MassHealth
Commonwealth of Massachusetts
EOHHS
www.mass.gov/masshealth

Direct Care Worker
Signature Form

Name of fiscal intermediary (FI) _____

- **All DCWs hired by a waiver participant must fill out and sign this form and give it to their employer (the Waiver Participant).**
- **The DCW's employer (the Waiver Participant) must submit this form to the FI, along with all other paperwork required by the FI and MassHealth.**
- **The FI cannot pay a DCW until all required paperwork is received and complete.**
- **MassHealth and the FI cannot pay a DCW to work**
  - **when the Waiver Participant is in an inpatient facility, such as a hospital or nursing facility; or**
  - **when the amount of time that has been authorized per week by the Waiver Participant's case manager has been exhausted or is insufficient.**
- **The DCW must read the rest of this form and sign below before receiving payment from the FI.**

I agree to accept the position of direct care worker (DCW) for _____
Waiver Participant's name

I understand that my employer is the Waiver Participant. My employer is responsible for hiring, firing, training and scheduling DCWs. My employer may select another person (a surrogate) to help manage his or her self-directed services. I must notify my employer and the surrogate (if any), of any changes in my circumstances that would affect my ability to perform my duties as a DCW. I must complete and provide accurate Waiver Activity Forms (time sheets) to my employer or the FI as soon as I can. The FI will process payroll for my employer. My employer is responsible for giving the check to me (unless I requested that my check be deposited directly into my bank account). I must provide proof of my identity to my employer to complete the Employment Eligibility Verification form (Form I-9), which the Department of Homeland Security requires all employees to complete. (The FI will give my employer this form.)

I understand that the MassHealth Waiver program pays for self-directed services provided by a DCW only when the DCW provides services to an eligible Waiver Participant who has obtained waiver authorization from his or her case manager for self-directed services. Self-directed services must be provided in accordance with the Waiver Participant's authorization, service agreement, and MassHealth regulations at 130 CMR 630.400.

In providing DCW services to my employer (the Waiver Participant) I agree to the following:

- If my employer has an advance directive concerning the provision of care in the event he or she becomes incapacitated, I agree to respect the terms of the advance directive, unless, as a matter of conscience, I cannot implement an advance directive. I agree not to condition the provision of care or otherwise discriminate against my employer based on whether or not the individual has executed an advance directive. I understand that I am not required to provide care that conflicts with an advanced directive.
- I agree to keep any records that are necessary to show the extent of the services I provide to my employer.
- I agree to furnish, upon request, copies of records in my possession and any information regarding payments I claimed for furnishing DCW services to my employer, to the Medicaid agency, the Secretary of the U.S. Department of Health and Human Services, or the State Medicaid fraud control unit.

I understand that I cannot be paid as a DCW if I am a spouse, surrogate, or legally responsible relative of the Waiver Participant.

I agree to comply with the disclosure requirements contained in 42 CFR Part 455, Subpart B as follows:

- Persuant to 42 CFR 455.104(a)(3), I am identifying below any other MassHealth provider entity in which I have ownership or control. (If none, please write "None"): _____
- If requested by MassHealth, I agree to provide information about business transactions in accordance with 42 CFR 455.105.
- In accordance with state statute M.G.L. c.118E, § 36, and federal requirement, 42 CFR 455.106, by signing this form, I am stating that I have not been convicted of a criminal offense related to my involvement in any program under Medicare, Medicaid, or the title XX services program.

I understand that my employer is required to offer me the option of having my DCW payments direct deposited into my bank account, or into a debit card service offered by the FI. If I do not elect my DCW payments to be direct deposited, I understand the FI will issue a check in my name and send it to my employer or give it to me.

Check here if you would like the FI to direct deposit your DCW payments. ☐

The following describes my relationship to my employer (the Waiver Participant). **(Please check one.)**

☐ adult child (18 yrs. or older) of waiver participant

☐ daughter-in-law of waiver participant

☐ son-in-law of waiver participant

☐ parent of adult (18 yrs. or older) waiver participant

☐ other relative (describe) _____

☐ non-relative (describe) _____

I certify under pains and penalties of perjury that the information on this signature form, and any accompanying statement that I have provided, has been reviewed and signed by me, and is true, accurate, and complete to the best of my knowledge. I also certify that I understand my duties, rights, and responsibilities as a DCW and that all the information I have provided to my employer (the Waiver Participant), to the fiscal intermediary, to the case management agency, or to MassHealth is true and accurate to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

X _____ _____ _____

DCW Signature | Print DCW name | Date