SHIAWASSEE Health & Wellness

Choice Voucher
EMPLOYMENT AGREEMENT FOR CHILDREN'S STAFF

This agreement is made on _____ (date) between _____
CHILD'S NAME
and _____ to describe the supports that the employee will
STAFF NAME

Provide to the employer and the terms and conditions of employment.

Article I
EMPLOYEE RESPONSIBILITIES

I, _____ (staff name) acknowledge and agree that employment is conditioned on the family's use of Choice Voucher arrangements administered by the CMHSP. If my employer ends the family's participation in Choice Voucher arrangements, 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 _____.
CHILD'S NAME

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 CMHSP. 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 FORM** which will be provided to me by my employer or obtained directly from the CMHSP case manager.
   c. All records I may have or assist in maintaining are the property of my employer. I will keep these records confidential, release them only with the consent of my employer, and return them to my employer if my employment ends.
   d. I will complete illness and incident reports when necessary as required or requested by the CMHSP and/or my employer.

5. I agree to abide by all of my employer's rules and CMHSP regulations (described throughout this agreement) regarding 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.
    b. Attachment C to this Agreement, which outlines the House Rules at my place of employment.

6. 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 on the basis of my race, religion, sex, disability or other protected status under federal or Michigan law. In addition, I agree to give 14 days written notice to my employer if I terminate my employment.

7. I understand and acknowledge that my employer is my sole employer and that I am not an employee of the CMHSP, which authorizes the supports I provider, or the FI, which is the financial administrator of the funds used to pay me.

8. Recipient Rights:
    a. I agree to assist my employer in filling recipient rights complaints upon request.
    b. 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.
    c. 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.
    d. I acknowledge receipt of the Booklet entitled "Your Rights" published by the State of Michigan. ATTACHMENT F
    e. I understand that Recipient Rights rules and regulations apply to Choice Voucher employment arrangements. The CMHSP's Recipient Rights Officer has the same jurisdiction in Choice Voucher arrangements as with any other service provider.
    f. I agree to submit to a recipient rights background check and to complete the Authorization to Disclose Employee Information and Release of Liability form which is included in the Payroll Forms Packet which will be provided to me by my employer. I understand that my employment is contingent on passing the recipient rights background check.
    g. I agree to participate in <u>mandatory annual</u> recipient rights training, CPI Training, CPR Training and Gentle Teaching Training which must be taken at the CMHSP.
        a. 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 CMHSP.
        b. My employer may require me to reimburse him/her for the no-show fee.
        By my signature below, I _____authorize my employer to deduct
        (employee)
        $50 from my payroll check to reimburse my employer's budget for each no-show fee I incur.

9. I agree not to sue the fiscal intermediary for its role as the financial administrator of my employer's Choice Voucher System funds or the CMHSP for its role in administering the Choice Voucher System.

10. I agree to execute a Provider Agreement with the CMHSP (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/Choice Voucher Initiative, and that my employer is _____. I understand that
NAME OF CHILD'S RESPONSIBLE PARENT
my employment is contingent on completing a Provider Agreement which is found in Attachment A.

11. I agree to participate in any meetings if requested to do so by my employer.

12. 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 time card on time. If I fail to do so I will not receive payment for my services until the next pay cycle (generally 1 week).

13. I agree to read, sign and adhere to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) summary. ATTACHMENT E

14. I agree to the following compensation for the services I shall perform:

a. Hourly Wage: $_____ per hour

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 an average of 35 hours worked per week.

Est. weekly hours scheduled: _____

c. 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:
1. Only Full-Time Staff are eligible to receive vacation pay. Full-Time is defined as working an average of 35-40 per week.
2. 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).
3. Vacation hours cannot be carried forward or "banked" beyond September 30th of each year.

4. 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.
5. If your employment terminates for any reason, all remaining vacation hours are forfeited.

g. Number of Paid Vacation Hours per Year: NO BUDGET FOR VACATION HOURS.

h. Number of Paid Training Hours per Year: 24 hours to be used for the mandatory training at CMHSP (Rights Training, CPI Training, CPR Training and Gentle Teaching Training).

15. Mileage Reimbursement:

a. 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.

b. Mileage will be reimbursed at $0.25 per mile

c. Other Mileage reimbursement information:

_____

_____

Article II
EMPLOYER RESPONSIBILITIES

I, _____ (responsible parent - “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.12 and described in ATTACHMENT D.

2. I will compensate my employee in the manner described in Article I.14 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 receives appropriate training.

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 executes a Medicaid Provider Assurance Agreement (42CFR 431.107 agreement) with the CMHSP. ATTACHMENT A

SIGNATURES ON THE NEXT PAGE

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

_____ _____

Employee Signature Date

_____ _____

Employer Signature Date

_____ _____

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

ATTACHMENT A

Provider Agreement

The parties of this contract are Shiawassee Health and Wellness ("herein referred to as the Host Agency"), and _____ (staff name - "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 be affixing their signatures below.

_____ _____
Self Determination Coordinator Date

_____ _____
Employee or Provider Agency 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 PM on Monday evening until 6 AM Tuesday morning, you would record your time as follows:

-Monday:	Start Time	10:00 PM
	End time	12:00 AM
-Tuesday	Start Time	12:01 AM
	End Time	6:00 AM

2. It is your responsibility to turn your time cards in on time to meet the payroll processing deadlines. Your employer will let you now what day and time your time cards are due.

4. If you fail to turn in your time sheet by the deadline stated above you will not receive your pay check on the normal pay day. You will have to wait until the next scheduled pay day to receive the wages owed to you.

5. 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.

6. 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 CMHSP 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 Signature Date

_____	_____
Employer Signature	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 CMHSP 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 or not 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 CMHSP 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 Name (please print) Date

_____ _____

Employee Signature date Witness Signature date