PALCO
Empowering Independence
PO Box 13260
Maumelle, AR 72113

Program: Michigan

Worker/Applicant Intake

Complete this form entirely to begin the enrollment process. All information on this form is required in order to enroll. Completion of this form does not constitute hiring by the employer. Services should not begin until you receive a notification from Palco that enrollment is approved.

PARTICIPANT/CLIENT INFORMATION	
Full Name	Palco ID

WORKER INFORMATION			
First Name	Middle Name	Last Name	
Social Security Number	Email	Date of Birth (mm/dd/yyyy)	Gender: ☐ Female ☐ Male
Is the worker related to the participant/client by blood or marriage? ☐ No ☐ Yes, I am the participant/client's: _____ (specify relationship)			
Do you share a residence with the participant/client? ☐ No ☐ Yes Is the worker at least 18 years of age? ☐ No ☐ Yes			
Have you lived in any other state other than Michigan within the last 5 years? ☐ Yes ☐ No If yes, which state/s have you lived in: _____			
Will you be providing transportation services to the Participant? ☐ Yes ☐ No			
Will you be administering medication to the Participant? ☐ Yes ☐ No			
The Participant IPOS requires training for Non-Aversive techniques for prevention (MANDT/CPI) and treatment of challenging behavior? ☐ Yes ☐ No			
Mailing Address			
City	State	Zip	County
Physical Address (Street Address, including Apt #, if different from mailing)			
City	State	Zip	County
Phone	Preferred Method of Communication ☐ Email ☐ Mail ☐ Phone/Voicemail		

Palco has a fully online enrollment process that is quick and easy. The worker will receive login instructions from Palco via email within 3-5 business days. Once you receive the email, complete your enrollment right away to avoid any delays.

☐ *Check this box If you are unable to complete Palco's online enrollment process and an enrollment specialist will contact you for further assistance.*

_____ _____

Worker Printed Name **Participant/Employer Printed Name**

_____ _____

Worker Signature **Date** **Participant/Employer Signature** **Date**

Please return this form to Palco via email: enrollment@palcofirst.com or via fax to 1.877.859.8757.

SELF DIRECTED SERVICES EMPLOYMENT AGREEMENT

This agreement is made on _____ (Date) between _____ ("Employer") and _____ ("Employee") to describe the supports that hat employee will provide to the employer and the terms and conditions of employment.

Article I

EMPLOYEE RESPONSIBILITIES

I, _____ (Employee) acknowledge and agree that the employment conditioned on my employer's participation in the Self Directed Services Arrangement /Choice Voucher System administered by the PIHP/CMHSP. If my employer ends participation in the Self Directed Services Arrangement /Choice Voucher System, my employment may end. I agree to the following terms of employment:

1. During the term of this agreement, I shall provide support to my employer by performing the duties outlined in this agreement and any attachments to it.

2. I agree to assist my employer in maintaining the documentation and records required by my employer or the PIHP/CMHSP. I agree to complete all necessary paperwork to secure mandatory payroll deductions from my pay day. All records I may have or assist in maintaining are the property of my employer. I will keep these records confidential, release them only with the consent of my employer, and return them to my employer if my employment ends. In addition, I will complete illness and incident reports, when necessary, as required or requested by the PIHP/CMHSP or my employer.

3. In the event pf a medical emergency I agree to notify my employer's contact person and to provide immediate medical attention. I will also notify my employer's contact person before taking my employer to the physician, except in case of an emergency.

4. I agree to participate in any meetings if requested to do so by my employer.

5. I agree to abide by all my employer's rules and PIHP/CMHSP regulations (described below) regarding my employment duties to the employer through the Self Directed Services Arrangement /Choice Voucher System, and I acknowledge receipt of the following rules and regulations:

    a. Attachment A to this agreement which outlines the supports that I will provide to my employer.

    b. Recipient Rights Booklet, I agree to assist my employer in filing right complaints upon request. I also understand that I have a responsibility to report rights violations of which I am aware or any potential abusive or neglectful situations I

observe, I understand that I may be requested to cooperate with a recipient rights investigation and/or assist my employer with exercising his or her rights.

c. Employer House Rules, any additional rules will be given by employer.

d. Additional information and procedures that the Self-Directed Services Arrangement/Choice Voucher System issues by the PIHP/CMHSP.

e. Reporting and documentation requirements for verifying hours worked.

6. I understand that this is an employment at will relationship, which can be terminated by me or by my employer at any time. However, my employer cannot terminate my employment on the basis of my race, religion, sex, disability or other protected status under federal or Michigan law. In addition, I agree to give _____ days written notice to my employer if I terminate my employment.

7. I understand and acknowledge that my employer is my sole employer and that I am not an employee of the PIHP/CMHSP, which authorizes the supports I provide, or the fiscal intermediary, which is the financial administrator of Self-Directed Services Arrangement/Choice Voucher System funds used to pay me.

8. I agree not to sue the fiscal intermediary for its role as the financial administrator of my employer's Self-Directed Services Arrangement/Choice Voucher System funds and the PIHP/CMHSP for its role in administering the Self-Directed Services Arrangement/Choice Voucher System.

