Personal Care Attendant
Provider Agreement

MassHealth
THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

Instructions and Important Information

- All Personal Care Attendants (PCAs) in the MassHealth PCA Program must read, sign, and return this form to their employer (the PCA consumer).
- The PCA's employer (the PCA consumer) must submit this form to the fiscal intermediary (FI), along with all other paperwork required by the FI and MassHealth.
- The PCA must complete and return all required paperwork before receiving payment as part of the PCA Program.
- MassHealth does not cover PCA services when:
  - The PCA consumer is in an inpatient facility, such as a hospital or nursing facility; or
  - The amount of time that has been authorized by MassHealth has been exhausted or is insufficient.
- **The PCA must read, sign, and return this agreement before receiving payment as part of the PCA Program.**

Provider Agreement

By signing below, I agree to the following:

1. I understand that, as a PCA provider, I must comply with the PCA provider eligibility requirements at 130 CMR 422.404(A)(1) and in accordance with the PCA provider scope of services at 130 CMR 422.404(B)(1) and 422.419(C).
2. **I understand that my employer is the PCA consumer. My employer is NOT MassHealth or the Fiscal Intermediary (FI).** My employer is responsible for hiring, firing, training, and scheduling PCA providers. My employer may select another person (a surrogate or administrative proxy) to help manage his or her PCA services. I must notify my employer and the surrogate or administrative proxy (if any), of any changes in my circumstances that would affect my ability to perform my duties as a PCA provider.
3. I understand that 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.)
4. I understand that I must comply with MassHealth regulations for the submission of Activity Forms (also known as "timesheets"), including the use of Electronic Visit Verification system, as specified by MassHealth.
5. I understand that the FI will process payroll for my employer. I understand that I must enroll in Direct Deposit, but may also enroll in payroll debit card, unless I have applied for and received an exemption to receive payment by paper check—if receiving payment by paper check, I acknowledge that the FI will issue a check in my name and send it to my employer (the PCA Consumer).
6. I understand it is my responsibility to immediately notify the FI and my employer (the PCA consumer) if any of my contact information changes, such as my name, address, email, phone number, or other information. I must immediately provide my updated contact information to my employer (the PCA consumer) and the FI any time this information changes.
7. I understand that the MassHealth PCA program pays for personal care services provided by a PCA only when the PCA provider provides physical assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs) to an eligible PCA consumer who has obtained prior authorization from MassHealth for PCA services. PCA services must be provided in accordance with the PCA consumer's Prior Authorization, as well as the authorized PCA evaluation or reevaluation, service agreement, and MassHealth regulations at 130 CMR 422.410.

8. I understand that ADLs include physically assisting the PCA consumer with transferring, walking, using medical equipment, taking medications, bathing and grooming, dressing and undressing, passive range-of-motion exercises, eating, and toileting. I understand that IADLs include household services that are instrumental to the PCA consumer's PCA care needs such as laundry, shopping, housekeeping, meal preparation and cleanup, transportation to medical appointments, activities such as maintenance of wheelchairs or other medical equipment, completing the paperwork required for receiving PCA services, and other activities approved by MassHealth as being instrumental to the health care needs of the PCA consumer.

9. I understand that my employer (the PCA consumer) will tell me which of these tasks they require for me to provide physical assistance.

10. I understand that I must adhere to weekly hour limits when working for one or more consumers. PCA providers are limited to working no more than 50 hours in total per week, unless the PCA Consumer(s) I work for have received an overtime approval, pursuant to 130 CMR 422.418(A).

11. I understand that I may be subject to sanction, such as suspension or termination as a PCA provider, for failure to comply with the MassHealth PCA program regulation at 130 CMR 422.000, including, but not limited to, failure to provide services covered by the MassHealth PCA provider, repeated failure to work within the weekly hour limit or authorized overtime hours, provider eligibility requirements, or other program requirements.

12. I understand that I cannot be paid as a PCA provider if I am a spouse, parent (if the PCA consumer is a minor child), surrogate or administrative proxy, foster parent, or legally responsible relative of the PCA consumer (including a relative who is a legal guardian).

In providing MassHealth covered PCA services to my employer (the PCA Consumer), I agree to the following:

13. 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.

14. I agree to keep any records that are necessary to show the extent of the services I provide to my employer (the PCA Consumer), including Activity Forms (also called "timesheets").

15. I agree to furnish, upon request, copies of records in my possession and any information regarding payments I claimed for furnishing PCA 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 agree to comply with the disclosure requirements contained in 42 CFR Part 455, Subpart B, as follows:

16. Pursuant to 42 CFR 455.104(a)(3), I am identifying below any other MassHealth provider entity in which I have ownership or control. A "MassHealth provider entity could include any provider type enrolled with MassHealth, including a Home Health agency, an Adult Foster Care agency, or any other provider type. Please complete this information on Page 3, below.

17. If requested by MassHealth, I agree to provide information about business transactions in accordance with 42 CFR 455.105.

18. 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.

19. I understand that certain relationships between me and my employer (the PCA consumer) may affect my tax exemption status. I understand that any tax exemption status resulting from my relationship with my employer is mandatory, based on applicable Federal and State tax rules. I understand that the FI is required to follow all Federal and State rules regarding tax withholding, and the FI cannot change such rules.

Provider Information and Attestation

Please check one option:

The following describes my relationship to my employer (the PCA consumer). Please check ONLY one:
◯ I am not related to my consumer-employer
◯ I am my consumer-employer's daughter or son
◯ I am my consumer-employer's daughter-in-law or son-in-law
◯ I am my consumer-employer's parent
◯ I am related to my consumer in a different way (please explain):

Please check one option:

Pursuant to 42 CFR 455.104(a)(3), I am identifying below any other MassHealth provider entity in which I have ownership or control. A "MassHealth provider entity could include any provider type enrolled with MassHealth, including a Home Health agency, an Adult Foster Care agency, or any other provider type. Please check one:

◯ I DO NOT have ownership or control of any other MassHealth provider entity

◯ I DO have ownership or control of any other MassHealth provider entity. The information for such entity/entities is as follows:

_____

Please complete and attest to the following information:

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 PCA and that all the information I have provided to my employer (the PCA consumer), to the fiscal intermediary, to the personal care 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.

I attest to all the above information, and agree to accept the position of personal care attendant (PCA) provider for:

_____

(Print name of PCA consumer)

PCA Provider Signature: _____

PCA Provider Printed Name: _____

Date Signed: _____