UTAH DEPARTMENT OF HEALTH
DIVISION OF MEDICAID & HEATLH FINANCING
NEW CHOICES WAIVER PROGRAM

SELF-ADMINISTERED SERVICES
EMPLOYMENT AGREEMENT
PARTICIPANT

PARTIES:

This Employment Agreement is between ______________________________ (EMPLOYER) and (EMPLOYEE)_______________________________________:

Employee Name: ___________________________________ SSN #: ________________
Address: ____
City: ______________________ State: ______________ Zip: _____________
Telephone:_________________________________

ONLY if a 'DESIGNEE' is listed on the EMPLOYER line above, please provide the name and date of birth of the actual waiver client who will be receiving the self-administered services. *(If the waiver client is listed as the EMPLOYER, please leave these lines blank and check: N/A ☐)*

Waiver client name:_______________________________ DOB:_____________________

AGREEMENT:

Identified below are the service(s) that the EMPLOYER has hired the EMPLOYEE to provide at the wage, number of units and frequency specified.

Self-Administered Service	Insert "✓" or "N/A"	Type of Service Unit	Maximum Allowable Wage Per Unit	Actual Wage Approved by Employer (or "N/A")	Number of Units Authorized (or "N/A")	Frequency of Service
Attendant Care Services		**15 Min**	**$4.12**			**Weekly**
Chore Services		**15 Min**	**$3.70**			**Weekly**
Homemaker Services		**Hour**	**$19.30**			**Weekly**
Respite Care - Hourly		**Hour**	**$22.49**			**Weekly**

As a condition of providing services under this agreement, EMPLOYEE represents and/or agrees to the following:

1. The EMPLOYEE shall not provide any services while the EMPLOYER is hospitalized or placed in a nursing or rehabilitation facility. All services shall be suspended during this time period.

2. The EMPLOYEE shall be employed at-will by the EMPLOYER. Employment at-will means that the EMPLOYEE may quite at any time for any reason or no reason; the EMPLOYER may terminate the EMPLOYEE at any time for any reason or no reason. **This at-will status may not be altered.**

3. The EMPLOYEE shall comply with all applicable policies, procedures, and directives of the EMPLOYER and of the Medicaid New Choices Waiver program. The EMPLOYEE acknowledges and agrees that the EMPLOYER and or the Medicaid New Choices Waiver program reserve the right to change their policies and procedures at any time for any reason without prior notice. If an order by the Legislature or the Governor, or a federal or state law, or local funding sources reduces the amount of funding to the State Medicaid Agency or if the funds available to the State Medicaid Agency are reduced, this may change the terms of employment

4. The EMPLOYEE will complete a criminal background check, if the EMPLOYER requests it.
5. The EMPLOYEE is 18 years of age or older.
6. The EMPLOYEE will provide a copy of his/her Social Security Card and picture I.D.
7. Valid Drivers License? Yes☐ No☐
   EMPLOYEES without a vald Drivers license <u>may not</u> transport individuals in connection with their employment responsibilities.
8. Personal automobile liability insurance? Yes☐ No☐
   EMPLOYEES without personal automobile liability insurance may not transport individuals in connection with their employment responsibilities.
9. The EMPLOYEE will obtain training and updates as necessary to maintain the participant safely in the home.
10. The EMPLOYEE will have the ability to follow verbal instructions from the EMPLOYER and verbally communicate with the EMPLOYER.
11. EMPLOYEE will adhere to the Financial Management Services Agency's policies and procedures for submitting time.
12. The funds used to pay EMPLOYEE for services rendered under this Agreement are public funds and the submission of false information may subject EMPLOYEE to criminal action, in addition to administrative sanctions and/or liability for repayment of any funds received.
13. Except as may be prohibited by law, EMPLOYEE must promptly repay any overpayment, regardless of fault.

14. Worker's Compensation insurance is provided under this Agreement.
15. Services provided by the EMPLOYEE are publicly funded Medicaid New Choices Waiver reimbursable services.
16. The employment of the EMPLOYEE will be terminated when there is evidence that authorized services are not being performed.
17. The Financial Management Services Agency will not reimburse for units of service that exceed units approved on the Care Plan.
18. The employment of the EMPLOYEE will be terminated when there is evidence of abuse, neglect or exploitation of the participant by the EMPLOYEE. The Case Manager will make a referral to the State of Utah Adult Protective Services in these situations as per legal requirements.

When employed to provide care or services for which Medicaid reimbursement will be claimed, the EMPLOYEE must:

1. Be aware of and comply with all appropriate and applicable Medicaid policies and procedures and state and federal rules and regulations in effect when services are provided.
2. Provide care and services as ordered on the Care Plan in accordance with all applicable Medicaid regulations and policies; be able to demonstrate that he/she is physically capable of providing the required services outlined in the Employee Agreement and identified in the participant's Care Plan.
3. Use a Financial Management Services Agency to submit claims for services in accordance with the Medicaid policy in effect at the time of service.
4. Not bill the EMPLOYER or otherwise attempt to collect payment for services except as specifically permitted by Medicaid policy. Further, the EMPLOYEE agrees to accept payment or claims adjudication from the Department of Health, as the State Medicaid Agency, as payment in full for services provided.
5. Agree that as an EMPLOYEE of the participant the EMPLOYEE has no authorization, express or implied, to bind the State of Utah, Department of Health, to any agreement, settlement, liability or understanding whatsoever.
6. Indemnify and hold harmless the Department of Health for any claims arising out of work performed by EMPLOYEE under authority of this agreement.
7. Be sensitive to the New Choices Waiver participant's right of privacy and not disclose information about the care or services given to the participant unless specifically allowed by state and federal laws and regulations.
8. Be oriented and trained by the EMPLOYER or their designee in all aspects of care to be provided to the participant including Activities of Daily Living and Instrumental Activities of Daily Living Support and Assistance.
9. Read, sign and adhere to the terms of the New Choices Waiver Provider Code of Conduct.

ACKNOWLEDGEMENT:

I acknowledge that the Department of Health New Choices Waiver Program and the State Medicaid Agency (the State agency authorizing Medicaid services) is not responsible for the actions of the EMPLOYER and will claim governmental immunity for any harm or damages that I may incur during the course of my employment pursuant to this Agreement.

By my signature, I certify that I have read and agree to be bound by the terms of this Agreement. I acknowledge that my failure to abide by this Agreement may result in the loss of employment with EMPLOYER. I further acknowledge either party (EMPLOYEE or EMPLOYER), with or without cause, may terminate this Agreement at any time.

____

EMPLOYEE NAME (printed)

____ ______________________

EMPLOYEE SIGNATURE DATE

____

EMPLOYER OR EMPLOYER DESIGNEE NAME (printed)

____ ______________________

EMPLOYER OR EMPLOYER DESIGNEE SIGNATURE DATE