9. I agree to the following compensation for the services I shall perform: $ _____/hour.

Benefits: (If any):_____

10. I agree to execute a Medicaid Provider Agreement with the PIHP/CMHSP and acknowledge that this agreement does not alter the fact that the PIHP/CMHSP is only the project administrator of the Self-Directed Services Arrangement/Choice Voucher System, and that my employer is _____ (employer). I understand that my employment is contingent on completing this agreement.

Article II

EMPLOYER RESPONSIBILITIES

I, _____ (Employer) agree to the following:

1. I will provide my fiscal intermediary with the necessary documentation to assure timely compensation of my employee.

2. I will compensate my employee in the following manner: $ _____/hour.

Benefits will include: _____

Payroll will be handled by my fiscal intermediary _____, which will withhold all necessary tax, unemployment, and other withholdings from the employee's paychecks.

3. I will assure my employee receives appropriate training.

4. I will evaluate the performance of my employees and provide appropriate feedback on an annual basis to assure that I am receiving quality supports.

5. I will assure that my employee executes as Medicaid Provider Agreement with PIHP/CMHSP.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

SDS Staff Job Description

Date	
Employee Name	
Consumer Name	
Position/Title	Community Living Support/Respite Care Provider/Direct Care Support Staff

Position Summary

Provides Medicaid covered Community Living Support and/or Respite Services under the direction of a client and/or authorized guardian or representative (Employer of Record).

Standard Requirements

1. Must be at least 18 years of age at the time of hire

2. Must obtain a criminal records clearance from Community Mental Health Agency

3. Has completed trainings required by Community Mental Health

4. Understand and abide by HIPAA and Recipient Rights

5. Is knowledgeable of the individualized service plan (IPOS) for the customer and ensure supports are provided to the customer according to the service plan

6. Ability to lift 20 pounds

7. Ability and willingness to toilet (including changing undergarment) several times daily without the support of another staff/family member if needed.

9. If required, staff must have the ability to implement the IPOS and Positive Behavioral Support Plan as written and make needed adjustments as changes are made by VBCMH.

Essential Functions

- Implements IPOS (and if needed the PBSP) as written
- Provides skill development related to activities of daily living by assisting, reminding, observing, guiding, or training the customer with:
    - Activities of daily living such as, but not limited to, bathing, eating, dressing, toileting, personal hygiene etc.
    - Routine household care and maintenance including Meal Planning/Preparation, Laundry, Cleaning, Shopping for food and other necessities of daily living
    - Skill developmental to achieve or maintain mobility, sensory-motor, communication, and socialization.
    - Implementation of goals and objectives listed in the most current IPOS and PBSP
- Ensures accurate documentation of skill development or lack thereof following IPOS, Medicaid Standards and SDS Arrangement Criteria
- Always stays alert and attentive knowing customers' whereabouts
- Responds appropriately in and emergency situation to ensure the safety of the customer, community and staff.
- Performs other related duties and responsibilities as deemed necessary/requested by supervisor.

_____

Employee Signature Date

MEDICAID PROVIDER AGREEMENT

This agreement is made on (Date)_____ between Van Buren Community Mental Health PIHP/CMHSP and (Employee Name/Medicaid Provider) _____ Employee/Medicaid Provider.

The purpose of this agreement is to define the roles and responsibilities of the above-named parties. This agreement shall remain in effect until such time it must be terminated or modified. Any party can initiate a termination or modification by providing written notice to the other of the desire to terminate or modify this agreement. This agreement should not be finalized until the provider has met any additional requirements to provide Medicaid Services (i.e. background check, training). Should the provider fail to meet Medicaid requirements, the Host Agency may suspend or terminate this agreement.

Upon receipt of this agreement, the PIHP/CMHSP will certify the Medicaid Provider as available to provide services to individuals who receive services and/or supports in accordance with their individual plans of services and supports developed in a person-centered planning process, authorized by the PIHP/CMHSP or one of its subcontractors, and financed through Michigan's Medicaid Specialty Pre-Paid Mental Health Plan.

The Medicaid Provider stipulates that it agrees to the following:

1. To keep any records required by the participant or the PIHP/CMHSP regarding the services provided to participants and to provide such information and any related invoices or billings, upon request, to the participant, PIHP/CMHSP, the state Medicaid Agency, the Secretary of the Department of Health and Human Services or the state Medicaid fraud control unit.
2. To comply with the ownership disclosure requirements specified in 42 CFR 455, subpart B, as applicable.
3. To comply with intent of the advance directive requirements specified in 42 CFR 489, Subpart I and 42 CFR 417.436 (d), as applicable, by finding out if a participant has an advance directive to refuse life sustaining medical treatment, and informing the participant, before the provider starts work, whether or not the provider will carry out that advance directive so the participant can make an informed choice during the hiring process.

Both parties expressly acknowledge that the sole purpose of this agreement is to assure compliance with 42 USC 1902 (a) 27. Further, both parties recognize and reaffirm that the PIHP/CMHSP is not the employer of the Medicaid Provider, and that the participant is the sole employer of the Medicaid Provider.

This agreement sets forth the entire understanding between the parties with respect to the subject matters, and supersedes any and all other arrangements, either oral or in writing between the parties pertaining to these matters. No change or modification of the terms of this agreement is valid unless it is in writing and signed by the parties.

_____ _____

Executive Director or Self-Determination Coordinator **Date**

_____ _____

Medicaid Provider Agency/Individual (Employee) **Date**