EMPLOYMENT TERMS AND CONDITIONS

The Employer/Designated Representative has elected to hire me to perform care services for the Individual Receiving Services (Individual) in accordance with the Missouri Department of Mental Health, Division of Developmental Disabilities (DMH-DD), Self-Directed Supports Program. I understand that PCG Public Partnerships, LLC (PPL) is the Fiscal Employer Agent (F/EA) who assists the employer with employer-related tasks and IS NOT my employer. The Federal Employer Identification Number (FEIN) holder is my employer. The employer may select a Designated Representative (DR) to be responsible for managing employees.

Enrollment - I have received an Employee Enrollment Packet that contains mandatory forms and information on trainings. I am responsible for understanding the information, and completing all documents.

Supervision - The Employer/DR is responsible for training, managing and supervising the Employee and controlling the Employee's workplace activities. The Employer/DR is solely responsible for the decisions to hire and retain or not retain Employee.

Training – Employee acknowledges that they must complete the pre and post-employment training requirements detailed in this application to be eligible for initial and on-going employment. Post-employment training must be completed within 30 days of employment. All training certifications must be remain current. Employees who do not to complete or maintain post-employment trainings and certifications will not be eligible for on-going employment.

- ✓ All employees must be trained annually on the Individuals new Support Plan (ISP).
- ✓ All employees must complete abuse and neglect training every two years.

Effective Date - Employment will be effective upon completion and review of the Employee Enrollment Packet and associated training modules. Your Employer/Designated Representative must receive a "Good to Go" notification before you begin work.

Age and Education Eligibility - Employee acknowledges that they meet the age and education eligibility requirements under the Self-Directed Supports Program:

- ✓ I am more than 18 years old and have a high school diploma or GED.
- ✓ If working as a Community Specialist, I have a bachelor's degree plus one year relevant experience, or I am licensed Registered Nurse, or I have an associate degree plus three years relevant experience.

Family as Caregiver Eligibility - Family is defined as a parent, step-parent, sibling, child by blood, adoption, or marriage, spouse, grandparent or grandchild. In order for a family member to be authorized as a paid caregiver, the following terms and conditions must be adhered to:

- ✓ No self-directed service may be provided by an Individual's spouse, Legal Guardian, Designated Representative or the Individual's parent if the Individual is a minor (under the age of 18).
- ✓ The Individual for whom the services are authorized must not be opposed to the family member providing the services.
- ✓ The Individual for whom the services are authorized has the right to make a change in selecting a paid personal assistant.
- ✓ The services to be provided are solely for the Individual and not household tasks expected to be shared with people living in the family unit.

- ✓ The planning team has determined the family member providing the service will best meet the Individual's needs.
- ✓ Only the hours of service determined necessary through the assessment and person-centered planning process may be authorized.
- ✓ A family member cannot be paid for more than 40 hours per week. Any support provided above this amount would be considered a natural or unpaid support that a family member would typically provide.
- ✓ A family member cannot be hired as a Support Broker or Community Specialist.

Other Conditions - The quality, appropriateness and timeliness of services reimbursed through this Agreement shall be subject to evaluation, thorough inspection or other means by the regional office of DMH-DD. The Support Coordinator shall monitor services on at least a quarterly basis. Other employment conditions include:

- ✓ Employees working more than 40 hours per week cannot be billed to the Medicaid Waiver program. Hours worked over 40 hours per week are the responsibly of the employer/Designated representative and must be paid through the FMS in order to ensure employer related taxes are withheld.
- ✓ Per the Medicaid Waiver program, Personal Assistant, services does not allow for payment of employees for sleep time. If an employer schedules an employee to work 24 hours or more, the employer and employee agree to exclude from hours worked up to 8 hours of sleep time if:
  - The employer furnishes sleep facilities
  - The employee can usually sleep uninterrupted

Acknowledgement - I acknowledge the following:

- ✓ I am an Employee of the Individual or their Guardian, and am not the Employee of PPL or the State of Missouri.
- ✓ I declare that I am an Employee receiving payments under a state Medicaid Home and Community-Based Services program.
- ✓ This Agreement does not guarantee the Employee a specific number of hours of work, nor does it limit the Employer from hiring other Employees under the Self-Directed Supports Program.
- ✓ This Agreement does not prohibit the Employee from working for more than one Individual under the Self- Directed Supports Program.
- ✓ Information shared with the Employee by the Employer/Designated Representative or the DMH-DD Regional Office and affiliated agencies regarding the Individual shall be confidential.
- ✓ I agree to carry out assigned duties and responsibilities explained by the Employer/Designated Representative, as outlined in the Individual Service Plan.
- ✓ I agree to fulfill and maintain all training requirements as outlined in this application.
- ✓ I understand I am expected to be dependable and report to work on time.
- ✓ I agree to call the Employer/Designated Representative with as much advance notice as possible if I am ill or unable to report to work on time.
- ✓ I agree to give the employer two weeks written notice if I decide to terminate this employment.
- ✓ The Employer/Designated Representative shall set the conditions of employment, and termination of employment shall be the prerogative of the Employer/Designated Representative.
- ✓ The Employer/Designated Representative will immediately dismiss the Employee if (1) they have been found to have been placed on an Employee Disqualification Registry or List maintained by either the Missouri Dept. of Health and Senior Services or the Missouri Dept. of Mental Health, (2) have committed abuse, neglect, or misuse of funds or property of an Individual receiving services, (3) have committed fraud or violated the terms of this Agreement, or (4) do not maintain annual training requirements.
- ✓ I understand I will be subject to an employee background screening through the Missouri Department of Health and Senior Services Family Care Safety Registry prior to employment and that that the results of the background screening may be shared with the Missouri Department of Mental Health, Division of

Developmental Disabilities (DMH-DD) and/or the Individual Receiving Services/Designated Representative with whom I work.

- ✓ I understand that I must report possible neglect, abuse or misuse of funds or property of an Individual to Individual's Service Coordinator immediately. Employee may also call the DMH-DD hotline at 1-800-364-9687.
- ✓ I understand that I not authorized to begin employment until the results of the background screening have been received and approved, I have completed all trainings, and my employer has received an "Good to Go" notification from PPL.
- ✓ I understand that I will be covered by workers' compensation insurance and unemployment insurance.
- ✓ I understand that PPL will pay me on behalf of the employer on a biweekly basis, following the submission of accurate and approved timesheets and service documentation.
- ✓ I understand that I must record daily service documentation that describe various covered activities in which the Individual participated and record situations or incidents (good or bad) that arise affecting the Individual.
- ✓ I understand that I may not bill Medicaid if the Individual becomes ineligible for Medicaid Services, (2) the Employee performs unauthorized tasks or works more hours than are approved on the Individual Service Plan, or (3) the Employee begins work prior to receiving notice of "Good-to-Go" from PPL.
- ✓ I understand that payment will be for normal services rendered as assigned by the Employer/DR and as outlined in the Individual Service Plan at the rate(s) described in this document.
- ✓ I understand that must notify PPL if/when my address or personal information changes or if I wish to change my payment and tax withholding preferences.