Direct Care Worker Provider Agreement for Self-Direction in the Acquired Brain Injury (ABI) / Moving Forward Plan (MFP) Waivers

This agreement is for a direct care worker (DCW) who is hired by a waiver participant. Please read, sign, and return this form to your employer (the waiver participant).

Instructions and Important Information

- Your employer (the waiver participant) must submit this form to the fiscal intermediary (FI), along with other paperwork required by the FI and MassHealth.
- The FI cannot pay you until all required paperwork is received and complete.
- MassHealth and the FI cannot pay you to work when:
  - the waiver participant is in an inpatient facility, such as a hospital or nursing facility; or
  - the amount of time that was authorized per week by the waiver participant's case manager has been exhausted or is insufficient.

You must read, sign, and return this agreement before receiving payment as part of the waiver program.

Provider Agreement

By signing below, I agree to the following:

1. I understand that, as a DCW and provider of MassHealth covered services, I must comply with the provider eligibility requirements at 130 CMR 630.404 and the scope of services at 130 CMR 630.000: *Home- and Community-Based Services Waiver* as applicable to the waiver services I provide.
2. **I understand that my employer is the waiver participant. My employer is NOT MassHealth or the fiscal intermediary (FI).** My employer is responsible for hiring, firing, training, and scheduling me and other DCWs. My employer may choose another person (a surrogate) to help manage their self-directed services. I must notify my employer and the surrogate (if one exists), of any changes in my circumstances that would affect my ability to perform my duties as a DCW.
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 complete and provide accurate Waiver Activity Forms (timesheets) to my employer or the FI as soon as I can, including through the use of Electronic Visit Verification (EVV) system for the delivery of services, as specified by MassHealth.
5. I understand that the FI will process payroll on behalf of my employer (the waiver participant). 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 approval to get payment by paper check. If I get paid by paper check, I acknowledge that the FI will issue a check in my name and send it to my employer (the waiver participant).

6. I understand it is my responsibility to immediately notify the FI and my employer (the waiver participant) 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 waiver participant) and the FI any time this information changes.
7. I understand that the MassHealth Waiver program pays for self-directed services provided by a direct care worker only when the DCW provides services to an eligible waiver participant who has obtained waiver authorization from their 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.
8. I understand that my employer (the waiver participant) will tell me what tasks they need me to provide for them, according to their waiver authorization.
9. I understand that I cannot be paid as a DCW if I am a spouse, surrogate, or legally responsible relative of the waiver participant.
10. I understand that the FI is required to follow all federal and state rules regarding tax withholding, and the FI cannot change such rules. I understand that certain relationships between me and my employer (the waiver participant) 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.
11. I understand that DCWs who provide waiver personal care to waiver participants in the Moving Forward Plan – Community Living (MFP-CL) Waiver are part of the Personal Care Attendant Collective Bargaining Unit, represented by the Personal Care Attendant Union.
12. I understand that if I provide waiver personal care to MFP-CL waiver participants, I must complete the New Hire Orientation if I haven't taken it before as a DCW or PCA and that I will receive payment for attending the New Hire Orientation. I understand that if I do not take the New Hire Orientation, it may affect my rate of pay for providing waiver personal care to MFP-CL waiver participants.

In providing DCW services to my employer (the waiver participant), I agree to the following:

13. If my employer has an advance directive concerning the provision of care in the event they become 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 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 waiver participant), including activity forms (also called "timesheets").
15. I agree to provide, upon request, copies of records in my possession and any information regarding payments I claimed for 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 agree to comply with the disclosure requirements contained in 42 CFR Part 455, Subpart B, as follows:

16. Under 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 following 42 CFR 455.105.
18. Under 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 waiver participant) 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 these rules.

Provider Information and Attestation

Please check one option.

The following describes my relationship to my employer (the waiver participant). Please check ONLY one.

☐ I am not related to my waiver participant-employer.

☐ I am the adult child (18 yrs. or older) of my waiver participant-employer.

☐ I am the daughter-in-law or son-in-law of my waiver participant-employer.

☐ I am the parent of my adult (18 yrs. or older) waiver participant-employer.

☐ I am related to my waiver participant-employer in a different way (please explain):

_____

Please check one option:

Under 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 check the box below to show understanding about the New Hire Orientation requirement:

☐ I understand that if I provide waiver personal care to MFP-CL waiver participants, I must complete a New Hire Orientation if I have not already taken it as a DCW or PCA and that I will receive payment for attending New Hire Orientation. I understand that if I do not take New Hire Orientation, it may affect my rate of pay.

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 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.

I attest to all the above information, and agree to accept the position of direct care worker (DCW) for

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(Print name of waiver participant)

DCW signature _____ DCW printed name _____

DCW email address _____

Date signed _____