (employer's guardian/Legal) _____ (date)

_____ (representative if necessary) _____ (date)