



CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

CONSUMER INFORMATION SHEET

Name: (last) (first) DOB:

Gender: Male Female

Medicaid Number:

Address: Phone:

Emergency Contact / Relationship (Address/ Phone):	Next of Kin/ Relationship (Address/ Phone):
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Designated Representative: Phone:

Relationship:

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DIVISION OF RESPONSABILITIES CONTRACT

This agreement is made and entered into as of _____ (effective date) between _____, (consumer) and SeniorCare HHA, Inc. Both parties agree as follows:

1. Consumer, or if applicable, the Designated Representative Responsibilities:

- a. The Consumer/Designated Representative must manage their plan of care developed post assessment/reassessment by the Managed Long-Term Care Organization.
- b. Plan of care management is to include the recruiting, hiring, and training a sufficient number of individuals who meet the definition of a personal assistant.
- c. The Consumer/Designated Representative, or in the case of a minor the parent or guardian, takes full and complete responsibility for the recruitment, hiring, training and termination of any and all Personal Assistants who provide service.
- d. I understand that it is against the New York State CDPAP regulations to work as a Personal Assistant if I am a spouse, or the consumer or the parent of a consumer 21 years of age or older who is legally responsible for the care and support of the consumer.
- e. The Consumer/Designated Representative will be responsible to arrange and schedule substitute coverage when a Personal Assistant is temporarily unavailable. It is understood that SeniorCare HHA, Inc. does not have a replacement list of Personal Assistants and will not be responsible in the event of an accident or injury incurred by the Consumer when the Consumer does not receive care during the approved scheduled hours.
- f. The Consumer/ Designated Representative will direct the Personal Assistant(s) to provide the services that are authorized on the plan of care.
- g. The Consumer must have Medicaid and prove assurance that it remains current.
- h. If a Consumer becomes ineligible for Medicaid benefits and fails to notify the office of this situation and continues to receive personal assistance services during the period of ineligibility the Consumer/ Consumer Designated Representative will be responsible for repayment to SeniorCare HHA, Inc. for any compensation received by the personal assistant during the said period.
- i. The Consumer/ Designated Representative is responsible for notifying the MLTC within five (5) business days of any change in the Consumer's medical condition or change in social/ environmental circumstances to include hospitalization or demographic changes.
- j. The Consumer/Designated Representative understands that personal assistance services under the Consumer Directed Personal Assistance Program will not be paid for by the program until all paperwork is completed and returned to the office of the Fiscal Intermediary.
- k. Consumer/ Designated Representative must acknowledge and agree that an overpayment, directly or indirectly, from the Medicaid program is to be reported and returned within sixty (60) days of identification of overpayment.

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- i. The Consumer/Consumer Designated Representative must attest to the accuracy of the personal assistant(s) time sheets.
- m. The Consumer/Designated Representative must transmit the time sheet to SeniorCare HHA, Inc. according to SeniorCare HHA, Inc Time and Attendance procedures, which will be communicated and written documentation given to the Consumer/Designated Representative.
- n. The Consumer/Designated Representative agrees to sign the Personal Assistant(s) time sheet on a weekly basis to comply with the timely distribution of each Consumer Directed Personal Assistant's paycheck by SeniorCare HHA, Inc.
- o. The Consumer/Designated Representative is responsible to notify SeniorCare HHA, Inc. of any changes in the employment status of each Personal Assistant employed by the Consumer.
- p. The Consumer/Designated Representative accepts responsibility for any and all items removed from or destroyed within the Consumer's primary residence or vehicle without the Consumer/Designated Representative's consent.
- q. Any arrangements regarding transportation of the Consumer as a duty of the Personal Assistant shall be an agreement made strictly between the Consumer and the Personal Assistant. It is understood that SeniorCare HHA, Inc. neither condones nor discourages this activity and accepts no liability in the event of an accident or injury.
- r. The Consumer/Designated Representative accepts responsibility for any and all items removed or destroyed within the Consumer's primary residence or vehicle without the Consumer's consent.
- s. The Consumer assumes full responsibility for payment to the Personal Assistant(s) of all unauthorized hours of service.
- t. The Consumer/Designated Representative is responsible to promptly notify SeniorCare HHA, Inc. in the event of termination of employment of a Personal Assistant(s).

II. Fiscal Intermediary Responsibilities

- a. SeniorCare HHA, Inc. will ensure the health status of each Personal Assistant is assessed prior to service delivery to the Consumer according to 10 NYCCRR 766.11.
- b. SeniorCare HHA, Inc. will process each Personal Assistant(s)'s wages and benefits according to the Home Care Worker Wage Parity regulation.
- c. SeniorCare HHA, Inc. will process all income tax and other required wage withholdings for each Personal Assistant and comply with worker's compensation, disability and unemployment requirements.
- d. SeniorCare HHA, Inc. will accept time slips and issue paychecks in the name of each Personal Assistant employed by the Consumer for the authorized number of hours per week. Personal Assistants will receive year-end W-2 earning statements.

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- e. SeniorCare HHA, Inc. will issue pay to the Consumer’s Personal Assistant(s) for only the authorized weekly hours worked. The Consumer assumes full responsibility for payment to the Personal Assistant(s) for any and all unauthorized hours of service.
- f. SeniorCare HHA, Inc. will maintain personnel records for each consumer directed personal assistant.
- g. SeniorCare HHA, Inc. will maintain consumer records for a period of six (6) years after the date of service. In the case of a minor the later date of either three years after the age of majority or six (6) years after the date of service, or for such a period as required by law, regulation or the contractual arrangement.
- h. SeniorCare HHA, Inc. will maintain Consumer records for a period of six (6) years after the date of service, and in the case of a minor, for three (3) years after the age of majority or six (6) years after the date of service, whichever is later, or for such longer period as required by law, regulation or the Medicaid Contract.

The signatures below signify understanding and acceptance of this agreement by all parties.

Name of Consumer	Signature of Consumer	Date
Designated Representative (If applicable)	Signature of Designated Representative	Date
SeniorCare HHA, Inc. Rep.	Signature of SeniorCare HHA, Inc. Representative	Date

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ACKNOWLEDGEMENT OF MEDICAID OVERPAYMENT

I, _____ as the **Consumer/Designated Representative** acknowledge and agree to the following conditions in regards to Medicaid payments:

1. Any direct or indirect overpayment from the Medicaid program will be reported and returned within sixty (60) days of the identification of the overpayment. Failure to do so may expose liability under the False Claims Act, including whistleblower actions, treble damage and penalties.
2. The Office of the Medicaid Inspector General or the MCO may suspend payments to the FI and participants in the Consumer Directed Personal Assistance Program, if applicable, pending an investigation of a credible allegation of fraud against the Fiscal Intermediary or Consumer Directed Personal Assistance, as applicable, unless the state determines there is good cause not to suspend such payments.

I have had the opportunity to ask questions about anything that I did not understand.

(Initial)

Name of Consumer	Signature of Consumer	Date
Designated Representative (If applicable)	Signature of Designated Representative	Date
SeniorCare HHA, Inc. Rep.	Signature of SeniorCare HHA, Inc. Representative	Date



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ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION ON FRAUD WASTE AND ABUSE

I _____, consumer of the Consumer Directed Assistance Program acknowledge that I have been provided with a copy of policies related to federal and state laws regarding fraud, waste and abuse and the Consumer Directed Personal Assistance Program. I have had the opportunity to ask questions about anything that I did not understand.

_____ Name of Consumer	_____ Signature of Consumer	_____ Date
_____ Designated Representative (If applicable)	_____ Signature of Designated Representative	_____ Date
_____ SeniorCare HHA, Inc. Rep.	_____ Signature of SeniorCare HHA, Inc. Representative	_____ Date



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, consumer of the Consumer Directed Personal Assistance Program, acknowledge that I have been provided with a copy of Notice of Privacy Practices that provides a description of protected information uses and disclosures. I have had the opportunity to ask questions about anything that I did not understand.

_____ Name of Consumer	_____ Signature of Consumer	_____ Date
_____ Designated Representative (If applicable)	_____ Signature of Designated Representative	_____ Date
_____ SeniorCare HHA, Inc. Rep.	_____ Signature of SeniorCare HHA, Inc. Representative	_____ Date



CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM

DRIVING WAIVER

I have been advised that SeniorCare HHA, Inc. is not liable or responsible for any injury, to person/people and/or property, which might occur as a result of being transported by my Personal Assistant.

I have been further advised that I should verify that my Personal Assistant(s) is a legally licensed and insured driver in New York State and has at least the minimum medical and liability coverage on his/her vehicle and its occupants, as required by the laws of New York State.

_____ Name of Consumer	_____ Signature of Consumer	_____ Date
_____ Designated Representative (If applicable)	_____ Signature of Designated Representative	_____ Date
_____ SeniorCare HHA, Inc. Rep.	_____ Signature of SeniorCare HHA, Inc. Representative	_____ Date



CONSUMER DIRECTED PERSONAL ASSISTANCE PROGRAM PAYROLL PROCESSING AGREEMENT

I, _____, as the Consumer/Designated Representative approve SeniorCare HHA, Inc. to process payroll for my personal assistant and have been informed and understand the time and attendance procedures as indicated by the following:

1. The Fiscal Intermediary follows the Home Care Worker Wage Parity rule, and shall provide the consumer, and if applicable the Designated Representative, with a list of base rate pay rates and benefits available. The Consumer, and if applicable the Designated Representative, shall choose the rate and benefits for his or her personal assistant.
2. For Payroll Processing, time slips/sheets for the Personal Assistant are due no later than end of business day on Tuesday of the following week.
3. Time slips/Sheets must be signed by both the Personal Assistant and the Consumer/Designated Representative.
4. Time slips may be:
 - a. Mailed: **SeniorCare HHA, Inc.
61-61 Woodhaven Blvd., Ste. 1P
Rego Park, NY 11374**
 - b. Faxed: **This Fiscal Intermediary does not accept faxed timesheets.
All originals must be received by end of business day on Tuesday for payroll processing.**
5. This FI payroll week runs from Saturday to Friday.
6. Checks are issued weekly and mailed.
7. Pay checks will be distributed on Friday. Pay checks will either be mailed directly to the consumer for distribution or direct deposit if requested by the consumer.

If you have any questions or concerns, please contact the office 718-285-0705 and speak with the Service Representative.

Name of Consumer	Signature of Consumer	Date
Designated Representative (If applicable)	Signature of Designated Representative	Date
SeniorCare HHA, Inc. Rep.	Signature of SeniorCare HHA, Inc. Representative	Date